The mission of the Journal of Student Social Work at Columbia University 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. Founded by students at 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.
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The views expressed by the authors are solely their own and do not necessarily reflect those held by the Editorial Board or Columbia University School of Social Work.
EDITORIAL INTRODUCTION

Welcome to the fourth volume of the *Journal of Student Social Work* at Columbia University. This year’s *Journal* includes seven articles by authors whose work clearly reflects the evolving social landscape, both abroad and closer to home. As social work students, the *Journal* editors were so moved by the events of Hurricane Katrina that we took the initiative to invite inclusion of a narrative piece written by two CUSSW students, Gabriella Cassandra and Natania Kremer, who participated in a special immersion course designed to explore the mitigating effects of race and class on disaster preparedness and recovery.

Two articles consider the intersection of global events and social work. Scott Miller addresses the clinical implications of treating military veterans with unresolved anger issues, and Sara Van Gunst proposes a refined definition of international social work practice and suggests how national schools of social work might strengthen their curricula.

Closer to home, many of us were struck by the recent high profile child fatality cases in New York City, which drew needed attention to the city’s foster care system. Kate Sheehan’s article specifically looks at sibling placement in foster care. Jane Kogan also argues for the needs of at-risk children and families in her article critiquing the efficacy of the Wellstone-Murray Family Violence Option for survivors of domestic violence applying for public assistance.

Next, Samantha Chipetz discusses the growing interest in the American hospice movement and how social workers can incorporate spirituality into end-of-life care. Finally, we hope that Jenna Benn’s article questioning the growth of private, clinical social work engenders healthy debate among social work students and social work professionals alike. Each of these articles represents a literary bridge from the student perspective to the greater scholarly conversation. We hope you will join in the larger discussion.

2006 Editorial Board

*Journal of Student Social Work*

Columbia University
EDITORIAL BOARD

JESSICA BELMONT AARON is a second year master’s student at CUSSW within the Advanced Generalist Practice and Programming method, in the Family, Youth, and Children’s Services field of practice. She is currently an intern at Court Appointed Special Advocates in Brooklyn, NY.

JENNIFER BELLAMY, LMSW is a doctoral candidate at CUSSW. She earned her master’s from the University of Texas at Austin. Her research interests include mental health services, child welfare, fatherhood, and evidence-based practice.

ELIZABETH S. BROWN is a second year master’s student at CUSSW within the Policy Practice method, in the Family, Youth, and Children’s Services field of practice. She is currently an intern at the Council on Accreditation for Children and Family Services in Manhattan, NY.

DANIELLE JATLOW is a second year master’s student at CUSSW within the Advanced Generalist Practice and Programming method, in the Health, Mental Health, and Disabilities field of practice. She is currently an intern at The Family Center in Manhattan, NY.

JACQUELINE SALVATORE is a first year master’s student at CUSSW within the Advanced Generalist Practice and Programming method, in the World of Work field of practice. She is currently an intern at Bowery Residents’ Committee Project Rescue Drop-In Center in Manhattan, NY.

ANDREA SIFFERMAN is a first year master’s student at CUSSW and is enrolled in the dual-degree program at Mailman School of Public Health to pursue a master’s degree in Public Health. She is currently an intern at Samuels Center for Comprehensive Care at Roosevelt Hospital in Manhattan, NY.

RACHEL WEINBERG is a first year master’s student at CUSSW within the Advanced Clinical Practice method, in the Contemporary Social Issues field of practice. She is currently an intern at Warbasse Cares for Seniors, a retirement community in Brooklyn, NY.
The Editorial Board would like to thank the Columbia University School of Social Work students and faculty, especially our Advisory Board, for supporting the Journal in its fourth year of publication and making it an integral part of the student experience at CUSSW. We are indebted to Karen Sappleton, Editorial Board Member 2004 and 2005, for her continued support and unwavering dedication to our blind review process. We would also like to thank Cat Cheng for her expert layout and design skills as well as Brad Byrum, Professor Sheila B. Kamerman, and Duy Nguyen for their invaluable and insightful contributions to this year’s Journal.
Anger is described as an emotional response to a perceived physical or psychological threat that induces feelings of vulnerability, powerlessness, and anxiety (Hollinworth, Clark, Harland, Johnson, & Partington, 2005). Anger can become a problem in multiple respects if it is experienced or expressed inappropriately. Physically, prolonged feelings of intense anger strain certain areas of the nervous system, increase blood pressure and heart rate, and may contribute to such health problems as hypertension, heart disease, and diminished immune system efficiency (Reilley & Shopshire, 2002). Psychologically, anger problems may inhibit psychosocial functioning and contribute to aggressive, anti-social behaviors, such as physical violence and verbal abuse. These behaviors carry many potentially negative consequences, including incarceration, assault, being viewed as untrustworthy, losing the emotional support of family and friends, expulsion from a substance abuse or other community support program, and feeling remorse, shame, or self-loathing (Reilley & Shopshire).

Due in part to the rise in demand for mental health services placed upon agencies by the current geopolitical climate, the treatment of problematic anger among veterans is an issue of pressing clinical significance (Hoge,
Auchterlonie, & Milliken, 2006). Anger problems among the members of this population (primarily male, although increasingly diverse) are associated with multiple factors related to military service including combat exposure, military culture, and war-induced psychological trauma (Gerlock, 1994). Veterans who were exposed to combat and are diagnosed with Posttraumatic Stress Disorder (PTSD) are most likely to suffer from anger problems, although former soldiers who have neither PTSD nor combat experience are also at risk (Calhoun et al., 2002; Chemtob, Hamada, Roitblat, & Muraoka, 1994; Novaco & Chemtob, 2002). Current treatments used to address this issue follow a group format based upon the principles of cognitive behavioral therapy that is time-limited, goal-oriented, and supported by empirical research attesting to its clinical efficacy (Beck & Fernandez, 1998; Gerlock, 1996; Reilly & Shopshire, 2002; Tang, 2001). The Department of Veterans Affairs uses these interventions because they are congruent with the practical and ethical expectations of evidence-based practice as well as the professional objectives of clinical social work.

The Etiology and Psychosocial Implications of Anger Problems in Military Veterans

Prior to 1920, psychological models focused solely on the sexual drive, or libido, as the primary behavioral and cognitive drive among humans (Horowitz, 1988). According to these early models, aggression is the result of sexual repression and is evident throughout the course of psychosexual development prior to the successful resolution of the Oedipus/Electra Complex. The identification of aggression as a separate drive element in 1920 introduced the notion that anger is instinctual and part of a natural dichotomy between two inherently opposed impulses: Eros, the ego and libidinal instinct for survival, and Thanatos, the death instinct. In this paradigm, negative energy displaced onto others to prevent the self-destruction of the individual is considered to be the basis of aggression and is first apparent in the infantile desire to possess and destroy the maternal breast (Hinshelwood, 1989).

The development of relational models in the 1940s rejected drive theory’s emphasis on aggression as an independent energy source and replaced it with the view that aggression is the behavioral expression of an induced emotional state that occurs due to the inability to achieve primary motivational aims (Greenberg & Mitchell, 1983). This approach provided the groundwork for the idea that feelings of anger and their subsequent behavioral expressions
are ostensibly elicited by anger-provoking events that trigger thoughts of disappointing and unresolved conflicts. According to this latter perspective, trigger events vary from individual to individual and are dependent upon one’s personal experiences and worldview. Similarly, anger cues — or the physical, emotional, behavioral, and cognitive reactions that occur in response to anger-provoking events — vary according to individual, as well as societal and cultural norms.

Among military veterans, anger problems are associated with trigger events and cues related to specific aspects of military experience, namely combat exposure, combat related psychological trauma, and military culture. Anger problems are especially prevalent in those who were exposed to combat and have been diagnosed with PTSD (Calhoun et al., 2002; Chemtob et al., 1994; Novaco & Chemtob, 2002). As noted in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.: DSM-IV-TR; American Psychiatric Association, 2000), problematic expressions of anger are a persistent symptom of PTSD, an Axis I diagnosis that may develop after one experiences, witnesses, or is confronted with a life-threatening event. Combat-exposed military veterans with PTSD are more likely than other veterans to suffer from anger problems that lead to impaired relationships, social isolation, and feelings of helplessness (Novaco & Chemtob). Research conducted by Calhoun et al. indicated that combat-exposed veterans with PTSD report more frequent arousals of unchecked anger accompanied by a hostile attitude towards others in a variety of situations. Similarly, Chemtob et al. reported that combat veterans with PTSD have significantly more incidents of problematic anger towards their partners and are also more likely to experience employment difficulties due to their inability to express anger in socially acceptable ways.

Veterans who were not exposed to combat and do not have PTSD typically exhibit fewer anger symptoms than those who were in combat and do have PTSD (Calhoun et al., 2002; Chemtob et al., 1994; Iversen et al., 2005; Novaco & Chemtob, 2002). Nevertheless, non-combat veterans, too, are at risk of suffering from anger problems and may seek anger treatment for similar or related symptoms. According to Gerlock (1994), this may be due to the role of unchecked anger as an integral part of military culture. Anger is presented in the military environment as a necessary element of the idealized version of masculine identity that defines the psyche of the successful combat soldier. Military training emphasizes the need to repress feelings such as sadness and fear so that soldiers are psychologically equipped for external
expressions of aggression (Gerlock). For the soldier, anger thus becomes a mechanism that enables him or her to ignore and overcome the emotional challenges inherent to the combat experience without succumbing to the deep and complex psychological reactions associated with such traumatic events as witnessing the death of a comrade.

Treating Anger Problems in Military Veterans

Current interventions that address anger problems in military veterans generally utilize a treatment plan based upon the principles of cognitive behavioral therapy (CBT) (Beck & Fernandez, 1998; Gerlock, 1996; Reilly & Shopshire, 2002; Tang, 2001). The group format of the cognitive behavioral model postulates that interventions should include five to ten participants and meet once per week for a period of up to 12 sessions. CBT interventions for anger problems are based upon the Stress Inoculation Training (SIT) model, which consists of three parts: (1) cognitive preparation, (2) skill acquisition, and (3) application training (Beck & Fernandez; Dwivedi & Gupta, 2000). According to Gerlock, a typical CBT anger management intervention follows a curriculum that focuses on identifying situational triggers, learning coping skills, and practicing role rehearsal through exposure to anger-provoking stimuli. Group sessions are typically divided into two parts. A didactic portion examines cues to anger, learned responses to anger, anger triggers, personal vulnerabilities to anger, and short-term payoffs versus long-term consequences of anger. A practice component included in each session offers structured role-plays and break-out periods during which participants may test their newly learned social skills.

Experts believe using CBT in the treatment of anger is justified by its effectiveness in achieving desired treatment goals via a time-limited, goal-oriented intervention format that empirically evaluates clinical change (Beck & Fernandez, 1998). For example, Tang’s (2001) retrospective quasi-experimental study on the effectiveness of a CBT anger management group for patients with mental health problems used the Anger Control Inventory (ACI) and the State-Trait Expression Inventory (STAXI) to measure clinical outcomes. The study revealed that the participants experienced a decrease in overall feelings of anger and an increase in anger coping skills as evidenced by reductions in maladaptive cognitions and behaviors, cognitive deficits, and behavioral deficits (Tang).

Interventions involving client samples consisting of current and former
members of the military suggest clinical outcomes similar to the results presented by Tang (2001) regarding the efficacy of CBT group therapy in the treatment of problematic anger. Conducted at a Veterans Affairs outpatient mental health center, Gerlock’s (1994) retrospective quasi-experimental study revealed that an anger management group using a CBT approach leads to significant improvement in anger coping mechanisms and a significant drop in sensitivity to anger provocation as evidenced by significant decreases in respondents’ self-reported feelings of anger. Similarly, a 4-session CBT anger management group study conducted by Linkh and Sonnek (2003) in a setting frequented by current and former members of the military concluded that a brief cognitive behavioral psychoeducational approach to treat anger problems is empirically justified; participants experienced a marked reduction in their subjective experience of anger and in potentially aggressive expressions of anger.

Strengths and Weaknesses of the Current Approach to Treatment

CBT anger management groups, such as those tested by Gerlock (1994), Linkh and Sonnek (2003), and Tang (2001), are particularly useful in the treatment of the military veteran population because they induce clinical change in clients from all genders, cultures, races, and ethnicities. This is particularly important given the increasingly diverse nature of the military veteran population. According to Reilly and Shopshire (2002), the strategy of identifying trigger events, cues to anger, and developing personalized coping skills effectuates equally positive clinical outcomes among members of both gender groups. Interventions based upon the CBT model can also successfully accommodate the culture-specific needs and situations of individuals from various racial and ethnic groups (Reilly & Shopshire). Finally, CBT anger management groups are valuable because they have been found to be effective in treating clients who have a history of substance abuse or who are diagnosed with co-occurring psychiatric disorders. For such clients, participation in CBT anger management groups leads to clinical improvement so long as participants abstain from drugs and alcohol, adhere to the stipulations of their medication treatment plan, and receive appropriate care for co-occurring disorders (Reilly & Shopshire). This latter point is especially relevant to treating military veterans, who, as was previously mentioned, often trace their anger problems back to combat experiences that precipitated the onset of psychiatric disorders, such as PTSD.
Despite its apparent clinical supremacy, shortcomings exist in the CBT approach that may call into question its position as the intervention of choice for the treatment of problematic anger. These shortcomings relate to CBT’s ability to affect long-term clinical improvement, as well as its capacity to address specific clinical symptoms vis-à-vis other types of interventions. Concerning the former shortcoming, Durham et al. (2005) suggested that improvements immediately following CBT treatments often fail to translate into lasting results and cannot be maintained by simply extending the CBT treatment. On the other hand, psychodynamic interventions have been shown to effectuate lasting clinical improvement. A study conducted by Muratori, Picchi, Bruni, Patarnello, and Romagnoli (2003) revealed that participants who received an intervention consisting of short-term psychodynamic psychotherapy were more likely to experience long-lasting clinical improvements than the members of the control group. Finally, psychodynamic group interventions have proven to be better able to improve clients’ behavioral control and coping despite CBT’s emphasis on these goals (Sandahl, Gerge, & Herlitz, 2004).

These clinical shortcomings call into question the two non-clinical elements that make CBT so appealing, namely its time-limited and cost-saving qualities. Participants in CBT anger management groups may have to participate in the group multiple times or receive another form of follow-up intervention given the increase in the number of veterans seeking treatment for anger management problems and other forms of psychological trauma. This is a critical point, especially in the wake of Operation Iraqi Freedom and Operation Enduring Freedom, as well as the limited amount of resources available to put towards treatment of veterans.

Implications for Clinical Social Work Practice

The need to treat military veterans with anger problems in a way that is clinically effective, ethical, and cost-efficient has never been greater. Military campaigns in Iraq, Afghanistan, and elsewhere mean more troops are being exposed to combat and other stressful situations that put them at risk of returning home with anger problems. A recent study conducted by Hoge et al. (2006) indicated that 19.1% of veterans returning from Iraq and 11.3% of veterans returning from Afghanistan reported a mental health problem. Overall, 35% of all returning Operation Iraqi Freedom veterans requested mental health services. As with previous research, this study indicated that
combat-exposed veterans are more likely to report and request services for mental health problems than other veterans. Given the relationship between combat exposure, psychiatric trauma, and problematic anger, this may mean more veterans will present with significant anger problems that require clinical intervention in the near future.

Institutions that offer services to returning veterans find themselves under increasing demands to treat more clients with fewer resources. These institutions are simultaneously incorporating elements of evidence-based practice into their institutional culture that are congruent with the ethical demands of accrediting organizations, such as the Joint Commission on Accreditation of Healthcare Organizations, and the financial realities of managed care. This is particularly true of the Department of Veterans Affairs (VA). As one of the nation’s primary providers of medical and psychiatric services to military veterans, the VA medical system is the largest integrated health care system in the country; it has a health care budget of approximately $30 billion, employs 196,000 health care professionals, and maintains 1,300 sites of care (Department of Veterans Affairs, 2006). The VA provided health care services to over 5 million veterans via its system of inpatient and outpatient clinics and hospitals in 2004. This represents an increase of 22% in the number of patients treated since the end of fiscal year 2001 (Department of Veterans Affairs, 2005).

The VA is also known for its position as the employer of over 4,000 licensed social workers and for its desire to become the employer of choice for qualified clinical social workers (Department of Veterans Affairs, 2004). Social workers at the VA fill a variety of roles that reflect the diversity of the social work profession. Social work services provided at VA medical centers include psychosocial screening and evaluation, pre-admission planning, discharge planning, psychosocial diagnosis and intervention, patient advocacy, end of life planning, and bereavement services (Department of Veterans Affairs). In the realm of mental health, social workers provide a specific array of services using a psychiatric, DSM IV-TR-based assessment, diagnostic, and treatment model. Services provided include individual psychotherapy, group psychotherapy, and psychosocial assessments. Social workers facilitate their interventions in partnership with other mental health professionals and are considered to be integral members of an interdisciplinary mental health team consisting of psychiatrists and psychologists.
Conclusion

Participation in the military exposes individuals to numerous potentially traumatic situations that can have long-lasting psychological, economic, and social ramifications (Dalenberg, 2000; Friedman, 2005; Iversen et al., 2005; Solomon & Kleinhaus, 1996). As a result, military veterans face multiple psychosocial stressors, one of the most salient of which is problematic anger. Anger problems, which are particularly chronic among combat veterans with PTSD, are believed to be due in part to the socially constructed role of aggression in military identity and culture, as well as combat exposure and war-induced psychological trauma (Calhoun et al., 2002; Chemtob et al., 1994; Gerlock, 1994; Novaco & Chemtob, 2002). Veterans with anger problems are at increased risk of suffering from economic, interpersonal, psychological, and physical problems. Multiple studies have illustrated the efficacy of CBT anger management groups in causing clinical change among military veterans who suffer from anger problems (Gerlock; Linkh & Sonnek, 2003; Tang, 2001).

Clinical social workers play an integral role in clinical work with military veterans who have anger problems at such institutions as the VA. Social workers’ efforts are sorely needed as demands for psychosocial services among military veterans are increasing and more anger-prone veterans are expected to return in dire need of assistance as a result of current military engagements overseas. To improve the odds of effectively helping returning veterans with anger problems, research might be conducted to assess the level of stigma perceived by veterans regarding obtaining mental health services. Though beyond the scope of this paper, additional research could look at how women in the military experience anger. Research might also address the current racial, gender, and other forms of demographical diversity that exist in today’s military. Greater empirical knowledge in each of these areas could be incorporated in culturally competent CBT anger management group interventions that are increasingly cognizant of how veterans with anger problems can be treated in a manner that is ethical, empirically-based, and resource efficient.

References

22(1), 63-74.

Calhoun, P., Beckham, J., Feldman, M., Barefoot, J., Haney, T., & Bosworth,
H. (2002). Partners’ ratings of combat veterans’ anger. *Journal of
Traumatic Stress, 15*(2), 133-136.

impulsivity, and anger control in combat-related Posttraumatic Stress


Department of Veterans Affairs. (2004). Clinical social work Veterans Health
Administration: Twenty-first century employer of choice. Retrieved
March 5, 2006, from http://www1.va.gov/socialwork/docs/SWBrochure
2004.pdf

Department of Veterans Affairs. (2005, June). Facts about the Department
va.gov/opa/fact/vafacts.html

Department of Veterans Affairs. (2006, February). Feeley appointed to
www1.va.gov/opa/pressrel/PressArtInternet.cfm?id=1077

Durham, R., Chambers, J., Power, K., Sharp, D., Macdonald, R., Major,
trials in central Scotland. *Health Technology Assessment, 9*(42), 1-174.

Dwivedi, K., & Gupta, A. (2000). “Keeping cool”: Anger management
through group work. *Support for Learning, 15*(2), 76-81.

England Journal of Medicine, 352*(13), 1287-1290.

*Issues in Mental Health Nursing, 15*(4), 393-408.

with PTSD. *NCP Clinical Quarterly, 6*(3), 61-64.


Free Association Books.

use of mental health services, and attrition from military service after
returning from deployment to Iraq or Afghanistan. *Journal of the


Scott Miller is a second year master’s student at CUSSW specializing in Advanced Clinical Practice in the field of mental health. His current field placement is at the Department of Veterans Affairs/New York Harbour Health Care System, where he provides individual and group psychotherapy to veterans in the outpatient psychiatry unit. He holds a bachelor’s degree in Foreign Service from Georgetown University. His email is swm2106@columbia.edu.
The Sibling Relationship in Foster Care: Policy Implications

Kate Sheehan

The majority of children placed into foster care are separated from their siblings upon entering the child welfare system. Some research suggests that siblings enjoy more stable home environments and fewer behavioral problems when placed together in care. The sibling relationship may provide stability, consistency, and unconditional positive regard to the children most at risk for poor outcomes such as anxiety, depression, low self-esteem, and loss of identity. This paper argues that foster care and child welfare agencies must institute the changes necessary to make sibling relationships a priority. Recommendations for integrating the protection of sibling relationships in the placement process are proposed.

Nearly 17,000 New York City children are in foster care (Administration for Children’s Services, 2005). The majority of children in foster care have siblings (Herrick & Piccus, 2005), yet strong efforts to preserve this critical relationship have yet to be put into practice within most states’ foster care systems. As a result, the majority of children with siblings in foster care are separated from their siblings (Herrick & Piccus). This paper will outline the arguments for the protection of, and support for, sibling placements in foster care, as well as offer practical recommendations for the child welfare and foster care systems.

The Sibling Relationship

A sibling relationship is usually the longest relationship in an individual’s life course (Groza, Maschmeier, Jamison, & Piccola, 2003). Children who are separated from siblings in foster care face potentially traumatic and long-term effects from this loss. Older children are “attachment figures for younger siblings” according to Groza et al. (p. 481). Children in chaotic homes with inconsistent parenting may come to rely more upon one another than on a parental figure (Hegar, 1993) such that the loss of this sibling relationship may, in fact, be more damaging than the loss of the parent.

Through the sibling relationship, children develop relationship skills
including how to successfully negotiate, empathize, and communicate emotions. Siblings who are separated based on a history of disagreements will learn to retreat from conflict rather than resolve it (Groza et al., 2003). Siblings placed separately may show more aggression and be more depressed than children who are placed with siblings (Smith, 1998). These two factors may be related in that children who have fewer interpersonal skills may experience greater conflict while together and then more aggression or depression when separated from their siblings. It is reasonable to believe that children might benefit by learning new communication skills while remaining with their siblings, even in the face of conflict, and could apply such skills across their life course.

The foster care system too frequently acknowledges the importance of sibling relationships for children in care without integrating the necessary supports for the preservation of those relationships into the system’s structure. Out of respect for the primacy of this relationship and its duration, New York State regulations mandate diligent efforts toward placing siblings together whenever it does not jeopardize the safety, health, or well-being of one of the siblings (Smith, 1996). However, in practice siblings may often be separated in foster care for reasons other than those specified by Administration of Children’s Services (ACS) regulations. These issues must be rectified in order to uphold the mandate and best serve children in foster care. Similarly, the importance of sibling placement has been recognized on a federal level. The Administration for Children and Families’ Child and Family Service Reviews (CFSR), a national effort to monitor state agency compliance with child welfare requirements, also considers sibling placement in its examination of child and family outcomes (Administration for Children and Families, 2004).

Risks and Consequences of Separation

Families facing chronic poverty and its potential stresses including high levels of internal chaos, a lack of clearly defined roles, or a want of parenting and disciplining skills, may be more likely to produce highly stressed and maladjusted children. These lower functioning children are in greater danger of being placed in foster care and, at that time, being separated from siblings due to behavioral or safety concerns. Older siblings are particularly at risk since they may have lived in adverse conditions for a longer period of time than their younger siblings and are at increased risk of reactive behavioral
problems (Tarren-Sweeney & Hazell, 2005). These behavioral problems and safety concerns, in turn, are used as arguments for separation of siblings during placement.

In a sample of nearly 12,000 children in care, less than half were placed with all of their siblings, while one third were not placed with any sibling (Shlonsky, Webster, & Needell, 2003). According to Hegar (2005), the greatest risk factors for separate placements are: age, sibling group size, timing of entrance into care, and the presence of special needs within the sibling group. Specifically, Hegar found that older children are kept with siblings less frequently, large sibling groups are harder to place, and children entering care at different times are not tracked as a sibling unit but as individuals. Children deprived of their sibling relationships may react behaviorally and emotionally, showing signs of guilt, a loss of self-esteem, grief, anger and acting out, anxiety, developmental setbacks (especially in identity formation), and depression (Tarren-Sweeney & Hazell, 2005; Herrick & Piccus, 2005).

The emotional and behavioral symptoms of children who have been separated from their siblings in care may resemble the symptoms of children experiencing the death of a parent or sibling. Many children in foster care experience multiple losses, which include the loss of parents, of home, of siblings, of school, of peers, and of their role within the family system. These losses are seldom acknowledged by others, leaving the children with disenfranchised, or, as Boss (1999) terms it, ambiguous grief; this is a grief that has no name, no rituals, and sometimes no end. DeVita-Raeburn (2004) warns that such losses, unacknowledged by others, can create a life of ennui ranging from strained relationships and dissatisfaction to self-destructive or even suicidal behaviors.

Certain demographic characteristics also place children at an increased risk for separation from siblings. For example, because of their developmental needs, younger children are often most attached to their siblings, yet are the least likely to be kept with their older siblings (Shlonsky et al., 2003). Gender, age, and ethnicity regularly limit the placement options for siblings (Smith, 1998). Sisters are more frequently kept together than brothers (Tarren-Sweeney & Hazell, 2005), even though some studies show that boys benefit more from the presence of their siblings (Smith). Mixed gender sibling groups are more frequently often apart than same gender siblings (Shlonsky et al.). Thus, children are often frequently and permanently deprived of an important relationship with someone of the opposite gender and all the
learning and growth that such a relationship offers. They are also deprived of the roles they play for one another: chaperone, confidante, challenger, mentor, caretaker, guardian, and clown. Wendy Piccus (2005), an author who has worked and published literature on sibling foster care, entered foster care and lost her “sole purpose” in life, which was being a big sister; she described her separation from her sibling as “devastating” (p. 848).

Recommendations

Though more research is needed on the best practices for making sibling placement decisions (Chapman, Wall, & Barth, 2004; Shlonsky et al., 2003; Smith, 1996; Smith, 1998), there is evidence that points to some of the potential benefits of keeping siblings together. Such benefits include less time in placement, fewer placements overall, and more stable behavior and emotions in the children who remain with siblings (Groza et al., 2003; Smith, 1998). Children who were placed with a consistent number of siblings, though not necessarily the same siblings, during the length of their out of home care were better adjusted to their foster homes than children separated from siblings or placed inconsistently with siblings (Leathers, 2005). Foster children placed with siblings were also more likely to be adopted (Leathers) and thus more likely to experience a long-term stable home environment. For children from unstable home environments, siblings may provide “a sense of safety and emotional continuity” (Shlonsky et al., p. 29). These children, perhaps more than any others, need stability, which siblings can offer (Herrick & Piccus, 2005).

The following changes would help foster care agencies meet the New York State standard for the best interests of siblings in foster care:

1) Ensure that children entering care are assigned to the same agency and the same worker. As it now stands in practice, children in foster care may be served by different caseworkers, or even different agencies. This is especially likely when children enter care at different times. Children entering care within one month of one another were found to be four times as likely to share a residence than if they entered care at separate times (Shlonsky et al., 2003). The need for consistency in caseworker assignment was furthered by the Adoption and Safe Families Act of 1997, which sped up the process of terminating parental rights in hopes of placing children...
into permanent homes more quickly. As a result, however, siblings separated during removal from their homes have less time to be reunited (Groza et al., 2003). Foster care workers now have less time to find a suitable home for a sibling group, which poses unique challenges to the system. Therefore, it is crucial that sibling relationships be considered from the very beginning of the placement process, otherwise it becomes unlikely that siblings may ever be reunited.

2) Work to recruit foster families and reserve foster homes specifically for sibling placements. At this time, foster care agencies do not specifically recruit foster homes for sibling groups. Often, those foster homes able to care for multiple children have already been filled by individual children and are unavailable when a sibling placement is needed. Homes that could potentially accept sibling groups should be reserved for sibling groups, rather than filled with single children as they enter the system (Leathers, 2005). Also, as Groza et al. (2003) note, the amount of physical space required per child could be reduced from the requirements currently in place for for single children, potentially freeing up more homes to accept sibling groups.

Even though most foster parents and caseworkers report that they want siblings to remain together and believe there is no added burden in keeping them together, caseworkers report that intact placement options are difficult to find (Smith, 1996). In contrast to the caseworkers’ views, foster parents generally felt that sibling groups were no more difficult to care for than non-related children (Smith). The foster mothers also felt that siblings integrated more easily into the foster family (Smith). Caseworkers believed the opposite: caseworkers felt that siblings had more trouble integrating into a new family (Smith). There seems to be a disconnect between the views of the workers and foster parents. Personal biases or preconceptions may be overriding policy and professional education is needed to address these discrepancies.

3) Set up regular case reviews for siblings who are separated after initial placement with the goal of sibling reunification whenever possible and as quickly as possible. Children in placement who have siblings should receive more frequent reviews of their placements (Groza et al., 2003). Whelan (2003) suggests that siblings should not always be kept together, especially if the presence of one endangers another or hinders that child’s development. He argues that older siblings who may have a parent-like
role in the context of an abusive home may be freed from this burden of responsibility, and ultimately benefit from an opportunity to take on a new, more appropriate role, if his siblings are placed elsewhere. Sensitivity to the roles children have played in what was likely an unsupportive home is critical. However, a parentified role may be a healthy coping response to an abusive situation and may change as children are given the opportunity to redefine their roles and relationships with one another in the context of a more supportive environment. Again, professional training would be helpful for caseworkers to be able to support foster parents as they attend to each child’s development. Morton and Browne (1998) and Whelen support the drive to attune workers to these relationships.

Though siblings may not always get along, if they are separated due to normal sibling rivalries and coping responses, they may regret the loss of that relationship as adults. Sibling relationships should be expected to be fluid and evolving. The regard one sibling has for another at any given point in time does not represent the breadth and depth of the relationship and should not determine the future of that relationship. Regular and frequent reviews of placements should be mandatory so that if siblings are placed separately they may be reunited as soon as possible, whenever possible.

4) Educate caseworkers on attachment theory, disenfranchised grief and ambiguous loss (Boss, 1999), and the importance of sibling relationships. The influence of siblings upon development should be mandatory training for all caseworkers so that keeping siblings together becomes an informed priority, rather than an unlikely hope. Caseworkers seem to need more training about attachment relationships (Grigsby, 1994). In a sample of caseworkers and foster mothers, nearly half did not view a sibling relationship as very important in a child’s life (Smith, 1996). Furthermore, caseworkers, legal representatives, and politicians may often overlook the “enormity of the losses” (Leathers, 2005, p. 817) already endured by children removed from their homes. For these children, as with children whose parent or sibling has died, the world loses its predictability (DeVita-Raeburn, 2004). Siblings have the unique ability to offer each other continuity and stability. Siblings, perhaps more than parents or other adults, help us to create and understand ourselves. Without them, that identity may be fractured or even lost (DeVita-Raeburn), which graduates of the foster care system acknowledge as a common feeling among separated siblings (Herrick & Piccus, 2005).
5) Empower the children to name their family members, to emphasize key relationships, and to build on their strengths. Very few studies cite the preferences or experiences of children in foster care, yet children know their family better than any caseworker. Children are best equipped to guide workers towards maintaining close sibling relationships (Leathers, 2005) or supporting existing roles within the family system (Herrick & Piccus, 2005). Sibling relationships may serve as “permanent, unconditional relationships” (Herrick & Piccus, p. 851) that the children can no longer experience with their birth parents nor can they anticipate enjoying from anybody unrelated to them. Siblings represent a lifetime relationship.

6) For those children who are separated from siblings, ensure and enforce their rights to regular visitation. Children in separate placements are supposed to have regular visitation with each other. However, there is no guarantee of any sibling visits in different placements, and indeed very little support of regular visitation is built into the child welfare system. Grigsby (1994) found that siblings placed separately into care lacked documentation of sibling visitations. Researchers have found that less than half of these children see their sibling at least monthly, while nearly 80% expressed the desire for more contact with their absent siblings (Chapman et al., 2004). Only half of children in separate placements believed they would ever live with their siblings again (Chapman et al.). Also, once children are separated, even if visitation plans are made, the foster and adoptive families may relocate to different communities, geographically severing the sibling bond.

7) Sibling supportive placement practices must be integrated into the foster care placement as a framework more than a goal. All forms should include, as a priority, sibling information including ages, educational needs, amount of time spent with the primary sibling, and other factors pointing to shared histories and emotional and practical interdependence. Forms could also include the children’s placement desires. Children in foster care are rarely given a voice, and, accordingly, emphasis should be placed on strengthening efforts to document children’s preferences as related to sibling placement.
Conclusion

New York State’s commitment to sibling relationships has been solidified by the best interests standard to keep siblings together in foster care whenever possible. It is now time to put policy into practice. New systems must be developed to accurately track siblings in placement. Sibling groups, even if placed separately, should all be guarded by the same caseworker who has been educated on sibling issues and supports the policy to reunite siblings as quickly as possible when it does not endanger one of the siblings to do so. Foster families have already indicated their support of sibling relationships and their belief that siblings are no more difficult to care for than unrelated children. Foster families, then, may be more receptive to accepting sibling groups than caseworkers imagine them to be.

More research needs to be conducted on the best practices when making sibling placement decisions. Future research should especially focus on the long-term effects of sibling separation from the point of view of the children themselves, particularly emotional well-being as measured by self-esteem, feelings of worth, and interpersonal skills. This information, along with the appropriate and supportive theoretical and practical frameworks, should be regularly disseminated to caseworkers in order that they may best serve the interests of the children they work to protect.

References


**KATHERINE SHEEHAN** is a second year master’s student at CUSSW. She is currently an intern at St. Vincent’s Services Families in Transition Program in Brooklyn, NY. She holds a master’s degree in Comparative Literature from the University of North Carolina at Chapel Hill, a DCF in French Literature from the University of Paris Sorbonne, and a bachelor’s degree in French and English from Birmingham-Southern College. Her email address is kms2123@columbia.edu.
This paper examines some of the challenges the social work profession faces in expanding the field at the international level. Defining what we mean by international social work is a fundamental issue to provide greater recognition for the field in order to recruit new students and expand the presence of social workers in international organizations. One of the main avenues for pursuing these goals is to strengthen the international social work curricula at universities. The paper looks to social work values in defining the field’s strengths in international work and uses this as a base to provide suggestions for deepening international social work curricula.

In today’s increasingly globalized world the social work profession is looking to expand its role to meet emerging demands at the international level. Such a monumental task poses substantial challenges. Because social work is geared toward working within the context of people and their environment, broadening social work education to the international level requires comprehensively evaluating the transferability of the field’s approaches across cultures. This paper will examine one of the main challenges to this growth, defining what social workers mean by international social work, and will provide suggestions about better structuring international social work programs in the United States (U.S.) to best prepare future practitioners.

Defining International Social Work

As Midgley (2001) points out, two of the greatest challenges in developing strong international social work curricula are both the lack of a common definition of what international social work is and, therefore, coherent professional goals. Definitions of international social work are inordinately broad, ranging from a practice area that affords practitioners skills that can be applied internationally, to a global awareness that...
enables social workers to view their own role and issues within a broader international context (Midgley). Part of the problem is that international social work can involve many different roles, including clinical work, policy, social administration, or generalist practice. In my experience, it is also unclear in talking with professors whether international social work should be a practice method or a field of practice. However, if social work is to move forward in establishing international competence, there must be a more coherent and cogent definition of the domain of international social work and how the goals are advanced by the different methods as a whole.

A sound definition of international social work is critical since social work is competing for students across a variety of other disciplines with strong international identities, such as political science, law, public policy, and area studies. In addition, social work must gain the trust of agencies working in international development. Currently, many international agencies do not recognize social work’s strengths and, as a result, social work does not have a strong presence in the international development field outside of academia (Caragata & Sanchez, 2002). Through an articulation of social work’s relevance to international development, social work can attract both more students interested in international work and also increase the presence of the profession in the field.

Taylor (1999) argues that social work should abandon clinical work to psychologists and psychiatrists and instead focus on community development and advocacy. This argument may be too drastic a move in the domestic arena, but it possesses merit when applied at the international level. For example, many argue that clinical casework is culture specific, both in terms of effective interventions and in its function as a luxury rather than a necessity in well-developed countries. These well-developed countries have the resources to focus on the psychological health of the population instead of on the struggles facing many developing countries, such as the acquisition of the more basic needs like food and shelter (Drucker, 2003; Taylor).

One way of addressing this dilemma is to examine the profession’s value system to determine what is most appropriate for international work. Social work’s values can be divided into two categories: fundamental, or primary, values and secondary, or instrumental, values. Fundamental values represent overarching humanitarian concerns of the profession, while secondary values pertain to the social, cultural, economic, and political conditions that impact how fundamental values are enacted (Mullaly, 1997). Taylor (1999) argues that fundamental values are more applicable to the international arena.
than are secondary or instrumental values. She proposes that social work’s fundamental values of “helping others, preventing harm and social justice” (p. 311) are transferable to other cultures, as well as social work’s dedication to empowerment, “both as a state of mind (feeling worthy or competent or perceiving power and control) and as exercising control over the course of events in the socio-political arena through social and political influence” (p. 311). However, the social, cultural, economic, and political environment of individual countries should determine how these fundamental values can be realized.

Starting with more commonly shared or transferable values, such as social justice, may be an effective way to unite social workers around the globe in common interests and may also be more appropriate in terms of the most pressing international needs. Even more importantly, these values maximize social work’s relative strength in working at the grassroots level as compared to other disciplines. This is not to minimize the importance of sharing successful clinical interventions on the international level, but perhaps practitioners need to tie clinical work more closely to the goals of social justice and carefully examine which interventions are most transferable to the international context.

Based on these arguments, the case can be made for a more narrow and targeted definition of international social work. One of the earliest definitions of international social work emphasized it as a field of practice that hones the skills and knowledge needed to work in international agencies (Midgley, 2001). While this definition can seem a bit confining at first, my personal experience in international development has taught me that most Americans working abroad in the field do so through international non-governmental organizations (NGOs), multi-lateral agencies, or government agencies, and this is, therefore, the most likely arena in which social workers would be employing their skills. This definition can be further refined to clarify the type of skills and knowledge most appropriate to international work. Thus, international social work may be delineated as a field of social work practice that hones the skills and knowledge needed to work in international agencies around issues of social justice and empowerment. Because of the unique set of skills required for work in this field, international social work should continue to be included as a field of practice, but careful consideration should be given to the nuances of working abroad for individual methods, such as clinical, policy, or generalist practice.
Establishing Criteria for Evaluating International Social Work Curriculum

In applying this new definition, which focuses on the skills needed for work in international agencies, it is important to review the role that international social work schools play in fostering relevant skills for international practice through appropriate topics of study. Healy has developed a continuum of internationalization by which to assess how well social work schools have internationalized their programs as outlined below (Johnson, 2004).

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<tr>
<th>Tolerance</th>
<th>Responsiveness</th>
<th>Commitment</th>
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<tr>
<td>Unsolicited presence of foreign students</td>
<td>Offering an occasional elective</td>
<td>Well-articulated program through program of study and independent work</td>
</tr>
<tr>
<td>Individual faculty doing international work</td>
<td>Occasional international field placement for a student who initiates it</td>
<td>International field placement program with adequate preparation</td>
</tr>
<tr>
<td>Doctoral dissertations</td>
<td></td>
<td>School-maintained program with specified purpose and accountability</td>
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<td>Independent study with international focus</td>
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The continuum provides a good starting place, but can be expanded to consider other critical aspects of the social work education process. First, the continuum needs to clarify what “well-articulated curriculum” means and should assess the depth of the curriculum. The following questions may be addressed: How many classes are offered? What do the courses cover and do they sufficiently prepare students for the nuances and unique challenges posed by international social work? What particular skill sets are taught to students through the curriculum and is this appropriate given the field’s definition of what international social work is and how the profession seeks
to assert itself in international development programming?

In order to refine the curriculum, it is important to identify the unique role social workers can bring to the international development arena and form courses around these topics. While there are many options to work towards this goal, based on the more narrow definition of international social work proposed above, a starting point might be the following:

**Bottom-Up Approach**

Social work takes a grassroots approach that focuses on community organizing to foster social change. Many recent program models in the civil society area focus on a community mobilization model rather than funding large, national-level agencies or organizations (USAID, 2005). Social work can help take the lead in developing appropriate approaches in this area.

**Empowerment**

Social work takes an empowerment or strengths-based approach to working with individuals and communities by identifying existing resources to solve problems rather than focusing on weaknesses and deficiencies (Taylor, 1999). The issue of empowerment has become a common theme in the international development field, and social work is well positioned to offer approaches and tools to give the concept real meaning in practice.

**Ecological Perspective**

Because social work focuses on the person and community within its own context, the profession has the skills to go beyond promoting a particular political ideology, such as free-market democracy, as an answer to a country’s development needs. This perspective provides the profession with important tools to avoid cultural imperialism and the creation of solutions that are not appropriate in other countries.

**Social Justice**

Social work values place particular importance on social justice and reducing poverty, arguably two of the most urgent international development needs. While other disciplines address these issues, they are central themes in social work and form the foundation of the profession.

While much work needs to be done to create a comprehensive list of social work’s international strengths, educators need to carefully direct
the type of specialized courses provided to students, rather than rely on a haphazard selection of international courses within other departments. For example, at Columbia University School of Social Work (CUSSW), there is only one required course offered for those choosing the International Social Welfare Immigrant and Refugee Services field of practice. To fulfill the remaining requirements for the field of practice, students take courses at other programs within Columbia University. In order to avoid reliance on other departments, international social work curricula should be a practice method, rather than just a field of practice, which would help to deepen the curricula and provide students with a more in-depth training in the nuances of working in international settings and how to responsibly employ Western or U.S. models of practice in the international context. Establishing international social work as a practice method would require that social work schools recruit and retain a committed group of professors with a strong international background, including experience conducting international research and projects, publishing articles in international social work publications, collaborating with international social work professionals, and maintaining contacts with international development agencies and organizations.

Comprehensive international social work curricula should also consider the diversity of the student body and faculty. A committed international social work program should include an institutionalized international exchange component that actively recruits students and professors from around the world. For example, CUSSW’s partnership with The Open Society Institute brings Central Asian students to CUSSW to receive their master degrees in social work. The U.S. State Department Bureau of Educational and Cultural Affairs (ECA) funds many international exchange programs that could also be tapped for attracting professors and professionals to teach and conduct research at U.S. universities. The Contemporary Issues Fellowship Program, which is currently coming to a close, recruited professionals across a broad array of fields, including social welfare, for four-month research positions at U.S. universities (IREX, 2005). The Fulbright Program’s Hubert H. Humphrey Fellowship Program is another active ECA program that brings talented mid-level professionals to the U.S. for a year of study at selected host universities (U.S. Department of State, 2006). Most costs for the program are covered by the government, making it a viable option for social work programs that may not have sufficient funds available to cover the costs of frequent international exchanges.
It is essential that committed international social work programs institutionalize opportunities for international learning and practice that extend to both research and field placements. While the Healy continuum does include international placements (cited in Johnson, 2004), more emphasis should be placed on the permanence and structure of this component. International field placements should not only be available, they should be an integral part of the degree process (cited in Johnson). Schools must have standards for international experience among students majoring in international social work and require international field placements for those not meeting the set standards.

Sufficient international, experiential learning is critical for students to develop the necessary cultural awareness and sensitivity to apply social work’s models effectively. Boyle, Nackerud, and Kilpartrick (1999) make a valuable point that too little emphasis has been given to the importance of experiential learning in fostering cross-cultural skills in social work students. They explain that experiencing culture shock helps students understand themselves better and develop new sensitivities. This experience is hard to simulate in the classroom, so cultural immersion programs are critical to gaining cultural competence.

Opportunities to participate in international research projects are also invaluable for helping students gain a deeper understanding of international social work and examine the nuances of applying social work interventions and approaches around the world. In order to develop both international placements and research, it seems that social work programs would greatly benefit from institutional agreements and contracts with other schools abroad. Having an established agreement in place, which outlines a formal relationship between universities, could help to break down bureaucratic barriers to collaboration on grant-funded or school-funded programs. Agreements could also contribute to clarifying expectations and setting goals for future collaboration, which can create a more solid, sustainable relationship.

Finally, the Healy continuum (cited in Johnson, 2004) does not address the need for programs to form ties to the professional international development community, including international NGOs, multi-lateral organizations, and government agencies. It is important to make the distinction between ties with agencies in terms of field placement arrangements and active collaboration at the institutional level that includes sharing professional expertise on common projects. Institutional connections with the professional community
have many advantages. They can lead to collaborative partnerships on international grant projects that open doors for more international research and field placement possibilities (USAID, 2005). In addition, links to the international community can raise the profile of the social work field and provide practitioners and academics with a stronger voice in setting priorities for international development programs.

How Well Do U.S. Universities Currently Prepare Students for International Social Work?

Many of the ideas posed above can be considered ideal scenarios and there may be realistic concerns about meeting these goals based on funding constraints. However, research indicates that social work programs have a long way to reach even the responsiveness level in the Healy continuum (cited in Johnson, 2004). Caragata and Sanchez (2002), for example, reviewed international social work curricula at U.S. and Canadian schools and found significant deficiencies. Of the U.S. schools interviewed, only 11% demonstrated linkages with other institutions or agencies in developing countries. Similarly, only 11% of U.S. schools had research projects in developing countries. A slightly higher number, 14%, of schools noted individual faculty members with research projects in developing countries. Twenty-seven percent of schools had international field placements which, in one case, included a summer course in Mexico. On a brighter note, 66% of schools at least had linkages or connections with international projects, although only 39% of the cases included formal relationships. Twenty-three percent of U.S. schools invite international students and teachers to visit or teach within their programs. While more research needs to be done to examine the effectiveness of international social work programs, these statistics point to a serious lack of progress on the part of many schools to internationalize their curricula.

Conclusion

While social work faces many challenges in establishing itself in the international arena, there is great potential for the field to play a key role in shaping international policy and intervention. The field must first establish a clear identity for international work by settling on a focused definition of the subfield and then move to evaluate social work programs to test how
well they prepare students. A superficial international focus combined with the general curricula cannot adequately prepare students for the myriad of challenges they will face in an international setting. Social work programs must establish more rigorous criteria if the field is to develop more capable professionals. The best way to prepare students is to develop a more focused curriculum that focuses in on social work’s strengths for international development, rather than covering a broad spectrum of issues. Social work has much to offer the international development arena and social work schools play an important role in providing that connection.

References


SARA VAN GUNST is a first year student at CUSSW. She holds a bachelor’s degree in International Relations with a focus on countries of the former Soviet Union from the College of William & Mary and a master’s degree in Russian Studies from Indiana University at Bloomington. She has over 5 years of experience developing and implementing civil society programs in the International development division of the International Research & Exchanges Board (IREX) in Washington, DC and Moscow, Russia. After finishing CUSSW, Sara plans to work with immigrant communities in the United States and explore social work opportunities abroad. Her email address is sev2107@columbia.edu.
The Failure of the Wellstone-Murray Family Violence Option to Provide Meaningful Assistance to Survivors of Domestic Violence

Jane Kogan

This paper addresses the failure of the Wellstone-Murray Family Violence Option (FVO), an amendment to the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), to provide meaningful assistance to survivors of domestic violence. The FVO allows states to waive federal public assistance requirements, such as work requirements and child support collection, for applicants who are survivors of domestic violence. The FVO, however, is inadequately implemented in New York City and across the country. Several suggestions are given to make the FVO more effective.

The Wellstone-Murray Family Violence Option (FVO) of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) aims to enable survivors of domestic violence, also called intimate partner violence, to achieve safety and self-sufficiency. The FVO allows states to waive public assistance requirements, such as child support enforcement cooperation and work requirements, in order to allow domestic violence survivors, who are primarily female, to safely escape abusive situations and achieve independence. In order to evaluate the success of the FVO, it is vital to consider both the text of the law itself and its practical implementation. The law’s primary flaws are its underlying assumption that it will be properly implemented and its lack of provisions for its own enforcement. Although some domestic violence survivors, with the help of the FVO, have been able to escape abusive situations, many other survivors are not screened for domestic violence, or are screened but still forced to comply with public assistance requirements even if compliance jeopardizes their safety. Even though the FVO provides states with considerable flexibility in accommodating public assistance applicants who are domestic violence survivors, the FVO is too often ignored or poorly implemented.
The Process

*Screening and Identification*

Every individual who applies for Family Assistance (FA), New York State’s version of Temporary Assistance to Needy Families (TANF), must be screened for domestic violence by a caseworker. Individuals are given a domestic violence handout, as well as a small palm card with the same information. The caseworker is obligated to ask direct questions about the presence of domestic violence. Applicants also have the option of filling out a domestic violence screening form, although the completion of the form is not necessary to receive public assistance. When a woman comes in with her partner, the caseworker is supposed to question the two individuals separately if domestic violence is suspected (New York, 1998).

Once an applicant identifies herself as a domestic violence survivor, she is referred to a domestic violence liaison who is trained to recognize when applicants are experiencing domestic violence and to grant the appropriate waivers to keep the applicant safe while she is receiving FA. When an individual is referred to the domestic violence liaison, all other processes related to the application of FA are postponed until the domestic violence liaison completes the assessment. The domestic violence liaison is responsible for evaluating the credibility of the domestic violence report by using corroborative evidence, such as police, medical, and child protective service records (New York, 1998). When verification documents are not available, the liaison may use collateral contacts, or individuals who are aware of the domestic violence, to establish client credibility. In the absence of other evidence, the domestic violence liaison can accept a sworn statement by the survivor as evidence of abuse. All information collected by caseworkers and domestic violence liaisons is confidential with the exception of information about suspected child abuse and neglect, as domestic violence liaisons are mandated reporters (New York).

The domestic violence liaison is responsible for working with the survivor to create a written service plan with the goal of helping the applicant attain safety and self-sufficiency. This plan should include the liaison’s recommendations and referrals and must also state which waivers the applicant has been granted and the length of time the waivers will remain in effect. The initial waiver must be for at least 4 months, and the domestic violence liaison must meet with the domestic violence survivor to re-evaluate the waivers every 6 months. The domestic violence survivor
must attend these meetings with the domestic violence liaison in order for the waivers to remain in effect (New York, 1998).

In order for a domestic violence survivor to be granted a waiver from a participation requirement based on the FVO, there must be evidence that compliance with requirements would make it more difficult for the survivor and her children to escape domestic violence or that compliance would subject them to further violence. In addition to exemptions from certain FA requirements, such as work and child support cooperation, domestic violence survivors may also be exempt from the 60 month lifetime limit on public assistance if they can show a physical or mental injury caused by domestic violence or if they are taking care of a child who is disabled as a result of domestic violence (New York, 1998). The most common waiver granted in New York City is a partial waiver on child support enforcement, which allows child support enforcement agencies to pursue absentee fathers for child support without the cooperation of the domestic violence survivor (Hearn, 2000). Waivers are optional in the sense that they can be turned down or terminated without penalty.

**Implementation Failures**

*Screening Inadequacies*

In New York State, a large number of domestic violence survivors do not get identified during the process of applying for public assistance. It is impossible to measure the full extent of this problem because individual states often do not track the number of applicants who were identified as domestic violence survivors. According to a report by the Government Accountability Office (U.S. Government Accountability Office, 2005), 15% to 56% of welfare recipients are survivors of domestic violence. In 1999, only 3,023 out of 180,000 (1.7%) public assistance applicants were referred to a domestic violence liaison in New York City (Hearn, 2000). Potsmus (2004) reports an even lower percentage (1.1%) of applicants who were identified as survivors of domestic violence in New York State in 1998.

Although New York has a universal notification system, in which everyone who applies for public assistance receives a handout and a palm card about the FVO, this system is insufficient if applicants are not subsequently questioned about domestic violence. The universal notification handout is just one of many handouts that public assistance applicants are given to fill out and, because its completion is optional, applicants may skip
it altogether. Many public assistance applicants failed to even recognize the domestic violence screening form in research studies (Hearn, 2000; Hagen & Owens-Manley, 2002; Lindhorst & Padgett, 2005; Potsmus, 2004; Tolman & Raphael, 2000), which suggests that they never received it or did not read it and consequently may not be aware of their eligibility for the FVO. Illiteracy also severely limits the effectiveness of a written form in screening for domestic violence without follow-up verbal screening; more than three quarters of TANF recipients have limited reading abilities (Lindhorst & Padgett). Written screening for domestic violence cannot be a substitute for direct questioning of public assistance applicants about their domestic violence history. Although most states do require verbal as well as written screening, the verbal requirement should explicitly be included within the text of the FVO (U.S. Government Accountability Office, 2005).

Even when public assistance applicants are asked directly about abuse, many women still fail to disclose. Eligibility interviews rarely happen in a private area because of space constraints, and this lack of privacy can make women uncomfortable during the interview process. New York does not have a privacy policy for interviewing survivors of domestic violence (U.S. Government Accountability Office, 2005) and many women fear that disclosing domestic violence could jeopardize custody of their children. In New York, the domestic violence screening form includes a warning in bold print that any information that indicates that a child might be in danger will be reported to child protective services (Brandwein & Filiano, 2000). Women may also hesitate to alert public assistance workers that they are in a relationship with a man because this information may affect their public assistance eligibility (Lindhorst & Padgett, 2005). Furthermore, caseworkers often carry caseloads of over 100 clients and, consequently, have limited time to spend with each individual applicant (U.S. Government Accountability Office).

Waiver Inadequacies

Just a fraction of applicants identified as survivors of domestic violence receive waivers from public assistance requirements, and many of these waivers are insufficient to meet their needs. Only 1,088 applicants, or 36% of those referred to a domestic violence liaison in New York City in 1999, were granted a waiver (Hearn, 2000). Of those waivers, 84% were partial waivers from work and child support requirements and only 16% of the small percentage of domestic violence survivors granted waivers actually
received full waivers (Hearn). Hearn’s study indicates that the majority of those referred to domestic violence liaisons do not receive waivers from public assistance requirements. Hearn suggests that domestic violence liaisons may be using a more stringent standard to grant waivers, such as escalation of violence or a history of stalking, than that which is indicated in the New York State’s Administrative Directive (1998).

Hearn (2000) also suggests that partial employment waivers may not be beneficial to domestic violence survivors. The most common partial employment waiver granted in New York City excuses the domestic violence survivor from a work assignment in the borough where the batterer lives. Compelling a domestic violence survivor to travel to another borough for a work assignment does not mean that she will not be followed there by her abuser, but it does guarantee a longer commute time to work, more time spent away from her children, and consequently more obstacles to employment and independence without the assurance of meaningful safety benefits. In addition, partial employment waivers can be confusing for domestic violence survivors, who sometimes mistakenly believe that they do not have to report to work and are subsequently sanctioned. In fact, when Hearn interviewed domestic violence survivors who had met with domestic violence liaisons in New York City, many did not understand what had occurred, or whether or not they had been granted waivers.

The Social Worker Role

Social workers have the ability and resources to serve as advocates for domestic violence survivors navigating the public assistance system in order to receive the services they need. As advocates, social workers can make sure that domestic violence survivors are properly identified and can help survivors seek redress through a fair hearing system. As policy experts, social workers can use their practical knowledge of the system to recommend effective mechanisms for identifying domestic violence survivors and addressing their needs. Social workers are also ideally suited to act as domestic violence liaisons within the public assistance system. A culturally competent social worker would be able to address the needs of domestic violence survivors in an empathetic and competent manner.
Conclusion

The inability of the FVO to address the needs of domestic violence survivors creates a population of individuals who cannot fulfill public assistance requirements because of domestic violence, yet might not consider leaving violent situations because of financial constraints. Thus, many women experiencing domestic violence become trapped in a Catch-22 situation. These women wind up cycling between public assistance and low-wage work, and between public assistance and domestic violence (Bell, 2003; Kimmerling & Baumrind, 2004). Survivors of domestic violence who do not disclose abuse are automatically precluded from the special consideration to which they are entitled. Consequently, they do not receive waivers from public assistance requirements and may be forced to place themselves and their children at risk in order to receive public assistance. Women who fail to comply with public assistance requirements because of domestic violence are often sanctioned. Those who are sanctioned for non-compliance with public assistance requirements are ineligible for rental subsidies (Lindhorst & Padgett, 2005) and therefore may also face eviction.

It is impossible for the FVO to adequately address the needs of domestic violence survivors if the law is improperly implemented and lacks provisions for adequate enforcement. In response to a Government Accountability report (U.S. Government Accountability Office, 2005), the Department of Health and Human Services expressed reservations about setting more stringent standards for screening of domestic violence survivors for fear that additional restrictions may deter individual states from passing the FVO (U.S. Government Accountability Office). Without enforcement or restrictions, however, government workers are not obliged to address the needs of survivors of domestic violence who are applying for public assistance. There should be a provision within the law for proper enforcement of the FVO. One preliminary step could be tracking the number of individuals who identify themselves as domestic violence survivors and compare that to the actual incidence of domestic violence.

The FVO is a part of the PRWORA of 1996, which was intended to prune the welfare rolls and make public assistance temporary and work based. PRWORA created a system of mutual distrust between welfare workers and welfare applicants and does not promote flexibility for applicants in extenuating circumstances. It should come as no surprise then that domestic violence survivors distrust their caseworkers and are unwilling
to disclose abuse, or that caseworkers and domestic violence liaisons do not inform applicants about the FVO and do not accommodate those who self-identify as survivors. More importantly, survivors of domestic violence are far less likely to achieve self-sufficiency because the abuse constitutes an additional barrier to meaningful employment and independence. In the absence of provisions and resources for all public assistance applicants to achieve meaningful financial independence, the FVO needs to provide a short-term safety net for those applicants who are survivors of domestic violence.

As is too often the case, laws are passed but not fully implemented and therefore fail to provide meaningful assistance to the people they are intended to protect. This failure is quite apparent in the implementation of the FVO, which has been adopted by 48 states (U.S. Government Accountability Office, 2005). The FVO, though an important legal step towards protecting survivors of domestic violence from further abuse when they leave their relationships, is in practice severely limited by inadequate implementation measures and enforcement provisions. Consequently, the FVO is presently unsuccessful at assisting domestic violence survivors to achieve independence in New York State.

References


JANE KOGAN is a first year master’s student at CUSSW. She is in the Extended Program and is currently employed as an educational advisor at an organization that provides early childhood education courses and staff development workshops to classroom staff at daycare centers and Head Start programs. She holds a bachelor’s degree in Psychology from New York University. Her email address is jk2580@columbia.edu.
The Hospice Movement: Spirituality Within the United States’ Health Care System

Samantha Chipetz

With the elderly population growing, there is a great need to improve the quality of end-of-life care. Traditionally, the healthcare industry has focused on the pathology-oriented medical model when assisting terminally ill patients. This focus can lead to patients feeling depressed, anxious, and hopeless about the dying process. By incorporating spirituality into the dying process, the hospice movement diverged from this medical model, but the role of social workers is often divided between these two very different paradigms. This paper discusses spiritual practice theories that hospice social workers can use to benefit the well-being of terminally ill patients while working within the current health care system.

The history of the American hospice movement reveals the importance of spirituality in end-of-life care. In the early hospice movement beginning in the fourth century, care for the dying was almost solely driven by religious communities that promoted spiritual well-being during a patient’s last phases of life. What differentiates the hospice movement today from these earlier efforts is the implementation of modern medicine (Garces-Foley, 2003). Within this new medical context, a question arises for social workers: How can we effectively work within the current medical model, which places value on curing, deficits, and pathology, and still attend to the patient’s social, emotional, and spiritual comfort in an increasingly secular society? This paper will seek to answer this question by exploring current theories and practices social workers can employ to promote the well-being of patients with terminal illness by focusing on spirituality in hospice care.

Choosing Hospice Care

Today more than 3,200 hospices have been established in the U.S. (“Brief History of Hospice Movement,” n.d.). Types of hospice care vary from independent, to nonprofit, and for-profit. The National Association for
Home Care and Hospice (NAHC) noted that in 2000, one in four terminally ill individuals in the U.S. received hospice care (NAHC, 2002). The majority of patients receiving hospice care are elderly, with more than 79% age 65 or older and only 3.9% of hospice patients under the age of 45 (NAHC).

Race and social class play a significant role in identifying patients most likely to use hospice services. NAHC (2005) asserted that although utilization of hospice services has increased among all racial and economic groups over the past decade, white, middle-class patients are still more likely to use hospice assistance than other groups. Blacker (2004) suggested that many vulnerable populations, including refugees, immigrants, those with severe physical and mental disabilities, and people of color, continue to be underserved during end-of-life situations. Barriers to hospice care may include a lack of knowledge concerning end-of-life options and the limited number of hospice services available in some local communities. In addition, different views on death and dying shaped by philosophical, spiritual, and social beliefs often lead to lower rates of hospice use by different cultural groups. For example, Sullivan (2001) asserted that many Latinos would not choose to be cared for in nursing homes or hospices due to their strong cultural emphasis on familial responsibility, privacy, and modesty.

With the growth of hospice care since the 1970s, an increasing number of Americans are choosing hospice as an option for themselves and their loved ones. Cicely Saunders, a social worker and founder of the first modern hospice in 1974, and Dr. Elisabeth Kubler-Ross, who wrote the groundbreaking book, *On Death and Dying*, both brought the topic of dying to public attention. They did so during a time when the medical community viewed terminal illness as something to be controlled rather than a condition that required relief. Saunders and Kubler-Ross illustrated how the medical community all too often ignored and abandoned the emotional needs of a dying patient, once it became apparent that the patient could not be cured (Raymer & Reese, 2004).

According to Tyrer and Exley (2005), the most common reasons patients choose hospice care over hospital facilities are the support and care available to families, the patient’s wishes to die at home, and the inability of medical interventions to cure the patient. NAHC (2005) also suggested that hospice policies that allow patients to stay with family in the comfort of their own home and policies that encourage family members to take an active role in the treatment of their loved one lead patients to prefer hospice care over hospital or nursing facilities. In addition, when compared to trained nursing and
hospital services, hospice is a more cost-effective option for eligible patients with a life expectancy of 6 months or less to live (NAHC). Hospice services are covered by both the Medicare Hospice Benefit under Medicare Part A, and the Medicaid Hospice Benefit. In addition, most private insurers will cover portions of hospice services. Since the majority of hospice recipients are 65 years of age or older, they qualify for entitlement services under the Medicare Hospice Benefit, resulting in almost no out-of-pocket costs to the patient (“Caring Connections,” n.d.). Due to its increased accessibility and cost-effectiveness, hospice use rose 20% from 1992 to 2000 (NAHC). Today, as a greater number of elderly patients seem to be choosing hospice as the baby boom generation continues to age, a focus on end-of-life care by the healthcare system is imperative (Nakashima & Canda, 2005).

Social Work Practice in Hospice Care

Social workers involved with hospice are part of a team of physicians, nurses, counselors, home health aides, clergy, therapists, and trained volunteers (NAHC, 2005). Together they offer support and emphasize a holistic framework that places attention on palliative as opposed to curative care. The hospice team relies on the skills and knowledge specific to each discipline in an effort to organize a unique and supportive plan beneficial to each patient and family (NAHC). Blacker (2004) noted that social workers have a unique role on the hospice team, which is to assist patients and families managing complicated psychological, medical, social, legal, and ethical decisions associated with end-of-life issues. Also, social workers serve as patient advocates on the hospice team by assisting the patient in navigating through complex medical and social systems. When developing a model for hospice care, Saunders conceptualized professionals working as a team comprised of many fields of study, since Saunders herself assumed the roles of social worker, physician, and nurse. The current model for hospice care, similar to social work practice, suggests that collaboration is essential for boosting the physical, mental, and social conditions of the patient (Parker-Oliver, Bronstein, & Kurzejeski, 2005).

Although social workers hold a distinct place within the interdisciplinary hospice team, Batten (1997) suggested that the social worker’s role in a hospice setting is often variable and unclear (NAHC, 2005). While providing patients’ psychosocial and spiritual care is an essential and standard aspect of hospice service, social workers do not exclusively
perform these tasks, but share the responsibilities with nurses, clergy, and volunteers. As Reese (2001) explained, “although hospice philosophy holds that all members of the team address spirituality, sometimes spirituality is considered the chaplain’s domain. Social workers may do the initial spiritual assessment, but not intervention with spiritual issues” (p. 149). Therefore competition may arise between social workers and chaplains regarding their core responsibilities. In addition, turf issues may also surface between social workers and nurses concerning the task of completing psychosocial assessments. Often, social workers in hospice settings perceive that nurses are assuming this duty, which is specifically assigned to social workers, creating high levels of frustration and conflict within the interdisciplinary team (Parker-Oliver et al., 2005). Although the role of the social worker is not clearly defined within many hospice settings, social workers’ diverse knowledge of intervention strategies can decrease conflict and motivate change within the hospice team (Parker-Oliver et al.). By working to assess and respond to the needs of the interdisciplinary team, social workers can improve the cooperation, communication, and success of the hospice team and enhance hospice service to patients and their families.

Spirituality in End-of-Life Care

Nakashima and Canda (2005) argued that while the hospice movement has played an important role in improving terminal care by providing a holistic approach, the leading philosophy of patient care is still embedded in a pathology-oriented medical framework. This medical approach can lead patients to feel depressed, anxious, and hopeless about the dying process. The current medical model does not address a patient’s spiritual concerns, such as questions about the origin and purpose of life and the meaning of suffering (Reese, 2001). While the hospice setting incorporates different religious and spiritual elements to address spiritual issues, social work as a profession has historically fought traditional religious paradigms that often blame individuals for their problems. As a result, social workers have successfully shifted the profession’s attention to the person-in-environment context (Bullis, 1996). Therefore, social work in hospice may differ from the current orientation of many in the social work profession. Hospice work requires social workers to attend to the spiritual dimension of a person, which is vital in understanding how patients define their environment during their final days (Garces-Foley, 2003). Nakashima and Canda maintained that
spiritual practices offered by social workers in a hospice setting can provide profound support for patients to heal, grow, and feel more comfortable in the last stages of life.

Transpersonal Social Work

Reese (2001) argued that focusing on spirituality when working with the terminally ill can act as a source of strength for patients. Reese claimed that, when faced with death, all adult patients can achieve a stage of spiritual growth. This stage, called transegoic, occurs when “ordinary life is infused with a sense of the sacred. Heightened empathy, compassion, and moral standards naturally arise as the individual experiences a profound connection with others” (p. 137). Although the transegoic level of consciousness is not an automatic development during the last stage of life, Reese contended that a smooth shift into the transegoic stage can support a comfortable death by reducing death anxiety and increasing social support. She pointed to the need for hospice social workers to incorporate transpersonal theory as a foundation for practice technique to assist dying patients and their relatives make the transition to the transegoic stage (Reese).

Application of these transpersonal techniques may help patients take full advantage of the time that remains and to live in as much peace as possible during their last phase of life. An example of one transpersonal technique is teaching meditation practice as a way to support spiritual growth and relieve stress. Specific meditation techniques include “paying attention” and “intentional breathing” (Reese, 2001, p. 152). Paying attention supports awareness by encouraging patients to take pleasure in a shower or appreciate each moment with a loved one. Intentional breathing is a technique that helps patients to diminish stress by repeating a mantra while concentrating on their breathing. Other transpersonal techniques used to help transegoic stage development are movement mediation, group chanting, dream interpretation, music and art therapy, acupuncture, and keeping a journal (Reese).

Focusing on a Patient’s Resiliency

Nakashima and Canda (2005) conducted a qualitative study that examined the opinions of older adults who had positive experiences during their last stages of life. From their findings, the researchers concluded that in order to promote the psychosocial and spiritual well-being of terminally ill patients, social workers need to create intervention plans to help patients identify their internal and external resources that have helped them cope
with adversity in the past. Through this process, patients will re-live past experiences of resiliency, which can lead to a more positive and peaceful death.

Examples of a patient’s internal and external resources might include spiritual attitudes, unique skills, talents, and relationships with others that can be shared with the social worker through narrating events of past resiliency. By storytelling past positive experiences, patients can create meaningful narratives of living and dying. Findings from Nakashima and Canda’s (2005) study also indicated that strong spiritual or religious relationships in the community strengthen the ability for individuals to cope during stressful situations. A strong connection to the church, involvement in prayer, or attending spiritual rituals all promote spiritual practices and beliefs and strengthen the ability of individuals to thrive and benefit in adverse circumstances (Nakashima & Canda).

**Buddhist Approach to End-of-Life Care**

While social workers need to focus on a patient’s resiliency and spiritual strengths to promote the well-being of terminally ill patients, Garces-Foley (2003) argued that it is also important to create a nonsectarian spiritual language, along with nonsectarian social work practices, to aid in a patient’s positive end-of-life experiences. Garces-Foley pointed out that over the past 20 years, Buddhism and hospice have created a mutually valuable relationship based on the attraction to nonsectarian language of spirituality, the craving for realistic techniques of coping with death, and the potential capacity of Buddhism to meet this need.

During the 1980s, the American hospice movement was searching for a spiritual language that was not associated with a particular religious denomination and that would be appropriate for clients of different ethnic, religious, or cultural backgrounds (Garces-Foley, 2003). In addition, hospice was becoming a mainstream option for terminally ill patients. Around this same time, Buddhism was expanding in popular culture through advocates of Buddhist practice who used books, Buddhist centers, conferences, and trainings to raise public awareness of Buddhist philosophies. Through this increased social consciousness, leaders of the hospice movement became aware of Buddhist wisdom towards death and dying and discovered that Buddhism offered an appropriate nonreligious language to use within hospice practice (Garces-Foley).

Within Buddhist philosophy, there are many teachings and applicable
practices that speak specifically to end-of-life issues. As a result, many religious and non-religious people who are searching for supportive practices during the dying process turn to Buddhism as a guide to dying and post-death rituals. Buddhist teachings present meditation practices for both the patient, whose objective is to begin to let go of life, and the caregiver, whose objective is to develop compassion. For either patient or caregiver, these practices permit the increase of a sense of power in times when people often feel powerless. In contrast to the view of medical institutions, which view death as a failure, Buddhist practices present a means to a successful and positive death, which can be accomplished through discipline during meditation practices (Garces-Foley, 2003).

Patients who are receiving hospice services may be attracted to Buddhist teachings on death and dying, but are not necessarily converting to Buddhism. Instead, religious and nonreligious hospice providers and patients are borrowing Buddhist practices to enhance their own religious ideals and practices. Garces-Foley (2003) called this type of melding of religious practices “religious mixing or combination” (p. 342). Through this process of religious selection, people can maintain their personal religious backgrounds while selecting aspects of Buddhism that seem appealing and applicable in their daily spiritual practices. With the establishment of Buddhism within the modern hospice movement, social workers have access to a unique spiritual language and applicable meditation practices that support positive spiritual end-of-life experiences for patients of diverse religious backgrounds.

The Future of Spirituality in Hospice Care

In addition to learning spiritual techniques and approaches, there is also a need for hospice social workers to be trained in spiritual assessment and intervention. Wesley, Tunney, and Duncan (2004) suggested that even though the Joint Commission on Accreditation of Healthcare Organizations includes spiritual assessment in its principles, it does not offer precise guidelines for social workers. Furthermore, the social work profession needs to define what constitutes standards of spiritual care, as little social work research exists concerning spirituality and terminal illness (Wesley et al.).

In addition, Reese (2001) suggested that there are inconsistencies among social workers to define, identify, and address spiritual issues. She proposed that social work education needs to focus attention on the various spiritual
beliefs about dying that exist within our society. Social workers also need to come to a consensus and create suitable documentation of spiritual interventions that can effectively monitor and evaluate the effectiveness of various approaches. Lastly, Reese noted that it is important for social work education to address the social worker’s personal beliefs about death and spirituality, which may influence their willingness to address spiritual matters with clients.

Conclusion

Social workers’ use of spirituality in a hospice setting can greatly enhance and promote a patient’s well-being during their last stages of life. As a result of the work of Saunders and Kubler-Ross, the topic of dying has been brought to public attention (“Brief History of Hospice Movement,” n.d.). There is now a critical need for social workers to move away from the current pathology-oriented medical model (Nakashima & Canda, 2005). Hospice social workers need to incorporate spirituality to support patients’ ability to emotionally heal, grow, and feel more comfortable in their last stages of life. Transpersonal social work, focusing on the resiliency of terminally ill patients, and incorporating a Buddhist approach to death practices are all types of spiritual practice theories that social workers can use to benefit the well-being of people with terminal illness. Spirituality training for social workers employed at hospice settings, as well as addressing spirituality and hospice in graduate social work programs, are also necessary to support the hospice movement’s use of spirituality in end-of-life care. Even with all of the existing theories and lessons for social workers to understand and apply when working with dying patients, Reese (2001) put it simply when she said, “in the end, the people who are dying will teach us these lessons more often than we will teach them” (p. 158).

References

University Press.


**Samantha Chipetz is a first year master’s student at CUSSW. She is currently an intern at a public elementary school in Bronx, NY. She is a graduate of the University of Vermont with a bachelor’s degree in Sociology and a double minor in Religion and Environmental Studies. Her email address is sc2517@columbia.edu.**
THE PRIVATIZATION OF SOCIAL WORK: A DEVIAION OR A LOGICAL PROGRESSION?

Jenna Benn

Since the 1980s, social workers have increasingly left the service of the public sector and entered into private practice. A substantial number of today’s social workers practice for-profit client-based therapy rather than agency-based public service. These recent changes are causing critics to question whether social work’s new focus on for-profit services has deviated from social work’s original purpose to forge allegiances with the poor, the disadvantaged, and the oppressed. Is this change in focus an abandonment of social work’s historical principles? Or is it simply a modern and logical evolution? This paper examines the debate between private and public social work practice. It describes how social work historically emerged and evolved on two interconnected fronts, one with a focus on change at the community level, and one with a focus on change at the individual level. This paper posits that the two approaches are not irreconcilable and that healthy debate has led, and continues to lead, the profession forward.

Private practice social work might be argued to be a cure for a wealthy man’s worries, or more simply, a cure for the worried well. This type of social work can have a higher earning potential and is generally available to those who have insurance or can afford to pay for the services. Social workers’ participation in private practice has the potential to draw criticism and debate regarding social work’s mission and ethics. Has social work in fact deviated from its historical definition and abandoned its mission to serve the underprivileged, or does private practice represent a logical and worthwhile modern progression, one reflecting the current social and political climate? This paper will examine some of the stereotypes and perceptions about public and private social work practice. It will explore how this dichotomy may be the newest incarnation of an old social work schism between whether the profession should focus on change at the community level or focus on change at the individual level. In addition, this paper will highlight how the two approaches to social work, historically and today, are not irreconcilable. On the contrary, healthy debate is critical to the ongoing development of the profession.
Social Work’s Professional Development and Debates

In the 19th century, social work emerged and evolved with two purposes in mind — to combat and change societal injustices, and to help individuals who directly suffer from the oppression of these systems. Jane Addams, founder of the settlement house movement, approached social work from a paradigm that emphasized grassroots social change within the community and larger society. She primarily focused on societal injustice rather than on individual maladjustment (McLaughlin, 2002). Her contemporary, Mary Richmond, founder of the Charity Organizational Society, used a social work case model that focused on the improvement of the family and the individual. Richmond primarily focused on the study, diagnosis, and treatment of casework on an individual and familial level, as distinguished from the betterment of the masses (McLaughlin). Together, these different schools of thought created the foundation for today’s practice of social work. It is important to note that although Jane Addams shaped early social work efforts and inspired some of the modern social work methods, such as groupwork (Goldstein, 1973), the settlement house movement for which she is most famous ultimately dissolved. In contrast, Mary Richmond’s model of casework continued to largely set the stage for modern social work practice. The tradition of community work and social justice seems to have often taken a secondary role in social work, perhaps in part because of social work’s strivings to be recognized as a full profession and compete with related disciplines for resources and clients.

Since the profession’s emergence, heated debates have ensued regarding social work’s definition and purpose. In 1915, Abraham Flexner, assistant secretary of the General Education Board, pronounced that social work was not a full and legitimate profession (Austin, 1983). He asserted that although social work was a useful social activity, particularly as it helped link individuals with problems to resources, it did not fulfill the criteria to be a formally recognized profession (Austin). Flexner’s argument came at a critical point in the early development of social work and social work education. His earlier criticism of medical education triggered important changes in that field. However, Flexner’s criticism of social work as a full profession ultimately seemed to, in response, cause social workers to question their own legitimacy and rethink the purpose and mission of social work. His standards for becoming a full profession included becoming more specific in purpose and developing a distinct body of presumably scientific
knowledge; Mary Richmond’s more individual-centered and medical-oriented model seems to have been more likely to forward this cause, and the reverberations can still be felt today. Schools, such as Columbia University’s School of Social Work, seem to be largely dominated by students who focus on clinical, rather than community or policy practice.

The latest incarnation of this division between individual focused versus society or community focused social work methods may be private versus public social work practice. Today 60% of social workers practice private clinical social work (Kassan, 1996). With this high level of participation in privatized social work, critics might argue that social work has abandoned its mission to serve the poor and oppressed, and failed to focus on broader contemporary social problems. Therapists in private practice primarily work with the individuals and families who are able to afford their services or have insurance. Medicaid and Medicare recipients, as well as individuals and families with restrictive insurance plans, are only eligible for a limited amount of treatment coverage, requiring in some cases that therapists restrict therapy when patients cannot pay out of pocket. The goal of treatment may only be to stabilize the problem, which may not be therapeutically adequate or beneficial for the patient over the long run. In contrast, the affluent are better able to pay for more comprehensive treatment. Today’s restrictive insurance plans may ultimately stunt the opportunity for successful private therapy for a large segment of the population.

Critics may also take issue with the average earnings of private practice therapists. On average, clinical social workers at public agencies earn between $42-45,000 a year (Linsley, 2003). In 2000, private practice social workers earned a median annual income of $55,512 (Linsley). Therapists in private practice can make a significantly higher income that can increase with years of experience. Private practice social workers who have more than 25 years of experience earn an average income of $79,600, nearly 1/3 more than social workers in the public sector (NASW, 2001). There is a perception among some that social workers who engage in private practice reflect a new wave of self-indulgence and radical individualism that has shifted social work’s mission to the treatment of the individual at the expense of the collective (Herron & Welt, 1992).

Some social workers may hold up icons like Jane Addams, who believed in living with the poor as neighbors, as a means to further our understanding of the implication of societal problems and may assert that private practice social work departs from these romantic ideals in two significant ways.
First, the therapist who commands high prices serves a less impoverished population. Second, private practice workers’ pursuit of higher salaries greatly reduces the possibility that they will live among, and ultimately serve, such a population. There seems to be a perception among some social workers that living among clients, and even struggling to survive on meager pay, is the best way to experience empathy for the populations they serve.

However, in private practice, just as in any method of social work, the focus is on the worth and dignity of the person. Private clinical social workers are strongly committed to helping the individual negotiate environmental stress, regardless of economic background (Herron & Welt, 1992). Moreover, these private practitioners may also serve clients who are stuck in the middle: those who do not have enough money or lack the insurance to afford the services of more expensive professionals, such as psychiatrists or psychologists, yet do not qualify for government benefits, such as Medicaid or Medicare. Clinical social workers argue that it is idealistic to try to change the world and more realistic to change one person at a time (Van Heugten & Daniels, 2001), and social work has a long tradition of individual-oriented practice.

Studies indicate that 15% of the population needs mental health services, and only 2% of the population receives them (Herron & Welt, 1992). There is a significant gap between those needing services and those receiving them. This reinforces the need for more social workers to treat mental health. Private practice, while often serving those who may have access to relatively more services, plays an important part in meeting this need. People of all economic backgrounds have legitimate issues that deserve attention. Critics may scoff at serving people with economic means, however they are not immune to pressures and hardships. People who are relatively well-off can and do suffer from mental health issues that can be just as serious and, at times, be associated with worse outcomes (Luthar, 2003). Dismissing or marginalizing this population in favor of serving people who have what may have judged to be “real” problems, seems to run counter to social works’ mandate to serve suffering community members regardless of economic status.

In addition, not all private practitioners exclusively serve the upper classes. Often therapists are willing to accept no fee or a low fee so the poor may access services (Herron & Welt, 1992). Social workers, more so than private psychologists, may be more likely to offer their clients options like sliding scale fees exactly because of their commitment to social justice, and thus open the door for clients to receive the benefit of a service that might
otherwise be unreachable. Proponents of private practice do not feel that therapists are selling out to the bourgeoisie or dominant class in society, but rather look at private practice as a career phase. More often than not, private clinical social workers return to the public sector at a senior or managerial level with skills gained through private clinical experience as a means to exert influence on the workplace and professional direction (Van Heugten & Daniels, 2001). In addition, social workers in clinical private practice may supplement their income by working concurrently at a public agency. Social workers returning to the public sector after private practice, or simultaneously working in both, are not necessarily neglecting a specific population but rather providing services to many varied populations.

In addition to serving wealthy and non-wealthy clients at some point in their career, social workers might question whether or not the trend toward privatization is a reflection of society’s capitalistic system co-opting the field. Some argue that criticism should be levied at the monetarily driven culture of the United States rather than pointing fingers at private practice (Van Heugten & Daniels, 2001). It is possible that the desire for a higher salary in private practice is a reflection of the highly individualized, money-oriented nature of a capitalistic society like the United States. Social workers, just like other human beings who must operate within the existing social structure, are arguably just as likely to be affected by socialization. Privatization of life is a product of a society highly focused on, and dominated by, private individuals, private spaces, and private institutions. This privatization has reshaped the context in which social workers live and practice (Fisher & Karger, 1997).

Reconcilable Differences

Perceptions, warranted or not, can spur debates that assume strong points of contention and criticism. In reality, it is not important to choose a side, but rather to create a common ground that includes and unites both schools of thought. Instead of seeing social work as a dichotomy between clinical social work and social action, or framing it as a choice between serving the wealthy versus the poor, it is more productive to recognize how both practices have a place under the social work umbrella. Jane Addams and Mary Richmond, though differing in philosophy and practice, both practiced social work. Their foundations of social work established two approaches, but one common goal remains that still resonates today, “...to enhance human well-being and
help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. And in addition to... pay attention to the environmental forces that create, contribute to, and address problems in living” (National Association of Social Workers, 1999). Social work problems occur on the individual and societal level (McLaughlin, 2002) and among all economic classes. Although dichotomous thinking, pitting one extreme side against the other, may be a useful tool for highlighting the core issues, it also oversimplifies the debate. Instead, there should be recognition of the critical interplay between society and individual functioning, and vulnerability and suffering among all communities. Private troubles are public issues and vice versa. Social workers, no matter where they practice and with whom, should not look at social problems and ignore the individual, and cannot examine the individual without looking at the lasting effects of social issues (McLaughlin).

Leading the Profession Forward

The conflict between the differing philosophies and approaches of social work’s public and private sector has the potential to encourage the growth and evolution of the profession. Today we may continue to be haunted by Abraham Flexner’s ghost. His belief that social work was not a profession continues to challenge the purpose and legitimacy of the field (Austin, 1983). Similar to the controversy and eventual professional growth that ensued after Flexner’s statement, the field’s current reevaluation of purpose and practice propels the profession forward. Professional insecurity, stemming from historical and current debates, is forcing the field to critically reexamine its ethics and mission, and inevitably make change (McLaughlin, 2002). The changing face of social work is not a deviation from its historical mission, but rather a modern logical progression that will continue to evolve and change on interconnected fronts in years to come. What is needed is a blending of social work’s versatile objectives toward an improved quality of life for all (McLaughlin). Social work’s greatest challenge, its diversity of method and focus, has arguably been its greatest strength. It is important to focus on the mission of the profession and ethical commonalities that unify us all, both in the public and private sectors, under a common professional identity.
References


**JENNA BENN** is a first year master’s student at CUSSW within the Social Enterprise and Administration Practice Method, in the World of Work field of practice. She is currently placed at Weston United Supported Housing in Harlem, New York. She holds a bachelor’s degree in History and a double minor in Psychology and Jewish studies from McGill University in Montreal, Quebec. Her email address is jeb2127@columbia.edu.
In January 2006, students from CUSSW and Union Theological Seminary participated in an immersion course entitled, Katrina: Poverty, Race, and Social Work Practice. The aim of the course was to explore experientially the inequality exposed by Hurricane Katrina and its effect on some of the poorest communities and individuals in the United States. This paper presents an overview of the course development. In addition, the authors describe some of their experiences and observations before, during, and after their travels to the Gulf Coast and other communities affected by Hurricane Katrina. The specific focus of the article is on the themes of poverty, racism, violence, governmental irresponsibility and disregard in the wake of this tragedy, and describes some of the efforts made towards supporting social justice in the Gulf Coast as it rebuilds.

In January 2006, 45 graduate students, faculty, and staff members from Union Theological Seminary (UTS) and the Columbia University School of Social Work (CUSSW) embarked together on an immersion course to the Gulf Coast titled Katrina: Poverty, Race, and Social Work Practice. The course was designed to give students the opportunity to witness and reflect on the systemic inequalities exposed by Hurricane Katrina and its effect on some of the poorest communities and individuals in the United States. As participants in the course, we explored poverty and race relations along the Gulf Coast in towns and cities with displaced Hurricane Katrina evacuees. Throughout the experience, we were struck by the similarity between the systemic issues highlighted by Hurricane Katrina and the social justice issues with which we struggle as social workers in New York City and across the nation. There is a vividly clear need for an integrated, race-conscious, and class-conscious approach to recovery and change, and this approach must reach beyond the immediate horror of the disaster. The aftermath of Hurricane Katrina brought poverty, racism, violence, and governmental irresponsibility and disregard into the general
consciousness of the American public. These realities, however, were too quickly forgotten by the media and, as a result, have largely disappeared from public discourse. Race and class injustices were ignored throughout the processes of evacuation, planning, and rebuilding.

Our goal in writing this paper is twofold. First, we want to share our experience in this uniquely hands-on and codisciplinary immersion course with other social work students. We feel the immersive learning opportunity provided through this course was invaluable, particularly in light of the uniquely raw and overwhelming subject matter, which we feel is difficult to grasp through any medium but experience. Second, we have a strong desire, as well as a responsibility, to raise awareness about the ongoing struggles that face many people and communities hit by this disaster and how race and class are inherently embedded within these struggles. We will first present an overview of the course and its development. Next, we will describe some of our travel experiences and highlight some of the inequality, trauma, and macro level issues that we witnessed. Finally, we will briefly address efforts being made to continue working toward social justice in the Gulf Coast and nationwide. In writing this paper, we are mindful that the story we tell represents our personal experiences and not the multiplicity of experiences and stories that emerged for other participants in this course.

Katrina: Race, Poverty, and Social Work Practice

The idea for this course started with students at UTS who were angered by the situation in the Gulf Coast following Hurricane Katrina. These students approached the Poverty Initiative\(^i\) and asked for help leading a community response. UTS students then worked in collaboration with the Poverty Initiative to prepare, plan for, and develop the framework for an immersion course. Soon after, social work students from CUSSW were invited to share in the learning and advocacy experience. As a codisciplinary effort, the course offered a unique perspective on healing, recovery, treatment, and community in the wake of devastation, both natural and human-made, by utilizing both a social work and theological framework.

The central questions of the course, which developed out of student

\(^i\) “The Poverty Initiative at Union Theological Seminary is a student-initiated program that brings poor people into all facets of Union’s life – classes, worship, workshops and informal discussions, where they are no longer regarded as objects of charity, but are appreciated as change agents, working for a more just society.” (www.povertyinitiative.org)
discourse, were: What are social workers, religious leaders, and other people of conscience to do in the face of growing poverty, homelessness, and misery? How are we, as a country, responding to the aftermath of natural disasters like Hurricane Katrina? To explore responses to these questions, we embarked on this immersion experience to fuel ourselves with facts and stories to share with others, so that we would be equipped to publicize and expose the continuing injustices devastating the Gulf Coast. We documented much of what we observed through writing, audiotaping, videotaping, and photography.

This course gave us an opportunity to meet, engage with, offer assistance to, listen to, and learn from many different families, community organizers, and professionals of varied ethnic, racial, and socioeconomic backgrounds. We explored the short and long-term impact of disaster and the ways in which trauma relief was and is delivered. UTS students and faculty contacted members of local congregations, community organizations, and other agencies involved in relief efforts to host our group during the week along the Gulf Coast. Specifically, the Christian Church (Disciples of Christ), the Presbyterian Church (USA), the Baptist Church, the Episcopalian Church, Common Ground Relief, Pastors for Peace, and member organizations of the Poor People’s Economic Human Rights Campaign organized forums for dialogue with community leaders who educated us about their own struggles when providing disaster relief. These groups connected us to families and organizations in need of support, as well as to individuals who were willing to share their stories.

We traveled with a strong and committed group of people led by Liz Theoharis and Willie Baptist of The Poverty Initiative at UTS alongside John Robertson of CUSSW. The social work and seminary students brought their perspectives and experiences to the group, which contributed to the richness of the codisciplinary learning that occurred. We engaged in dialogue to build sensitivity toward and knowledge about the issues of health care, housing, education, food, and living wages. We also examined response efforts to disasters with particular attention to the influence of poverty, homelessness, and racism. Throughout this experience, we made efforts to incorporate

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ii The Poor People’s Economic Human Rights Campaign is “committed to unite the poor across color lines as the leadership base for a broad movement to abolish poverty. They work to accomplish this through advancing economic human rights as named in the Universal Declaration of Human Rights, such as the rights to food, housing, health, education, communication and a living wage job.” (www.economichumanrights.org)
what we saw and what we learned into our social work knowledge while renewing and deepening our commitment to social and economic justice.

New York City: Groundwork

In New York City, we met for 2 days of intense preparation before our trip to the Gulf Coast. We began by introducing ourselves to the history and culture of the area, poverty programs in the South and nationally, and the economic and social impact of Hurricane Katrina and other natural disasters on communities and individuals. Through readings and videos, we studied the structure of race and poverty in America, the effects of the Hurricane on the poorest communities, and efforts to address short-term needs and long-term empowerment of affected families and communities.

Additionally, we learned from experts and other professionals as we prepared for our journey to the Gulf Coast. For example, David Billings from the People’s Institute for Survival and Beyond provided a helpful framework for understanding the situation in New Orleans post-Katrina and described some of the experiences of Hurricane Katrina evacuees in the New York City area. Mary Ragan, a woman who worked with Hurricane Katrina survivors as they returned to their neighborhoods and their devastated homes, shared stories and images that she witnessed during her own trip to New Orleans. We found that hearing these first-hand accounts and viewing the photographs gave us a sense of what we might encounter on our trip, yet two days of speakers and pictures could not fully prepare us.

Atlanta, Georgia: A People Displaced

Our group had decided to visit Atlanta, Georgia due to the large number of Hurricane Katrina evacuees relocated there; we arrived in Atlanta on Saturday, January 7th. We visited homeless shelters and met with grassroots organizations in the city to critically explore the structural manifestation

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iii The People’s Institute for Survival and Beyond was created to “develop more analytical, culturally-rooted and effective community organizers. Over the past 24 years, The People’s Institute Undooing Racism™ Community Organizing process has impacted the lives of nearly 100,000 people both nationally and internationally. Through this process, it has built a national collective of anti-racist, multicultural community organizers who do their work with an understanding of history, culture, and the impact of racism on communities. These anti-racist organizers build leadership in and account to the constituencies where they are organizing.” (www.pifsab.org)
of racism, classism, and poverty highlighted by the displacement of 200,000 Hurricane Katrina evacuees. Atlanta residents described increases in homelessness, housing shortages, and unemployment. As the Federal Emergency Management Administration (FEMA) winds down its emergency shelter program and plans to drop 20,000 people from its hotel subsidy program, the problems will be compounded. Although one could argue that money is better spent directly on housing vouchers rather than hotel subsidies, thousands of people are not receiving emergency housing benefits and are in need immediate shelter. Disorganized management of housing assistance is pushing locals and Hurricane Katrina evacuees into homelessness. Some Atlanta residents described their concerns about unemployment, fewer job opportunities with living wages, and an increasing number of day laborers who work for substandard pay.

We also visited the Task Force for the Homeless shelter, a privately owned and funded shelter that nightly houses between 300 and 500 men – the homeless from Atlanta and Hurricane Katrina evacuees. The shelter was an overcrowded, dirty, and noisy warehouse. The already overburdened shelter system in the city will be further taxed by an influx of Hurricane Katrina survivors as they lose their housing subsidies. The inadequate government response has pitted the poor against the poor in competition for scarce resources. Atlanta had few systemic responses, and little support from the federal government, to address these housing and employment issues. The situation will likely deteriorate as recovery efforts are discontinued and the pervasive problems of homelessness and unemployment are once again deprioritized.

Pensacola, Florida: Community in Convalescence

Although our country’s experience of Hurricane Katrina may have been unique in that it forced many, if only for a moment, to consider race and class inequity, this storm was not the first to wreak havoc on vulnerable people. After 2 days in Atlanta, we moved on to Pensacola, Florida to look at recovery and rebuilding a year and a half after Hurricane Ivan ravaged the area. As in Atlanta, we met with local church leaders, as well as a social worker and a case manager from United Ministries, a cooperative crisis assistance effort of many different denominations in Pensacola. We discussed needs assessment systems that were used by these individuals and examined the role of social workers in coordination and case management following learning from katrina
Hurricane Ivan. The social workers and community leaders highlighted the importance of monitoring systems and formal documentation, not only for accessing support but also as a means to establish the extent of the destruction that occurred and the number of lives lost.

Although many people are aware of the more immediate and tangible impacts of a hurricane, less obvious consequences radiate well beyond the storm and reverberate through already marginalized communities. On several occasions, we were told by church and community leaders that the rates of child abuse, substance use, and domestic abuse significantly increased in the year following the disaster of Hurricane Ivan. Additionally, a pastor who spoke with us shared that due to the high levels of stress and lack of appropriate outlets and support, some individuals were channeling their stress through family violence. In Pensacola, even though the local leaders we met had an awareness of these social concerns, they continued to struggle with how best to address post-Ivan problems. We became aware of the extent to which a community continues to suffer years after a disaster without adequate supports and resources. Post-Katrina rebuilding efforts could benefit substantially from the knowledge of what was effective and ineffective in supporting communities in Pensacola in the aftermath of Hurricane Ivan and use this knowledge to anticipate long-term effects in the Gulf Coast.

Biloxi, Mississippi: Inadequate Assistance

After 2 days in Pensacola, we drove by van to Mississippi and worked in demolished communities. We were told by residents that the death toll from Hurricane Katrina in Mississippi alone was 5,000, although this number was not found in media reports. As freezer trailers for unidentified bodies were pointed out to us by church leaders acting as our guides, we were struck by the sheer number of people still missing in Biloxi. We also saw FEMA trailer parks throughout the city where people have been living in cramped quarters for months. Others have yet to receive their FEMA trailers due to problems accessing and completing forms. Residential areas closest to the water were completely destroyed and laying in ruin. In contrast, the neighboring casinos were rebuilt and fully functioning, seemingly untouched by the storm. Residents told us that current casino patrons were primarily locals from Mississippi, struggling in desperate attempts to regain some of what was lost.
In addition to the homes destroyed along the coastline of Mississippi, many houses further inland were also significantly affected by the storm surge that accompanied Hurricane Katrina. We helped some families gut and remove up to 6 feet of moldy, black sheetrock inside of their homes. They were living in FEMA trailers on their front lawns while working to make their houses habitable again, which was clearly an emotionally and physically daunting task.

We worked with churches in Mississippi that were actively providing basic assistance to families in the area. We canvassed communities, providing outreach to residents by asking them about their immediate needs. During our time in Biloxi, we saw church groups and social service organizations working with Hurricane Katrina survivors. We noticed that most of the interventions being provided only addressed their basic needs, as the physical rebuilding of communities had barely begun. In the months that follow our trip, the need for extensive mental health support will increase dramatically as survivors move beyond physical recovery and struggle to recover emotionally from the trauma they experienced. Indeed, the extent of the trauma experienced by Hurricane Katrina survivors became increasingly clear to us as we moved through Mississippi and on to Louisiana.

New Orleans, Louisiana: Abandoned Citizens

Our final 2 days were spent in New Orleans. We had the privilege of spending time at the Ashé Cultural Arts Center iv where we spoke to local residents and professionals who lived through Hurricane Katrina and continue to work in the city. Throughout our conversations, we took on the role of listener, feeling that these individuals wanted and needed to be heard as we listened to their stories of trauma and survival. Many individuals shared stories of how they were affected by the lack of sufficient aid and the woefully inadequate intervention efforts before, during, and after Hurricane Katrina. Most of the stories we heard had undertones of racism and classism. Although the New Orleans residents with whom we spoke experienced class and race disparities pre-Katrina, the disaster reinforced their worldviews that the local and national governments did not value the lives of minorities

iv “Ashé is an effort to combine the intentions of community development and economic development with the awesome creative forces of community, culture and art to revive and reclaim a historically significant corridor of New Orleans’ Central City community.” (www.ashecac.org)
and the poor. We were told by a community leader that 80% of New Orleans residents had not returned to their city, and those who had returned were predominantly white and wealthy. Many residents expressed frustration and anger about the government neglecting to ensure that non-white residents were able to return to their homes, demonstrating a lack of commitment to rebuilding the city for all of its citizens.

Those who shared their stories with us were each unique in their recounting. The following account by Tim, an African American man in his mid-fifties who has lived in New Orleans for many years and is a professor of music, provides one example of the many powerful experiences that were shared with us.

I tried to leave the city but it was too late. They turned us back. I was stranded with my 3 sons on the bridge in utter blackness for 7 hours with many, many others. I sat on top of them throughout this time to ensure that they were still there with me in the morning. We saw helicopters overhead but could not get them to stop for us. I felt helpless and scared. It has been 5 months since the storm and since the levees were breached, but this is the first time that I have been able to share my story in this way.

Tim’s story highlights the human experience of disaster and its consequences, but does not begin to describe the work yet to be done. In New Orleans we saw the need for extensive rebuilding months after the disaster and the need for repairing and implementing basic systems like water and electricity before survivors could be treated for trauma. Relief workers found another body one day after we left the area in mid-January, 5 months after the storm. The city of New Orleans remains in a state of emergency with most residents unable to return. Local advocates describe how few public housing units have been reopened and landlords intend to evict people in mass numbers upon their return. Many residents shared their feeling that the local and federal governments had abandoned them in their recovery just as they were abandoned during the first days of the storm.

Where Do We Go From Here?

Upon return from the Gulf Coast region, our group took time to reflect on the social work implications of the visit and the course. Social work
students met for three seminar sessions in the month following our return. We continue to encourage each other to value social change and to incorporate racial, cultural, and socio-economic considerations into our practice.

This paper is a brief overview and an introduction to our immersion experience in Atlanta, Pensacola, Biloxi, and New Orleans through the course *Katrina: Poverty, Race, and Social Work Practice*. One goal of our trip was to reclaim public attention for the continued plight of Hurricane Katrina’s survivors as well as the long-standing race and class inequality pervasive along the Gulf Coast and throughout the United States. We have sought to share our awareness by developing consciousness-raising efforts through presentations, writing articles, displaying artwork and photography, and holding public forums at CUSSW and outside communities. As we reflect on our experiences, we hope to continue these conversations and inspire others to participate in the dialogue and take action.

Contacts

The Poverty Initiative
Union Theological Seminary
3041 Broadway
New York, NY 10027
poverty@uts.columbia.edu

WRFG RADIO (Radio Free Georgia)
1083 Austin Avenue, NE
Atlanta, GA 30307-1940
Phone: (404) 523-8989
info@wrgf.org

Project South: Institute for the Elimination of Poverty and Genocide
National Office:
9 Gammon Ave.
Atlanta, GA 30315
Phone: (404) 622-0602
general-info@projectsouth.org

Washington Office:
1525 Newton St. NW
Washington, DC 20010
Phone: (202) 332-5333
projectsouthdc@earthlink.net

Common Ground in New Orleans
1415 Franklin Street
New Orleans, LA 70117
www.commongroundrelief.org
Volunteer Coordination Team
Phone: (504) 218-6613
commongroundvolunteers@gmail.com
GABRIELLA CASSANDRA is a second year master’s student at CUSSW within the Advanced Generalist Practice and Programming method, in the Family, Youth, and Children’s Services field of practice. She holds a bachelor’s degree in Psychology and French from Skidmore College. She is currently an intern at a residence for pregnant teenagers at the New York Foundling Hospital in Manhattan, NY. She is interested in trauma intervention. Her email address is gsc2102@columbia.edu.

NATANIA KREMER is a second year master’s student in the dual degree master’s program with Bank Street College of Education for Special Education and CUSSW, within the Advanced Clinical Practice method, in the Family, Youth, and Children’s Services field of practice. She is a graduate of Swarthmore College with a bachelor’s degree in Psychology and Education. She is currently an intern at the Child Development Center of the Jewish Board of Family and Children’s Services in Manhattan, NY. Her email address is nek2104@columbia.edu.