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From The Editors

Dear Readers,

      We present the Fall 2009 issue of *Perspectives on Social Work* with pride in the progress this journal has made since its birth six years ago. Our original intent was to provide an opportunity for social work doctoral students to share high quality work in a wide range of topics relevant to social work theory and research. Faithful to our original mission, we now receive papers from students across the nation and have developed a blind peer review process to ensure the high quality of articles chosen for publication. We are grateful to the students willing to submit papers for consideration. We are also grateful to the many doctoral students from universities across the country that contribute their time and energy to review the articles and insure a valid blind process.

      In this issue, we include the abstracts from the papers presented at the Fifth Doctoral Social Work Student Research Symposium, held at the University of Houston on March 5, 2009. The Symposium represents another effort on the part of doctoral students at the Graduate College of Social Work at the University of Houston to promote a diverse range of high quality research and dissemination within social work. As the abstracts reveal, a wide variety of interesting work is being pursued by doctoral students, and it is our pleasure to help promote awareness of social work students' accomplishments.

      We would like to extend our warmest thanks to our invited reviewers who make this journal possible through their selfless dedication to service: Gail Marva Augustine, Indiana University-Purdue University Indiana; Stephen Baldridge, University of Texas at Arlington; Darla Beaty, University of Houston; Ada Cheung, University of Houston; Haresh Dalvi, Indiana School of Social Work; Scott Easton, University of Iowa; Roberta Leal, University of Houston; Joy Malbrough, University of Houston; Saralyn McIver, University of Houston; Tomi Thomas, University of Utah; Venus Tsui, University of Houston; and Ray Woodcock, Indiana University.

Sincerely,
The Editors

Guidelines for Submission

Empirical, theoretical, and conceptual articles as well as book reviews are welcome. In order to be considered for publication in *Perspectives on Social Work*, all submissions must meet the following criteria:

- The author must be a currently enrolled doctoral social work student.
- Only original work will be considered. Editors will consider work that has been published elsewhere or is currently under consideration on a case by case basis as long as it is the student's original work and has not been copyrighted elsewhere.
- Only electronic submissions are accepted. Submissions should be e-mailed as a Microsoft Word attachment to the following e-mail address: journal@sw.uh.edu
- Submissions for the featured articles should be 5 – 7 pages in length with not less than one-inch margins and 12-point font. Submissions for book reviews may be 2-4 double-spaced pages. Submissions must be double-spaced.
- If you plan to submit an empirical study with human subjects ensure there has been an IRB review and notate the approval in your paper.
- Submissions must meet APA guidelines (5th Edition) for text, tables, and references.

For more information, inquiries and submissions:
Journal@sw.uh.edu

Abstracts from the 5th Social Work Doctoral Student Research Symposium
Graduate College of Social Work, University of Houston
March 5, 2008

We are pleased to publish the abstracts from the 5th Annual Social Work Doctoral Student Research Symposium. The purpose of the annual symposium is to give doctoral students an opportunity to present their research interests to their peers, professors, and the community. Since 2008, social work students from all over the United States have been invited to submit abstracts. This year, the number of submissions was impressive. Following are the accepted abstracts.

Internalized Symbolic Capital and Day Labor:
Setting the Discourse through a Conceptual and Theoretical Framework
Elena Delavega, MSW
University of Houston

There has been increasing interest in researching day labor in the past ten years, and ethnographic studies and surveys have been conducted. However, no conceptual framework for the study of day laborers has been developed. Given the importance of a theoretical framework for the continuance of research, and quantitative research in particular, it is imperative that a conceptual framework be developed now. Social work has a vested interest in the promotion of social justice, and a theoretical paradigm is fundamental to the setting of discursive parameters on the topic of day labor. It behooves social work to be involved in the development of such a paradigm. I propose a conceptual framework that incorporates elements of structural functionalism, the conflict paradigm, social identity theory, the minority identity development model, and Bourdeusian social capital theory.

Creating a Legacy with Older Adults
Felina Franklin, LMSW
University of Houston

The world population is aging at an unprecedented rate and demographic trends indicate an increase in the older adult population. As a result, dramatic age trends with both challenges and opportunities are surfacing. Challenges occur when major transitions in later life lead to social isolation, depression and illness. The purpose of this paper is to explore the opportunity of assisting the growing number of elders in creating a legacy that focuses on the survival and strength of each individual's experiences. Existing literature is reviewed that includes defining legacy, the need for creating a legacy, gaining control over legacy, and translating legacy into present learning. A framework utilizing existential, gestalt, and narrative theory will be used to discuss the importance of legacy. Future implications include suggestions for further study in areas of defining variables and developing measures that capture the effects of creating a legacy.

Impact of Childhood Abuse on Early Sexual Activity: A Longitudinal Study
Mugdha S. Galande, MSW
University of South Carolina

Extant research suggests that sexual activity during adolescence has unfavorable and often irreversible consequences that affect individuals. This study builds a theoretical framework by integrating attachment and social learning theories to examine the associations among three types of childhood abuse and early sexual activity. Specifically, this research proposes to examine associations between physical abuse, sexual abuse, and neglect, and early sexual activity using longitudinal research design and logical temporal order of constructs. A series of nested logistic regressions will be employed to analyze nationally representative data of the National Longitudinal Study of Adolescent Health (AddHealth) Wave I –Wave III. It is expected all types of abuse will be positively associated with increased early sexual activity however; this association may be attenuated by factors underlying parent-child relationships. Findings of the study will inform social work practitioners and policy-makers enhance the quality of existing pregnancy and HIV prevention programs.

The Baby-Boomers Meet Menopause: Attitudes and Roles
Judy Strauss, LMSW
Yeshiva University

Attitudes toward menopause were examined in a sample of 1,037 baby-boomer women who took part in the Midlife in the United States survey. Attitudes to menopause were assessed in terms of four critical questions, based on the work of Rossi (2004): feelings about fertility, health, attractiveness, and overall affective response to menopause (i.e., regret vs. relief). Analyses were replicated in two waves of the study seperated by nine years. More positive attitudes towards menopause were found among younger women who occupied more roles and who reported fewer menopausal symptoms, as well as older women (particularly older women who were financially secure). Contrary to expectations, less-educated women reported more positive attitudes. Baby-boomers may experience menopause differently as a result of having multiple roles as homemaker, wife, mother, caregiver for elderly or frail family members, and employee. Findings suggest ways in which social workers can support women in the "sandwich generation" during the menopausal transition.

Older Prisoner Health
Lisa Jennings, LCSW
University of Alabama

Older prisoner health is a public health issue. Inmate health affects individuals, prisons, families, institutional caregivers, and communities. There are over 150,000 elder prisoners in correctional facilities nationwide (Aday, 2003). Aged prisoner health is poor; there is a prevalence of chronic health concerns: hypertension, diabetes, arthritis, cancer, heart problems and sensory losses.
This case study explores health in a facility for aged/infirm prisoners. Semi-structured, in-depth interviews were conducted (four older male prisoners (60 and up), and twelve collateral

participants: healthcare staff, families, and church volunteers. Each inmate's healthcare story represents a case. Emergent themes (challenges, care process; support; communication; policies) were derived by constant comparative approach.

There are direct implications for social workers. Participants expressed frustration and satisfaction with components of the current system. Older inmates face critical needs. New policies could provide avenues for change in prison healthcare and how the outside community views this marginalized group in society.

Interdisciplinary and Multidisciplinary Research: Concepts and Practice
Panel Discussion
Betul Balkan, MA, Tawana Cummings**,** MA, LMSW, CHES, Roberta Leal, LMSW, Monique Pappadis, M.Ed., CHES, CCRP, Alexis Rose, M.S.W, Corrine Walijarvi, MS, MBA, MSW
University of Houston

The panel presentation will consist of an interactive discussion on multidisciplinary and interdisciplinary research by six doctoral students from the Graduate College of Social Work. Multidisciplinary and interdisciplinary research has been widely used in the natural sciences and is becoming increasingly common in the social sciences. Social workers, in particular, often work in settings where they interact with policy makers, health care workers, and mental health workers. The students will discuss actual or planned experiences with multidisciplinary and interdisciplinary work and will highlight the benefits and challenges of working with other disciplines. In addition, the panel will discuss ways to develop and promote multidisciplinary and interdisciplinary research in doctoral programs.

The Impact of Acculturation on First Generation Puerto Rican Women's Identity: An Exploratory Study
Ana Selma Berrios, LCSW
Smith College

The purpose of the study is to explore and advance knowledge about the impact of the acculturation process on first generation Puerto Rican women's identity. What is the impact of the process of acculturation on the identity of first generation Puerto Rican women? Do these women feel a sense of loss and how is it manifested in their daily lives? This study uses a mixed method design, qualitative and quantitative, with an emphasis on defining the experience of loss and its manifestation during the redefinition of identity. The mixed method is not equally balanced as the emphasis was placed on the use of a semi-structured interview. It aims to identify themes embedded within the migration narrative that might be similar for other immigrant women. It seeks to contribute to the knowledge of cultural competent mental health practices.

A Description and Analysis of Problems and Interventions Used to Improve the Well-being of Nursing Home Residents with Advanced Dementia

Dennis Chapman, LICW-R
State University of New York

This dissertation described and analyzed the problems and interventions used to improve the well-being of 118 nursing home residents with dementia. The problems were identified and interventions were developed during an evaluation of advanced illness care teams at two skilled nursing facilities. All of the identified problems were categorized using a six-dimensional assessment framework. A count of the problems by category and a reliability analysis were carried out to evaluate the usefulness of the six-dimensional model. A low frequency of problems in some categories and a Cohen's kappa of .73 (reliability analysis) provided little support for the six-dimensional model. Implications for social work practice: the biopsychosocial assessment traditionally used by social workers captures the common problems of pain and depression observed in the study population. The prevalence of agitation suggests that a behavioral dimension could be added to the biopsychosocial assessment as a discrete domain.

Six Major Themes Emerging from a Review of Recent Articles on Grief and Bereavement

Corrine Walijarvi, MS, MBA, MSW
University of Houston

The presentation will identify six key themes in the field of grief and bereavement that emerged from an analysis of 61 peer-reviewed articles published during the last decade. Each article was selected on the basis of presenting a contribution to grief and bereavement research and theories. Identified themes include developments in theories regarding the concept of pathological grief, developments in theories regarding factors that promote recovery from grief, and developments in theories of growth following a traumatic loss. Research findings regarding the effectiveness of programs and interventions designed to assist the bereaved will be highlighted. The recent theoretical developments and research findings include significant departures from stage-based models of grief, and will be beneficial for social workers who provide services to grieving individuals or families.

Application of the Feminist Perspective in Social Work Practice with Women in Abusive Relationships

Marcela Sarmiento Mellinger

University of Georgia

Working with women who have been abused by an intimate partner is something many social workers do at some point in their careers. Most have heard, and were likely taught, that approaches to working with abused women are based on the feminist perspective. However, although feminist theories have been developed, it is still difficult for some social workers to explain what they mean by "feminist perspective". This paper will briefly discuss how the feminist perspective differs from feminist theories, will address five tenets of the feminist perspective as applied to situations where intimate partner violence (IPV) is present, and discuss areas where the application of this perspective can be strengthened.

From the beginning of feminism, creating and aligning with a theory has been controversial. One reason was the fear that the construction of feminist theories would create a group of elite that would isolate the views of other feminists, consequently silencing their voices (Orme, 2003). Additionally, the alignment of feminism with postmodern thinking challenged established knowledge, raising questions about creating additional theories, which would be a contribution to this already established knowledge (Van Den Berg, 1995). Although theories were developed, some believe the original reluctance to define feminism led to a lack of a clear model for feminist social work practice (Payne, 2005).

In light of the proliferation of feminist theories, which seek to explain women's lives and experiences in the context of a society beset with gender inequality, feminism can no longer be treated as one theory (Collins, 1986; Gould, 1987). Additionally, this proliferation has made it difficult to explain why we believe we are using feminist interventions in any given situation giving the appearance of a divided voice (Orme, 2003). One way in which feminists have sought to bring clarity to the broad feminist philosophy has been by highlighting principles that represent common ideologies or enduring themes (Bricker-Jenkins & Hooyman, 1986; Gould, 1987; Van Voorhis, 2008). In general, these themes have brought unity to feminist thought and are ideologies that most feminists can endorse. Ideologies such as empowerment, unity and diversity, and the belief that the personal is political (Bricker-Jenkins & Hooyman, 1986) bring feminist theories together and allow us to speak of a feminist perspective.

The Feminism Perspective and Intimate Partner Violence

One area of social work where the feminist perspective has been widely utilized is the area of IPV (Orme, 2003). It was in the late 1960s and early 1970s that IPV was recognized as an issue in need of public attention. Feminists were the first to publicly identify this societal ill (Bograd, 1988; Gould, 1987; Orme, 2003); a problem that women were experiencing in the secret of their own homes. Since then, feminist analysis has been used to describe and explore IPV, the area to which feminists have perhaps contributed the most knowledge (Orme, 2003).

From a feminist perspective, the problem of IPV is rooted in a patriarchal system that in many ways supports and promotes violence against women (Bograd, 1988; Gutierrez, 1987; Shepard, 1991; Sugihara & Warner, 2002). This violence, mainly perpetrated by men toward women, is one expression of a socially learned desire to control and exert power over an intimate partner (Gould, 1987; Sugihara & Warner, 2002). Furthermore, it is connected to society's

broader support of a culture of dominance and aggression (Shepard, 1991). Feminists see IPV as a social issue that demands attention. This perspective takes the responsibility for the violence away from victims and places it on perpetrators and society. The following section outlines five ideological themes of the feminist perspective as they apply to social work practice and IPV.

It is important to clarify that using a feminist perspective does not mean that there are prescribed steps to follow in an intervention. The following feminist values serve as the basis for many feminist social work interventions and they start with the premise that patriarchal attitudes create and promote violence against women. Additionally, it should be recognized that although a majority of intimate abuse in this society is perpetrated by men toward women, there are cases where men are also abused. This issue, however, is beyond the scope of this paper.

Empowerment is an important tenet of the feminist perspective (Bricker-Jenkins & Hooyman, 1986) as well as of the social work profession. Empowerment can be employed in many ways when working with women in abusive relationships, and one fundamental area is that of addressing who is responsible for the abuse. It is imperative that social workers help women understand that the abuse is not their fault. This empowers women to achieve greater control over their lives, and helps them understand how the dynamics of power at various levels affect their lives. In many cases, women feel they are the reason for their partner's abuse and blame themselves for the relationship's failure. Social workers are in a position of helping women understand relationship dynamics that can allow them to see their role in relationships in a different light. Additionally, social workers need to be aware that as women are empowered to make their own decisions those decisions may not always correspond with what the worker would see as the best alternative.

In order for women to be empowered, they need to understand the dynamics of patriarchy. This includes their understanding of a system in which women have learned to accept and fulfill certain roles (Sugihara & Warner, 2002), including the preservation of the family structure, sometimes in spite of their own safety. Social workers need to help women understand the oppression they have experienced and encourage them to view their needs and perspectives as valuable. Women in abusive relationships tend to see their needs as irritations that provoke violence. By acknowledging and valuing their own needs they can begin to set themselves free from the oppression to which they have been subjugated.

The value of *process* is also an important feminist concept (Bricker-Jenkins & Hooyman, 1986). For women in abusive relationships their decision to leave the abuser is often a process, one that is frequently misunderstood by society and even practitioners. It is important for women to go through this process without feeling judged for their choices. For many women, the process begins after they leave the abuser and as they begin to rebuild their lives.

Process as a feminist intervention is also used in settings where women can share their stories. Giving abused women a voice is important in their journey to healing. Wood and Roche (2001) called this process radical listening. They view it as a process that allows women to see themselves as experts of their own situation and that allows them to feel validated.

It is important for practitioners to recognize that they are also going through a process as they work with clients to find solutions. Feminists believe that there is no such thing as value free interventions (Collins, 1986; Van Voorhis, 2008); therefore, part of the process should be for practitioners to explore their own values and biases. This is especially important when we add to this discussion cultural differences, class differences, and spirituality, issues that must be taken into consideration with any intervention.

The above mentioned issues lead us to the principle of *unity and diversity*. Its major thrust is the respect we show each other (Bricker-Jenkins & Hooyman, 1986), even if our views differ from the views of those we are helping. For situations where IPV is present, it can be difficult to respect someone's choices regarding the abusive relationship. This may include staying or going back to the relationship, continued contact with the abuser, shared custody of children, among others. Whatever the decision made, it must be the client's decision. Expecting her to do what the worker thinks is best, places the worker in the same position the abuser occupied, that of controlling her and not allowing her autonomy. This is not only an issue of respect of her views, but also part of empowering women to take control of their own lives. Obvious safety issues must be taken into consideration; however, autonomy is not autonomy if we place our own values on those we help.

One challenge for practitioners is to help women understand that their experiences, although unique, are not only personal but impact society at large (Gould, 1987). The feminist perspective emphasizes that the *personal is political*. Understanding that violence against women is an issue that has historical and cultural roots helps women realize that the abuse is a societal issue that necessitates broad interventions. It also helps them see that they are not powerless and that they can join other women in taking action to solve this problem.

Feminism goes beyond presenting principles or ideas that can bring feminists together. A feminist perspective is an ideology that encourages action (Gould, 1987), through c*onsciousness raising.* The battered women's movement was founded on the thought that only the force of a collective voice would someday end violence against women. There is still a long road ahead for this goal to be reached, but the need to continue to think globally and act locally (Bricker-Jenkins & Hooyman, 1986) is the same today as it was when feminists first brought the issue of IPV to light. This is a challenge for direct service practitioners as they seek to balance the need for services with diminishing resources. It is imperative that they continue to make the needs of women known in their communities in order to maintain IPV at the forefront of policy making, program development, and funding distributions. It has been argued that no profession is in a better place to ascertain the impact of social policy than social work (Domanski, 1998; Haynes & Mickelson, 2000; Schneider & Netting, 1999). Social workers are in a unique position to continue to raise consciousness regarding the detriments of IPV, not only for the lives of women, but for the lives of their children and our communities.

Strengthening the feminist perspective's application to IPV

Using a feminist perspective to help women in abusive situations has many strengths. However, as is the case with all theories and perspectives, there are also areas that leave gaps in our interventions. These gaps and weaknesses must be addressed in order to strengthen the perspective. The following section outlines some of these areas.

One of the challenges in addressing IPV has been the reluctance and perhaps inability of some programs to address the mental health issues women who have been abused bring with them when seeking services (Powell, 2009, personal communication). Dutton and Gondolf (2000) stated that the number of abused women with major psychiatric disorders is small. This may be true; however, regardless of how small these numbers are, this issue needs to be addressed. Using a feminist perspective should not preclude us from seeking the help of mental health professionals who can address these issues. One of the fears has been that identifying mental health issues can somehow be utilized to justify the abuse (Berg, 2002; Humphreys & Thiara, 2003; Petretick-Jackson & Jackson, 1996). Although a reasonable concern, in order for

true empowerment to occur, women's programs must address mental health issues. Identifying and treating mental health problems does not have to be anti-feminist.

Another challenge for the feminist perspective is the potential bias some of the principles promote. Baines (1997) questions whether some feminist principles are based on the experiences of white middle-class women and do not encompass issues faced by minorities and women of lower socio-economic status. This is a sensitive issue and one that calls on the need for self-awareness and constant self-evaluation. Recognizing that different experiences give us different lenses through which we see the world can help social workers utilize appropriate interventions.

One last area to mention is the meaning of feminism; unfortunately, feminism is a laden word that has polarized women who support and believe the principles discussed in this paper. One of the major consequences of this polarization has been the seemingly divided voice in addressing women's issues, something that has social policy implications. Perhaps in our quest to advocate and voice women's concerns, we have marginalized groups that can help make a difference in the lives of women who are abused—law enforcement, judges, and non-offending men who could be allies in the work of ending violence against women. In order to honor feminist principles, we must strive to be inclusive and not divisive.

This list is obviously not inclusive, but a sample of areas where an honest discussion about the application of the feminist perspective can begin. As stated earlier, pointing out the gaps of this perspective is not intended to dismiss its value. The feminist perspective has considerably informed social work practice in the area of IPV. Gaps are pointed out with the intention of challenging the profession to continue to analyze the perspectives and interventions used with clients. One arena in which this can occur is in schools of social work. The profession would benefit from incorporating feminist understandings of oppression, not just of women but also of other groups, in education and practice. By doing so, areas in which the perspective can be strengthened can be addressed at the same time that students are learning to apply it in their practice. It is important that social work education does not simply present women as victims of oppression, but also as active creators and promoters of knowledge. Students need to know that feminism is more than a way of viewing women's problems; it is a valid perspective that can be utilized to influence social policy, build knowledge, and improve social work practice.

Conclusion

This brief analysis of the feminist perspective sought to show its value in working with women in situations where IPV is present. In spite of criticism that the feminist voice has been divided by the proliferation of feminist theories, the common ideologies of feminism bring these theories together to provide a unified front. The feminist perspective continues to be beneficial in working with women and other disadvantaged groups. It is our challenge as social work practitioners, educators, and supporters of equality to continue to move these principles forward and give them a solid and valid place in social work practice.

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Online ethnography and vulnerable populations: A pilot test of data collection via a popular Instant Messaging service

Michael J. McCarthy, MSW

Portland State University

The internet is rapidly becoming a vibrant topic of study, source of data, and tool for qualitative inquiry in social work (Rybas & Gajjala, 2007). Variously termed *virtual, cyber,* or *online ethnography* (Beaulieu, 2004; Markham, 2005; Rybas & Gajjala, 2007), internet-based methods of data collection include observations of online communities (e.g., internet chat rooms), analysis of online narratives (e.g., internet web-logs or digital video), interviews via email or instant messaging (IM), and others. While holding great promise for advancing knowledge development and advancing practice, caution has been recommended in using computer-mediated methods to solicit information from vulnerable populations on sensitive topics (Grinyer, 2007). The principle goal of this pilot test was to critically examine the process, benefits, and challenges of collecting potentially sensitive qualitative information from research participants over the Internet.

Positive associations between technological connectedness and enhanced quality of life, as well as lack of technological connectedness and psychiatric illness (e.g., major depressive disorder, post traumatic stress disorder, complicated grief), have been demonstrated in the general population (Vanderwerker & Prigerson, 2003). Computer-mediated self-interviews have also been well received by vulnerable populations including alcohol and other substance abusers, postpartum women, victims of intimate partner violence, persons with HIV/AIDS, persons at risk for suicide, adolescents with high-risk health behaviors, and individuals with disabilities (Garb, 2007; Paperny, Aono, Lehman, Hammar & Risser, 1993; Renker & Tonkin, 2007; Rhodes, Lauderdale, He, Howes, & Levinson, 2002;Turner & Ku, 1998, Oschwald et al., 2009).

Among individuals with disabilities, computer-mediated interviewing may serve to minimize the consequences of impaired physical or sensory functioning or lack of mobility (Collie, Cubranic, & Long, 2002). Many vulnerable populations, including persons with disabilities and other chronic health conditions, may also be reaching a saturation point in terms of being recruited to participate in traditional research (Kroll, Barbour, & Harris, 2007), making new methods of data collection appealing from a participant perspective and leading to improved participation rates. From a research standpoint, computer-mediated interviewing may also be cost effective in terms of researcher time and expenses related to travel.

A small number of authors have written about the benefits of interviewing participants via IM services and other internet-based mediums. Opendenakker (2006) notes the value of this method for accessing geographically difficult to reach individuals; the anonymity it provides for both interviewer and interviewee; and its potential for resulting in richer interview responses that are less subject to social desirability on the part of participants. Lewis (2006) describes how computer-mediated interviewing methods allow participants to "feel at ease in discussing their health disorders in a perceived setting of privacy" (Lewis, 2006, p. 4). The present study sought to answer two research questions:

1) What are the benefits and challenges of interviewing participants via an IM service?
2) Are web-based methods appropriate and effective for interviewing participants around potentially sensitive topics?

A related goal of this project was to explore the topical area of the impact of stroke on younger adults and their families. The American Heart Association (AHA, 2008) reports that, in 2005, an estimated 261,000 U.S. stroke survivors were between the ages of 20 and 60 years old. Unfortunately, relatively few empirical studies have been conducted with this unique population. Existing literature describes the specialized needs of this population, including instrumental support and social role fulfillment, and their developmentally-specific goals such as returning to active parenting and gainful employment (Kersten, Low, Ashburn, George, & McLellan, 2002; Low, Kersten, Ashburn, George, & McLellan, 2003; Roding, Lindstrom, Malm, and Ohman, 2003). In order to gain insight into the first-hand experiences of younger survivors, the author conducted several interviews with community members and experts in the field via telephone and face-to-face interviews. From a topical standpoint, the pilot test described in this article represented another effort to validate and augment the author's current understanding of this field.

Methods

Google's *Google Chat*® IM service was used for this pilot test. An individual whose older sibling experienced a stroke approximately one year before data collection was recruited

through personal contacts to participate in this study. This person will be referred to here as *Jim*. Jim was initially approached via email and, after having the opportunity to review the interview questions, was consented via telephone as well as at the beginning of the IM interview. Although the interview schedule was structured around topics gleaned from the literature, efforts were made to keep the interview loose enough for Jim to raise unanticipated issues.

The interview for this project lasted approximately 90 minutes and, because of the nature of interviewing via IM, 3 pages of time-coded, written transcripts were automatically generated by the Google software. Content analysis of the transcript was conducted and illustrative data directly addressing the research questions, as well as some unanticipated methodological issues discussed below, were extracted. A handheld digital recording device was used by the interviewer to *memo* (Birks, Chapman, & Francis, 2008) throughout the interview with thoughts and observations related to the research questions. The digital recording was reviewed throughout data analysis to assist in understanding and clarifying interpretations of the written transcript.

To further ensure authenticity of the data, all communications about the project were confined to IM services and email, accept for one telephone call immediately in advance of the interview and one afterwards by way of a follow-up debriefing. A brief interview schedule was created in order to provide for fidelity between this pilot test and future interviews around this same topic. Jim was also given the opportunity to review and offer suggestions for the improvement of the present report prior to submitting it for review.

<div align="center">Results and Discussion</div>

This pilot test was educational both topically and methodologically as the interviewer became more comfortable with the technical and interpersonal aspects of computer-mediated interviewing. From a research standpoint this method was extremely convenient in terms of travel and resources necessary for conducting the interview. Another practical benefit was the time-coded, written interview transcript the Google Chat software automatically generates. The solitude of the interviewer's work space as he conducted the interview also allowed for intense focus on the content and process of the interview, especially when the topics became more sensitive.

Many of these same benefits might be observed from a participant's standpoint. Jim did not comment on the convenience of the method but it may be that he perceived interviewing via IM as more convenient than visiting the interviewer's office or meeting in the community and less intrusive than the interviewer visiting his home in person for this interview. Jim reported that the technical aspects of the process (e.g., logging on, interfacing with the system, typing) were "fine" and validated the usefulness of providing interviewees with questions in advance. When asked to compare this method with face-to-face interviews in terms of comfort level, Jim reported that this method was "[p]robably a little more comfortable" and that he would likely participate in an interview of this sort again.

Aside from issues related to participants downloading and installing necessary software for IM communication, the principle challenge imposed by technology in this case related to the communication time lag between questions, responses, and subsequent follow-up questions. The interview lasted almost 90 minutes but only generated 3 pages of single-spaced, printed text for analysis. By comparison, one hour of interview or focus group audio recording can generate up to twenty pages of written transcripts. In addition to yielding less data, this time lag challenged the interviewer to stay engaged in the interview for the duration and avoid becoming distracted

by other tasks (e.g., work tasks, email). This may also have been an issue from the standpoint of obtaining thoughtful, accurate information from Jim if he was also subject to similar distractions.

The time lag Jim and the interviewer experienced in this pilot test could have been a function of the specific IM service used for this project, firewall or server delays, the speed of the internet connections, or factors related to the individual machines being used (e.g. hard disk space, processor speed, open applications). It would be worth exploring other IM services under different conditions to determine whether time lags are consistent between providers. If long time lags are typical of all communication via IM service, they may be a significant barrier to using this data collection method. Regardless, one should be thoughtful and sparing with questions posed in an IM interview in order to minimize participant burden and make the process as efficient as possible.

A more fundamental challenge of this method related to the difficulty of assessing Jim's reaction to questions without the benefit of being able to express or observe nonverbal communication. Similarly, this method limited the interviewer's ability to offer Jim human comfort when the subject matter became difficult. For example, the interviewer struggled to find a suitable text-based response when Jim described how his brother's stroke "was extremely difficult for [him] and [his] family" and how "[he] and everybody in [his] family went through a lot of sadness and anger" when his brother died from related complications.

This example illustrates the potential for emotional leveling that exists with computer-mediated communication. It may be possible to convey emotions via the keyboard with emoticons or other symbols but, generally, it is difficult to effectively modulate one's tone of voice or affect to facilitate deep intrapersonal reflection among participants. When converted to text, the strategic pauses and simple affirmations of understanding common in face-to-face interviews may take on different meanings.

In reference to the goal of gaining a better understanding of the experiences younger survivors and their family members, this pilot test confirmed much of what has been reported in the literature. Most notably, the perceived inadequacy of rehabilitation services in general and, for younger survivors, in particular. Jim related how "once [his brother] was involved with the recovery end of the health care system [his] family became quite upset and disillusioned with the entire recovery process." He went on to describe how the care facility to which his brother was discharged "was basically a rest home / hospice for elders and the staff basically could not cope with a young stroke victim" and how, had it not been for his "[m]other's strong will and persistence, [his brother] would probably have stayed bed ridden there." The other themes that emerged during the interview included the importance of survivors maintaining their independence in spite of the effects of stroke, the experience of grief among survivors and family members, and the importance of social support for survivors and their families.

Conclusion

Interviewing individuals around potentially sensitive topics via IM has both benefits and challenges. The method has potential, however, especially for certain populations who may have access to web technology but have limited functioning or mobility. The importance of allowing our method of inquiry to be driven by our research questions, as opposed to structuring our questions around an innovative data collection method, was reinforced through this pilot test. The idea of pairing this method with other more traditional methods of qualitative data collection in social work such as face-to-face or focus group interviews should also be considered.

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The Role of Social Work in the Lives of Home Care Workers
Natsuko Ryosho, MSW
Virginia Commonwealth University

Demand for quality home health care has been growing as more and more persons who are old, chronically ill, or disabled choose to receive long-term care services in community-based, rather than in institutional settings. Home care has been driven by three primary trends: an individual's preference to remain in his or her own home for as long as possible, advancements in medicine and technology which support complex care at home, and a political interest in deinstitutionalization with the goal of containing health care costs (Kaye, Chapman, Newcomer, & Harrington, 2006; Stone, 2004). The Bureau of Labor Statistics (2007) projects that between 2006 to 2016, the demand for home care workers will grow by 50.6%.

Traditionally, social work practice and research in the field of home care have centered upon helping long-term care consumers by responding to their physical, emotional, and social needs (Lee, 2002). Dyeson (2005) described five primary roles of a home care social worker: (a) advocating for consumers, (b) organizing community resources, (c) educating interdisciplinary treatment team members about the role and function of medical social services, (d) providing consultation to team members regarding treatment plans, and (e) helping reduce the overall cost of providing health care.

While these traditional roles continue to be important, given their significant influence on the quality of care consumers receive, there is an increasing need for social workers to engage in promoting the rights and well-being of direct home care workers. On a daily basis, home care workers provide assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) that enable individuals to maintain their health and functional abilities, participate in social activities, and most of all avoid or delay institutionalization (Kaye et al., 2006). Given the intimacy of these close, personal caregiving relationships, home care workers also respond to the affective needs of consumers and family members.

Despite the significance of their work in supporting vulnerable individuals in the most intimate manner, these workers, who are typically low income, minority or immigrant women, are the least valued group of people in the health care industry, in terms of status, salary, and privileges. Within the logic of the business practice, they are treated like a commodity and their physical and emotional needs are largely disregarded (Donovan, 1987; Olson, 2003). In order to draw more attention from social workers to the experiences of this "terribly neglected profession" (Amato, 2004, p. 243), this paper describes the current status and working conditions of home care workers and their effects on the quality of care provided to consumers. It then discusses implications for social work practice in promoting the well-being of home care workers. This, in turn, can have positive consequences for consumer quality of life through improved care.

Status and Working Conditions of Home Care Workers

Low status of the home care workforce reflects the intersecting disadvantages of gender, social class, and race. Care work is traditionally "a taken-for-granted female activity" (Dodson & Zincavage, 2007, p. 906) that receives no social recognition. Particularly home care is often regarded as an extension of ordinary, unskilled domestic labor that has little value and significance (Aronson & Neysmith, 1996). Due to its easy job entry requirements, home care work attracts socially and economically marginalized groups of women with few occupational choices. Compared with all female workers and even with all direct care workers, home care workers are more likely to be minority, foreign-born, who have high school or less education, and who live below the poverty line (Smith & Baughman, 2007). Such socioeconomic characteristics of workers mirror the historical image of women of color working as submissive

servants in private homes, resulting in a lack of social respect and a negative public perception of the occupation.

Within the health care community, home care workers are at the bottom of the hierarchy. Even though they work most closely with consumers, they usually have no input into care planning, decision making, and scheduling. They receive none or minimal training and supervision and have little opportunity for advancement (Stone, 2004). They are grossly underpaid and earn only $5.41 to 11.38 on the average, which is likely insufficient for an adult with dependent children (Paraprofessional Healthcare Institute, 2008). While their work is physically and emotionally demanding and many of them suffer from job-related injuries and mental health problems, only one-third of them are covered under their own employment-based health care coverage (Kaye et al., 2006). Moreover, they are typically not paid for travel time between jobs and do not have pensions, paid sick leave, paid holiday and vacation time, and gas or mileage reimbursement (Hayashi, Gibson, & Weatherley, 1994).

In their relations with consumers and their family members, they frequently suffer from mistreatment and lack of respect. Working in isolation of individual homes without any immediate support or backup, they are extremely vulnerable to exploitation and discrimination. They are often treated as maids or cleaning ladies and become subject to physical and verbal abuse, sexual harassment, racial discrimination, and unreasonable or inappropriate demands (Aronson & Neysmith, 1996; Ebenstein, 1998; Neysmith & Aronson, 1997; Stacey, 2005). Despite the heavy workload they already have, many of them make personal sacrifices and provide unpaid extra services to meet consumers' needs out of the fear of losing their job as well as a sense of moral obligation (Aronson & Neysmith, 1996). The blurred boundary between formal and informal labor also pushes them to act like a friend or family member of the consumer and take on added responsibilities, all while they struggle to maintain their own household (Stacey, 2005). Consequently, they become physically and emotionally overstretched to the point where they are either no longer able to continue working or providing quality care. Studies have identified high stress levels, low job satisfaction, and high intent to leave the job among home care workers (Denton, Zeytinoğlu, & Davies, 2002; Matthias & Benjamin, 2005)

Effects on Quality of Care

Despite the low social status of the occupation, many home care workers take pride in their job. They are dedicated to helping people and enjoy their close, personal relationships with consumers. They report feelings of fulfillment as they see consumers improve because of their efforts (Ebenstein, 1998). However, current working conditions make it difficult for even the most dedicated workers to stay on their jobs. Stone and Wiener (2001) reported that turnover rates among direct home care workers range from 10 to 76%. Considering the fact that many entry-level positions in fast-food restaurants and retail stores offer more stable, safer, less demanding, and better paying jobs, attracting and retaining workers in this field is obviously difficult (Potter, Churilla, & Smith, 2006). As a result, the long-term care system is experiencing a severe shortage of direct care workers. Vacancy rates of home health and home care agencies range from 14 to 27% (Stone & Wiener, 2001). Nationally there is only one home care worker per ten potential consumers which suggests substantial competition among these agencies to recruit an appropriate number of workers (Kaye et al., 2006).

This situation is causing further deterioration in the quality of work life and in the delivery of care. Care workers are under pressure to increase productivity by accomplishing tasks in a shorter time and by visiting more clients per day. They have fewer mentors and more limited

time available for on-the-job training and receive little support from supervisors who are themselves overworked (Bureau of Health Professions, 2004). An inability of the workers to provide satisfactory care is making not only the job more stressful, but is also threatening consumer well-being. Care provided in a rushed manner by less qualified workers likely affects consumer safety and comfort. Limited interactions between care workers and consumers hinder the development of trusting, personal relationships. Moreover, turnover causes disruption in the continuity of care and creates extra burdens for consumers who have to orient a new worker and reestablish mutually acceptable care routines (Soodeen, Gregory, & Bond, 2007). The lack of a reliable workforce also causes reduced access to care and may force individuals to choose more restrictive, more costly institutional care (Bureau of Health Professions, 2004). In one study, approximately 29% of adults of all ages with a disability who need community-based services in two or more of the five basic ADLs have unmet needs because of lack of paid help (LaPlante, Kaye, Kang, & Harrington, 2004).

The costs associated with recruiting and replacing workers have also become primary concerns for home care service agencies. A shortage of workers means decreased productivity, service volume, and profits. Agencies have to bear the extra cost associated with turnover including an additional advertisement for recruitment, hiring incentives, orientation activities, administrative resources for separation, and resources for temporary staffing (Bureau of Health Professions, 2004). The direct cost of turnover per care worker is estimated to be at least $2,500 (Seavey, 2004). Cost-cutting efforts of agencies to retrieve this economical loss result in worsening working conditions for their employees, thus further increasing their likelihood of leaving the job.

<div align="center">Implications for Social Work</div>

The quality of work life of care workers and the quality of life of consumers are closely interrelated. As Kane (1994) described, consumers can never be more empowered than those who provide care. Until these workers supporting the long-term care system feel rewarded and motivated to perform their best on the job, social workers cannot ensure the well-being of consumers. With its expertise and knowledge in group work, policy making, and research, social work can make a significant contribution in facilitating necessary changes in the current working conditions of home care workers.

For example, as a social worker, Amato (2004) described her efforts to organize and facilitate a mutual aid group for female home care workers who came to an adult day care center with their clients. The group created an opportunity for these women, who normally work in isolation, to interact with each other and to share their concerns and experiences in a safe and non-judgmental atmosphere. Through the group discussion, they were able to identify issues they were facing and collaboratively engage in the problem solving process. The support group not only satisfied the women's needs to be heard, but it also provided them an ongoing sense of community.

These small group efforts can grow into a larger, collective action to fight for achieving economic and social justice in the long-term care industry. Home care workers have started unionizing for better wages, benefits, and working conditions (Boris & Klein, 2006; Donovan, Kurzman, & Rotman, 1993). Social workers would be better able to influence health care and labor policies if they joined these forces and brought other health care professionals and interest groups together. Donovan and colleagues (1993) described a collaborative project jointly undertaken by a school of social work and a labor union. The school first conducted research to

identify the demographic characteristics and the health and social needs of union members. Building on the research findings, it then established a union-based social assistance program to address individual needs in the areas of housing, child care, and family issues. At the same time, the union used research data as a foundation for collective bargaining, legislative action, and public education. In the end, the project positioned the union to successfully negotiate for more state funding for home care resulting in increased wages and basic health benefits for workers.

These cases indicate that by working at multiple levels, social work can fulfill its dual commitment to social services and social change (Donovan et al., 1993). By responding to individual voices and incorporating them into policy reform efforts, social work can effectively promote social and economic justice for these neglected, but critically important workers in supporting the long-term care system.

Conclusion

This paper described concerns related to the working conditions of home care workers and called for social work involvement in the efforts to improve their work life. Given the inherent social injustice these workers are experiencing and the significant role they are playing in the daily lives of individuals struggling to maintain care at home, the advocacy for their well-being and rights needs to be a social work priority. Through individual and collective efforts, social work can contribute to creating a system where every person involved in care is treated with respect and human dignity. As a result, social work would be able to ensure a better quality of life for millions of people and fully achieve its mission.

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Long Term Care in the United States and Turkey
Felina Franklin, LMSW
University of Houston

The World Health Organization (WHO) (2009b) defines active ageing as "the process of optimizing opportunities for health participation and security in order to enhance quality of life as people age" and accepts people 60 and over as old (p.1). According to WHO (2009a), a proportion of people aged 60 and over in the world is growing faster than ever due to longer life expectancy and declines in fertility rates. Increases are seen as a success of improved health care and technologies, however, new challenges include adaptation and maximizing and utilizing health resources (WHO, 2009b). A shift in health care systems towards geriatric care, including prevention and management of chronic diseases and more formal long-term care systems is needed (WHO, 2005). The purpose of this paper is to compare long-term health care systems of the U.S. and Turkey in reference to similar population changes. Practice, policy, and research implications are discussed.

Health care in US

Population increase and health issues

In 2007, there were 37 million (12.6% of population) people age 65 and older in the United States, an increase of 635,000 people since 2006 (U.S. Census, 2009). Growth in population and life expectancy has resulted in increased health problems (i.e., heart disease, cancer, diabetes) (CDC, 2007). Mental health issues of concern for older adults include social isolation (Grant, Hamer, & Steptoe, 2009), depression (Hybels & Blazer, 2003), limited physical functioning (Roberts, Kaplan, Shema, & Strawbridge, 1997), and suicide deaths (people age 65 and older 16 percent in 2004) (NIMH, 2009).

As health and mental health issues increase as does the level of care required. Functional assistance with activities of daily living (ADLs) such as bathing, personal hygiene, and dressing along with incontinence care and medication management are reported most frequently (Golant, 2004; Quinn, Johnson, Andress, McGinnis, & Ramesh, 1999). Falls and mobility problems are two of the most common and serious concerns facing older adults' ability to function independently (Rubenstein, Powers, & MacLean, 2001). A higher level of care for a growing population requires a long-term care system.

American Culture

The ideal choice for long-term care is to age in place (at home), however a shortage of informal caregivers (friends, families, etc.) indicates a need for alternative provisions of care (Quinn et al., 1999). This shortage of caregivers is partly due to their full-time employment statuses (Scharlach, Gustavson & Dal Santo, 2007). When caregivers are not available, care alternatives including facility placements are considered.

Long-term care

Long-term care is a variety of services and supports provided to meet health or personal care needs over an extended period of time; mostly consisting of non-skilled personal care assistance with ADLs (U.S. Department of Health and Human Services (DHHS), 2008). The goal in the U.S. is to maximize independence and functioning when being fully independent is not possible. Factors increasing risk of needing long-term care include being older, single, and female; as well as lifestyle factors (i.e., poor diet and exercise habits, health and family history). As older adults age in America, long-term care needs are expected to change from short rehabilitation treatment to daily contact with personal care staff (DHHS, 2008).

Most common care alternatives include nursing homes with 24-hour presence of licensed nursing personnel (Quinn, et al., 1999) and assisted living facilities with 24-hour supervision, not required to be medically licensed personnel (Aud & Rantz, 2004; Maas & Buckwalter, 2006). Nursing homes are preferred, when it is no longer possible to care for a person at home safely or when care in the home becomes too expensive, because they are federally regulated and must be licensed by state governments (DHHS, 2008). In 2004, about 1.5 million people lived in nursing homes in the U.S. (AARP, 2007). Alternatively, there are roughly 800,000 residents living in 33,000 assisted living facilities nation-wide; however, unlike nursing homes standard policy regulations are nonexistent (Aud et al., 2007).

Community-based health care is increasingly providing the least restrictive environments for elders who no longer function independently (Quinn et al., 1999). Personal care homes are community-based facilities that provide living arrangements, assistance with basic needs and protective oversight (Quinn et al., 1999). Board and care settings offer a combination of

affordability, homelike environment, and personalized care; however, limited studies report the effect of regulations on quality of care (Carder et al., 2006).

Financing long-term care further confounds older adults' struggle with extended care needs. Medicare solely pays for long-term care if skilled services or a short period of recuperative care is needed. It does not cover non-skilled assistance with ADLs; the most common need for long-term care (DHHS, 2008). Medicaid is available for the largest share of long-term care services; however recipients must meet financial and functional criteria (DHHS, 2008). The Older Americans Act and Veterans Affairs pay for long-term care, but are restricted to special populations (DHHS, 2008). Similar to Medicare, HMOs long-term care plans usually cover only skilled, short-term medically necessary care (DHHS, 2008). Another option for finding is Supplemental Security Income (SSI), a Federal income supplement program payable to people 65 and older without disabilities who meet the financial limits (Social Security Administration, 2009).

Federal Regulations

In the U. S., long-term care environments have not been regulated outside of nursing homes. Nursing homes providing skilled nursing services have federal regulations that define the rights of residents and standards of care. In contrast, individual states are responsible for developing regulations and licensure mechanisms for assisted living, personal care and board and care level settings (Aud & Rantz, 2004; Maas & Buckwalter, 2006).

Health care in Turkey

Population increase and health issues

Turkey's population is considered relatively young; however, an increase in the elderly population is present. In 2003, life expectancy was on average 70 years, and since 1990, Turks have gained about four years in life expectancy (WHO, 2005). In 2005, 5.9% of the population in Turkey was 65 and older, and it is estimated to reach 8% by 2012 (Cankurtaran & Eker, 2007).

Three main socioeconomic factors effecting health in Turkey include income, education and employment. The poor generally suffer worse health and die younger than people with higher income because goods and services that contribute to better health (i.e., nutritious food, good living conditions) are more affordable (WHO, 2005). The government pays a quarterly salary to adults 65 and older; however, it is not enough to meet an older adult's needs (Celik & Celik, 2001). Education contributes to an individual's job opportunities, in turn, improving income which affects health outcomes (WHO, 2005). Living longer magnifies the areas of income, education, and employment. Older adults pose a more serious challenge for many public pension schemes and there is greater financial need for those adults living beyond the expected retirement years (Celik & Celik, 2001; Dogan & Deger, 2004).

Physical and mental health issues are on the rise as the population ages. Ninety percent of people aged 65 and over have chronic health problems such as hypertension, cardiovascular and respiratory system problems, thyroid and malignant disease (Altun I, 1998). Mental health concerns (i.e., depression and dementia) require services for strengthening and maintaining relationships with others (Celik & Celik, 2001; Cankurtarian & Eker, 2007). Increased physical and mental health changes lead to lower functioning and higher need for assistance; however, access to and availability of health care services are limited (Celik & Celik, 2001; Dogan & Deger, 2004).

Turkish Culture

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Irregular income and loneliness are big problems in Turkey and more serious considering Turkish culture. Elderly may not express accurate and consistent needs to strangers, even when in great need (Celik & Celik, 2001). Therefore, studies might underestimate needs of older adults. Historically and currently in rural areas, Turkish people die at home under family care where religious rituals are performed in the last moments of life. However, urban migration has increased the number of deaths in hospitals. Turkish elders prefer to be cared for at home, or in a familiar environment by family members (Dogan & Deger, 2004; Evci, Ergin, & Beser, 2006). Elders desire caregivers with good communication, continuity of care, and maintaining their respect and dignity (Dogan & Deger, 2004). Increased need for women to work, former caregivers of dying elderly, leaves many elders spending their last days traveling to distant hospitals or on waiting lists (Oguz, Miles, Buken, & Civaner, 2003).

Long term care

Long term care in Turkey, provides older adults with home care including assistance with daily activities no longer performed alone or by the family (Celik & Celik, 2001). The majority of older adults do not want to be hospitalized and preferred hospitalization to be brief with a goal of returning home (Dogan & Deger, 2004). Older adults are particularly tied to their homes both emotionally and physically; and there is a strong need to remain at home until death (Celik & Celik, 2001).

Home safety is a concern for the elderly population due to hazards and accidents occurring with decreased functioning; however, most accidents are preventable (Evci et al., 2006). Home accidents increase with chronic illnesses, use of eye glasses and assistive devices, hearing problems, physical disability, losing a spouse and medication side effects (Evci et al., 2006). Unfortunately, designing homes specifically for older people is not a routine practice in Turkey.

There are no hospices in Turkey for palliative or end of life care. Policies for end of life care, pain management, DNR orders, or a framework for advance directives do not exist (Oguz et al., 2003). Private home care services are not covered by state insurance and families lack support and resources to properly care for their loved ones.

Government Regulations

Currently, Turkey belongs to the World Health Organization (WHO) and the Organization of Economic Cooperation and Development (OECD). Turkey provides three levels of health care: primary health care system which focuses on preventing infectious disease and on treating acute and chronic disease; secondary healthcare which is structured around state hospitals, with a national insurance system for workers and their dependents managing its own state hospitals; and tertiary healthcare which include the University hospitals (Oguz et al., 2003).

Older adults do not hold special status in the health insurance system in Turkey. The system lacks a professional standard for informing and educating patients and families about the severity of health situations (Oguz et al., 2003). When an elder has social insurance, she/he can go to primary health care centers or state hospitals or to other state hospitals (i.e., University hospitals) with a social security hospital referral. In 2003, legislation changes allowed some private hospitals to accept some state insurance schemes; otherwise only elders with private insurance are eligible for private hospital treatment. Private physician examinations or any kind of home care or home visits are not covered by any state insurances, only by special categories of private insurance (Dogan & Deger, 2004).

<div align="center">Implications</div>

Socioeconomic concerns for elders in the U.S. were studied mostly in the 1990s with similar outcomes as Turkey reports currently including education and income (Ciesla, 1997; House et al., 1994). Current U.S. research is focused on the critique of the existing long-term care system. In contrast, Turkish literature focuses more on key variables of the aging population and suggestions for creating a long-term care system.

The most common suggestion in the literature for creating and sustaining long-term care system is a new treatment philosophy that describes the types and levels of care and quality of care and services provided, and includes public discussion about needs of older adults (Oguz et al., 2003), creating legislative agendas including long term care policies (Celik & Celik, 2001), and establishing quality control and training in accessible and available services (Aud et al., 2007; Celik & Celik, 2001; Dogan & Deger, 2004; Maas, & Buckwalter, 2006). Additionally, improving quality of housing and preservation of independence for elders living at home (Evci et al., 2006) and empowering older adults to be actively involved in their care for improved self-efficacy and more efficient use of services (Celik & Celik, 2001; Cankurtaran & Eker, 2007).

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Understanding the Impact Of A Property Tax Levy on Provision
of Senior Services and Quality of Life for Missouri Seniors
Amber Moodie-Dyer, MSW
University of Missouri Columbia

Background

Property tax levies or mill taxes have been increasingly relied upon to support senior services due to inadequate federal and state funding (Payne & Applebaum, 2008). Analysis of the effects of property tax levies on service availability, provision and access for seniors is in its infancy. Given the growing population of seniors and the aging out of the baby-boomer population, needs will continue to grow (Payne & Applebaum). The importance of effective funding techniques is paramount to the adequate provision of services to meet the needs of seniors in their communities. This study is based on a similar study conducted in the state of Ohio, the only other of its kind, in which counties with a senior service tax levy were surveyed about the number of seniors served, types of services, and amount of the levies (Payne, Applebaum, Molea & Ross, 2007). Ohio and Missouri are two of eight states which use county property tax levies to help fund senior services. Results of the Ohio survey indicated that levy funds are very popular and generally pass at a 65 to 35 percent margin. In addition, funds are most often spent on nutrition, transportation and in-home services (Payne et al.).

In Missouri, mill taxes exist for mental health, children's services and group homes for people with developmental disabilities, as well as for seniors and are passed on a county by county basis. In 1990, Missouri's enabling statute took effect allowing counties to begin passing a mill tax for senior services. Currently several services and programs are provided for Missouri

seniors through a variety of means including the mill tax. In 1973, an amendment to the Older Americans Act (OAA) required states to create local Area Agencies on Aging (AAAs) to provide servicers for older Americans (Achenbaum, 2008). In Missouri, ten AAA service areas were created and provide services including nutrition programs, in-home services, legal services, disease prevention and access issues such as transportation (State of Missouri, Department of Health and Senior Services, n.d.). Health services for older Missourians are also coordinated by the MO HealthNet Division which administers the Medicaid program in Missouri for those age 65 years or older (State of Missouri, Family Support Division, 2009). According to Achenbaum, traditional funding streams such as Medicare, Medicaid and OAA have been stretched to their limit in times of Federal budget crunches and states have picked up the slack in terms of coordination of services, funding oversight and the development of local funding streams. The current study contributes to a gap in knowledge which exists in the state addressing whether needs of seniors are being adequately met. The assessment of the effect of property tax levies on senior services in Missouri is one piece of the puzzle.

Methods

Missouri's 114 counties and the independent city of St. Louis are eligible by Missouri statute to implement a mil tax to fund services for seniors such as nutrition, transportation, home care, etc. The state of Missouri was interested in understanding how tax levies affect senior service provision so they can better work with communities in meeting the needs of Missouri seniors. This study collected public information through a survey administered by the Missouri Department of Health and Senior Services. Using a telephone and mail survey design, Senior Service Tax Levy Board chairs in each of the 46 counties in Missouri with senior service tax levies were contacted. Twenty-three completed surveys, yielding a return rate of 50 percent, were obtained via mail, email and telephone throughout 2008 and 2009. The survey collected information such as how long the levy has been in place, the level of support for the levy, the dollar amount collected, and the number and types of services receiving funding through the board. The survey also included questions assessing the organization level and administrative functions of the boards.

Results

The responding 23 counties were distributed evenly throughout the state and were diverse in terms of size. Thirty-nine percent of respondents were U.S. Census Bureau-defined metropolitan counties, 17 percent were micropolitan, and 44 percent were rural. The average county population in 2007 for reporting counties was 43,096 with a range from 4,913 to 263,980. The average senior population in reporting counties for the same year was 5,822 with a range from 950 to 35,964. In addition, the average percent of seniors in reporting counties was about 16 percent with a range from about 9 to 21 percent.

Responding counties were also diverse in terms of how long the levy had been in place. The enabling statute took effect and the first mils were passed in 1990, while the most recent levy was passed in 2008. About 40 percent of respondents passed the mil prior to 2000, and about 60 percent of respondents passed the mil in the last eight years. The average margin for the passage of the levy was 60 percent to 40 percent. Slightly over half of counties had a campaign committee which helped assist with the passage of the levy. The majority of counties passed the levy the first time it was on the ballot (91 percent) and none of the counties have had repeal actions to get rid of the tax. Most counties collect $.05 for every $100 of property assessed. In terms of the average amount collected over the past three years for counties, the mean is

$303,988 with a range of $12,243 to $2,045,304. Because of the large variability, it is important to include the median amount collected which was $87,589. The variability also affected the standard deviation in reporting total population, senior population and amount of money spent through the levy. On each of these measures, the standard deviation exceeded the mean because of the large range. In addition, demographic information was also obtained from the US Census Bureau's Annual Estimates program and the American Communities Survey program to calculate average per capita and per senior spending estimates in each county. The average amount spent per senior was about $37 and per capita was about $5 (see Table 1).

With regards to board information and management of the funds, 18 of 23 county boards had bylaws, and about half of the counties met at least once a month (11) while nine met 3-6 times a year and three met once a year or as needed. Only two county boards employed paid staff, and the majority of boards placed either the board treasurer or county treasurer in charge of the accounting functions of the fund. All counties reported board members being selected by county commissioners with slightly under half of counties reporting a formal application process. Most counties made an effort to obtain geographic and professional diversity on their board. Half of counties reported having board members from at least four cities within their county, and the majority of board members in most counties were seniors. Professions represented include health, education, government, business, military, homemaking, finance, social services, and farming, among others.

With regards to the application, review and approval process for submitting requests for funding, almost all counties reported using a formal written application form and about half reported using a request for proposal format, while others had a rolling application process. All counties reported that reviewing and final decisions on funding were determined by the board. All counties also reported there was at least an annual reporting requirement for agencies who receive funding.

The average number of grantees reported by counties was nine, with a median of six and a range of two to 28. When asked about the top three service providers funded through the levy, the service types most commonly reported were Senior Centers, transportation and nutrition services in that order. In addition to these types of services, counties reported on other types of services funded through the levy including (percents determined by number of counties who reported funding the following services): 1) Information and Referral – 24 percent; 2) Senior center administration & maintenance – 62 percent; 3) Home delivered meals – 76 percent; 4) Home making/personal care/chores assistance – 43 percent; 5) In-home health care assistance (personal care/respite) – 33 percent; 6) Home medical equipment – 5 percent; 7) Home repairs – 33 percent; 8) Emergency response assistance – 33 percent; 9) Life enrichment programs/healthy aging/educational programs – 38 percent; 10) Alzheimer's/dementia – 10 percent; 11) Adult day care – 24 percent; 12) Caregiver services/support – 19 percent; and 13) Case management – 19 percent. Five counties reported having a waiting list for services, four of which were for home making/personal care/chores assistance (see Table 2).

With regards to collaboration and fund development , slightly under half of responding counties reported coordinating services with Area Agencies on Aging (AAA's) or other agencies (43 percent). In addition slightly over half of counties reported allowing recipients to make voluntary contributions to the fund (57 percent), and 32 percent of counties reported using senior services tax funds as a match to leverage other funds such as Older Adults Transportation Services (OATS), Missouri Department of Transportation (MODOT), and the Older Americans

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Act. In terms of keeping the community informed about funds and how they benefit the community, 73 percent of respondents reported using the newspaper and other media outlets, 23 percent reported using community presentations, and 18 percent reported using word of mouth and/or other agencies. One respondent reported using a senior tax levy board website, and one reported using a mass mailing. To determine the needs of the community, 45 percent reported conducting a needs assessment, 68 percent reported using discussions with community leaders and service providers, and 55 percent reported relying on constituent requests.

Discussion

These findings provide information to fill a gap in knowledge on the effects of property tax levies on local service provision for seniors. Devolution of funding for social services in the aging community and increasingly strapped state budgets has important implications for the need of increased organization and advocacy at the local level to meet the needs of an aging population (Hornbostel, 2004; Payne & Applebaum, 2008; Payne et al., 2007). Nationally, evidence has shown a growing need among seniors for services to support home care, however traditional avenues such as Medicare and Medicaid may not address the mental, emotional, and social needs of older Americans or their caregivers (Lee & Rock, 2009). This is one type of need that local senior tax levy boards may be more equipped to address due to its ability to support services that local seniors need most, whether they be information and referral to counseling services, funding local senior centers, caregiver support services, or chore assistance.

Criticism of this funding strategy centers on the argument that it creates a fragmented system which does not provide an equitable solution to senior service provision. In addition, according to Hornbostel (2004), in rural counties the tax base is lower, yet the proportion of seniors in the population is higher. However as federal and state availability of funds continues to shrink in the current economic environment, local tax levies may be one of the only viable options to support a growing senior population. Further research will need to continue to examine the effects of these levies as they are passed and implemented in additional states. Programs funded by tax levies and the funding landscape of senior services must continually be monitored in order to accurately measure the success of this particular funding strategy. This will help identify best practices and possibilities for collaboration along with the development of more equitable solutions.

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Table 1
Descriptive Statistics for Reporting Counties

Measure	N	Mean	Standard Deviation	Minimum	Maximum
Population	23	42,475	63,777	4,977	259,450
Senior Population	23	5,713	7,871	941	35,232
Total Amount Spent	21	$303,988.00	$548,384.00	$12,243.00	$2,045,304.00
Amount spent per senior	21	$37.16	$20.96	$13.01	$103.69
Amount spent per capita	21	$5.45	$2.09	$2.07	$9.85
Number of grantees	23	9	8	2	28

Table 2
Services Funded through the Senior Tax Levy

Service	N	Yes	No
Information and referral	21	5	16
Senior centers administration and maintenance	21	13	8
Nutrition services	21	18	3
Transportation services	21	18	3
Home delivered meals	21	16	5
Home making, personal care, chores assistance	21	9	12
In-home health care assistance (personal care/respite)	21	7	14
Home medical equipment	21	1	20
Home repairs, handyman assistance	21	7	14
Personal emergency response assistance	21	7	14
Life enrichment programs, health aging, educational programs	21	8	13
Alzheimer's, dementia	21	2	19
Adult Day Care	21	5	16
Caregiver services/support	21	4	17
Case management	21	4	17

Blazing a New Frontier
Matthew B. Drake
Colorado State University

My life changed drastically two years ago when my daughter was born. My wife and I prepared for parenthood as well as any other couple by attending parenting preparation classes, reading books, and talking late into the evenings. However, we were exploring the additional elements of unchartered gender roles. Now two years later, I am a stay-at-home father (SAHF).

I am one of the many men across the United States taking on this new and unfamiliar frontier. The roles of men and women have been changing rapidly in today's communities, especially how they relate to division of family labor in the home. Like me, many fathers are choosing to stay at home and raise the children while more women are staying in the work force. The U.S. Census Bureau (2002) reported an 18% increase in fathers who stayed at home from 1994 to 2001. Furthermore, the 2006 Census estimated that 159,000 men remained out of the labor force for at least one year to be the primary caregiver to a child while their wives or partners worked (U.S. Census Bureau, 2006).

Despite the growing trend of fathers staying home to be with their children there is very little research in this area. This paper will address the challenges that this new frontier is presenting both men and women and I will draw from the current literature and my own personal experience.

I never expected part of my identity would be a SAHF. Growing up I identified with both the masculine and feminine narratives of my culture. I understood society had norms and prescribed behaviors for standards of masculinity however they were never a concern. I valued my own ability to determine what becoming a man meant and identified with men role models who were masculine yet comfortable expressing emotion. This high level of ease with emotional content was a big contributor in the decision to take on unchartered parenting roles. This sentiment is echoed in a qualitative study performed by Rochlen, Suizzo, McKelley, and Scaringi (2008a) that sampled 14 stay-at-home fathers who described feeling acutely aware of the importance of connecting with and caring for their children by expressing affection and being responsive to their needs.

For most men the transition to parenthood is a critical time for gender roles to influence the dynamics of a relationship. Men typically begin to work more and women begin to cut back assuming traditional roles. These prescribed gender roles tend to dictate how men and women behave and respond to others (Brescoll and Uhlmann, 2005). But when men and women anticipate a role that is contradictory to the norm it is difficult to plan.

Making the decision to be a SAHF was difficult. My clinical practice was beginning to have success but my wife's income was substantially more than mine with health benefits. Most of all she enjoyed and identified with her work. SAHFs typically reinforce this thinking by mentioning their partner's employment in a rewarding profession with good career prospects and security helped shape their decision to stay at home. Rochlen et al. (2008a) reported half of the SAHFs in their study stated their wives identity was strongly consumed in work. Further

research continues to support the idea SAHFs tend to base the new arrangement on the practicality of the mother's salary and benefits (Zimmerman, 2000). My wife and I also believed it was extremely important to have at least one parent in the home to avoid daycare if we could. Rochlen et al. (2008a) discovered 12 of the 14 dads had the same sentiment. The shared value and commitment placed on at least parent in the home is a binding commonality for SAHF families.

After three months of maternity leave we made the transition and soon thereafter the assimilation into our new roles began to consume our identities. I quickly realized my role as a SAHF was challenged with a range of judgments and negative consequences (Martin & Mahoney, 2005). My experience confirmed what I had read about people holding more negative attitudes toward nontraditional parents than their traditional peers (Brescoll and Uhlmann, 2005). SAHFs are confronted with remarks and negative reactions throughout the day serving as a constant reminder that they are engaged in an inappropriate role (Merla, 2008). SAHFs are sent the message that they are not masculine, that they are slackers both inside and outside of the home (Merla, 2008), and that they are the objects of confusion and fascination (Zimmerman, 2000). Research consistently demonstrates that the stay-at-home parent role is inherently viewed as low in status and the role of SAHF is perceived to be the worst parent and the lowest in social regard as compared to career fathers, career mothers, and stay-at-home mothers (Brescoll and Uhlmann, 2005).

Ultimately, I began to have tremendous empathy for career mothers juggling everything. I watched my wife struggle to balance work and her mothering instincts while vocalizing frustration with the incongruence of roles. Her plight was not unique. Career mothers report feeling a personal tug-of-war between the financial responsibilities of working out of the home and their desire to be at home with the children (Zimmerman, 2000). They also report feeling judged for not being with their children while working full-time (Zimmerman, 2000). Parenting is sacrifice and choosing to live off one income, have one parent stay at home, and go against societal norms is challenging and stressful. In fact, the majority of career mothers reported the belief that their job added stress to the family dynamic (Zimmerman, 2000).

Having a baby in a traditional family with traditional roles is difficult enough. The introduction of a child creates major changes in a marriage often for the worse. In the first year, 70 % of wives experience a plummet in their relationship satisfaction (Gottman, 1999). John Gottman, a leading researcher within the field of marriage and family, suggests mothers relationship dissatisfaction with their partners doesn't have to do with the temperament of the child or the child's sleeping habits, he believes it has everything to do with whether her partner experiences the transformation into parenthood with her. With unhappiness and relational discord abounding in traditional role couples it is unique that most SAHF couples report satisfaction with their decision and their relationships (Merla, 2005; Rochlen et al. 2008a; Rochlen, McKelley, Suizzo, & Scaringi, 2008b; Zimmerman, 2000).

In contrast to the Gottman (1999) research presented above, SAHFs have no choice but to share in the profundity of life change within the relationship with their partners and their newly discovered gender roles. Furthermore, a cooperative spirit and strong communication skills are prevalent in stay-at-home couples (Zimmerman, 2000). One of the strongest predictors of marital satisfaction is equality within a couple's relationship and the sharing of power and division of labor (Zimmerman, 2000) which is prevalent in SAHF couples. And as a result SAHF couples

report higher self-esteem than their counterpart stay-at-home mother couples (Zimmerman, 2000).

Despite expressing relationship satisfaction the difficulty of being a SAHF can be overwhelming. This experience has been the most isolating endeavor of my life and research supports my sentiment with SAHFs reporting the most feelings loneliness and boredom as compared to other parenting roles (Zimmerman, 2000). Merla (2008) discovered public spaces are almost exclusively occupied by women and that the presence of a man in these environments can seem strange. This added visibility reminds men they are taking on a role that others may have difficulty with and may lead to SAHFs feeling disconnected with the community. Merla (2005) reported three factors preventing SAHFs from integrating into women's groups: women's resistance to men joining their groups, fear that their attempts to join would be considered seduction strategies, and difficulty adapting to conversational topics that they were not used to and uncomfortable. Furthermore, relationships with other stay-at-home mothers are often considered to be sexual by friends and neighbors (Merla, 2005) virtually eliminating any desire to make friends with women.

Having some kind of support network is critical for the adjustment into the new role of SAHF. Wester, Christianson, Vogel, and Wei (2007) found social support plays a role in reducing the negative consequences associated with certain aspects of gender role conflict. A social support network provides a man with a safe environment in which he may grow beyond social norms and masculine constraints. Web sites like rebeldad.com can link new SAHFs to others and create a sense of community and brotherhood. Literature also suggests men who feel supported by friends, are confident in their overall parenting skills, and secure in their ability to foster independence in their children are more likely to report higher levels of psychological well-being (Rochlen, et al., 2008b). In addition, men who feel supported by their spouse and endorse less traditional masculine norms report higher overall life and relationship satisfaction in their new role (Rochlen, et al., 2008b). My experience supports these findings. When I am frustrated questioning what I am doing as a SAHF the support of my wife and those closest to me helps me remember the vision of our decision.

Being at home has given me time to reflect and see the world through the eyes of a child. It has been humbling yet the role is transitory. Zimmerman's (2000) research discovered most mothers listed stay-at-home mother as their occupation whereas only four of the SAHFs listed it as theirs suggesting they may not be completely comfortable within the role and that it is temporary. Zimmerman (2000) also reported most friends and co-workers of SAHFs described the arrangement as temporary. Many fathers begin doing supplemental work to give them a sense of purpose beyond home. For me, having a small private practice and attending graduate school has been of the upmost importance.

The topic of SAHFs is limited in today's research and with the U. S. Census Bureau (2002, 2006) data showing more and more men choosing to be SAHFs there is a tremendous need to produce more. These men and their families are trailblazing new territory, morphing stereotypical gender roles, and raising children. There is no doubt that SAHFs understand the importance of their responsibility to father and transmit values of strength, confidence, independence, and curiosity to their young children. I remind myself every morning of the extreme privilege I have caring for our daughter. I have spent more hours with her than some men spend with their children in a lifetime. However, I watch my wife struggle to give her a kiss

and walk out the door for work. I wrestle with my own manhood, frustration, and doubt. I am not unique. I am a modern day pioneer, a part of a group of men blazing a new frontier.

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Dishing from the Cultural Pot: An African Instructor's Experience Teaching BSW Courses
Adedoyin Christson, MSW
University of Kentucky

Introduction

Social work literature abounds with reports of collaboration of U.S. social work schools with other schools of social work abroad, and the experiences of U.S. social work faculty teaching in foreign countries (Boyle, Nackerud, & Kilpatrick, 1999; Cornelius & Greif, 2005; Gilin & Young, 2009; Johnson, 1999; Tunney, 2002). Similarly, the narratives of the fieldwork experiences of U.S. social work students abroad are documented (Horncastle, 1994; Mathiesen & Lager, 2007; Rai, 2004). However, not much attention has been devoted to capturing the experiences of international educators teaching social work courses in the U.S. This paper seeks to fill this gap by describing some of the differences and challenges faced by those who come into America and teach BSW courses. It is presented from the point of view of an African doctoral student and his teaching experiences at a major university.

International students travel to America in their search for quality education, research opportunities, and most importantly, the contribution of an international education in securing more lucrative job opportunities. Social work scholars have identified a range of crucial issues facing international social work students. These issues are social, cultural and financial adjustments (Garrett & Herman, 2006), loneliness and mental health challenges (Lui, 2009), English language proficiency and the different pedagogical environment in the U.S. (Centingok & Hirayama, 1990; Rai, 2002). The same issues can be hypothesized as facing foreign instructors of BSW or MSW courses in the U.S.

Most universities have international students and faculty colleagues who face steep learning curves about America and American students. Social work educators who have been

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educated in the U.S. and who have spent little time living in other countries may not be attuned to the uniqueness and characteristic differences that we accept every day. Some of the differences are cultural; others are pedagogical and structural. For instance, in Nigeria every classroom has a student "class representative or governor" (i.e. a liaison between the students and the instructor), who cleans the blackboard and waits for all the students to arrive and be seated. The student rep then informs the professor that the class is ready. It is only then that the professor enters the room. Similarly, syllabi in that country do not contain the prohibitions against cell phone use and internet surfing during class time because students wouldn't dream of being so disrespectful.

The contrasts between African and American education are instructive for U.S. instructors in terms of helping those from other countries prepare themselves for the "American way" and the American undergraduate student. Accordingly, this article will make suggestions about orientation that can be used with baccalaureate and master of social work programs to prepare international instructors for the American undergraduate student.

Internationalization of Social Work Education

Awareness of diversity and internationalization is no doubt a cardinal objective of the Council on Social Work education (CSWE). To underscore the importance of this mission, the CSWE over the years has consistently emphasized infusing international content and knowledge in social work curriculum (Asamoah & Beverly, 1988; Healy, 1986; Healy & Thomas, 2007; Horncastle, 1994; Johnson, 1999) .The most recent CSWE Educational Policy and Accreditation Standards (EPAS) 2008, (Section 2.1.5) reaffirms this commitment.. The implication of the EPAS requirement as mandated by the CSWE is the new responsibility required of instructors to prepare the next generation of social work students as competent and knowledgeable practitioners in human, civil rights and global justice issues.

One of the strategies for achieving this internationalization mission is providing international instructors and graduate teaching assistants the opportunity to teach social work courses in the U. S. This provides the exchange of social work knowledge, cultural expectations, indigenous practice wisdom and education about the competences required to practice social work in Africa. International instructors, however, face challenges inside and outside of the classroom in the U.S. in their quest to contribute to internationalizing American students.

Challenges Faced by International Instructors and Adjustment Strategies

Inside the Classroom Challenges

Studies have shown that international students and instructors face a lot of classroom challenges in the U.S.(Adelegan & Parks, 1985; Cetingok & Hirayama, 1990; Foote, Li, Monk, & Theobald, 2008; Herrington & et al., 1993; Kavas & Kavas, 2008; Rao, 1993). Some of the common challenges international instructors face are: English language proficiency (Rao, 1993); complaints about accents or pronunciation (Kavas & Kavas, 2008); teaching skills and effectiveness (Neves & Sanyal, 1991). Others are : different grading system, students' expectations (Alberts, 2008); and students' stereotypes about foreign instructors (Foote, Li, Mony, & Theobald , 2008), to mention but a few.

From an African social work instructor's experience teaching BSW and MSW courses, the following are other potential problems faced in the classroom. These include: absence of a class representative, culture shock of being called by first name by the students, revealing clothing that some students wear, the challenge of mastering the use of different technologies to teach (e.g. Blackboard software), inability to use local socio-economic, pop culture and political

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issues as examples in teaching, and the different pedagogical approach to teaching social work (e.g. social development versus remedial approaches. See Anucha, 2008). The African instructor will also have to deconstruct media portrayal of all African as living in huts, slums, squalid villages and in perpetual poverty. This distorted impression influences students' perception, of Africans in general as well as the self-worth and overall demeanor of the African instructor in the classroom.

In addition, the African instructor will have to grapple with understanding the contractual obligation of the syllabus and perhaps the role of an academic ombud. Moreover, the pressure of having to learn rapidly to understand the different social welfare policies and programs in the U.S. (e.g. Food stamps, TANF, Medicare, Medicaid e.t.c), is another herculean task. The reason is that such policies and programs do not exist in most African countries. Finally, African instructors must adjust to the enormous power of American students in advocating for themselves as well as evaluating the instructor at the end of the semester. Students' evaluation of faculty is not common in African institutions.

Strategies to Overcome the Classroom Challenges

To address the classroom challenges faced by African instructors in American social work programs, the following strategies are suggested. First, the director of doctoral/graduate studies or a well-known faculty should introduce the new instructor on the first day of classes. This serves as an "ice-breaker" and helps to connect the instructor and the students. Second, prior to the initial class contact foreign instructors in social work programs should be given an orientation to the teaching styles (e.g., active learning), and technologies, as well as a brief overview of what American students expect of faculty and themselves. International instructors who are to teach in specific content areas (e.g., policy) might be given a reading list and sufficient time to learn about the various social welfare policies and programs in the U.S. Third, foreign instructors should be informed not to try to speak like Americans as this makes their communication more complicated and could elicit frowns from students. The emphasis should be on clarity of speech and slow but steady tempo of their communication in class. It helps students to follow and understand the teacher. Lastly, African instructors should be oriented about cultural and social behaviors of American students (e.g., dating, involvement in fraternities and sororities, etc); this will help international instructors to become culturally competent.

Outside Classroom Challenges

Beyond the four walls of the classroom, foreign social work instructors also face a lot of psycho-social challenges which may affect their teaching. Evidence from literature indicates that the most prominent of these problems are: loneliness, isolation, and mental health problems (Lui, 2009) as well as the demands of acculturation (Mittal & Wieling, 2006).Other issues include, financial difficulties (Rai, 2002) and meeting the expectations of American graduate studies (Reynolds & Constantine, 2007).

Furthermore, foreign instructors feel detached from faculty governance, student activities, and often desire research collaboration with their U.S. counterparts. In addition, non-native instructors often feel the need for a supportive environment for their spiritual and religious identity.

Strategies to Address These Problems.

Social work programs and faculty can help address many of these problems. First, faculty can link-up African instructors with professors or other students from their country through their

office of international affairs. Second, social work programs can do an initial background search of resources that foreign instructors might need. These include grocery stores, places of worship, and immigrant organizations. This greatly hastens the acculturating process.

Foreign instructors can be integrated into faculty governance and the life of the college by being invited to serve on committees and by being asked to present in brown bag sessions to social work students' associations and faculty. Similarly, international graduate students who are instructors should be specially mentored to further develop their teaching and research competencies. A potential benefit of this is that it may be the bridge and resource for future collaboration, whether the foreign instructor needs a dissertation topic or to returns to his or her country and wishes to continue a research interest. Knowing about and participating in ongoing research projects provides the international teaching assistant/instructor with real examples that enhance lectures and classroom activities.

Conclusion

International instructors can enrich and broaden undergraduates' knowledge about social work in other countries. Implications for social work programs include cross-cultural knowledge, competence, and education (Carrilio & Mathiesen, 2006). It provides a new lens for understanding diversity, while internationalizing the curriculum and fulfilling the CSWE EPAS requirements. In addition, it exposes students to social work practice and professional opportunities outside of the U.S. as well as supplying opportunities for collaboration, various types of exchange programs. Despite the challenges international instructors face, social work programs are adequately fit to meet these challenges and. encouraged to give more opportunities to international instructors.

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