

THE SCHOOL OF SOCIAL SERVICE ADMINISTRATION



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ADVOCATES' FORUM 2008 STUDENTS OF THE SCHOOL OF SOCIAL SERVICE ADMINISTRATION THE UNIVERSITY OF CHICAGO

# Advocates' FORUM

*Advocates'*  
FORUM  
2008



2008

# *Advocates'* FORUM

2008

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Advocates' Forum is an academic journal that explores implications of clinical social work practice, social issues, administration, and public policies linked to the social work profession. The Editorial Board of Advocates' Forum seeks to provide a medium through which SSA students can contribute to public thinking about social welfare and policy in theory and practice. Above all, Advocates' Forum will serve to encourage and facilitate an open, scholarly exchange of ideas among individuals working toward the shared goal of a more just and humane society.

EDITORIAL POLICY

Advocates' Forum is published by the students of the School of Social Service Administration (SSA) at the University of Chicago. Submissions to the journal are selected by the editorial board from works submitted by SSA students and edited in an extensive revision process with the authors' permission. Responsibility for the accuracy of information contained in written submissions rests solely with the author. Views expressed within each article belong to the author and do not necessarily reflect the views of the editorial board, the School of Social Service Administration, or the University of Chicago. All inquiries and submissions should be directed to:

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ESSAYS AND ARTICLES

The Emergence and Obstacles of the Immigrant Rights Movement  
by Kathryn Hoban . . . . . 1

The Childhood Obesity Epidemic as a Burgeoning Site of Social Stratification  
by Charity Samantha Fitzgerald . . . . . 19

Adolescents and Adherence to Medication Protocol: An Evidence-Based Approach  
by Eric Brown and Marissa Morris-Jones . . . . . 37

Myths, Ceremonies, and Power-Dependence Relationships: Organizational Theory and Charter School Autonomy  
by John J. Fanning . . . . . 54

An Introduction to Interpersonal Violence Prevention  
by Marita K. Herkert and April L. Kopp . . . . . 63

Strengths and Limitations of Home Visiting to Prevent Child Maltreatment by Teen Parents  
by Marita K. Herkert . . . . . 65

Child Sexual Abuse Prevention and Social Connection  
by April L. Kopp . . . . . 78

DISSERTATION ABSTRACTS

Employers' Use of Labor Market Intermediaries (LMIs) in Filling Lower-Level Jobs and Implications for Lower-Skilled LMI Clients  
by Timothy P. Hilton . . . . . 101

The Impact of Provider Characteristics on the Quality of the Client-Provider Relationship in Mental Health Services  
by Colleen A. Mahoney . . . . . 103

ON THE COVER

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

## FROM THE EDITORS

**I**n light of the centennial achievements of the University of Chicago's School of Social Service Administration, *Advocates' Forum* is similarly celebrating an unprecedented publication year. The Editorial Board expanded from eight to 15 members and received the highest number of submissions in the history of the journal. The journal also said "farewell" and "thank you" to long-time faculty advisor, Virginia Parks, Ph.D., to welcome new faculty advisor, Malitta Engstrom, Ph.D.

The 2008 issue of *Advocates' Forum* is set to complement the proceedings of social service organizations and activities at both domestic and international levels. The articles chosen reflect the dedication of the School of Social Service Administration to the community in a variety of domains. Indicative of the diverse interests and concerns of social workers, the themes of this issue include immigration, public health, and education. Each article uniquely combines social work theory with case example application, including current events, field placements, and social service programs.

Authors Kathryn Hoban and Charity Samantha Fitzgerald investigate how social movements in immigrant rights and public health accomplish goals both specific and challenging to their respective agendas. Ms. Hoban conducts a reflexive analysis of the Chicago demonstrations for immigrant rights, seeking to understand the proclaimed strategies and goals in her article, "The emergence and obstacles of the immigrant rights movement." In "The childhood obesity epidemic as a burgeoning site of social stratification," Ms. Fitzgerald examines how the field of public health has reinforced social stratification in the anthropological, social, and political spheres of childhood obesity.

Three authors use Chicago field placement sites as case studies for medical social work intervention and organizational analysis. In their article, "Adolescents and adherence to medication protocol: An evidence-based approach," Eric Brown and Marissa Morris-Jones use the Client-Oriented Practical Evidence Search (COPES) methodology to develop an evidence-based intervention for increasing an adolescent client's medication adherence while respecting the client's need for increasing autonomy. John J. Fanning presents a critical analysis of the power structure of charter schools in his

article, “Myths, ceremonies, and power-dependence relationships: Organizational theory and charter school autonomy.”

Finally, this issue features a section on interpersonal violence prevention. In her article, “Strengths and limitations of home visiting to prevent child maltreatment by teen parents,” Marita K. Herkert reviews four programs for their effectiveness in supporting adolescent parents and preventing interpersonal violence in their families. April L. Kopp, in her article, “Child sexual abuse and social connection,” uses the Stop It Now campaign as a case study to consider public health and social connection approaches to child sexual abuse prevention. Both articles encourage the use of a public health model for preventing family violence before it occurs.

The authors of the 2008 issue advocate for public awareness and critical analysis of efforts to address immigrant rights, medication adherence, childhood obesity, charter schools, teen parenting challenges, and child sexual abuse. These are only a handful of the concerns currently on the minds of social workers. *Advocates’ Forum* authors, readers, and clients alike are stakeholders in the future outcomes of these issues. It is our hope as coeditors that these articles move readers to assume responsibility to debate, respond, and continue in their advocacy for social justice and welfare.

April L. Kopp  
Kathryn Saclarides

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## EDITORS

APRIL L. KOPP is a second-year clinical student at the School of Social Service Administration. She is grateful for support from the Beatrice Cummings Mayer Fellowship in Violence Prevention and the William S. and Doris Jean Keller Family Scholarship in Child Welfare. She was educated at the University of Chicago and the University of Iowa Writers' Workshop. Her current field placement is with the Chicago Child Care Society, where she provides counseling to children and families.

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SARAH SCHUTZ is very proud to be a 2008 graduate of the School of Social Service Administration and hopes to work in healthcare planning and development, fundraising, or consulting. She leaves SSA with an administration and policy concentration, as well as a certificate from the Graduate Program in Health Administration and Policy (GPHAP). She has served as a GPHAP student representative during the 2007–2008 year.

SARAH WURZBURG is a second-year social administration student at the School of Social Service Administration, with a concentration in policy analysis. As an undergraduate, Sarah majored in English writing. She has enjoyed the opportunity to work on this journal.



# THE EMERGENCE AND OBSTACLES OF THE IMMIGRANT RIGHTS MOVEMENT

*By Kathryn Hoban*

In March and May of 2006, an unprecedented number of people took to the streets to demonstrate for immigrant rights. These marches marked the public emergence of a social movement. The article uses social movement theory to conduct a reflexive analysis of the current immigrant rights mobilization, exploring its emergence and goals. This study concludes by examining strategies for the movement's success.

On December 16, 2005, the U.S. House of Representatives approved the Border Protection, Antiterrorism, and Illegal Immigration Control Act (H.R. 4437) with a vote of 239 to 182 (Lazos Vargas, 2006). The legislation, introduced by Rep. James Sensenbrenner on December 6, 2005, is also popularly known as the Sensenbrenner bill. Among other things, the bill proposed to make it a felony offense to be an undocumented immigrant, make assistance to immigrants a felony, authorize the building of an additional 700 miles of wall along the U.S.-Mexico Border, require government officials to detain undocumented individuals, and require employers to confirm employees' immigration status by conducting background checks (H.R. 4437, 2006).

As the bill was taken up in the Senate, concern began to filter through the Latino community, radio stations began to discuss H.R. 4437 on air, and immigrant groups began to mobilize opposition (Lazos Vargas, 2006). The first large protest took place in Chicago on March 10, 2006, with an estimated 100,000 to 300,000 participants. On March 26, 2006, a "national day of action," marches were organized in cities all across the nation. Marches took place in Chicago, New York, Atlanta, Washington, DC, Phoenix, Dallas,

Houston, Tucson, Denver, and many more cities (Robinson, 2006, p. 78). Estimates of attendance for the march in Los Angeles range from 500,000 to 1.3 million people. Demonstrations included widespread student walkouts (Loyd and Burrige, 2007). On May 1, 2006 another series of national protests was organized. Immigrant workers, students, and supporters were encouraged to participate in a nationwide boycott in order to demonstrate immigrant contributions to the United States (Pulido, 2007).

The first series of protests aimed to demonstrate opposition to H.R. 4437. Angela Sanbrano, one of the organizers of the March 26 demonstration in Los Angeles, is reported to have said: "We needed to send a strong and clear message to Congress and to President Bush that the immigrant community will not allow the criminalization of our people" (Bernstein, 2006, p. 1). At later marches, "instead of merely demanding the rejection of punitive immigration measures, the protesters sought nothing less than justice for immigrants and supported legislation allowing undocumented immigrants the opportunity to regularize their immigration status" (Johnson and Hing, 2007, p. 100).

The Sensenbrenner bill was not passed by the Senate. Instead, in May 2006, the Senate passed a compromise measure (S. 2611) that did not include the most controversial aspects of the Sensenbrenner bill. Congress did authorize the building of the 700-mile wall (120 Stat. 2638 [2006]). By the end of the summer, Congress turned its attention away from immigration issues, and attendance at immigrant rights demonstrations appeared to have diminished (Johnson and Hing, 2007).

This article looks at the immigrant rights movement from a national perspective. Discussion of events in particular cities are intended to contribute to an understanding of the movement as a whole. The article does not attempt the question of whether the marches in 2006 constitute a movement. The phrases "immigrant rights movement," "the movement," and "mobilizations" are used synonymously here to refer to the collective occurrence of demonstrations in many cities in the United States in spring 2006. The term "immigrant rights" is not used here to refer specifically to concrete legal rights. Rather, "immigrant rights" refers to the collective grievances expressed during the spring 2006 marches.

The aim of this article is to utilize frameworks for analyzing the emergence and obstacles of social movements in order to better understand the immigrant rights movement. Theoretical analysis and literature review contribute to greater understanding of what led to the emergence of the immigrant rights movement. They also contribute to a discussion of the movement's capacity

to achieve such goals as transforming class structure, democratizing society, redefining cultural identity, and confronting neoliberalism.

#### THE EMERGENCE OF A MOVEMENT

In their book, *Dynamics of Contention*, Doug McAdam, Sidney Tarrow, and Charles Tilly (2001) write that during the 1960s and 1970s, much of social movement analysis focused on four key concepts. Those four concepts were:

*Political opportunities*, sometimes crystallized as static opportunity structures, sometimes as changing political environments; *mobilizing structures*, both formal movement organizations and the social networks of everyday life; *collective action frames*, both the cultural constants that orient participants and those they themselves construct; established *repertoires of contention*, and how these repertoires evolve in response to changes in capitalism, state building, and other less monumental processes. (pp. 14–15)

According to McAdam and associates (2001), focus on these four concepts took the forefront of the discussion of social movements in response to critique of prior social movement analysis. McAdam and associates (2001) lay out the primary schools of thought that developed from this critique. Resource mobilization models give emphasis to “organizational bases, resource accumulation, and collective coordination for popular political actors” (2001, p. 15). Political-process analysts, however, stress “dynamism, strategic interaction, and response to the political environment” (2001, p.16). The work of political-process analysts highlighted the role of “repertoires of contention” (15) in social movements. “Repertoires of contention” are “the culturally encoded ways in which people interact in contentious politics” (2001, p. 16). More recent research has added a fourth component to social movement studies. It draws on “social-psychological and cultural perspectives” (2001, p. 16), which contribute to social movement analysis an understanding of “how social actors frame the claims, their opponents, and their identities” (2001, p. 16). These perspectives view framing as “an active, creative, and constitutive process” (p. 16).

McAdam and associates (2001) contend that one can draw boundaries between the schools of thought: “It would do no good to exaggerate the distinctions among enthusiasts for resource mobilization, political process, repertoires of contention, and framing” (p. 16). They add: “In fact, by the 1980s, most North American students of social movements had adopted a

common social movement agenda and differed chiefly in their relative emphasis on different components of that agenda” (2001, p. 16). Thus, McAdam and Associates have taken elements from different perspectives on social movement theory, resource mobilization, political process, repertoires of contention, and framing, merging those perspectives into a single model. McAdam and colleagues (2001, p. 14) term their synthesized model “the classic social movement agenda.” The model depicts social change, mobilizing structures, opportunity, threat, framing processes, and repertoires of contention, all in dynamic interaction leading towards contentious encounters. They respond to critiques that the classic social movement model is “overly structural and static” (2001, p. 18) by emphasizing aspects of dynamic mobilization. In doing so, they “try to identify the dynamic mechanisms that bring these variables into relation with one another and with other significant actors” (p. 43). This article utilizes McAdam and associates’ (2001) model as an analytical framework for describing the emergence of the contentious interaction that took place in spring 2006, when millions marched nationwide in demonstration for immigrant rights.

## PARTS OF A CAMPAIGN

### *Social Change*

McAdam and associates (2001) write that social change processes “initiate a process of change and trigger changes in the political, cultural, and economic environments” (p. 41). Their discussion of social change looks at the way changes in the political, cultural, and economic environments impact the other components of the model, thus contributing to the emergence of a social movement. McAdam and associates (2001) discuss the social changes that facilitated the emergence of the civil rights movement. For example, the extension of voting rights to African Americans led to political opportunity, and southern urbanization led to the development of mobilizing structures. McAdam and associates (2001, p. 43) further note: “These changes thus loosened the cultural hold of Jim Crow, enabling civil rights forces to *frame grievances* in new and more contentious ways.” The changes also “gave them the capacity to embrace a broader *repertoire of contention*” (p. 43).

The increase in the size of the immigrant population is contemporary social change that serves as a catalyst for mobilization around issues related to immigration. In addition, mobilization on immigration can be triggered by population growth within a single cultural group. Nilda Flores-Gonzalez and associates (2006) note that 36 million Latinos live in the United States, and there are an estimated 12 million undocumented immigrants in the United

States (Lazos Vargas, 2006). At the May 1 demonstration in Chicago, Flores-Gonzalez and associates (2006) surveyed 410 participants using a “multi-stage block sampling technique to give respondents an equal chance of being selected for the study” (p. 2). They followed-up the survey by interviewing “participants, organizers, and leaders of organizations that participated in the mobilizations” (2006, p. 1). The Mexican cultural group is prominent among Latino immigrants in Chicago, and the salience of the Mexican cultural group is noteworthy within the current social context. Flores-Gonzalez and colleagues (2006) note that 52 percent of all surveyed individuals indicated having Mexican heritage, and 81 percent of foreign-born surveyed individuals self-identified using a term that indicated some form of Mexican cultural identity. Though unconfirmed, perhaps the perception of power derived from such a context may expand immigrants’ willingness to contend politically and to push for rights.

The political climate’s hostility toward immigrant policy is another social change that is prompting immigrant mobilization (Johnson and Hing, 2007; Lazos Vargas, 2006; Pulido, 2007). For example, Aristide Zolberg (2006) discusses how the events of September 11, 2001, and George Bush’s focus on terrorism changed the political discourse around immigration, immigration policy, and diplomacy with Mexico’s President Vicente Fox. The Sensenbrenner bill, which includes “antiterrorism” within its formal name, identifies illegal immigration as a threat to national security. Since September 11, 2001, immigration policy has been reshaped “largely as a means of fighting terrorism” (Tumlin, 2004, p. 1175). The impact of the Bush administration’s antiterrorism agenda is not lost on participants in the immigrant rights movement. Gilberto Castro, while protesting in Los Angeles, is reported to have said: “We came here to protest. They want to pass a law to treat immigrants like terrorists” (Reynolds and Fiore, 2006, p. 1).

### *Political Opportunity and Threat*

McAdam and associates (2001) describe political opportunity and threat in changes to the political environment that shape the “ebb and flow of a movement’s activities” (p. 41). They write: “*Political opportunities and constraints* confront a given challenger” (p. 41; i.e., a challenger to the social condition), and, “The political environment at any time is not immutable; the political opportunities for a challenger to engage in successful collective action vary over time” (p. 41). They note by way of example that black suffrage served as a political opportunity for the civil rights movement, “transforming the previously nonexistent ‘black vote’ into an increasingly important electoral resource in presidential politics” (McAdam et al., 2001, p. 42).

As their numbers grow, immigrants gain a political opportunity to increase their power and influence. Gastón Espinosa (2007, p. 153) writes: "The critical role of Latinos in the 2004 election ... has also prompted many Democratic and Republican politicians to pay close attention to the immigration policy reform debate." Anti-immigrant sentiment and policy, however, represent political threats to these groups. The threat of the Sensenbrenner bill certainly motivated many people to participate in demonstrations (Johnson and Hing, 2007; Larzos Vargas, 2006; Pulido, 2007). Opportunity and threat are represented in Amy Shannon's (2007) analysis of the 2006 events. She writes: "Whereas the March and April events focused on opposition to H.R. 4437, the May 1 rallies called for an immigration reform that would allow those in the United States to legalize their status" (2007, p. 29). The May 1 rally demonstrated a shift from mobilizing in response to political threat to mobilizing to act on perceived political opportunity.

As McAdam and associates (2001) observe, this component makes the classic social movement model more dynamic: "Opportunities and threats are not objective categories, but depend on the kind of collective attribution that the classical agenda limited to framing of movement goals" (p. 45). The impact of opportunities and threats depends upon whether or not they are recognized and how they are interpreted or constructed. An interesting example of how the Latino community came to recognize the threat of anti-immigrant sentiment took place on the radio in Los Angeles. Sylvia Lazos Vargas (2006) describes an interview that El Piolin, a popular radio announcer, conducted on the air with a member of the Minuteman organization, characterizing the event as a "pivotal moment" (p. 813). The minuteman's rant about how all Latinos should be deported "convinced listeners that anti-immigrant sentiment was real and very ugly, and it shook many out of complacency" (2006, p. 813).

### *Mobilizing Structures*

McAdam and associates (2001) define the mobilizing structures component of the classic social movement model as "both formal movement organizations and the social networks of everyday life" (p. 14). Mobilizing structures "promote communication, coordination, and commitment within and among potential actors" (p. 16). They offer black churches, black colleges, and NAACP chapters as examples of mobilizing structures in the civil rights movement.

Irene Bloemraad and Christine Trost (2007) outline some of the mobilizing structures that brought youth and adults to the rally in Oakland, California, on May 1, 2006. Bloemraad and Trost (2007) emphasize the role of the family

as a mobilizing structure in which youth were likely to have encouraged parents to participate. They also found that schools, youth groups, and peers most often influenced youth participation in the rally, but work, church, and peers encouraged parent participation. Nik Theodore and Nina Martin (2007) examine the role of community organizations within the primarily immigrant community of Chicago's Albany Park, documenting the organizations' role in "immigrant incorporation, political mobilization, and civic engagement" (p. 270). The media is another mobilizing structure. Flores-Gonzalez and associates (2006) found that more than half of those surveyed reported having heard about the May 1, 2006 march in the media, especially through the Spanish-language media.

In reframing the mobilizing structure as one in an increased state of dynamism, McAdam and associates (2001, p. 45) note: "Mobilizing structures can be preexisting or created in the course of contention but in any case need to be appropriated as vehicles of struggle." This new understanding of mobilizing structures suggests that they are no longer static. Instead, existing organizations shift their goals and become vehicles of struggle, and new mobilizing structures can emerge. The dynamic understanding of mobilizing structures is evident in the immigrant rights movement, as students transformed schools into spaces for organizing and workers caused their places of employment to close for the day (Pulido, 2007).

### *Collective Action Frames*

McAdam and associates (2001) describe the "collective action frames" component of the classic social movement model as "both the cultural constants that orient participants and those they themselves construct" (p. 14). In other words, frames that guide participation in movements are both built into social norms and consciously constructed. Framing, "a collective process of interpretation, attribution, and social construction, mediates between opportunity and action," producing "shared definitions of what is happening" (2001, p. 16). They write that through this "collective process ... movements frame specific grievances within general collective action frames which dignify claims, connect them to others, and help to produce a collective identity among claimants" (p. 41). McAdam and associates (2001) reinterpret framing as a dynamic process by arguing that framing is not restricted to only impacting movement goals. Instead, it takes place throughout all parts of a social movement. They write: "Entire episodes, their actors, and their actions are interactively framed by participants, their opponents, the press, and important third parties" (2001, p. 45).

Two main frames have substantially affected the movement under discussion. The first frame shifted from an initial response to political threat at the March and April rallies to a later response to political opportunity at the May 1 rally. Organizers of the March and April demonstrations framed the events as opportunities to demonstrate against the threats they saw in H.R. 4437. The May 1, 2006, rally represents the frame's shift to emphasize collective power to assert demands. As they marched, participants chanted, "*Hoy marchamos, mañana votamos!*" [Today we march, tomorrow we vote!] (Shannon 2007, p. 31), as an opportunity to demonstrate the movement's political power to politicians, media, and the movement's many participants. Kevin Johnson and Bill Hing (2007, p. 103) write: "The nascent movement, at least at the outset, represented a reaction to the Sensenbrenner bill, not a proactive movement seeking positive change.... At least for a time, however, the movement later transformed itself into a quest for justice for immigrants that moved well beyond blocking the passage of one restrictionist bill."

In this movement, a second frame is the perception that anti-immigrant sentiment and policy pose threats to all Latinos, not just to new undocumented immigrants. The relevant threats are seen as dangerous to the Latino American culture, not simply to immigrants. In her study on Latino high school seniors in Los Angeles, Lisa García Bedolla (2000) found that youths' participation in the movement was guided by (1) whether they felt connected to or identified with the immigrant community, and (2) whether they viewed immigrant legislation as only anti-immigrant or also as anti-Latino.

### *Repertoires of Contention*

McAdam and associates (2001) describe "repertoires of contention," another component of the classic social movement model, as "the array of means by which participants in contentious politics make collective claims" (p. 18). They distinguish between two types of contention: transgressive and contained contention. Transgressive contention "offers the advantages of surprise, uncertainty, and novelty" (2001, 41). Contained contention has "the advantage of being accepted, familiar, and relatively easy to employ by claimants without special resources or willingness to incur costs and take great risks" (p. 41). Examples of the repertoires of contention used in the civil rights movement include "marches, sit-ins, and other transgressions of white power" (p. 43). McAdam and associates (2001, p. 49) then present a dynamic interpretation of the component: "Innovative contention is action that incorporates claims, selects objects of claims, includes collective self-representations, and/or adopts means that are either unprecedented or forbidden within the regime in



question.” Rarely, however, do these parties to the conflict adopt innovative forms of action that are truly new.

Two main threads of contention can be seen within the current mobilization around immigrant rights. Both expressions represent contained contention in that they are common culturally and politically acceptable forms of social resistance. The rallies represent the first expression of contention. Media reports note the high numbers of participants and comment on the peaceful, well-contained nature of the demonstrations. One article described the May 1 demonstration as “a peaceful gathering awash with American flags” (Avila and Olivo, 2006b, p. 1). Another characterized the March 10 demonstration as a “festive” event full of baby-stroller pushers and, as a Chicago Police deputy superintendent put it, “a very good march” (Avila and Olivo, 2006a, p. 1).

The second strategy of contention within this movement is evident in the informal strikes by workers and students. In noting the effects of the marches on local businesses and schools, the *Chicago Tribune* observed that immigrant participants in the rallies made a “powerful statement elsewhere by their absence” (Avila and Olivo, 2006a, p. 1). While their immigrant (and immigrant-supporting) employees were demonstrating, many businesses across the nation were forced to close. Also remarkable, were the empty classrooms that resulted from droves of high school students opting out of school for the day to participate in the demonstrations (Lazos Vargas, 2006; Loyd and Burridge, 2007; Robinson, 2006).

### *Emergence Explained by the City and beyond*

An additional way to understand the emergence of the movement is to examine it within the geographic context of the city. The density of social ties and networks in the city, and their diversity, shapes the emergence of social movements (Nicholls, 2007). Regional and national networks also contribute to the emergence of social movements (Pastor, 2001).

### *Utilizing Social Ties*

Walter Nicholls (2007), a contemporary social movement theorist, considers cities to be hot spots for social movements because of the richness of relationships that urban settings foster, both within and across communities. At an organizational level, there are “strong tie” connections within social change organizations, as well as “weak tie” connections that link organizations with each other and with political structures (Nicholls, 2007, p. 3). The presence of both strong and weak ties within cities offers a valuable foundation for social

change organizing. Nicholls's theory builds upon the classical discussion of the role of mobilizing structures in promoting the emergence of social movements. He observes the value of organizations operating independently but also the value of organizations working together in networks towards shared or complementary goals.

In the current mobilization, there is evidence that both strong and weak ties play important roles in mobilizing people. Bloemraad and Trost (2007) focus on the crucial role that youth played by informing their parents about the movement and motivating them to participate. This is an example of how Nicholls's (2007, p. 3) "strong tie" networks play a role in mobilizing participation in the movement. Bloemraad and Trost (2007) also discuss the role of the media and the Web site MySpace in dispersing information about the marches. Media and online networks facilitate communication between "weak tie" networks (Nicholls, 2007, p. 3). Flores-Gonzalez and colleagues (2006) note the role of personal relationships in mobilizing movement participants, finding that 56 percent of participants in Chicago's May 1 march came with family members and 54 percent came with friends. Their results also suggest that weak ties can be influential in mobilization. They find that 71 percent of surveyed march participants reported receiving encouragement from religious leaders to attend the march, and 56 percent reported that they heard about the march on the radio.

### *Networking beyond the City*

Byron Miller (2000) and Manuel Pastor (2001) discuss the benefit of organizing around an issue that transcends restrictive identities or locations. Pastor (2001) identifies potential opportunity for mobilization around issues that extend beyond the impact of local geographies. Miller (2000) identifies opportunity for mobilization through the use of "place-based collective identities ... [that] can offer social movements a very effective means ... by which to bridge or partially transcend identities constructed along lines of class, race, ethnicity, gender, and sexuality" (Miller, 2000, p. 61).

Immigration issues have the potential to unite diverse groups, but the extent of that potential depends on the scope of the issues confronted and the tactics used in doing so. Pastor (2001) identifies opportunity for successful social movements in taking on issues, using frames, and choosing tactics that extend the scope of the movement beyond the local and beyond a single identity group. By framing immigrant issues as broadly relevant to Latino culture, organizers may incite participation, but this framing may also alienate immigrant groups and may therefore diminish opportunities for cross-cultural organizing,

weakening the potential for success. In addition, organizing around immigrant issues can be very location-specific, resulting, for example, in the establishment of a day-labor center in a particular neighborhood (Theodore and Martin, 2007). Such efforts bring valuable accomplishments but fail to maximize participation beyond the immediate location due to the geographic limits of the organizing goals. Manuel Castells (1983) is concerned that urban social movements have the tendency to take on issues of municipal resource allocation rather than confronting broad underlying issues of class and racial inequality. Movement strategies, and the cultural groups thus included or excluded by each strategy, can have great implications for the success of a movement.

## ANALYZING THE SOCIAL MOVEMENT

### *Taking on the Challenge: Castells's Goals for a Social Movement*

Castells (1983) identifies three potential goals for urban social movements. He defines goals as “purposive desires and demands present in the collective practice of the movement” (1983, p. 319). His three goals are: “collective consumption demands, community culture, and political self management” (p. 322). By making demands concerning city resource allocation, urban social movements aim to transform class structure. By pushing to define community culture internally or to bridge cultural identities, movements redefine cultural identity. As movements promote increased power in government, they further democratize society. In his analysis of various social movements, Castells observed: “Not all of the movements we observed had the three basic goals; nor did they pursue them with the same intensity” (p. 319). Yet, Castells argues: “To accomplish the transformation of urban meaning in the full extent of its political and cultural implications, an urban movement must articulate in its praxis the three goals” (1983, p. 322). The following section analyzes the current immigrant rights mobilization in light of Castells’s three goals, arguing that the immigrant rights movement has the capacity to take on all three of the goals.

### *Transforming Class Structure*

Castells asserts that successful social movements challenge class structure. He argues that they must also push for a redistribution of power and resources for workers. Castells (1979) challenges social movements to achieve their revolutionary potential by partnering with labor organizations and radical political groups.

The mobilization under study here is tied to labor issues. Some participants in the demonstrations expressed a clear desire for workers' rights and legalized working status. Flores-Gonzalez and associates (2006) found that 12 percent of surveyed participants identified work or workers' rights as reasons for marching. They also note that 27 percent of surveyed marchers said they were marching for legalization. Legalization would offer political legitimacy and legal work status. Other participants expressed a desire for recognition of immigrant contributions to the city and economy. One demonstrator is reported to have said: "Most people don't realize how much work we do, but it's part of their daily lives.... We are putting up all the buildings and cooking all the food. Today, they'll understand" (Avila and Olivo, 2006a, p. 1).

The current class structure within the United States relies upon subclass laborers who have compromised protection under U.S. labor laws (Ontiveros, 2008; Robinson, 2006). Maria Linda Ontiveros (2008, p. 157) writes: "Historically, labor laws systematically excluded immigrant workers from their protections in several ways." First, immigrant workers are excluded by industry; "many of the industries in which immigrants labor, such as agriculture and domestic work, are excluded from federal statutory protections for the right to from unions" (p. 158). Additionally, most labor laws extend only to those who are employees, and exclude from protection temporary or subcontracted employment, the very type of employment agreements under which many immigrants work. William Robinson (2006) writes that Latino immigration benefits employers because they "want to sustain a vast exploitable labor pool that exists under precarious conditions, that does not enjoy the civil, political, and labour rights of citizens and is disposable through deportation" (p. 84). He describes the "new class relations of the global capitalism," relations that "dissolve the notion of responsibility, however minimal, that governments have for their citizens or that employers have towards their employees" (2006, p. 89). He states that workers are the archetypes of the new class relations because "they are a naked commodity, no longer embedded in relations of reciprocity rooted in social and political communities that have, historically been institutionalised in nation states" (p. 89).

Robinson notes that the movement's success in challenging the U.S. and transnational class structure depends upon how the movement sets its goals. First, the movement has potential to transform class structure by taking a role in shaping policy that impacts workers. The Sensenbrenner bill is an example of such a policy (Robinson, 2006). Second, as the movement sets its goals at achieving legalized status for undocumented workers and paths toward citizenship, there is potential to transform the class structure. Robinson (2006,

p. 89) writes that the immigrant rights movement demands “full rights for all immigrants, including amnesty, worker protections, family reunification measure, a path to citizenship or permanent residency ... an end to attacks against immigrants and to the criminalisation of immigrant communities.” He asserts that the movement goes “beyond immediate demands; it challenges the class relations that are at the very core of global capitalism” (p. 89). He thus concludes that “the struggle for immigrant rights is at the cutting edge of the global working-class fight-back against capitalist globalisation” (2006, p. 89).

### *Redefining Cultural Identity*

Two elements comprise Castells’s (1983) second classification of social movement goals. The first way that movements have the capacity to redefine cultural identity is by developing community and asserting the right for a cultural group to maintain or develop its own identity. The second way that movements can redefine cultural identity is by connecting cultural groups that do not normally align, thereby creating transcultural networks.

According to Sylvia Lazos Vargas (2006), the immigrant rights movement has both reconstructed the cultural narrative of immigrants and redefined American cultural identity. She writes:

The *new* immigrant narrative was about risking one’s life to cross the border, working tirelessly in difficult jobs to make a better life for one’s children, living in fear of deportation but somehow hanging on until one could legalize immigration status. In this new narrative, the immigrant, whether authorized or unauthorized, was part of America and could lay claim to the American dream, too. (p. 808)

Results of the survey by Flores-Gonzalez and associates (2006, p. 5) indicated that 91 percent of respondents “expressed strong love” for the United States; 94 percent maintain that dual-citizens can be dually loyal. These results suggest that the movement’s participants do not view cultural identity as a barrier to national identity. This is an example of what Richard Alba (2005) would view as a blurred, or ambiguous, boundary.

Castells (1983) cautions social movements against defining themselves as culturally homogenous. Rather, he argues, they should work to ground identity in constructs that transcend individual racial or cultural groups. Flores-Gonzalez and colleagues (2006) observe that the May 1 demonstration showed “the potential for Latinos of different national backgrounds to work together towards a common goal” (p. 4). Lazos Vargas (2006) agrees that “this movement

began to forge a new political Latina/o common identity and break down the identity silos that have divided Latina/os” (p. 808). García Bedolla’s (2000) research with Latino high school seniors indicates that whether the movement is framed as an immigrant movement or a Latino rights movement impacts the students’ level of identification with the movement as well as their participation. Broadening the movement to address issues that all Latinos face may enable a successful social movement to bridge differences among Latino cultural groups. Framing the movement as a Latino movement too firmly, however, may have unintended consequences. Doing so may exclude other immigrant and culturally oppressed groups. Johnson and Hing (2007, p. 102) observe: “Although masses of people participated, the marchers were not as representative of different minority groups as might have been desired.” They argue that, for the immigrant rights movement to develop into a new civil rights movement, it “must not just be about immigration, but also must include African Americans” (p. 101). To build such a movement, they suggest finding common ground on such issues as wage and labor protections, housing, education, and racial discrimination.

### *Democratizing Society*

Castells’s third category is the struggle to increase citizens’ power and to build a more democratic society. Included in this goal is the aspiration to increase local self-government at the expense of the centralized state.

Flores-Gonzalez and associates (2006) suggest that the rallies may have “awakened the ‘sleeping giant,’ propelling people who were not politicized to march on the streets and risk losing their jobs for something that matters deeply to them” (p. 4). Demonstrations in March of 2006 had record-breaking attendance in both Chicago and Los Angeles (Robinson, 2006). By drawing participants in this way, the immigrant rights movement has already succeeded in democratizing society. Lazos Vargas (2006) describes the impact of movement participation on high school students who organized student strikes in Las Vegas, Nevada. She writes: “Students’ political consciousness was awakened.... The students were determined to be heard” (p. 814). The increased political participation within the movement carries a strong message to policy makers. Johnson and Hing (2007, p. 104) write: “In future debates over immigration, lawmakers will not soon be able to forget the power, emotion, and sheer size of the spring of 2006 mass marches. Nor will they forget the firestorm of anger, controversy, and resistance created by the punitive immigration measures in the Sensenbrenner bill.” The immigrant rights movement has created a space for public participation in the immigration policy process.

Attempts to democratize by organizing face several challenges. This is particularly true of attempts to organize a social group that is not politically enfranchised. Citizenship “affects the sense of membership and the willingness to make claims asserting rights” (Alba, 2005, p. 27). Yet, even Latinos who are citizens are underrepresented at voting polls (García Bedolla, 2000). Latinos are 14 percent of the population but only 8 percent of the electorate (Lazos Vargas, 2006). One way that the immigrant rights movement expands democratization in the Latino community is by offering many the opportunity for political participation without citizenship. In this case, such participation took the form of demonstrations and strikes. Through participation, noncitizens exercised civic power. The networks of community organizations and service agencies that comprise the “migrant civil society” have “emerged as a leading voice in policy debates at the federal, state, and local levels” on behalf of those who cannot make themselves heard through voting (Theodore and Martin, 2007, p. 271). Such organizations are also “crucial conduits of information and assistance with political incorporation” (Bloemraad, 2006, p. 678).

The popular slogan, “*Hoy marchamos, mañana votamos!*” (Shannon, 2007, p. 31), demonstrates the centrality of democratization as a goal for the immigrant rights movement. Yet, the difficulty the movement has encountered in following through on this assertion reveals the challenge of working with a group that represents the politically alienated and disempowered. Lazos Vargas (2006, p. 840) reports that “independent exit polls of Latina/os voters for the 2006 elections show that Latina/o voter turnout in November 2006 (58.9%) was only slightly higher than it was in the last midterm elections of 2002 (57.9%).” The slight differences do not indicate increased Latino voter turnout. However, Latinos were much more likely to vote Democrat, turning away from the party of the Republican Representative Sensenbrenner. She concludes: “The promise—or threat—of ‘*hoy marchamos, mañana votamos*’ may take several election cycles to show tangible numerical results” (Lazos Vargas, 2006, p. 840).

### *Confronting Neoliberalism at (the New) Home*

Globalization and neoliberalism have made immigration a central issue in domestic policy. The expansion of global poverty has been due in part to the aggressive implementation of capitalism in developing countries, an implementation driven by policies of the International Monetary Fund and the World Bank (Davis, 2006). Robinson (2006) discusses the push-and-pull factors that shape immigration flows: “If capital’s need for cheap, malleable and deportable labour in the centres of the global economy is the main ‘pull

factor' inducing Latino immigration into the US, the 'push factor' is the devastation left by two decades of neoliberalism in Latin America" (p. 85). These factors, and the growth of modern transportation technology have lifted many natural restrictions on the flow of immigration (Zolberg, 2006). Although immigration is a transnational issue, the policies of the nation-state have significant effects on the political incorporation of immigrants (Bloemraad, 2006), and the nation's policies are implemented by individual states and cities (Ellis, 2006). The city, state, and nation-state are therefore all appropriate levels at which to contest neoliberalism, the transnational system at the root of injustice against immigrants (Margit Mayer, 2007; Pastor, 2001). Theodore and Martin (2007) document the role of social movement and community-based organizations in mediating between immigrants and the "forces of global capitalism" that affect their "everyday lived experiences" (p. 275). The challenge for the immigrant rights movement is to identify local, state, and national opportunities to effectively push against neoliberalism.

## CONCLUSION

Castells's critique of urban social movements is that too often "they are a reaction not an alternative" (Castells, 1983, p. 322). To avoid falling into this pit, the immigrant rights movement can direct efforts to extend rights for immigrants rather than only reacting against bills that limit immigrant rights. The shift in framing, from resisting H.R. 4437 to making demands for legalization, demonstrates a sense of the movement's power and a strong strategic use of framing. To promote a movement's success, Castells (1983) recommends that actors should avoid setting goals too small. Successful movements also bridge identities (Castells, 1983), build networks (Nicholls, 2007), and extend both the geographical and cultural reach of the campaign (Pastor, 2001; Theodore and Martin 2007). Local action may offer opportunities to confront the underlying power inequalities inherent in neoliberalism where it touches down (Margit Mayer, 2007).

Revisiting theoretical considerations can enhance understanding of the ways by which social movements emerge. The application of Castells's three types of social movement goals enables one to examine the extent to which the movement is succeeding in efforts to effect social change. Pausing to consider the movement's challenges creates the opportunity to strategically overcome them.



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# THE CHILDHOOD OBESITY EPIDEMIC AS A BURGEONING SITE OF SOCIAL STRATIFICATION

*By Charity Samantha Fitzgerald*

This article deconstructs the childhood obesity epidemic, examining the anthropological, social, and political meanings of the constructs of fatness, obesity, and epidemic. It chronicles the emergence of a speciously objective obesity construct that preserves the underlying moral significance of a fatness construct. The political deployment of the obesity construct marginalizes certain groups, such as low socioeconomic-status (SES), racial-minority, and ethnic-minority families, in ostensibly scientific terms. So too, the political deployment of the epidemic construct secures the ascendancy of childhood obesity on the policy agenda. The article argues that social workers are obligated to deconstruct the constructs of obesity and epidemic.

*F*atness and obesity: the terms are related yet distinct. Crusaders who constitute a group of people that includes researchers, physicians, public health officials, and activists (Basham, Gori, and Luik, 2006) have subsumed the moral aversion to the construct of fatness under the speciously objective construct of obesity. Hereafter, the article eschews the moniker “crusaders,” coined by Paul Campos (2004, p. ix), for the less-emotive moniker “stakeholders.” This article presents the results of analysis of the ways in which the stakeholders have constructed obesity through the use of body mass index (BMI). Although the construct of obesity is ostensibly based in science and statistics, the stakeholders deployed it ahead of, or in spite of, attenuated and ambiguous evidence (Basham et al., 2006). Indeed, the obesity construct is value-infused and culturally produced (Cogan, 1999), in spite of its objective veneer. This article argues that the putative scientific aura of obesity shields the stakeholders from potential allegations of discrimination associated with class- and race-related discourse.

To fatness and obesity, one can add two additional terms: epidemic and childhood. Both of the latter terms heighten the salience of childhood obesity

on the policy agenda. The term “epidemic” functions as a warning that all must be vigilant against childhood obesity, as it is allegedly a highly contagious disease that can strike anyone anywhere (Gard and Wright, 2005). However, stakeholders also assert that obesity does not strike all equally; poverty and cultural values allegedly render some children more vulnerable than others to the epidemic (Okie, 2005). The modifier “childhood” elevates the obesity epidemic in agenda-setting processes. Children occupy a unique position in the realms of policy and politics. They have potential as future citizens and as limitations due to their developmental stage (Basham et al., 2006). Thus, policy makers both privilege and protect children; this raises child-related initiatives to the agenda (Basham et al., 2006).

The deployment of the obesity and epidemic constructs reveals the underlying social anxiety associated with an ostensibly health-related problem. Recommendations for policy interventions focus on low-SES, racial-minority, and ethnic-minority families. Children from these families are susceptible to being classified as obese according to the construct. Thus, the obesity construct ostensibly validates intervention into the lives of such families on the basis of health, yet the article contends that the posited interventions confound morality with health.

The article concludes with an analysis of the commitments social work has to the deconstruction of the childhood obesity epidemic. The profession’s role to examine the largely taken-as-a-given childhood obesity epidemic stems from a commitment to evidence-based practice. Based on this commitment, the article concludes that social workers might question existing policies that purport to eradicate the childhood obesity epidemic.

#### FATNESS: THE MORAL EPICENTER OF THE CHILDHOOD OBESITY EPIDEMIC

Cultural and social significances imbue the concept of fatness. The symbolic value of fatness differs over time and across cultures (Gard and Wright, 2005). At times, fatness has signified good health; at others, poor health. At times, it has signified high moral standing; at others, low moral standing (Gard and Wright, 2005). Presently, fatness connotes poor health and moral deviance (see National Association for Advancement of Fat Acceptance, n.d., for stereotypes about fat persons). Its current commonly held, though not monolithic, significance initially emerged at the end of the Victorian Era (Gard and Wright, 2005).

An aversion to fatness surfaced in both the medical literature (Gard and Wright, 2005) and the popular press (Stearns, 1999) at the turn of the twentieth century. The *Ladies Home Journal*, for example, noted in 1901 that every pound of unneeded fat should be shed (Stearns, 1999). Peter Stearns (1999) notes that moral stigma quickly attached to fatness during this epoch. Published texts, such as magazines and novels, portrayed fatness as a result of moral indiscretion (Stearns, 1999). The negative moral connotation of fat has persisted from the turn of the century until today (Seid, 1989). Writes Roberta Seid: “We, too, view with horror ... every bit of subcutaneous fat” (p. 22). Seid describes society’s revulsion to fat, which is perceived as “evil” (p. 22). Society perceives fatness as a “crime,” a result of personal deviance (Seid, 1989, p. 22). In the popular imagination, fatness signifies the moral failings of sloth and gluttony (Gard and Wright, 2005).

The moral aversion to child fatness did not rise concurrently with the moral aversion to adult fatness. Rather, the moral aversion to child fatness lagged several decades behind. Stearns (1999) chronicles this imbalance. Until the 1940s, underweightness preoccupied doctors more than overweightness. In the 1940s, medical articles began to indicate that excess fatness in children could cause problems. Popular opinion caught up to published medical texts in the 1960s. According to Stearns (1999), several causal mechanisms, two of which are discussed here, explain the temporal lag that separated moral aversion to fatness among adults from that among children. First, middle-class parents prior to the mid-twentieth century plentifully fed their children in order to distinguish them from undernourished immigrant children. Second, Stearns (1999) delineates a shift in religious culture. There was a softening in the Puritan conception of original sin, a conception that called for strict discipline of children; parents at the turn of the twentieth century began to regard children as innocent. Middle-class parents perceived the moral cleansing that a diet could provide as unnecessary for children. Eventually, however, the anxiety surrounding the fatness construct subjugated the hallowedness of the childhood construct. Both medical and popular opinion shifted to accommodate an emphasis on regulating children’s weight (Stearns, 1999). This article argues that the results of the opinion change persist to present day, albeit not universally.

In spite of the present prevailing consensus that fatness is inherently bad, subpopulations do not universally concur with this view (Gard and Wright, 2005). Among some Latino populations in the United States, for example, fatness is a sign of good health. Examining fatness of Latino children in San Antonio, TX, Lisa Tartamella, Elaine Herscher, and Chris Woolston (2004)

note that some of the mothers of these children perceive food as an expression of love. Thus, the significance of fatness is not immutable but rather is contingent on time and culture. Fatness does not inherently constitute a social problem; it must be shaped in order to construct one.

This article argues that the dominant significance of fatness has played a role in the construction of a social problem. The obesity stakeholders and the media have eschewed the fatness construct, which is infused with an explicit connotation of moral laxity (Seid, 1989), for obesity. The concept of obesity is perceived as a medicalized and, thus, a neutral category. Patrick Basham and colleagues (2006) buttress this assertion:

The focus—perhaps even obsession—with obesity is due to a carefully orchestrated campaign on the part of a group of researchers, physicians, public health officials, activists and, more recently, the plaintiff bar, many with significant financial interests in the obesity issue, who have managed to use Europe's and America's moral aversion to fat as the foundation for a way by the public health establishment and the government on obesity. (pp. 33–34)

This article next turns to the political constructions of obesity and epidemic. The author argues that both are underpinned by the construct of fatness.

## CONFLAGRATION OF SCIENCE AND POLITICS

Estimates indicate that nearly half of children are either obese or at risk of becoming obese (Hedley et al., 2004). Some researchers predict that, if left unchecked, the childhood obesity epidemic may negatively affect life expectancy for children born after 2000, contributing to the first decline in life expectancy in the modern era (Olshansky et al., 2005). This article asserts that such statistics and predictions are repeated so frequently and without scrutiny that the childhood obesity epidemic and its high-priority status on the policy agenda are largely unquestioned. This section subjects the constructs of obesity and epidemic to close examination and deconstruction.

### *Obesity Construction and Deconstruction*

The stakeholders have offered obesity as a scientific construct that is contingent on neither time nor culture. Obesity is defined as excess body fat (Cole and Rolland-Cachera, 2002). The obesity construct relies on the BMI to quantify

excess fat; indeed, the BMI has played an intrinsic role to the medicalization of obesity (Basham et al., 2006). In the process of medicalization, obesity came to be classified as a disease with defined symptoms, diagnosis, and treatment plans. The BMI is the ratio of weight in kilograms to the square of height in meters. It does not directly measure the percentage of fat in the body (Cole, 2002), but the Centers for Disease Control and Prevention (CDC) claim that the BMI serves as a reasonable proxy for body fat (Anderson and Butcher, 2006). Because of its universality, accessibility, noninvasiveness, and affordability, BMI maintains status as an acceptable measure of fat, in spite of the fact that it does not measure fat directly (Cole, 2002).

A child's BMI is compared to standardized distributions by age and sex to ascertain whether the child is obese. Children's normal curves are statistically constructed to correspond with the adult definitions of obesity; an adult is considered obese if he or she has a BMI greater than 30 kg/m<sup>2</sup> at age 18 (Cole, 2006). The distributions were generated from data collected between 1963 and 1980 for children ages 6 to 19 and from data collected between 1971 and 1994 for children ages 2 to 5 (Institute of Medicine, 2005). If a child's BMI is at or above the ninety-fifth percentile, he or she is considered to be overweight. If a child's BMI is between the eighty-fifth and the ninety-fifth percentiles, he or she is considered to be at risk of becoming overweight. Children with BMI's that fall between the fifth and the eighty-fifth percentiles are considered to be of healthy weight. A child whose BMI is less than the fifth percentile is considered to be underweight (CDC [Centers for Disease Control and Prevention], n.d.).

The classification system highlights political dimensions of the obesity construct. First, it does not include obesity as a category. Despite the classification system's exclusion of the term, stakeholders continue to rely on the term obesity in reference to children. For example, U.S. Surgeon General Richard Carmona testified on July 16, 2003, before a congressional subcommittee about a growing epidemic: "childhood obesity" (The Obesity Crisis in America, 2003). The Institute of Medicine, which also plays a prominent role in public health, published an influential 2005 report entitled *Preventing Childhood Obesity: Health in the Balance*. The report justified using the term "obese" in lieu of "overweight," because "'obese' more effectively conveys the seriousness, urgency, and medical nature of this concern than does the term 'overweight,' thereby reinforcing the importance of taking immediate action" (2005, p. 80). Hence, both the surgeon general and the Institute of Medicine are complicit in intentionally propagating the obesity construct in reference to children. Such a designation elevates the political urgency of the problem.

Second, deciding which children's measurements to include in the normalized data set is, at least in part, a political decision (Cole, 2002). Tim Cole (2002) questions whether the sample should be chosen based on its health status or on the extent to which it is representative of the population. Indeed, depending on the chosen sample, the normal curves generated may be applicable only to the children who constitute the sample (Pařízková and Hills, 2005).

The decisions to include or exclude data sets to generate normal curves were political decisions. Data from 1988 to 1994 were not included in the BMI charts for children 6 and older (Institute of Medicine, 2005). Including such data would have shifted the curves upward, decreasing the number of children classified as obese (CDC, 2002). Shifting the curves upward was deemed "biologically and medically undesirable" by unspecified actors (Institute of Medicine, 2005, p. 89). Negatively framing obesity as a widespread condition is in the best interest of the obesity stakeholders, as such framing facilitates research funding (Campos, 2004). Thus, in light of the curves' political foundations, it should not be taken for granted that curves deemed normal are, in fact, normal.

Third, the BMI does not measure what it sets out to measure: fatness. Rather, it is a ratio that indirectly represents fatness (Institute of Medicine, 2005). J. Eric Oliver (2006) traces the BMI's development as the established measure of obesity, finding that its roots lie not in the measurement of fatness but rather in efforts to map a population's normal weight distributions. In the 1800s, Adolphe Quetelet mapped the heights and the weights of army conscripts. In doing so, he realized that the heights and the weights clustered around the mean were similarly proportional to each other. He concluded without any scientific basis that height and weight should be proportional to each other (Oliver, 2006).

The relationship between weight and height resurfaced in the 1940s as a predictive measure of mortality (Oliver, 2006). Louis Dublin, the chief statistician for the Metropolitan Life Insurance Company, found that thinner people tended to live longer (Oliver, 2006). He constructed ideal weight tables according to height. People soon mistook the weight-to-height correlation's predictive capacities for causality (Oliver, 2006). Since the 1950s, the weight-to-height ratio has become lodged in the medical landscape as a measure of obesity and, ostensibly, of fatness (Oliver, 2006). Indeed, BMI has been instrumental in constructing obesity as both a disease and an epidemic (Basham et al., 2006).



Recent evaluation of the BMI suggests that it is not an accurate measure of body fat. The index captures only 60 to 75 percent of body fat variation (Gard and Wright, 2005). This is due in part to the BMI's inability to account for the effect of muscle mass density on the height-to-weight ratio. For example, actors Russell Crowe and George Clooney would both be considered obese according to BMI distributions (Campos, 2004). Applying the BMI to children is especially problematic. Children grow at varying rates, and taller children are more likely to have higher BMIs than shorter children (Cole, 2002). Also, stage of sexual maturation affects a child's BMI (Daniels, Khoury, and Morrison, 1997). Among children with similar BMIs, the more sexually mature children have lower percentages of body fat than the less sexually mature children (Daniels et al., 1997). Additionally, the application of BMI yields results that differ according to a child's race (Daniels et al., 1997). Among children with similar BMIs, White children have higher percentages of body fat than Black children do (Daniels et al., 1997). Interpreting a child's BMI in reference to a standardized distribution can subject the child to stigmatization and ultimately can be more harmful than beneficial. Sharron Dalton (2004) observes, "Labeling a child 'overweight' can risk not only his or her physical development but the child's social and emotional development as well" (p. 13). Thus, children may suffer needlessly because of a fallible, inaccurate measure.

Finally, there is no objective basis to establish BMI cutoffs with respect to the categories overweight, at risk for overweight, healthy weight, and underweight (Cole, 2006). Such cutoffs are arbitrary for at least two reasons. First, a logical cutoff, if one exists, would be based on an outcome for which obesity is a risk factor (Cole and Rolland-Cachera, 2002). Given that children have less obesity-related disease than adults, no such self-evident cutoff exists (Cole and Rolland-Cachera, 2002). Few studies link the BMIs of children and adolescents to comorbidity and mortality (Cole and Rolland-Cachera, 2002). Second, the link between childhood obesity and health conditions experienced as an adult is mediated by adult obesity (Cole and Rolland-Cachera, 2002). Adult obesity is the bridge between childhood obesity and putative adult disease (Cole and Rolland-Cachera, 2002). Thus, childhood obesity is once-removed from many health conditions for which it could be a risk factor. In sum, the cutoffs delineating childhood obesity are inherently political (Cole, 2002).

By deploying BMI as a scientific measure, the obesity stakeholders have been able to supplant the discourse of fatness with that of obesity. Fatness is laden with moral assumptions. It is difficult to bend public will to act on such a construct. The BMI effectively repackaged the concept of fatness into the

purportedly neutral construct of obesity or, to be more precise, into the category of overweight. Although careful not to pursue an antiscience agenda, Michael Gard and Jan Wright (2005) caution that scientists may have constructed obesity in a way that is “unhelpful” and “misleading” (p. 11). Indeed, science is not infallible. Georges Dreyer, for example, posited that doctors could determine one’s physical well-being solely from the relationship between lung capacity and such body measures as weight and sitting height (Smith and Horrocks, 1999). For several years, his construct met no documented opposition. Government institutions and medical establishments employed the construct as if it were valid until a few dissenting statisticians proved it to be erroneous (Smith and Horrocks, 1999) and the construct was abandoned. In sum, the quantitative nature of BMI does not render it self-evident. Rather, this article posits that it is a political construction. Calls to monitor BMI as consistently as vital signs (Dietz, 2006) could be “unhelpful” and “misleading” (Gard and Wright, 2005, p. 11) without explicit acknowledgment of its limitations.

### *Epidemic Construction and Deconstruction*

Epidemic, similar to obesity, is another concept central to the creation of childhood obesity as a problem. In 1998, the World Health Organization officially classified obesity as an epidemic (Mahoney, Lord, and Carryl, 2005). Through its links with AIDS, malaria, and tuberculosis, the epidemic concept has become associated in the popular imagination with infectious diseases. Constructing obesity as an epidemic reinforces the perception that obesity is a distinctly medical problem. It also conveys a sense that obesity is a matter of extreme urgency. Gard and Wright (2005) state: “Using the term ‘epidemic’ in relation to increases in rates of ‘obesity’ thus metaphorically evokes the high levels of emotion associated with infectious disease epidemics and legitimates the same kinds and levels of intervention and public response” (p. 174). Public responses to the language of epidemic may include media attention, financial support for research, and heightened professional prestige for those who address obesity (Oliver, 2006). Furthermore, there is the perception that “it is not just a minority of children who are classified as overweight and obese who are at risk—obesity is now a disease that can strike anywhere, anytime and we must all be vigilant” (Gard and Wright, 2005, p. 25).

To support claims of epidemic status, stakeholders delineate associations with childhood obesity. Childhood obesity is associated with increased blood pressure, increased total cholesterol, insulin resistance, and sleep apnea (Berg, 2004). Socially, obese children are more likely than nonobese peers to be stigmatized, rejected, and victimized; they are less likely to be befriended than

nonobese peers (Mahoney et al., 2005). In addition to physical and social morbidities, obesity has been linked to decreased academic performance (Cline, Spradlin, and Plucker, 2005). In fact, obese children and adolescents are more likely to receive low scores than “healthy” children and adolescents on several measures of development, including those that assess physical, psychosocial, emotional, social, and school functioning (Schwimmer, Burwinkle, and Varni, 2003, p. 1817).

Stakeholders speciously package these assertions such that only an attentive reader can distinguish correlation from causation. For example, Stephen Daniels (2006) titled an article “The Consequences of Childhood Overweight and Obesity.” The term “consequence” implies causality, according to Merriam-Webster’s (n.d.) online dictionary. In the body of the article, however, the author writes about “obesity-related health conditions” (Daniels, 2006, p. 47) and “health problems associated with obesity” (p. 48). The incongruence between the article’s title and its content may lead readers into conflating correlation with causation. In another example, the influential Institute of Medicine report notes that childhood obesity has “ramifications” for children’s health (2005, p. 22). A synonym for the word “ramification” is the word “consequence,” according to Merriam Webster’s (n.d.) dictionary. As previously argued, “consequence” connotes causality. In the paragraph following the use of the word “ramifications,” the report’s authors comment on the startling increase of type-2 diabetes incidence (Institute of Medicine, 2005, 22). The casual reader may infer from the report’s structure that type-2 diabetes is a ramification of childhood obesity rather than associated with it.

According to existing evidence, obesity is the cause of few comorbidities (Oliver, 2006), and interventions may create rather than alleviate comorbidities. Although childhood obesity has been associated with several diseases, such as diabetes, it is found to cause only osteoarthritis and uterine cancer (Oliver, 2006). With regard to the psychosocial comorbidities, evidence suggests that the stigma of obesity and the resulting repercussions may be manufactured by the same people who claim to fight against the perceived epidemic (Dalton, 2004). In Arkansas, for example, parents receive report cards that chart their children’s BMI scores. Thus far, no study evaluates the psychological effects of receiving such a report card, but anecdotal evidence suggests that BMI report cards may negatively impact children’s self-concept (Kantor, 2007).

In spite of the lack of evidence to substantiate the causal potency of obesity, stakeholders imply that childhood obesity has causal potency to inflict steep monetary and social costs. An influential obesity-related report, *The Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity*

(USDHHS [U.S. Department of Health and Human Services], 2001), claims that obesity cost \$117 billion in 2000, an increase from \$99 billion in 1995. The calculated cost includes both direct expenses, such as those incurred by treatment, and indirect costs, such as wages lost due to premature death (USDHHS, 2001). Many of the costs are attributable to diabetes, heart disease, and hypertension (USDHHS, 2001). Medicaid and Medicare finance about half of medical expenditures related to obesity (Institute of Medicine, 2005).

The large cost attributed to obesity, \$117 billion, and the commitment of public funds through Medicaid and Medicare, suggest that obesity is a public problem requiring immediate attention. A close inspection, however, identifies egregious methodological assumptions in the research (Oliver, 2006). Oliver (2006) refutes the \$117 billion figure by noting that it was assumed that obesity, as opposed to poor diet and physical inactivity, is what had instigated medical costs. Additionally, it should be noted that obesity per se was not the cause of the health care expenditures. Rather, the expenses that the surgeon general's report attributed to obesity were mediated through other health conditions, such as diabetes (USDHHS, 2001). The report did not provide evidence that obesity was the causal mechanism for these health conditions. In fact, the report carefully noted that obesity was associated with these conditions, not the cause of them (USDHHS, 2001).

In another influential obesity-related report in the *Journal of the American Medical Association*, several authors, one of whom was the director of the CDC, claimed that poor diet and inadequate physical activity causes 400,000 deaths annually (Mokdad et al., 2004). The report measured poor diet and inadequate physical activity by the prevalence of obesity (Mokdad et al., 2004). It claimed that obesity, if left unaddressed, would soon rival cigarette smoking as a leading cause of preventable death. The CDC heavily promoted the findings, and the report received global media coverage (Basham et al., 2006). The report was shocking; it may have been “*the* crucial moment in the making of the obesity panic” (Basham et al., 2006, p. 61). Internal review of the methodological and political underpinnings of the report, however, cast doubt on its astounding claims (Basham et al., 2006).

The report is methodologically flawed. Although the report claimed that 400,000 deaths are attributable to obesity each year (Mokdad et al., 2004), the CDC deflated that figure to 25,814 after an internal review of the data and the methods used in initial calculations (Basham et al., 2006). Basham and associates (2006) assert that the report was based on data that was outdated

and cherry-picked. In fact, the CDC authors used a lot of data from studies funded by the weight-loss and the pharmaceutical industries (Basham et al., 2006); this could pose a conflict of interest. Oliver (2006) further notes that some of the report's calculations assumed that all deceased, obese people had died because of their fatness. If an obese person died in a car accident, for example, that death was attributed to obesity (Oliver, 2006). Although the estimates were later corrected, this article argues that public health officials and the media repeated the statistics frequently until the public took the existence of an obesity epidemic as a given. The subsequent retraction received no media blitz. The numbers circulated through the media flourish around the uncorrected report had already lodged themselves in the popular imagination. The stakeholders benefited from the erroneous statistics; once these findings were recognized as conventional wisdom, the public was more inclined to support obesity research (Basham et al. 2006).

In addition to citing methodological flaws, Basham and colleagues (2006) also intensely critique the political underpinnings of the initial publication of the report (Mokdad et al., 2004) and the subsequent internal review of its claims. They argue that the report is more aptly classified as science fiction than as hard science, because not only did good politics subordinate good science, but the report also cloaked policy as science. They support this claim with a quote from an internal reviewer who is reported to have noted: "The authors were under some political pressure to get this report out," and it "might have been better off presented as a policy exercise rather than a scientific study" (Basham et al., 2004, p. 62). Upon further analysis of the internal review, Basham and associates (2006) also note evidence that the authors of the report (Mokdad et al., 2004) knew that the report was flawed but proceeded to publish it anyway.

In sum, examination of constructs of obesity and epidemic reveals that both have methodologically flawed foundations. In spite of their limitations, they continue to be deployed in the construction of an ostensible public health problem. This article argues that the fatness construct underpins both the obesity and the epidemic constructs; that is, even though there is a lack of evidence, the childhood obesity epidemic construct continues to garner attention on the basis of the moral aversion to the fatness construct. The next section analyzes literature from academia and the popular media in order to substantiate this claim.

## DEPLOYMENT OF THE OBESITY AND EPIDEMIC CONSTRUCTS

To write, to pass, and to implement childhood obesity epidemic policy entails the deployment of the two constructs: obesity and epidemic. The article asserts that both function to create a public health problem that allegedly can be addressed through policy solutions. In the words of Gard and Wright (2005, p. 1):

Characterizing obesity firstly as a disease and then one of epidemic proportions requires the immediate mobilization of resources to bring about change. In the context of the “obesity epidemic” this is translated into a sense that anyone might “catch it,” that people who are overweight or obese have already succumbed and are thereby dangerous “carriers” to be avoided. This permits their stigmatization and permits actions to be taken because of the “danger” to themselves and to society.

Many of those referenced by Gard and Wright (2005), the people who are already overweight or obese, are classified as having a low-SES or as being a racial or ethnic minority (Institute of Medicine, 2005). Thus, the obesity epidemic is a site at which policy makers can take actions on behalf of the so-called best interests of these traditionally marginalized groups. According to Basham and colleagues (2006), the obesity epidemic becomes a vehicle by which to express class- and race-based anxieties. Science thus provides the basis for policies to intervene into the lives of low-SES and nonwhite families to rectify their putative moral failings. Such failings are evidenced by a high prevalence of obesity, and that prevalence is established through the use of the construct.

Articles in academia (see Gordon-Larsen, Adair, and Popkin, 2003; Strauss and Pollack, 2001; Vieweg et al., 2007) are prone to listing the groups most vulnerable to the childhood obesity epidemic construct. Articles in the popular media (see Park, 2008; Santora, 2006; Weil, 2005) are quick to focus on the groups most vulnerable to said condition. According to results from existing measures based on the obesity construct, SES is inversely correlated to obesity, and nonwhite children are more likely to be classified as obese than are White children (Institute of Medicine, 2005). In light of the high incidence of obesity among low-SES and nonwhite children, the Institute of Medicine's (2005) report called for targeted attention to these two groups. Andrew Hill and Inge Lissau (2002) advocate directing special attention not only to the children classified as obese but also to their families. They note that families with obese children are more dysfunctional than families with nonobese

children. Families with obese children, according to these authors, define themselves as being less cohesive, less independent, and less interested in social and cultural activities.

Other stakeholders have advocated for interventions directed at families. Dalton (2004), for example, argues that entire families should change their lifestyles in order to curb the childhood obesity epidemic. She provides a list of recommendations for parents. These recommendations include such elements as listening, communicating, and helping children learn from their mistakes. She notes that families with few resources are susceptible to obesity. She also expounds on the cultural values of nonwhite families that increase vulnerability to the childhood obesity epidemic. According to Dalton (2004), Hispanic and Black families are more accepting of large bodies. Additionally, she argues that recent-immigrant parents are likely to restrict physical activity and to provide high-calorie treats to children. This article posits that a normative argument underpins her book; that is, she implicitly suggests that low-SES and nonwhite families should adopt the view that the childhood obesity epidemic is a problem, and these families should take her suggestions to eradicate said epidemic. The childhood obesity epidemic construct, however, does not provide evidence to support her underlying assumption that the construct is a problem. According to Glenn Gaesser (2002), the notion that thinner is better has nothing to do with health; healthy bodies come in varying shapes and sizes.

Journalist Elizabeth Weil (2005) provides an example from the popular media of the tendency to link the childhood obesity epidemic, a putative public health problem, to maladaptive social norms. She notes that 50 percent of the boys and 35 percent of the girls in Starr County, TX, a Mexican American community, are obese or overweight by the time they reach elementary school. After presenting these statistics, she proceeds to critique social norms. Weil details what she sees as the breakdown of self-reliance: “Now government assistance is a major part of the fabric of society. In addition to free meals for their children in school, many adults in Starr County receive food stamps, health care and utility and housing subsidies” (2005, p. 34). According to Roel Gonzalez, a school superintendent in Starr County, old norms were “eroding” (34). The article conveys the message that the obesity construct disproportionately impacts the Mexican American families in Starr County as a result of nature and, most chiefly, as a result of nurture. The current article presents Weil’s (2005) work as a case study to argue that the driving force behind the childhood obesity epidemic construct stems not from concerns about children’s health but rather from social anxiety directed toward poor and nonwhite families.

The childhood obesity epidemic construct provides a gateway for policy intrusion into the lives of low-SES, racial-minority, and ethnic-minority families. In both *Preventing Childhood Obesity: Health in the Balance* (Institute of Medicine, 2005) and the subsequent *Progress in Preventing Childhood Obesity* (Koplan, 2007), the authors of the two reports call for obesity prevention programs to be appended to various publicly funded programs that are geared towards low-income families (e.g., Head Start; Food Stamp Program; the Special Supplemental Nutrition Program for Women, Infants, and Children [or WIC]; Medicaid; and State Children's Health Insurance Program).

The 2005 report noted that an ecological perspective is necessary in order to combat the alleged childhood obesity epidemic. According to the report, the home is the most influential determinant of childhood obesity, yet it is also the most inaccessible (Institute of Medicine, 2005). The report thus advocates for seizing opportunities to influence nonhome settings in order to shape social norms within the home toward healthful lifestyles. Although the authors of the report remark that the childhood obesity epidemic places a collective responsibility on society, they maintain that special efforts should be extended to low-SES and nonwhite families. This article contends that implicit in the text is the notion that children prone to obesity, those from low-SES and nonwhite families, come from environments with maladaptive social norms. Within this is the idea that such norms must be changed in order to eradicate the childhood obesity epidemic.

The Institute of Medicine's (2005) report assumes an emotive tone, arguing for preventive action even though the authors explicitly acknowledge that there is a lack of scientific evidence to establish causality and to guide best practices. This article argues that the actions called for by the report should not be implemented without reflection. Indeed, Seid (1989) echoes the sentiments of Basham and colleagues (2006); she states that it is important to distinguish between health issues and moral issues because the current preoccupation with obesity is using illness as a metaphor for cultural prejudices. Without reflection, social workers might be complicit in perpetuating cultural prejudices through the childhood obesity epidemic construct.

#### IMPLICATIONS FOR SOCIAL WORK PRACTICE

The National Association of Social Workers' *Code of Ethics* (1999, sec. 5.02) mandates that social workers critically examine existing evidence. In whichever setting social workers may work, whether they draft policy founded on the obesity and epidemic constructs, whether they implement policies founded on



the childhood obesity epidemic construct, or whether they work with clients who are impacted by such policies. Current evidence does not confirm the existence of a childhood obesity epidemic. In fact, the current article argues that acting on the childhood obesity epidemic's flawed knowledge base may inflict harm. For example, Basham and colleagues (2006) review findings from several studies, arguing that controlling children's eating patterns may be ineffective, may result in children eating more than prior to the intervention, may distort body image, and may lead to eating disorders. To combat the medicalization of the childhood obesity epidemic, the authors sardonically remind their audience of the first principle of medicine: Do no harm (Basham et al., 2006).

The Institute of Medicine (2005) acknowledges that there is a lack of a robust evidence base to substantiate the childhood obesity epidemic construct, yet it maintains that there is an urgent need to respond to the epidemic. The popular media echoes this sentiment. In a recent article in *Time* magazine (Park, 2008), the reporter admitted that there are no existing studies on long-term consequences of childhood obesity, yet "doctors know enough from work on adults to be worried" (p. 90). The article suggests that the negative influence of obesity on health in children is commonsensical, yet the current article takes a different position: inferring that obesity has the same health implications for two distinct populations does not constitute evidence-based practice.

Social workers' commitment to evidence-based practice suggests that there may be a need for reflective and selective application of policies aimed at curbing the childhood obesity epidemic. Furthermore, a commitment to evidence-based practice signifies that social workers might play a role in ensuring that research questions are framed in an open-ended manner. Shiriki Kumanyika (2006) argues, for example, that an important question for research is: "Do minority populations simply have more problems and fewer safe neighborhoods?" (p. 18). Questions like this one preclude open-ended research that investigates whether obesity constitutes a bona fide health condition and whether the condition impacts health negatively, positively, or ambivalently. Finally, social workers can bring to light all available evidence. Often, the scientific community ignores evidence that contradicts the obesity epidemic construct (Cogan, 1999). Jeanine Cogan (1999) calls for parity and accuracy of information offered to the public, and social workers can play a role in responding to such a call.

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# ADOLESCENTS AND ADHERENCE TO MEDICATION PROTOCOL: AN EVIDENCE-BASED APPROACH

*By Eric Brown and Marissa Morris-Jones*

This article utilizes a case example to illustrate the process of developing an evidenced-based clinical intervention for an adolescent client who presents with nonadherence to a medication protocol. The process encompasses a literature search guided by the Client-Oriented Practical Evidence Search (COPES) methodology; the development of an intervention comprised of psychoeducation and behavioral methods; and the creation and adaptation of instruments to monitor and evaluate the effectiveness of each intervention chosen.

Evidence-based practice (EBP) has evolved within the field of social work over the last 50 years (Reid, 1994). According to Leonard Gibbs (2003, p. 6), evidence-based clinical practice for social work practitioners encompasses “a process of lifelong learning that involves continually posing specific questions of direct practical importance to clients, searching objectively and efficiently for the current best evidence relative to each question and taking appropriate action guided by the evidence.” The initial shift towards EBP occurred during the 1960s, as the federal government required social workers to prove the effectiveness of clinical interventions (Reid, 1994). Critics of this mandate suggested that the movement towards EBP resulted in routinized clinical interventions and the loss of the flexibility that would enable professionals to tailor these interventions to the needs of their clients (Reid, 1994). Today, EBP is viewed as a method for formulating clinical interventions by integrating the client’s values and expectations for treatment with evidence found in the research literature (Mullen and Streiner, 2006). This article uses case material to demonstrate the process for developing an evidence-based

clinical intervention with an adolescent client who presents with nonadherence to a medication protocol.

#### CASE DESCRIPTION

John is a 13-year-old male who has been diagnosed with Wegener's disease.<sup>1</sup> Wegener's disease, or Wegener's granulomatosis, is a chronic illness that affects his kidneys. The National Institutes of Health (n.d.a) describe it as "an uncommon disease in which the blood vessels are inflamed (vasculitis). This inflammation damages important organs of the body by limiting blood flow to those organs or destroying normal tissue. Although the disease can involve any organ system, Wegener's mainly affects the respiratory tract and the kidneys." During a routine visit to the outpatient nephrology clinic, John's mother reports that he is not taking his medication as prescribed. The physician requests a consultation with a social worker to assess the circumstances surrounding John's instances of nonadherence. In conducting a biopsychosocial assessment, the social worker discovers that John is given complete independence to take his medication in the morning and evenings when he is at home. The nurse at school administers John's afternoon dose and confirms that he actually swallows the medication. John also reports that he often forgets to take his medication on time at home and sometimes skips a dose. John indicates to the social worker his belief that if he is not experiencing physiological symptoms, there are no repercussions for missing or skipping a dose of medication.

John is close with his parents and believes they are supportive. However, he also feels that they "nag" him too much by "telling him what to do." John reports being the only individual in his peer group who has a chronic illness. As a result, he reports that he feels different and alienated from his friends. He also reports low self-esteem. He has gained some weight as a result of the prescribed medication and expresses feeling self-conscious about his body changing.<sup>2</sup> According to his mother, John's parents have given him complete freedom at home to take his medication because they understand his need to be independent. However, they are concerned that these instances of nonadherence will complicate his long-term prognosis. John's parents want him to be responsible, and they are sensitive to his accusations of "nagging." They want to figure out a method for encouraging him to take his medication without being overbearing towards him.

John Rolland (1994) outlines a model for understanding how family characteristics interact with characteristics of an illness within a systemic context. The determination of a psychosocial typology for Wegener's disease is

important for illustrating the demands this illness places upon John's family system. The psychosocial typology of an illness refers to the "relationship between family or individual dynamics and chronic disease" (Rolland, 1994, p. 23). According to Rolland (1994), the psychosocial typology encompasses five characteristics of the illness (onset, course, outcome, type and degree of incapacitation, and degree of uncertainty), as well as the impact of these characteristics on the challenges a family system has to contend with over the time phases of the illness (crisis, chronic, and terminal). The initial onset of John's illness was acute and characterized by biological changes over a brief period of time. These changes culminated in his presentation at the hospital with symptoms and eventual diagnosis. The course of John's illness is relapsing or episodic, as he experienced a period during which his symptoms flared-up, and this was followed by a period of stability. Although John is not physically incapacitated as a result of his chronic illness, Wegener's disease can be fatal. The current period of stability that John experiences is managed with use of a continual medication protocol. The experience of relapse largely underscores John's parents' concern regarding his instances of nonadherence. John's illness is currently in the chronic time phase. Helping his family to continue effectively managing the demands of his illness can prevent the illness from transitioning to a terminal phase and becoming fatal for John.

At the conclusion of an interview with John and his mother, the social worker determines that John's instances of nonadherence may stem from a lack of adherence monitoring at home. His parents desire to be supportive of John while respecting and encouraging his need to feel independent. At the same time, they are concerned that his decisions to take his medication inconsistently might cause a relapse of his illness.

John is simultaneously contending with the demands of adolescence and managing his chronic illness. The illness has isolated him from peers, and the side effects of his steroid medication include weight gain (National Institutes of Health, n.d.*b*). John can benefit from having increased social support as well as an increased understanding of how taking his medication as prescribed affects the progression of his illness. The family's current communication style does not allow them to meet the demands of helping John to adhere to his medication protocol. As part of a family system experiencing John's illness, John and his parents could benefit from improved communication and accountability. These features would allay John and his parents' concerns that his illness might relapse while enabling them to continue encouraging John's need for independence. Additionally, reframing their relationship within a cooperative context could help John understand his parents' concern as supportive rather than authoritative.

## ADHERENCE: LITERATURE REVIEW

The case description raises the following research question: For adolescents who require the continual use of medication to manage a chronic illness, what is the most effective intervention to increase adherence to a medication protocol? The review of the research literature for this article is informed by the Client-Oriented Practical Evidence Search (COPEs) methodology, which is employed to outline the extent to which various clinical interventions can be utilized effectively to pursue the resolution of a problem that presents in clinical practice (Yeager and Roberts, 2006). The three essential criteria for a COPEs question include: (1) focusing on issues that matter to the client's welfare in the development in the question; (2) addressing a problem that is relevant to clinical practice; and (3) specifying the question adequately to generate pertinent resources in an electronic search for a literature review (Yeager and Roberts, 2006).

Adherence describes the extent to which patients follow the instructions they are given for prescribed treatments from physicians (Haynes et al., 2005). Robin DiMatteo (2004*b*) reports that typical adherence rates for prescribed medications are approximately 25 to 40 percent, although studies report that rates can vary from 0 to 100 percent (Anderson, and Collier, 1999; DiMatteo, 2004*b*; Haynes et al., 2005; Lyon et al., 2003). Medication adherence rates are lowest among individuals with a chronic illness and among individuals who require continual use of a medication protocol to manage symptoms (Lyon et al., 2003). In comparison to the general population, adolescents face more challenges with adherence. The challenges are due to developmental factors associated with an increased need to assert their independence and the need to identify with peer groups (Anderson and Collier, 1999; DiMatteo, 2004*b*).

It is important to understand common forms of nonadherence because an awareness of these factors clarifies areas that might be instrumental in bolstering adherence rates among clients. The types of nonadherence identified in the research literature include: (1) self-determination (i.e., client chooses not to take medication); (2) improper dosage as a result of misunderstanding the instructions; (3) missed doses; (4) increasing or decreasing a medication dosage; and (5) using medications for the wrong purpose or using outdated medications (Anderson and Collier, 1999; DiMatteo, 2004*b*). In a study of electronic devices that monitor medication adherence, findings reveal that nonadherence most commonly takes the form of missed doses and not taking doses at the prescribed time (Osterberg and Blaschke, 2005). The frequency of dosage also has an affect on adherence rates. Lars Osterberg and Terrence Blaschke (2005) cite a systematic review of 76 clinical trials that use electronic



medication monitoring. In that review, adherence was found to be inversely proportional to frequency of dosage; hence, medications prescribed at one dose per day are found to maximize adherence. Osterberg and Blaschke (2005) also state that the potential to experience no relief from symptoms is much more of a significant predictor of nonadherence than are such demographic factors as race, sex, and socioeconomic status.

Research also identifies risk factors and mediating factors relevant to nonadherence among the adolescent population. Common barriers related to medication adherence among adolescents include: problems with the medication regimen (such as adverse side effects), unclear or confusing instructions, an inadequate patient-provider relationship, poor patient memory, patient denial of need for medication, patient transportation difficulties, language barriers, inability to pay for care or supplies, the need to take too many pills, the taste of pills, and not feeling sick (Anderson and Collier, 1999; DiMatteo, 2004*a*; Haynes et al., 2005; Lyon et al., 2003). However, a number of factors promote medication adherence for adolescent clients. DiMatteo (2004*a*, p. 207) suggests that support from friends and family can increase adherence “by encouraging optimism and self-esteem, buffering the stresses of being ill, reducing patient depression, improving sick-role behavior, and giving practical assistance.” Additionally, Thomas Campbell (2003, p. 265) cites a number of family factors associated with positive health outcomes: “Family closeness or connectedness, caregiver coping skills, mutually supportive relationships, clear family organization, and direct communication about the illness.” The intervention developed for John’s family should consider two factors that are highlighted by the research literature and that pertain to his case. John can benefit from additional peer support, which he does not receive from his current peer group. The family’s communication style is largely avoidant concerning when John takes his medication. Troubleshooting around this area could involve developing a more open communication style that respects existing family dynamics.

The research literature does not identify any one intervention as effective in addressing all forms of nonadherence. R. Brian Haynes and associates (2005) found that, out of 58 interventions reported in 49 randomized control trials, only 26 interventions were associated with improvement in adherence, and only 18 of these 26 led to improvement in at least one treatment outcome. Haynes and associates (2005) found that, among the 26 successful interventions identified, some interventions improve short-term adherence and others improve it for long periods. Counseling, written information, and personal phone calls produced increases in short-term adherence, but complex interventions

were necessary to improve long-term adherence (Haynes et al., 2005). The study suggests that long-term adherence is increased by combining convenient medical care, information, counseling, reminders, self-monitoring, reinforcement, family therapy, psychological therapy, crisis intervention, telephone follow-up, and additional supervision or attention (Haynes et al., 2005). In addition, Andrew Peterson and associates (2003) suggest that educational interventions are more effective among patients who are invested in and willing to take their medication than they are among patients who are not motivated to adhere or who forget to take their medication.

Maureen Lyon and colleagues (2003) and Carolyn Anderson and Julie Collier (1999) studied interventions to increase medication adherence among adolescents. Lyon and associates (2003) tested an intervention that involved parents and peers as “treatment buddies” (p. 299) and sources of social support for adolescent clients with a chronic illness. Ninety-one percent of the clients reported that their adherence increased after completing the program. Despite the presence of many interventions, including peer support groups, family support groups, and psychoeducation, participants identified the multiple-alarm watch as the most effective intervention to prevent missing a dose (Lyon et al., 2003).<sup>3</sup> Anderson and Collier (1999) examined an intervention for adolescents who were in the hospital due to medication nonadherence. Their intervention focused primarily on psychoeducation and behavioral efforts that involved the adolescent as well as his or her family.

Both studies utilize interventions that operate within a developmentally appropriate framework in which adolescents were encouraged to take responsibility for and control of their own treatment and health (Anderson and Collier, 1999; Lyon et al., 2003). Osterberg and Blaschke (2005) suggest that in order to provide a developmentally appropriate intervention, successful adherence interventions with adolescents should involve the patient’s family members as well as school personnel. Furthermore, the use of behavioral interventions to increase medication adherence for adolescents is cited as an effective practice in their study (Osterberg and Blaschke, 2005). A most notable common component among these interventions is the token reinforcement system. This system provides token rewards, incentives, and privileges to adolescent patients for taking medications as prescribed (Osterberg and Blaschke, 2005).

Much of the literature on successful interventions to increase medical adherence is hindered by small sample sizes and the reliance upon client self-reporting to determine results (Anderson and Collier, 1999; Haynes et al., 2005; Lyon et al., 2003). The task of increasing adherence among adolescent

clients is confounded by the developmental tasks associated with adolescence. Findings from studies on general adherence provide some direction, but successful interventions with adolescents should also increase social support within the family system to assist adolescent clients in adhering to medication protocols (Anderson and Collier, 1999; DiMatteo, 2004*b*; Lyon et al., 2003). Forming an alliance between clients and caregivers, as well as providing psychoeducation, comprise the bedrock of these interventions. Behavioral interventions, such as token reinforcement systems, can be built in to existing interventions to maximize the chances for successful adherence rates among this group.

#### AN EVIDENCE-BASED INTERVENTION TO INCREASE ADHERENCE

For this study, the authors drew upon evidence-based interventions to address an adolescent client's nonadherence to a medication protocol. The target areas and goals of the intervention were identified through an examination of data from the case. These objectives are presented in a logic model (see Appendix A) that enables the social worker and physician to plan and map the interventions that will occur throughout John's care. The logic model has several different components. First, it identifies the antecedent condition or the problem (McCracken and Rzepnicki, in press). For John, this is that he is not adhering to his medication protocol, which subsequently places his health in jeopardy.

The second component identifies the objectives to be accomplished (results, changes, goals; McCracken and Rzepnicki, in press). For John, this includes increasing the rate of medication adherence and increasing his sense of social support. The model's third component identifies the methods that will be utilized to accomplish the objectives (McCracken and Rzepnicki, in press). For John, some of the methods utilized include participating in a support group, receiving a text message reminder to take medication, and creating a token reinforcement system to provide incentives for adherence. The next component (input) identifies the resources that will be utilized to accomplish the aforementioned goals (McCracken and Rzepnicki, in press). In John's case, some of the resources include: a physician, a cell phone, and a therapeutic relationship with a social worker. Finally, the logic model provides a visual map of how each of these components relates to the others (McCracken and Rzepnicki, in press).

After creating a therapeutic alliance with John and his family, the physician and social worker provide education about John's illness and medication to

both John and his family. The social worker also provides psychoeducation for John. This helps John to increase his problem-solving abilities and coping skills in order to address the stress associated with being an adolescent who has a chronic illness. In this intervention, medication education and psychoeducation are provided to John independently of his parents in order to support him in taking more responsibility for his own care. Additionally, the social worker can help John to have an understanding of how his illness impacts the entire family system.

John's role in the family system is clarified by the intervention's emphasis on explaining the importance of communication between John and his parents. It is also clarified by the focus on accountability as it relates to John's independence and adherence to his medication protocol. His parents' role is clarified as that of supportive monitors (rather than authoritarian parents) who cooperate with him to achieve a goal. Medication education and psychoeducation with John's parents acquaint them with the details of John's medication protocol and provides a description of the interventions to increase adherence. Their willingness to allow John some independence is affirmed. The emphasis on their role as monitors highlights the need for balance between independence and interdependence within the family system.

A pretest is administered before John and his parents are provided with educational information by a physician and social worker. This information is then followed by a posttest. The same test, which is presented in Appendix B, is used at both rounds. The use of the pretest and posttest instruments enables practitioners to gauge whether education improves the client and parents' knowledge about the medication protocol. It also provides an entrée for social workers to conduct psychoeducation around some of the family's misperceptions about the illness, medication, and importance of developing problem-solving capacities to meet the demands of an illness. According to Campbell (2003), family psychoeducation helps families cope effectively with an illness by providing specific problem-solving skills. In this case, the family's communication style prevented the parents from being involved with John's care and from providing optimal support for medication adherence at home. The collaborative process of redefining their roles and the addition of the adherence checklist help to facilitate improved communication. John's parents know that he has taken his medication because he brings the checklist to either parent for a signature. John, in turn, does not feel "nagged" because they are not asking him about taking his medication.

An additional aspect of the intervention involves the use of a token reinforcement system. A token system is operationally defined as rewards or

incentives that are given to clients for taking medication successfully. This type of behavioral intervention is cited in the literature as an effective method for improving adherence among adolescents (Osterberg and Blaschke, 2005). The social worker will work directly with both John and his parents to create a token reinforcement system that is cost-effective for John's parents, motivates John, and provides him with incentives. The client receives a weekly medication adherence checklist (see Appendix C) that outlines the day and time when he is to take the medication. John is responsible for taking his medication; however, he must also obtain signatures from his parents and the school nurse to attest to the fact that they have seen him take his medication. The checklist facilitates accountability and communication between John and his parents. John takes the initiative to demonstrate to his parents that he is being responsible by taking his medication in front of them. His parents commit to rewarding him with an incentive for following his medication protocol as prescribed.

The checklist is returned to practitioners at the weekly support-group meeting. The client receives a point for taking the prescribed dosage of medication on time. These points are redeemed for rewards at home (rewards are determined by parents and client in collaboration with the social worker, as stated above). It is important to note that the token reinforcement system not only incentivizes adherence but also supports the client's responsibility for his own care. The token reinforcement system also establishes a partnership between John and his parents. The partnership respects his independence while allowing his parents to be more involved with his care. In other words, John is ultimately responsible for adhering to his medication protocol but understands that his parents are functioning in a supportive role as monitors rather than in an authoritarian role as parents telling him what to do.

As the preceding discussion briefly mentions, the client also enrolls in an adherence support group for adolescent clients seen in the outpatient nephrology clinic. The group meets on a weekly basis for 12 weeks. Social workers facilitate the support group and specifically address developmental characteristics that contribute to nonadherence among adolescent patients. Group participants have chances to build relationships as well as to provide and receive support from peers who also have a chronic illness that requires medication management. Support-group attendance is noted on the medication adherence checklist, and the client earns additional points toward rewards by attending group sessions. Clients are also responsible for identifying at least two group members whom they can contact for support. Each week, a different group member bears the responsibility of sending a text-message reminder to the individuals identified as his treatment buddies. Text-messaging is an

inexpensive approach to leverage the technology that the adolescent clients already possess. It also enables the intervention to draw upon the research findings concerning the effectiveness of alarm-watch reminders in interventions to improve adherence. In 2007, the Center on Media and Child Health (2007) reported that over 60 percent of adolescents have cell phones, and the current intervention assumes that John has a cell phone. This aspect of the intervention is cost-effective because it does not require clients to purchase a costly alarm watch in order to participate. Furthermore, text-messaging can serve as a pathway for adolescent clients to build relationships with other individuals who have a chronic illness. Such relationships may decrease clients' sense of social isolation and low self-esteem.

## MEASUREMENT

The measurement used to assess this intervention reflects the intervention's single-subject design. In order to capture how John responds to the intervention, the measure must collect data on his adherence rates and self-esteem during the baseline (4 weeks) and treatment (12 weeks) phases. The baseline phase for collecting data occurs while client and parents are provided with medication education and psychoeducation. Under normal circumstances of nonadherence, medication education would be provided to families. The redefinition of family roles is necessary for implementing the successive interventions. During this period, data are collected to enable a comparison of the pretreatment phase to the treatment phase, when the text-message reminder, token reinforcement system, and support-group interventions are implemented. The adherence monitoring checklist and results from the Rosenberg Self-Esteem Scale (Rosenberg, 1965) will be analyzed on a weekly basis to determine how the client is responding to the interventions. The analysis of the checklist also facilitates the process of monitoring because the social worker can identify, on a weekly basis, whether instances of nonadherence coincide with an absence of signatures, noncompliance with text-messaging responsibility, nonattendance at support-group meetings, or a combination of these three factors.

## CONCLUSION

This article proposes the importance and process of creating an evidence-based intervention, as well as a model of intervention with adolescents who present with nonadherence to a medication protocol. An evidence-based approach is utilized to ensure that the interventions have been shown to be effective. Evidence-based practices enable clinicians to combine research, evaluation, and clinical decision-making in a way that meets the client's individual needs.

The interventions mentioned in this article, as well as other interventions highlighted in the research literature, can be implemented under circumstances where: (1) the client and family show a willingness to participate in an intervention; (2) the agency setting is flexible and supports the use of innovative social work interventions; and (3) the collaborative relationship between physician and social worker on a multidisciplinary team is characterized by a mutual respect and understanding of how differences in training inform approaches to interventions with clients and families.

This particular intervention was individualized on multiple levels. It works with John and his family to create a token system that is effective for their lifestyle. It utilizes creative interventions determined by the social worker while providing psychoeducation sessions that engage John. These sessions also enable him to increase his problem-solving and coping abilities. John's family possessed the resources to facilitate his participation in other interventions, such as text-messaging and the support group. If John's family circumstances differed, the social worker would develop alternatives that increase social support but do not require technological devices or the use of personal modes of transportation. For example, the social worker might cultivate support within the client's existing family and social network.

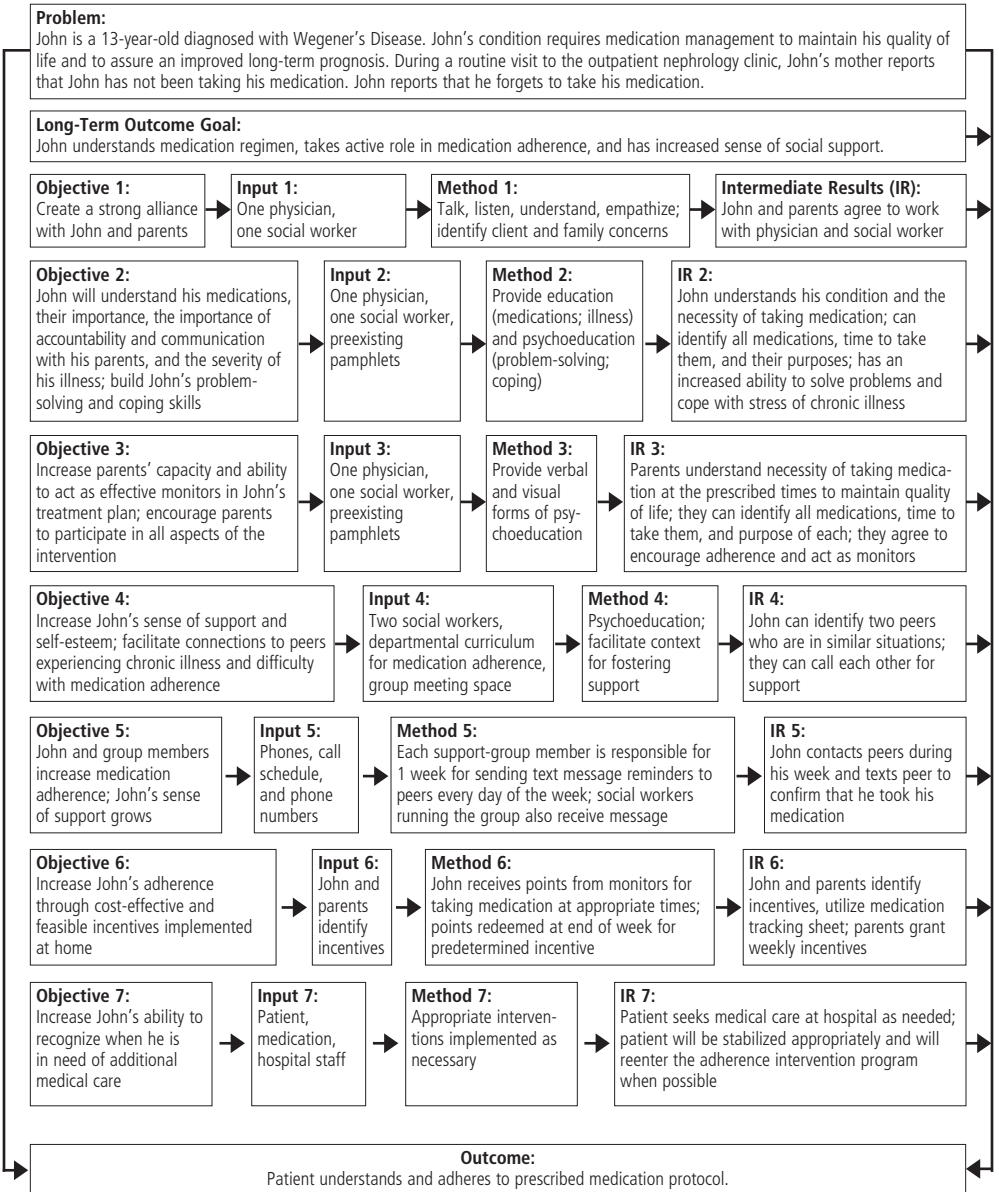
APPENDIX A

LOGIC MODEL

This logic model makes the following assumptions:

1. Client and parents understand his medical condition.
2. Client has family support.
3. Parents will assist with monitoring to ensure accuracy.
4. Trust of parent and patient to self-report with honesty.
5. Patient has a mobile phone.
6. Patient and parents are motivated to participate in all aspects of the intervention.





APPENDIX B

INSTRUMENT FOR PRETEST AND POSTTEST

Medication	Dosage	Frequency

*Questions*

1. Is it permissible to skip a dosage of medication? Why or why not?
  
2. Is it permissible to double-up on medication when a dosage is missed?
  
3. In what instances can I increase or decrease a dosage of my medication?
  
4. How does taking medication affect my illness?
  
5. What are some possible side effects my medication may cause?
  
6. Who should I notify if I experience intolerable or painful side effects?

APPENDIX C

MEDICATION ADHERENCE CHECKLIST

*Part A (To be completed by monitors)*

Instructions for Monitors: Please initial the appropriate box to indicate that the client has taken the prescribed dosage of medication. Include any relevant notes (e.g., side effects, reasons for missed dosage).

Day	Morning	Afternoon	Evening	Notes
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

*Part B (To be completed by social worker at weekly support group)*

Weekly adherence rate (points equals adherence percentage): \_\_\_\_\_

Text message reminder sent: \_\_\_\_\_

Peer support-group attendance: \_\_\_\_\_

Total points awarded (sum of all points): \_\_\_\_\_

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## NOTES

<sup>1</sup>The client's name has been changed to protect his confidentiality. In addition, details that could potentially identify the client, family, or agency setting were omitted from the case description in order to ensure privacy and protect confidentiality.

<sup>2</sup>Treatment for Wegener's Disease usually involves a combination of steroids and cytotoxic medicines. A common side effect of steroid medication is weight gain. Approximately half of all people diagnosed with Wegener's can experience a return of the disease; however, treatment improves the long-term prognosis (National Institutes of Health, n.d.b).

<sup>3</sup>The multiple-alarm watch is a device that enables an individual to program different alarms on the same watch. The alarm rings throughout the day to remind the individual to take the scheduled dose of medication (Lyon et al., 2003).

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# MYTHS, CEREMONIES, AND POWER-DEPENDENCE RELATIONSHIPS: ORGANIZATIONAL THEORY AND CHARTER SCHOOL AUTONOMY

*By John J. Fanning*

Public school systems grant charter schools significant autonomy from public school system oversight. This article employs organizational theory and a case study to argue that this autonomy is compromised by school and school system activities as well as by dynamics between the school and external organizations, including school system governing bodies. Furthermore, it suggests that this autonomy exists as a dynamic (rather than static) state and affects strategic choices made by leaders at both the school and school system levels, thereby altering the nature of the autonomy itself.

The purpose of this article is to explore the institutional environment of a specific Chicago Public Schools (CPS) charter high school, here described as School X in order to protect the confidentiality of school faculty, staff, students, and families. The article considers (1) the extent to which charter schools actually operate autonomously from oversight by CPS and community members; and (2) whether this actual, or operative, autonomy is aligned with charter schools' formal, or stated, autonomy (Bedeian and Zammuto, 1991), as it is set forth in CPS policy (CPS, n.d.).

The article borrows the words “operative” and “stated” from Arthur Bedeian and Raymond Zammuto’s work on organizational goals (1991). In that work, “operative” refers to what actually happens in organizational practice, and “stated” refers to what is set forth in such organizational documents as mission statements, policies, and procedures. The context here (autonomy) is different than that in Bedeian and Zammuto’s (1991) work on goals, but the terms aptly describe a potential gap between stated intentions and operative reality.

## PROBLEM

This article examines the hypothesis that charter school autonomy is not a static state determined solely by written word (i.e., CPS policy). It asserts that autonomy is instead shaped dynamically through interorganizational relationships in a charter school's environment. Furthermore, these interorganizational relationships, steeped in power and dependence, can render actual, or operative, autonomy (i.e., what really happens day-to-day) different from formal, or stated, autonomy (i.e., what policy makers write). To support these claims, the article explores charter school autonomy through the lens of organizational theory frameworks developed by John Meyer and Brian Rowan (1977) and Yeheskel Hasenfeld (1983).

## BACKGROUND

In 1994, Chicago Mayor Richard Daley launched Renaissance 2010 (Ren10), an ambitious public education reform plan that aims, by the year 2010, to close low-performing and low-enrollment public schools, opening 100 new, smaller, and more autonomous schools in their places. According to the policy, each new school will be managed according to one of three school management models: charter, performance, and contract (CPS, n.d.).

This article focuses solely on charter schools, as School X is a charter school. Of the three school management models, charter schools are granted the most formal (i.e., stated) autonomy when compared to the other two models (CPS, n.d.). Given that Ren10 schools receive public funds according to the same per-pupil formula as traditional (i.e., non-Ren10) schools (CPS, 2007), the granting of this autonomy is quite significant. To some critics, this autonomy results in a problematic private use of public funds without public oversight (Lipman, 2005).

Under CPS policy, charter schools are exempt from two sources of oversight. First, CPS policy provides charter schools with nearly complete freedom from CPS oversight (CPS, 2007). According to the policy, charter schools are organized as nonprofit organizations. They are not accountable to CPS beyond initial charter approval and regularly scheduled charter renewal processes (CPS, 2007). This leaves charter schools free to make decisions concerning personnel, finances, management, curricula, and programmatic functions. For example, charter schools are not required to hire from the teachers union, to hire certified professionals, to pay union-level wages, to offer union-level benefits, to utilize CPS programs (i.e., food and custodial services), or to follow CPS hiring protocols (i.e., counselor-to-student ratios).

Second, charter schools are also exempt from traditional forms of community oversight. In traditional (i.e., non-Ren10) CPS schools, this oversight is entrusted to democratically elected local school councils (LSCs) that have complete hiring and budgetary oversight. Charter schools, however, avoid democratically elected LSCs as well as their oversight. Instead, charter schools create and are overseen by their own nonprofit boards, which vote members on and off at will (CPS, 2007). As a result, charter schools determine who performs oversight duties, as well as the nature, rigor, and significance of these activities.

## SCHOOL X

School X is one of Chicago's first charter schools. It is located in a very low-income neighborhood. According to School X student records, approximately three-quarters of School X students live either in the neighborhood or in the immediately adjacent neighborhoods (as defined by zip codes).

Per CPS policy, charter school enrollment is open to all students, who are admitted via a blind, audited lottery, and no admissions tests are used (CPS, 2007). The only exception to the lottery process at School X is that siblings of current and former students are granted admission.

### *Framework 1: Meyer and Rowan's Myths and Ceremonies*

Two conceptual frameworks provide a helpful lens through which to better understand the functioning of charter school autonomy. The first, from Meyer and Rowan (1977), offers the concepts of organizational myths and ceremonies. In Meyer and Rowan's analysis, the authors assert that formal organizational structures (such as policies, programs, techniques, services, and even products) are myths akin to stories. Organizational leaders employ these stories in an attempt to describe cause-and-effect relationships that will lead their organizations to successful outcomes and overall survival. Myths are reinforced through organizational ceremonies, such as celebrations, announcements, awards, and assessments, which aim to attest to the validity of these myths (1977, p. 340). This article hypothesizes that charter school autonomy is an example of such a myth.

According to Meyer and Rowan (1977, p. 346–48), myths and ceremonies are highly reflective of and influenced by forces that are external to the organization but within its environment. This environment can include the court system, peer organizations, regulating organizations, educational systems, job training systems, current technology, public opinion, and social prestige.



In promoting myths and ceremonies, organizations simultaneously adapt to their environments and contribute to the future shape of them. For School X, CPS and its policies are examples of external forces.

Meyer and Rowan (1977) note that myths and ceremonies often have very little to do with an organization's day-to-day activities. The authors sharply distinguish the formal organization (made up of structures, or myths and their associated ceremonies) from the informal organization (made up of activities, or what actually happens).

Regardless of the match (or mismatch) between an organization's myths and its activities, these myths are nonetheless important to organizational survival. Organizational leaders adopt myths and reinforce them with ceremonies in order to better grapple with the complexities and instabilities inherent in modern society and, especially, in the organization's environment (Meyer and Rowan, 1977, 346–48). Through the use of myths, organization leaders seek to (1) garner external legitimacy from peer organizations and authorizing bodies, thereby enabling the organization to (2) secure resources, which are mobilized to (3) capitalize upon opportunities, and, when this is done successfully, to (4) increase the organization's chances of survival in a highly competitive environment.

The case of School X illustrates Meyer and Rowan's (1977) framework well in three ways. First, charter school autonomy is a myth produced in School X's environment through the written words of CPS policy (CPS, n.d.). This myth is then reinforced through the practices of other institutions in School X's environment (e.g., other Illinois charter schools, corporations, and foundations that fund charter schools). These reinforcing practices include such ceremonies as the issuing of foundation reports and corporate press releases, the holding of events of public record (e.g., CPS board meetings), and the making of public statements by opinion leaders (such as the mayor), all extolling the virtues of charter school autonomy.

Second, this case illustrates how myths and ceremonies are not always aligned with operative reality. For example, CPS officials pressured School X into abandoning its innovative senior management model and hiring a traditional principal to lead the school. This pressure was applied in an attempt to address the stagnant standardized test scores of School X students.

Third, this case shows how the upholding of myths and ceremonies can be critical to organizational success and survival, even if a gap separates operative reality from these myths and ceremonies. For example, upholding the myth of charter school autonomy is important to School X's survival, as the school's largest funder (CPS, through the per-pupil allocation given to all public

schools) is firmly invested in the myths embedded in Ren10 policies; charter school autonomy is one such myth (CPS, n.d.). Challenging this myth could cost School X some of its legitimacy with CPS, thereby endangering the school's charter, critical financial resources (the per-pupil allocation), and the ability to capitalize upon other opportunities for survival (such as competing for corporate and foundation grants).

*Framework 2: Hasenfeld's Exchange Relationships and Power-Dependence Relations*

Hasenfeld (1983) also examines the organizational and environmental relationships described by Meyer and Rowan (1977). In doing so, he introduces the concepts of exchange relationships and power-dependence relations. Hasenfeld (1983) defines an exchange relationship as one between two or more organizations that engage in the transfer of resources for the benefit of each. He explains that one organization becomes dependent upon another to the extent that (1) the organization controls a resource needed by the other and (2) this needed resource is not readily available elsewhere in the environment.

This dependence then determines the balance of power between the organizations, leading to a power-dependence relation. In Hasenfeld's (1983) model, organizations are mutually dependent upon each other. However, through an imbalance in resource provision and control, one organization can become more powerful than the other. As the power of one organization grows, so grows the ability of its leaders to determine the terms of the exchange relationship.

Power-dependence relations exist and function within a complex network that links organizations in the environment. This environment is the arena in which various organizations interact. For example, it may be a geographical location (e.g., Chicago) or an organizational construct (e.g., the CPS district in which a school is located). The environment includes recipients, consumers, competing organizations, providers of fiscal resources, providers of clients, providers of authority, providers of legitimation, and providers of complementary services.

Hasenfeld (1983) argues that power-dependence relations are dynamic in that these relations change as the various organizations in an environment alter strategies and behaviors. The School X case is easily considered within Hasenfeld's (1983) framework.

First, CPS and School X are engaged in an exchange relationship. As one participant in the relationship, CPS has control over two key resources needed by School X. The first resource is the legitimacy inherent in the charter approval and renewal processes. The second resource is the per-pupil funding

provided by CPS as long as charter status is preserved. School X could not operate at all without the first resource and most likely could not survive without the second.

In turn, School X has control over two key resources needed by CPS. The first resource is the operational capacity to run a successful and safe CPS high school in School X's neighborhood, where the current non-charter high schools have long been documented as substandard and unsafe. This resource is critical to demonstrating the success and potential of CPS's school reform strategies, including Ren10.

The second resource, ironically, is funding. School X's board shares membership with the board of one of Chicago's most wealthy family foundations, which happens to be one of Ren10's most stalwart and public supporters. This provides CPS access to the foundation's financial resources as well as to contacts and legitimacy that enable CPS to successfully attract other financial resources. Thus, School X controls funding for CPS at the same time that CPS is funding School X.

This case illustrates Hasenfeld's (1983) model in a second way. School X and CPS are engaged in a dynamic power-dependence relationship, such that changes in the environment alter the balance of power and dependence between the organizations. In this case, CPS offered the opportunity for school operators (charters and others) to open a new school in a CPS facility in School X's neighborhood. School X submitted a proposal, thus adding to its dependence on CPS beyond the routine charter renewal process for its existing school. This shift in dependence enabled CPS to assert additional power over School X, pressuring the school's leaders to abandon its innovative senior management model and to hire a traditional principal leader (as previously mentioned).

## FROM FRAMEWORKS TO STRATEGIES

The frameworks discussed in this article extend beyond organizational characteristics and interorganizational dynamics. They also provide a lens through which to better understand the strategic choices made by organizational leaders at both the school and school system levels.

For example, one strategy observed by Meyer and Rowan (1977) is that of decoupling. Decoupling occurs when organizational leaders purposefully create or allow a situation in which myths and operative realities do not match. In employing this strategy, the leaders uphold the prevailing myth even while endorsing practices that are not aligned with this myth. They may do so

because both the myth and the practices (that do not align with it) are critical to organizational survival.

This is clearly the situation in which School X finds itself. School X leaders know that they are not completely autonomous from CPS oversight. This awareness is demonstrated in the appointment of a new principal in response to CPS pressure. At the same time, School X leaders must publicly affirm charter school autonomy because CPS reform strategy and foundation support are both predicated upon it. School X also is dependent upon CPS and these funders for legitimation, resources, and survival. Thus, by saying one thing while doing another, School X leaders decouple their pronouncements from their practices, doing so in pursuit of the school's prosperity and survival.

Hasenfeld (1983) also observes multiple strategies for interorganizational work. He notes that, in the context of power-dependence relations, if the power is evenly distributed between two organizations, the organizations employ cooperative strategies in order to exchange resources and accomplish mutual goals. This describes well the strategy employed by CPS and School X prior to School X's proposal to CPS to open a new school.

Hasenfeld (1983) notes, however, that if power is not evenly distributed, the more powerful organization employs an authoritative strategy through which its leaders dictate the terms of the exchange relationship. This strategy was employed by CPS when it pressured School X to hire a new principal. School X's application to open a new school increased its dependence upon CPS, shifting the balance of power in CPS's favor and allowing CPS to infringe upon School X's autonomy.

## CONCLUSION

In this article, organizational theory is used to question the reality of charter school autonomy. As the case example of School X illustrates, even when autonomy exists in writing, it is often compromised in reality.

This observation is not an indictment of charter school autonomy. Rather, in this article, autonomy can be seen as rendering the system more flexible and (hopefully) more effective. For example, by operating a safe high school in a neighborhood where no traditional (non-charter) high school has succeeded in accomplishing the same, School X represents an example of how this flexibility can lead to positive outcomes for students.

However, this article also makes note of the darker side of charter school autonomy. Lacking formal authority to oversee School X's activities, CPS had to wait for a shift in its power-dependence relationship with the school (in the

form of the school's application to open a new school) before it could pressure School X to address the stagnating standardized test scores of its students. This situation illustrates how charter school autonomy can result in systematic inflexibility that leads to negative outcomes for students.

In challenging the notion that charter schools are indeed autonomous, this article opens the possibility of discussing when and how charter school autonomy is connected to positive outcomes for students, and when it is not. Following from that discussion, ideally, is a deeper understanding of how schools and school systems can manage such elements as autonomy, its accompanying myths and ceremonies, the exchange relationships between schools and school systems, and balances of power and dependence, in order to achieve improved student outcomes, which are the ultimate goal.

For example, autonomy could be granted to schools, charter and non-charter alike, based on past and current student outcomes rather than on organizational status (e.g., Ren10 school, charter school). Furthermore, autonomy could be granted categorically and incrementally, perhaps in tiers (e.g., tier 1 autonomy, tier 2 autonomy) or programmatically. Schools that have earned autonomy might be awarded sums of money or full-time positions to be utilized outside of usual budgetary and union constraints. Such strategies would make autonomy something to be earned, not something to be granted, and the most successful schools would earn opportunities for increased levels of autonomy.

### *Limitations*

The author notes that the purpose of this paper is not to determine causal relationships or generate findings worthy of broader generalization. Rather, this is a single-case study intended only to identify patterns worthy of further inquiry.

Furthermore, while the scope of this article precluded an extensive discussion of how Meyer and Rowan's (1977) and Hasenfeld's (1983) frameworks could impact organizational and interorganizational strategies as well as student outcomes, a brief foray into this territory was provided in order to present the pragmatic quality of these frameworks and their potential for practical use.

### *Implications for Future Research*

One potential area for future research is to examine the extent to which charter school leaders consider issues of power and dependence in making strategic decisions. In following this research strand, researchers could seek out correlations between these leaders' decision-making styles and a variety of student outcomes.

A similar research strategy could seek out correlations between the extent of operative autonomy that school leaders exercise and, again, a variety of student outcomes. In essence, both of these strategies for future research could help policy makers and school leaders to better understand the relationship between school-level autonomy and student performance.

A more extensive and rigorous control study could seek out causal relationships between charter school autonomy and student performance. Such a study might examine whether student outcomes are related to differing levels of operative autonomy at the charter school level and whether student outcomes might be linked to the decision-making styles of the school leaders operationalizing this autonomy.

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## NOTE

<sup>1</sup>This and other information about School X, and about its relationship with CPS, is derived from the author's experiences during a year-long internship at School X.

## ABOUT THE AUTHOR

JOHN J. FANNING is a recent graduate of the part-time master's degree program at the School of Social Service Administration (SSA) at the University of Chicago. At SSA, Mr. Fanning was a McCormick-Tribune fellow and a Community Schools fellow. He was the first student to complete a double concentration in community development and community schools. He interned at a public charter high school in Chicago and is currently employed as the Director of Counseling and College Counseling at Jones College Prep, a Chicago Public Schools selective enrollment high school.

# AN INTRODUCTION TO INTERPERSONAL VIOLENCE PREVENTION

*By Marita K. Herkert and April L. Kopp*

**I**nterpersonal and self-directed violence affects the health, safety, and well-being of many individuals; it has been documented as an incredibly costly burden to society (Corso et al., 2007). Violence prevention has recently emerged as a field, and social workers are beginning to understand how they can expand their repertoire beyond treatment to prevention through the public health model.

The public health model employs three levels of prevention (Institute of Medicine, 1994). Primary prevention targets entire communities to reduce the incidence of a disorder or the occurrence of new cases. Secondary prevention aims to reduce the prevalence and recurrence of interpersonal violence by targeting individuals who have been exposed to violence or are at risk for exposure. The model's tertiary level of interpersonal violence prevention works to reduce the consequences and complications arising from the problem or disorder once it manifests. Prevention efforts can target entire general populations (universal prevention), subgroups that are vulnerable to violence exposure or perpetration (selected prevention), and individuals with early signs of exposure or perpetration (indicated prevention) (Eaton and Harrison, 1996).

The public health model of violence prevention is an alternative to the traditional criminal justice approach (Moore, 1995). The criminal justice model responds to violence after the fact, focuses on the perpetrator, and uses punishment and judgment of individual moral issues as means to deter future violence (p. 241). The public health model, by contrast, focuses across multiple systems on the vulnerabilities and resilience of victims and perpetrators. The model aims to promote healing, restore social connection, and ultimately, to prevent future occurrence of violence (p. 241).

The following two articles by Marita Herkert and April Kopp examine what may be considered proactive approaches within social work. They focus

on systemic factors that contribute to violence, attempting to understand the benefits and challenges of preventing child maltreatment. The articles replicate objectives of the public health model by defining the problem, examining its causal pathways, identifying risk and protective factors, reviewing prevention strategies, and promoting best practices to assure widespread adoption.

During a spring 2008 colloquium for students of the Beatrice Cummings Mayer Program in Violence Prevention at the University of Chicago School of Social Service Administration, Deborah A. Bretag, Executive Director of the Illinois Center for Violence Prevention, stated, "Everybody can be a preventionist." The authors encourage readers to view social work through the preventionist lens in promoting the physical and psychological health of clients, systems, and environments.

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# STRENGTHS AND LIMITATIONS OF HOME VISITING TO PREVENT CHILD MALTREATMENT BY TEEN PARENTS

*By Marita K. Herkert*

The use of home visiting services to prevent child maltreatment has been widely studied with adult parents, but few studies examine their use among teen parents. In 1991 the U.S. Advisory Board on Child Abuse and Neglect recommended implementation of universal, voluntary home visiting for pregnant women. This article examines a sample of current models of home visiting as they affect the risk of child maltreatment among teen parents. Programs reviewed include the Nurse Home Visiting Program, Healthy Families America, Parents as Teachers, and the Colorado Adolescent Maternity Program. Evaluations of existing home visiting programs are reviewed and recommendations are made for future research.

Several promising programs have been developed to prevent child abuse and neglect. Home visiting with new parents is one of the most widely studied and utilized intervention methods (e.g., Bilukha et al., 2005; Guterman, 2001; Murphey and Braner, 2000). The underlying goal of this method is to reduce child abuse rates by providing support and education to new parents (Daro and Harding, 1999; Krugman, 1993; Wagner and Clayton, 1999). Research shows that home visiting improves home safety, infant-parent attachment, and parent understanding of child development; however, program evaluations identify mixed results, often with minimal change in rates of child abuse and neglect (Britner and Reppucci 1997; Chaffin, Bonner, and Hill, 2001; Gomby, Cubross, and Behrman, 1999; Roberts, Kramer, and Suissa, 1996). These programs are often difficult to evaluate because of the subjective nature of the home visits. Three challenges in the evaluation of home visiting programs are attrition rates, consistency in delivery of curriculum, and the impact of multiple goals on the visits. These challenges are considered in the following review of program effectiveness.

Program effectiveness is especially important to consider in working with adolescent parents because of the unique challenges and stressors that teen parents face. Programs to prevent child abuse are particularly relevant for adolescent parents because, in theory, early intervention will reduce risk of future child abuse by addressing child and parent risk factors. However, traditional home visiting programs cannot always be used with adolescent populations in the same way that they are used with adult parents.

This article explores the effectiveness of several current intervention and prevention models of home visiting on the risk of child abuse and neglect among adolescent parents. In this article, the term “teen parent” refers to an adolescent parent between the ages of 15 and 19. Programs for very young teens are not examined here because those parents face a unique set of challenges. Child abuse and neglect here refer primarily to physical and emotional abuse, as sexual abuse is not addressed specifically. The abuse rates described below reflect the U.S. Department of Health and Human Services’ (2007, p. xiii) definition of abuse: “Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm.” The term “child maltreatment” is used interchangeably with the phrase “child abuse and neglect.”

#### TEEN PREGNANCY AND CHILD MALTREATMENT RATES

In 2004, there were 415,262 live births to U.S. mothers between the ages of 15 and 19; these births represent nearly 10 percent of live births recorded in the United States. The rate of births to teen mothers was 4.1 live births per 1,000 (Martin et al., 2006). In 1991, the birth rate for 15- to 19-year-old mothers of all races was 61.7 per 1,000. By 2005, the rate was 40.5 per 1,000. Among African American teenagers, the decline was greater: from 118.2 per 1,000 in 1991 to 60.9 per 1,000 in 2005 (Martin et al., 2007). These rates indicate that the teen birth rate has been in decline since 1990, but teen mothers are a highly vulnerable population, often in need of concrete resources and parenting education. Such vulnerability increases risk for child maltreatment.

Rates of child abuse and neglect are high among the parents of children under 4 years old. In 2005, 30.4 percent of child maltreatment victims were under the age of 4 (USDHHS [U.S. Department of Health and Human Services], 2007). Vulnerability of both the parents and children increases the risk of abuse and neglect dramatically, intensifying the need for prevention efforts. In 2005, there were 42,640 reports of child abuse committed by U.S.

parents 19 years or younger. These reports represent 5.1 percent of child abuse reports (USDHHS, 2007). The rates suggest that a significant number of child abuse and neglect cases are associated with teen parents. Specific prevention efforts are needed to address the issue.

Several additional factors increase the risk for abuse and neglect by teen parents. These include subsequent pregnancies, socioeconomic stressors, and low educational attainment (Klass, 2003; Middlemiss and McGuigan, 2005). Each of these issues is related to the struggles (and success) of a teen parent. The wide variety of risk factors suggests the need for an approach to child maltreatment prevention that considers the teen parent's developmental phase and unique needs while working to address heightened risk.

## CONSIDERATIONS IN WORKING WITH TEEN PARENTS

Evidence from the home visiting evaluations reviewed below suggests that it is difficult to create a model to successfully reduce risk and rates of child maltreatment. Regardless of the program model, working with teen parents poses additional challenges not present in interventions with at-risk adult parents. These challenges stem from the teen's vulnerable situation and developmental stage (Klass, 2003). Teen parents are often difficult to engage, so delivery of the curriculum may not be effective. Moreover, teen parents may have difficulty understanding the purpose of the program, connecting with a home visitor and working with him or her. These difficulties may be related to the significant psychological and biological changes that occur during this stage of the teen parent's life. Carol Klass (2003, p. 27) explains, "The serotonin level declines in most adolescents, leading to increased impulsivity and the inability to process information in a mature way." The developmental stage along with the responsibility of caring for a new baby increases the teenager's risk of maltreating the child. This combination also makes it difficult for the home visitor to connect with the teen parent, share resources, and provide education (Klass, 2003).

The teen parent's stage of development affects his or her area of interest and may lead to a narcissistic focus. Klass (2003) points out that the teenager may be more focused on his or her own needs than on the child's. This focus increases the risk of child maltreatment and neglect. Klass suggests that the home visitor should begin the relationship by focusing on the teen's needs rather than on those of the baby. By attending to the parent's potential for feelings of loneliness and isolation, the worker can help improve the teen parent's focus on the child and his or her self-esteem in the parenting role.

The home visitor's relationship with the teen is another important factor in working with teen parents to prevent child maltreatment. Wendy Middlemiss and William McGuigan (2005) explain the importance of this relationship and the program curriculum, observing that "enhanced parent interactions [with the visitor] are also suggestive of more secure attachments between high-risk adolescent mothers and infants who receive home visits" (p. 222). The relationship is at least partially developed through the amount of time spent with the teen and the number of visits conducted (Klass, 2003). The strength of the relationship between the home visitor and the teen parent has a direct effect on the success of the prevention program (Klass, 2003).

A final consideration in working with teen parents is the fact that they often have more concrete needs than adult parents do. These needs include limited education, little or no income, and difficulty accessing resources (Klass, 2003). Klass (2003) notes that all of these factors increase the likelihood of child maltreatment and must be considered by home visiting programs. Addressing these needs must be attended to for child maltreatment prevention. Parents of all ages have concrete needs, but teen parents are more likely than adult parents to have such needs and limited access to assistance (Klass, 2003).

#### THE RISE OF HOME VISITING PROGRAMS

Home visiting has been used in various helping professions, including social work and nursing, for over a century (Weiss, 1993). It has been utilized as a means to reach at-risk clients for a variety of reasons. Child maltreatment prevention is one of the most widely researched uses of home visiting. In 1991, the U.S. Advisory Board on Child Abuse and Neglect recommended home visiting as an effective secondary prevention strategy for child abuse and neglect. It also recommended focusing on families most at risk for child maltreatment (Krugman, 1993).

The advisory board specifically recommended home visiting programs that were universal, voluntary, lasted for the first 2 years of the child's life, and used both professional and paraprofessional visitors. The programs were intended to provide support and parenting education to new parents, reducing the risk of child abuse and neglect (Krugman, 1993). Although the entire board supported the recommendation, it was not implemented federally. Federal funding and support for home visiting were lacking. Nevertheless, thousands of local and state home visiting programs were created as a result of the recommendation. By 1993, as many as 550,000 children were served by one of six program models (Gomby et al., 1999). Since then, home visiting

programs have continued to grow, although research questions their effectiveness in reducing child maltreatment rates (Chaffin et al., 2001; Daro and Harding, 1999; Middlemiss and McGuigan, 2005; Murphey and Braner, 2000; Roberts et al., 1996). These evaluations assess home visiting programs across parent age groups. Because of teen parents' high-risk status, a few programs are designed specifically for them, although programs often include teen parents in the high-risk families that they serve.

## TYPES OF HOME VISITING PROGRAMS

Home visiting programs are often one component of an agency's intervention services, although not all home visiting programs are used in conjunction with other child maltreatment prevention services. These additional prevention services often include parenting education classes, support groups, doula services (pregnancy and birthing support), and child care (Middlemiss and McGuigan, 2005). Although home visiting programs vary, three factors define and are present in such programs: (1) regular home visits intended to ensure access to services; (2) initiation of services perinatally and continuation of them for at least 2 years; and (3) a focus on parenting skills, child development, and encouraging developmentally appropriate parent-child interactions (Middlemiss and McGuigan, 2005).

This article reviews three of the most widely studied and implemented home visiting programs: the Nurse Home Visitation Program, Healthy Families America, and Parents as Teachers. It also examines the Colorado Adolescent Maternity Program as a model that works specifically with teen mothers. Home visiting programs have had successful outcomes with a wide range of populations, but, according to Middlemiss and McGuigan (2005, p. 213), "outcome research for adolescent mothers has not been entirely consistent."

### *Nurse Home Visitation Program*

The Nurse Home Visitation Program (NHVP), a family support model developed by David Olds, has been evaluated extensively over the past two decades. Olds and colleagues have implemented and are evaluating pilot programs in Elmira, NY, Memphis, TN, and Denver, CO. These programs serve a wide variety of populations, and results are promising (Olds et al., 1999). In the NHVP, visits are initiated at the end of the second trimester of pregnancy and continue for the first 24 months of the child's life. Initially, visits are frequent (often weekly) and become less so as the child grows. Monthly visits conclude when the child nears the age of 2 years. Visits last

approximately 75–90 minutes. All home visits in the NHVP are made by nurses with professional training, while many other programs use paraprofessional home visitors (Olds et al., 1999). The NHVP uses a structured curriculum in which the focus of the visits falls on health, relationships, and building community resources.

Findings from the Elmira, NY, site indicate that program participants are the subjects of “fewer verified child abuse and neglect reports” (Olds et al., 1999, p. 52) than are members of a control group. An evaluation of another site suggests that NHVP participation decreases child abuse and neglect by adolescent parents (Murphy and Braner, 2000). Four percent of parents in the home visiting group were reported for abuse or neglect; the rate among the control group parents was 19 percent (Murphey and Braner, 2000). All participants were identified as high-risk parents; participants included both adolescent and adult parents. Ian Roberts and colleagues (1996) review a wide range of home visiting programs, including the NHVP. Despite the promising findings mentioned above, Roberts and associates (1996) note that many programs, including the NHVP, did not reduce rates of reported child abuse and neglect. By contrast, Oleg Bilukha and associates (2005) find that prevention programs, including the NHVP, have some effect on reducing child abuse and neglect. These studies demonstrate the ongoing debate concerning the most extensively researched home visiting program.

### *Healthy Families America*

Healthy Families America (HFA) is a home visiting and family support program modeled after the Hawaii Healthy Start Program, which initial evaluations found to be highly successful at affecting child maltreatment rates (Guterman, 2001). The HFA program “seeks to expand the availability of high-quality, intensive home visitation services and to create communitywide commitments to these services and others that promote a supportive atmosphere for all new parents” (Daro and Harding, 1999, p. 154). These services are provided primarily to high-risk families and are initiated perinatally. In this, HFA differs from the NHVP, which begins services prenatally. The HFA program has been widely implemented. By 1997, over 270 HFA programs served nearly 18,000 families in 38 states (Daro and Harding, 1999, p. 157). Evaluations suggest that HFA programs have mixed results in reducing child maltreatment risk and rates. Less than 6 percent of parents in HFA programs are the subject of a maltreatment report, but the national average is 4.6 percent, a rate higher than that found for the Hawaii Healthy Start Program (Daro and Harding, 1999). These differences are significant, although it is

important to keep in mind that HFA programs often serve high-risk families, and these families are vulnerable to many external factors not addressed in the home visiting programs. This vulnerability may suggest that it is problematic to compare HFA program parents with parents in the general population.

The format of HFA differs from that of the NHVP but has the same basic goals: to reduce child maltreatment and promote positive parenting. The HFA program does not limit services to first-time parents. It uses screenings and assessments to identify high-risk families, targeting them with services and a flexible curriculum. Home visits are made by trained paraprofessionals, rather than by nurses (Guterman, 2001). The issue of staff training levels is an area of debate within the home visitation research, but some argue that engagement and relationship-building are beneficial when done by paraprofessionals who can connect with the parents on a relational level (Guterman, 2001).

In an evaluation of an HFA program with adolescent mothers, the risk of child abuse and neglect was “reduced when mothers increase their parenting skills and their ability to cope with stress” (Middlemiss and McGuigan, 2005, p. 220). Middlemiss and McGuigan (2005) find that the HFA program encourages parent-infant attachment and parent responsiveness to their child’s needs. They suggest that the skills taught in the home visiting program are empowering to the teen mothers, and they note that empowerment is important in reducing risk for child maltreatment. Mothers with improved coping and parenting skills had a lower risk of child maltreatment than that found for a control group. Concerns over the use of HFA with teen parents include difficulty in engagement with the teen parent, attrition, and the absence of a direct effect on abuse and neglect rates (Middlemiss and McGuigan, 2005).

### *Parents as Teachers*

The Parents as Teachers (PAT) program, started in 1981, is an education-based model that is designed to increase parent knowledge, child school readiness, parent competence, and parent confidence (Gomby et al., 1999). It now has over 2,000 sites and serves over 500,000 families (Wagner and Clayton, 1999). The program is a universal access model that uses a standard, perinatally implemented curriculum and serves the family until the child’s third birthday. Parenting support groups, also available through PAT, are designed to complement the home visiting services (Wagner and Clayton, 1999).

In addition, Mary Wagner and Serena Clayton (1999) describe the Teen PAT program, a two-generational approach that combines PAT with case management services for teen parents. The unique goals of the Teen PAT

program are to increase the educational achievement of parents and to postpone additional pregnancies. Additional pregnancies and lack of such achievement are risk factors for child maltreatment that are especially relevant to teen parents (Wagner and Clayton, 1999). Wagner and Clayton (1999) also note that concerns with the Teen PAT include high attrition rates (48 percent) and workers' difficulty in engagement or initial relationship-building with the teen parents. The outcomes of the Teen PAT program have not been promising: "Analyses showed little or no benefit on most outcome measures for either parents or children from PAT services" among teen parents (Wagner and Clayton, 1999, p. 111). However, "fewer child abuse and neglect cases were opened among the group that received both PAT home visiting and comprehensive case management services" (Gomby et al., 1999, p. 14). The PAT program's use of comprehensive services and services directed toward teen mothers, (e.g., case management) is unique among home visiting programs, but the program has not demonstrated consistent success in addressing child abuse rates.

#### *Colorado Adolescent Maternity Program*

The Colorado Adolescent Maternity Program (CAMP) is a "comprehensive, multidisciplinary prenatal, delivery, and postnatal care program" designed for mothers between the ages of 13 and 19 (Stevens-Simon, Nelligan, and Kelly, 2001, p. 756). This model is unique among home visiting programs because it was designed specifically for teen parents. They are screened into the program, and home visits are offered by trained paraprofessionals at least two times per month. The admission screening uses the Family Stress Checklist to assess teen parents' risk for mistreating their children (Stevens-Simon et al., 2001), and the assessment is made in a clinic or hospital setting. The CAMP home visiting program is designed to meet the individual needs of participating families. Services are centered on building parental self-efficacy, providing informal support, offering education on infant temperament and development, and coordinating services (Stevens-Simon et al., 2001). An evaluation of the CAMP program finds that the child maltreatment rates for parents receiving home visiting services do not differ from those for the comparison group. Catherine Stevens-Simon and colleagues (2001, p. 753) find that "the incidence of maltreatment rose in tandem with the predicted risk status of the mother." Similar to the other home visiting programs reviewed above, the CAMP program, although designed specifically for teen parents, is not shown to be significantly effective at reducing risk for child abuse and neglect.



## BENEFITS OF HOME VISITING PROGRAMS

Research fails to show that the programs outlined consistently reduce child maltreatment rates; however, home visiting programs have some benefits that indirectly affect risk for child abuse and neglect. These benefits may accrue through such other program features as parenting education, emotional support for the parent, and home safety lessons (Stevens-Simon et al., 2001). A philosophy behind home visiting support programs is that addressing parent needs, both concrete and psychological, will reduce risk of child maltreatment. For example, programs designed specifically for teen parents may alleviate the transportation concerns that prevent teen parent participation, help with motivation to follow through with services, and provide support to isolated parents (Middlemiss and McGuigan, 2005). Teen parents are often isolated from friends, and this isolation can increase the risk for child maltreatment. By meeting with the teen parents in their home, home visitors are able to understand the teen's living situation and address issues that may concern the mother or father. Understanding the home environment can also help the home visitor become aware of the teens' relationships with parents or other family members. Such knowledge can also reveal economic concerns, home safety concerns, and the general family environment (Gomby et al., 1999).

By addressing both concrete and relational needs, the home visitor is able to work with the teen parent to reduce the stress in the home. As Klass (2003) points out, the home can be seen as neutral territory for the teen parent, a space where the home visitor is able to collaborate with the teen rather than appear to be the expert. The home environment is also generally comfortable for the teen parent. The home visitor can work with him or her on parenting skills, attachment concerns, and boundary issues within the setting in which the parent and child most frequently interact (Klass, 2003).

Finally, home visiting services can be beneficial in working with teen parents to reduce risk of child maltreatment because the visits can complement services offered by family support agencies and other programs (Daro and Harding, 1999). Home visiting is often an individualized, relationship-based program that focuses directly on the parent's needs. The home visitor can work with the parent to apply what is learned in parenting classes or support groups to the parent's relationship with his or her child. Overall, there are significant intrinsic benefits to home visiting services that indirectly target child maltreatment risk among adolescent parents. Research suggests that the evaluated programs do not reduce rates of child abuse and neglect, but findings do associate participation in those programs with improvements in such other program goals as understanding of child development, parent self-esteem,

and parent-child relationship-building (Daro and Harding, 1999; Gomby et al., 1999; Middlemiss and McGuigan, 2005; Olds et al., 1999). These benefits are important to consider, despite the limitations of home visiting programs for teen parents.

#### CHALLENGES OF HOME VISITING PROGRAMS

Significant challenges and limitations impede the success of home visiting programs in reducing risk of child maltreatment. These challenges make evaluation findings difficult to generalize, and it has even been suggested that trends in child abuse rates over time are not appropriate measures of success (Daro and Harding, 1999). Reduction of child maltreatment rates is the primary goal of these programs, but they also have other goals. Such goals can be beneficial for the overall intervention, but program goals may be too ambitious or may contain too many objectives to effectively target child maltreatment risk (Gomby, 1999; Murphey and Braner, 2000). Inclusion of multiple goals is particularly difficult with programs for teen parents, because goals in teen parent visiting programs include parenting skills and child development, as well as parent education and prevention of additional pregnancies (Stevens-Simon et al., 2001).

In many studies of home visiting programs, attrition rates are found to be high. They are particularly high among teen parents (Middlemiss and McGuigan, 2005; Wagner and Clayton, 1999). For example, Middlemiss and McGuigan (1999) reported a 48 percent attrition rate among the teen parents evaluated in the Teen PAT program. Programs are often intensive and serve high-risk populations. Attrition may impede evaluation efforts and, if it prevents delivery of the curriculum or services offered, may impede attainment of program goals. Attrition may also jeopardize consistency of curriculum delivery and intensity of visits. These challenges may particularly affect programs (such as HFA) that have a flexible curriculum, because it is not always clear as to whether or not the curriculum is being delivered, so the parents may not always receive the program content.

In addition, concerns over staffing, caseloads, and use of evaluation may impede the effectiveness of home visiting programs in meeting the goal of reducing risk of child maltreatment. There has been an ongoing debate about whether home visits should be conducted by paraprofessional staff (e.g., Daro and Harding, 1999; Guterman, 2001; Olds et al., 1999). The NHVP model only uses professional nursing staff as home visitors, and rates of abuse or neglect by participants are lower than the rates among nonparticipants (Olds

et al., 1999). However, Neil Guterman (2001) argues that trained paraprofessional staff, such as those in the HFA programs, can be effective at delivering home visiting programs because they often have personal experience and ties to the community. He also suggests that they are able to relate more effectively with the parents. Finally, high caseloads and the intensity of working with teen parents on multiple needs in high-risk situations can reduce potential effectiveness of home visiting programs, adding yet another challenge to home visiting services (Guterman, 2001).

## RECOMMENDATIONS

Child maltreatment prevention among teen parents poses important challenges. The teenage years are a time of both high risk and great opportunity for parents and their very young children. Teen parents are at a higher risk for concrete and developmental stressors than are nonparenting teens, and children are most vulnerable to be abused during early childhood (Neil Guterman, personal communication, September 25, 2007). The risk for child maltreatment is thus high among teen parents. Many programs have been developed to prevent child abuse by teen parents, but evaluations of home visiting programs have not shown promising results. This may be because the programs work with a high-risk population, because home visitors are mandated reporters and may have a surveillance bias, or because child maltreatment is difficult to conceptualize and measure (Stevens-Simon et al., 2001).

Suggestions for future research and evaluation of home visiting programs include the use of home visiting programs in conjunction with other interventions, such as doula services during pregnancy and childbirth, parenting classes, and work and education programs. Future research should evaluate maltreatment rates over time and consider additional interventions that affect child abuse and neglect rates. Established home visiting programs may be beneficial to teen parents, but research suggests that they fall short of preventing child maltreatment.

Teen parents present significant challenges to the home visitor. If these programs are to have lasting effects on the rates of child abuse and neglect by teen parents, methods must be developed to address the unique issues and needs faced by these parents, as existing services may fail to address the population's unique needs. The teenage years are a time of risk and opportunity; research must continue to work to develop effective interventions that address the specific and unique needs of teen parents and their children.

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# CHILD SEXUAL ABUSE PREVENTION AND SOCIAL CONNECTION

*By April L. Kopp*

Child sexual abuse (CSA) is a widespread problem that can affect victims' well-being and functioning across the lifespan. For the past few decades, response to the problem has mainly consisted of early CSA prevention education for children and retribution for perpetrators. This article examines CSA and prevention efforts through a public health model, applying that theoretical frame to the case of the Stop It Now media campaign. It also recommends ways to expand the public health response to CSA to enhance both adult responsibility for addressing CSA and social connection between children and their caregivers.

Child sexual abuse (CSA) affects an estimated 30 to 40 percent of girls and more than 13 percent of boys (Bolen and Scannapieco, 1999).<sup>1</sup> Historically, the field of social work has responded to CSA through school-based interventions that teach children how to protect themselves (Daro and Cohn Donnelly, 2002; Kenny and McEachern, 2000; Renk et al., 2002). In the most recent era, CSA prevention has focused on systemic prevention and holds adults responsible for the CSA that occurs in their communities (Berkowitz, 1994; Chasan-Taber and Joan Tabachnick, 1999; Renk et al., 2002; Rheingold et al., 2007; Virginia Department of Health, n.d.a). Since 2005, the Stop It Now campaign has flooded radios in Virginia with a public service announcement about CSA. Over the andante strains of what sounds like nursery music, the announcement asserts: "Ninety percent of all sexual abuse happens with people kids know and trust" (Virginia Department of Health, n.d.c).

This article seeks to examine the systemic features of the problem of CSA, as well as corresponding systemic responses and interventions. It uses a public health model to examine CSA and a number of associated factors. It also

explores the history of efforts to prevent CSA, focusing particularly on the Stop It Now organization as an important case example. The theoretical framework is applied in analysis of the case to reveal successes and challenges in prevention efforts. The article considers the implications of systemic models and concludes with recommendations to expand the current public health response to CSA in order to incorporate the theory of social connection.

#### A PUBLIC HEALTH MODEL AND SOCIAL CONNECTION

A public health model of violence prevention is an alternative to a criminal justice model (Moore, 1995). A criminal justice model responds to violence with retribution against perpetrators. A public health model, in contrast, employs a systemic understanding of the vulnerabilities and resilience of both victims and perpetrators. The model aims to prevent future occurrence of violence through collective change. Based in science and proactive engagement, the public health model encompasses: (1) surveillance to monitor the extent of the problem; (2) research on risk and protective factors; (3) development and research of prevention strategies; and (4) widespread dissemination and eventual adoption of promising practices for prevention and intervention (Whitaker, Lutzker, Shelley, 2005, p. 246). These four elements are meant to approach public health problems systemically by understanding scope and causal factors, as well as by articulating responses to the problem that motivate collective change.

A public health response to CSA recognizes multiple opportunities for prevention and intervention. According to Patricia Crittenden (1998, p. 28), “Child abuse is an interactive process (a) in each instance, (b) across the childhood of each child, and (c) across generations as children mature and become parents.” Children who have been sexually abused may experience the negative sequelae of CSA across the lifespan, and the effects of abuse may ripple across generations (Whitaker et al., 2005).<sup>2</sup> The scope of a public health model extends beyond identifying perpetrators and providing mental health treatment for victims. Research suggests that CSA is preventable, and the persistence of the problem indicates the need for systemic changes in the ways by which caregivers connect with children (Moore, 1995).

The public health approach has its limitations. These can include the assumption that causal pathways can be identified, the focus on disease and diagnosis in defining the problem, and the challenge of measuring multiple levels of causation in violence (Moore, 1995). These limitations bear upon the problem of CSA through unclear causal pathways, a focus on child self-

protection, and a majority of prevention efforts that do not address the larger macrosystems, including gender, masculinity, and family roles, that contribute to inequality and violence. While it is essential that law enforcement hold CSA perpetrators accountable and also provide mental health treatment to victims, it is also important to consider systemic factors that may have contributed to perpetration and victimization (Trepper and Barrett, 1989). Iris Young (2007, p. 175) proposed a “social connection model of responsibility” for the field of global justice. In this model, “individuals bear responsibility for structural injustice because they contribute by their actions to the processes that produce unjust outcomes” (2007, p. 175). This particular model differs from a “liability model” (p. 175), which attributes blame for harm to individuals directly connected to causing the harm. The liability model often isolates perpetrators and the causes of harm by linking them to direct actions. The model may be considered retroactive in its approach, as it responds to injustice by seeking retribution.

According to Young (2007), a social connection model features the following important elements. First, a social connection model does not isolate responsibility. Second, the model implicitly promotes questions about what background conditions contributed to the occurrence of harm. Third, the model is preventative and seeks to incorporate in the process of collective change all those affected by the problem. This article will apply Young’s idea of social connection to relationships between individuals who belong to “a system of interdependent processes” (2007, p. 175), a system that contributes to the problem of CSA. Social connection will refer to those relationships between children and adults that promote universal protection of children from harm by adults. Derived from Young’s theory, social connection promotes adults’ responsibility for preventing CSA in their families, communities, and larger societies. Although a public health model and a social connection model stem from different fields and are supported by different theories and research, these models appear to respond to CSA in a systemic manner and to promote collective change of contributing conditions.

#### ARTICULATING THE PROBLEM OF CSA

Jeffrey Haugaard (2000) argues that sexual abuse exists on a continuum. Definitions of CSA vary widely among researchers, clinicians, and lawmakers, possibly due to professionals differently operationalizing each word in the term (Haugaard, 2000). Recognizing that the concept of abuse and the gravity of the event are culturally determined, David Finkelhor and Jill Korbin (1988,



p. 4) conceptualized child maltreatment as “the portion of harm to children that results from human action that is proscribed [i.e., negatively valued], proximate, and preventable.” While professionals negotiate the details of the definition, the public appears to recognize CSA but has difficulty articulating a definition. Lisa Chasan-Taber and Joan Tabachnick (1999) assessed perceptions of CSA in Vermont. They found that nearly all respondents (96.5 percent) were familiar with CSA; 74 percent of respondents considered CSA to be a problem in Vermont. However, more than half of the respondents were unable to define CSA and did not know the warning signs that indicate possible CSA by an adult.

According to Deborah Daro and Anne Cohn Donnelly (2002, p. 434), “The values and attitudes that people hold about children and how to raise them, the behaviors they engage in as parents toward their own and other children, and the degree to which they support or fail to support certain public policies all help explain the existence of child abuse and its increase or decrease over time.” The occurrence of CSA appears to challenge conventional notions of caretaker obligations and the value of children in society. It also challenges standards of moral conduct, as well as social constructs associated with gender, family systems, and sexuality (Haaken and Lamb, 2000). It is problematic depending upon its associated, culturally accepted taboos, the parameters of its continuum (from sexual suggestiveness to genital penetration), and assumptions about the responsibility, mental health, and self-control of individuals who perpetrate CSA. Only 31 percent of respondents in the Vermont study thought that CSA perpetrators could stop their behaviors (Chasan-Taber and Tabachnick, 1999). Vermont residents also anticipated the difficulty they might have in confronting family members suspected of CSA. They expressed concerns that reporting CSA could do more harm than good for the child and family.

#### THE EXTENT OF THE PROBLEM: PREVALENCE AND TRENDS

Recent estimates suggest that as many as one in every three girls and one in every six boys experience CSA (Bolen and Scannapieco, 1999; Briere and Elliott, 2003; Russell, 1984; Wyatt et al., 1999). The most current national data come from a 2005 survey, in which 83,810 children were identified as victims of indicated sexual abuse (USDHHS, 2007). That number represents 9.3 percent of all child maltreatment victims. The overall rate of maltreatment victimization is inversely related to child age groups, in that the risk of

maltreatment diminishes as the child ages; nevertheless, CSA is most commonly found (17.3 percent of cases) among children between the ages of 12 and 15 (USDHHS, 2007). Although findings from the 2005 survey indicate that more than half (54.2 percent) of reported CSA victims are at or above the age of 4, other studies indicate that younger children may be more likely than older children to experience CSA (Romero et al., 1999; Tolan and Guerra, 1998).

The population of individuals who have experienced CSA may be much larger than current research documents. For example, research shows that medical examinations detect sexual abuse at incredibly small rates (4 percent) in cases referred for medical evaluation, regardless of severity of abuse (Heger et al., 2002). Although prevalence ranges indicate that CSA is a significant public health problem (Bolen and Scannapieco, 1999; Briere and Elliott, 2003; Russell, 1984), it is unknown how much CSA goes unreported. Maryann Amodeo and colleagues (2006) found that approximately half of a community sample of 290 adult women reported that no one knew that they were sexually abused as children. These women also reported that they dealt with the experience alone. Estimates of CSA may particularly underrepresent the incidence among young children. There are a number of reasons why child victims and adults may not report CSA. Children who lack the language abilities to indicate and describe harm may not recognize sexual abuse (such as single events of fondling) when it occurs or may be reluctant to disclose to trusted adults (Bolen and Scannapieco, 1999). In addition, children may fear disclosure of CSA because of coercion from the abuser, because of duration and severity of the abuse, or because the child fears that it will adversely affect the family (Cohen et al., 2001; Wyatt et al., 1999). Should a child disclose the abuse, adults may not believe that CSA occurred (Wyatt et al., 1999). Children under the age of 4 may not be exposed to caretaker adults (e.g., teachers, coaches) who could recognize indicative behaviors (Bolen and Scannapieco, 1999). These factors intensify the need for a thorough understanding of the factors that place children at risk for sexual abuse and of those that place adults at risk for becoming abusers. They also highlight the importance of understanding aspects of the relationship between victim and perpetrator.

#### VICTIM-PERPETRATOR RELATIONSHIPS

Children are most likely to be abused by adults (e.g., caregivers, relatives) they know and trust (Bulik, Prescott, and Kendler, 2001; Feiring, Miller-Johnson, and Cleland, 2007; Heger et al., 2002; Tolan and Guerra, 1998; USDHHS, 2007). Biological parents are less likely to sexually abuse their children than

are parental substitutes, extended family, and strangers (Heger et al., 2002). Fathers involved with early and routine care of their daughters are less likely to sexual abuse their children as they grow up than are, for example, stepfathers who join the family as their stepdaughters enter adolescence (Parker and Parker, 1986). Some research has shown that approximately half of CSA victims lived with the perpetrators at the time of the abuse (Amodeo et al., 2006; Crew Solomon, 1992; Feiring et al., 2007; Romero et al., 1999; Wyatt et al., 1999). Perpetrators are typically male, and victims are typically female (Crew Solomon, 1992; Putnam, 2003; Wyatt et al., 1999). Child sex offenders have reported in multiple studies that they sexually abuse children who are socially isolated and vulnerable; further, “a loved and cared-for child is less likely to become a victim” (Renk et al., 2002, p. 81). Astrid Heger and colleagues (2002) argue, “Children are usually abused by an individual known to them who wants continued access to them” (p. 654).

#### RISK FACTORS FOR CHILDREN

Gender is a significant risk factor for CSA. The risk of CSA is estimated to be 2.5 to 3 times higher among female children than among their male counterparts (Putnam, 2003). Nevertheless, boys comprise 22 to 29 percent of all CSA victims (Putnam, 2003). There are mixed findings about whether risk for CSA increases with age. Some findings indicate that adolescents are at higher risk for becoming CSA victims than are younger youth (Putnam, 2003; USDHHS, 2007). However, other studies indicate that risk for CSA decreases with age. These studies relate risk to the physical vulnerability of young children, as well as to the difficulty they may have in recognizing, resisting, and reporting CSA (Parker and Parker, 1986; Romero et al., 1999; Tolan and Guerra, 1998). Research also suggests that a child’s physical disability places him or her at risk (Putnam, 2003). Family constellation is considered a risk factor that contributes to CSA; for example, the absence of one or both parents places children at risk (Putnam, 2003). Research suggests that social isolation is a risk factor for CSA; this is true of children who are socially isolated and of children whose families experience social isolation (Black, Heyman, and Smith Slep, 2001; Putnam, 2003).

Low socioeconomic status is a prevailing risk factor for child physical abuse and neglect, but it is only moderately related to CSA (Black et al., 2001; Putnam, 2003). Findings are mixed on whether race and ethnicity are significant risk factors for CSA (Amodeo et al., 2006; Putnam, 2003). However, some studies indicate that race, ethnicity, class, and gender each influence disclosure,

severity of trauma symptoms after CSA, and other long-term effects among victims of CSA (Amodeo et al., 2006; Banyard, Williams, and Siegel, 2004; Cohen et al., 2001; Feiring et al., 2007; Putnam, 2003; Spataro et al., 2004; Wyatt et al., 1999).

#### PATHWAYS TO CSA: RISK FACTORS FOR PERPETRATION

Research identifies a few factors associated with the commission of CSA. Tony Ward and Richard Siegert (2002) argue that CSA perpetrators share certain characteristics. Typically, adults who sexually abuse children have difficulties with emotional regulation, intimacy, sexual arousal, and distortions in thinking (Ward and Siegert, 2002). Stress appears to be a significant risk factor for CSA perpetration, as offenders have reported that they tend to abuse during times of heightened stress (Elliott, Browne, and Kilcoyne, 1995). Michele Elliott and colleagues (1995) found that two-thirds of offenders reported experiencing increased stress that precipitated their sexual abuse of children.

Adults are not the only perpetrators of CSA, and the theory that perpetrators share characteristics (Ward and Siegert, 2002) does not account for the developmentally inappropriate sexual behaviors of children and adolescents. Estimates suggest that between 30 and 50 percent of child molestations are perpetrated by juveniles (Becker, 1994). Between 60 and 80 percent of adult offenders are estimated to have begun sexually abusing children as juveniles (Groth, Longo, McFadin, 1982). The nonprofit organization Stop It Now (2008*b*) identified warning signs that may indicate adolescent perpetrators of CSA. Adolescent perpetrators may refuse to let a child set his or her own limits, may insist upon intruding on a child's physical boundaries, may insist upon spending time alone with a child (e.g., may offer to babysit for free or to take children on overnight outings), may give gifts and money for no apparent reason, may encourage silence and secrets, and may choose a particular favorite child among, for example, many children in a family (Stop It Now, 2008*b*). There is no current research that validates these warning signs as indicators of CSA perpetration; rather, it appears that these signs have been collected as anecdotal evidence (Oliver, 2007).

#### NEGATIVE SEQUELAE OF CSA

Children who have been sexually abused may have heightened risk for experiencing several negative outcomes, including inappropriate sexual behaviors, substance use, psychopathology, and revictimization. Diana English (1998)

observes that the consequences of child maltreatment are shaped by “the intensity, duration, and type of abuse; the presence of supportive adults; and the age of the child at the time” (p. 48). Victim-blaming and oppositely, social support, are not sequelae of CSA; however, the occurrence of each mediates CSA sequelae (Amodeo et al., 2006; Bolen, 2002; Feiring et al., 2007; McClure et al., 2008; Whiffen and MacIntosh, 2005).

Victims of CSA may exhibit developmentally inappropriate or harmful sexual behaviors (Friedrich et al., 2001; Putnam, 2003; Ward and Siegert, 2002). Researchers found that children who experience sexual abuse have a greater number of sexual-behavioral incidents than do children who have not been sexually abused, and the severity of such behaviors increases with the number, severity, frequency, and duration of abuse incidents (Friedrich et al., 2001; Putnam, 2003; Ward and Siegert, 2002).

Some research suggests that children who have been sexually abused have heightened risk for experiencing substance use problems in adolescence and adulthood (Briere and Elliott, 1994; Bulik et al., 2001; Burgdorf et al., 2004; Dube et al., 2005). One study, however, finds no association between CSA and substance use in adulthood (Lo and Cheng, 2007). The study’s authors observe that the findings are limited by an inadequate measure (through a single question) of sexual abuse (Lo and Cheng, 2007). This discrepancy may also be related to the study’s screening methodology. It is noteworthy that Kenneth Burgdorf and associates (2004) found a high prevalence rate of CSA (48 to 64 percent) in a population of women receiving substance use treatment, but the finding represents those individuals who sought treatment or whose treatment was mandated by law. The finding may therefore underrepresent CSA prevalence among individuals who use substances but do not participate in treatment.

In clinical samples of adults with some psychiatric conditions, a high proportion of participants reports that, in childhood, they were victims of CSA (Banyard et al., 2004; Bulik et al., 2001; Owens and Chard, 2003; Putnam, 2003). These conditions include symptomology of posttraumatic stress disorder, dissociative identity disorder, other anxiety disorders, depression, substance abuse disorders, eating disorders, and others (Banyard et al., 2004; Briere and Elliott, 2003; Bulik et al., 2001; Dube et al., 2005; Putnam, 2003). Victims of CSA also face heightened risk of impairments in functioning (e.g., impulsivity, interpersonal difficulties, self-mutilation, and other forms of self-harm; Whiffen and MacIntosh, 2005). Persistent psychopathology (the manifestation of psychiatric disorders) is positively correlated with the severity of abuse (e.g., penetration), the duration of abuse, and abuse by a

perpetrator who is a relative of the victim (Banyard et al., 2004; Bulik et al., 2001; Dube et al., 2005; Owens and Chard, 2003; Putnam, 2003; Spataro et al., 2004). One study found that 12.4 percent of victims of CSA (both male and female) came into contact with mental health services. In contrast, 3.6 percent of counterparts in the general population sought psychiatric treatment (Spataro et al., 2004). Occurrence of CSA does not necessarily explain variance in adult mental health; rather, one study found that multiple CSA experiences, maltreatment by a caregiver, the number of traumatic experiences, and overall living situation were associated with psychopathology outcomes for both females and males (Banyard et al., 2004).

Children who are victims of CSA are at risk for revictimization, which includes reoccurrence of CSA, child assault, or sexual assault in adulthood (Briere and Elliott, 2003; Classen, Paresh, and Aggarwal, 2005; Urquiza and Goodlin-Jones, 1994; Romero et al., 1999). In a review of approximately 90 empirical studies on sexual revictimization, its prevalence, and risk factors, Catherine Classen and associates (2005) found that occurrence and severity of CSA were the best predictors of sexual revictimization. Further, risk for revictimization is found to increase among sexually abused children if they also experienced multiple traumas, especially physical abuse. The study also notes that sexual revictimization is associated with clinically significant distress and such psychiatric disorders as affective disorders, posttraumatic stress disorder, and other anxiety disorders. Revictimization is found to be associated with increased dissociation and substance use.

Individuals who were revictimized exhibited clinically significant self-blame and shame (Classen et al., 2005). They also expressed difficulty in building relationships, as well as in affect regulation, coping, and self-representations (Classen et al., 2005). Although research is limited on revictimization's relationship with race and ethnicity, one study found that rates of revictimization were highest for African American women (61.5 percent; Urquiza and Goodlin-Jones, 1994). Revictimization rates for other groups were 44.2 percent among White women, 40 percent among Latinas, and 25 percent among Asian American women (Urquiza and Goodlin-Jones, 1994). Gloria Romero and associates (1999) found that one in three Latinas reported CSA, and more than one-third of those women also reported revictimization. Research indicates that the severity of CSA may affect the risk of revictimization (Classen et al., 2005).

## MODERATORS OF CSA AND PROTECTIVE FACTORS

Applying a public health model to CSA prevention entails understanding factors that moderate the effects of CSA and help protect children from adverse outcomes that may develop subsequent to the abuse, abuse discovery, or disclosure. Moderators of CSA influence how child victims and their family members deal with the trauma and other sequelae. Some of these moderators are identified by empirical studies (Bolen, 2002; Wilcox, Richards, O'Keeffe, 2004; Jonzon and Lindblad, 2006). The victim's decision to attribute the blame for sexual abuse to the perpetrator may serve as such a moderator (Wilcox et al., 2004). Support from caregivers may also moderate the effects of CSA, and approximately 75% of nonoffending caregivers provide at least some support after their child's disclosure that he or she has been sexually abused (Bolen, 2002).

Although no known research identifies protective factors that prevent sexual victimization of children, some findings suggest that future research should consider whether several factors can play moderating or even protective roles in the lives of CSA victims. For example, research indicates that self-esteem, social skills, family support, and external social support help children develop resiliency (Bolen, 2002; Wilcox et al., 2004; Jonzon and Lindblad, 2006), and research should evaluate whether these factors enable CSA victims to develop resiliency as a way to moderate the effects of victimization. So too, Joseph Chandy, Robert Blum, and Michael Resnick (1996) identified factors that appear to guard female teenagers against adverse outcomes of low school achievement, suicidality, substance use, risk for pregnancy, and eating disorders. They also found that distress is moderated by spirituality, awareness of health, and social support, which they define as relationships with adults, a two-parent living situation, and the presence of a nurse or clinic at their school (Chandy et al., 1996). Research should consider whether those factors can influence outcomes related to CSA.

## A BRIEF HISTORY OF SCHOOL-BASED CSA PREVENTION

For nearly 30 years, efforts to curb CSA have focused on incarcerating perpetrators, establishing a national sex offender registry, and linking perpetrators to mental health treatment (Daro and Cohn Donnelly, 2002). Efforts also focused on the use of developmentally appropriate prevention education in classrooms, attempting to teach children how to protect themselves and resist abuse (Daro and Cohn Donnelly, 2002; Davis and Gidycz, 2000; Kenny et al., 2008; Kenny and McEachern, 2000; MacIntyre and Carr, 2000;

Renk et al., 2002). Specifically, school-based programs to prevent sexual abuse aim to improve children's abilities to recognize inappropriate physical contact and also to empower children to disclose the abuse to nonoffending, trusted adults (Kenny and McEachern, 2000; Renk et al., 2002).

Children most often encounter these programs during elementary and secondary school, as well as through national youth organizations (e.g., Boy Scouts of America; Daro and Cohn Donnelly, 2002). The programs often use role-playing and discussion to help children understand how to keep their bodies safe by recognizing inappropriate touching from others (Daro and Cohn Donnelly, 2002). Children also learn that it is important for them to disclose to a trusted adult if they ever experience a situation that makes them feel uncomfortable or unsafe. Lastly, children learn in these programs that CSA is never their fault.

Most empirically evaluated programs appear to effect small but statistically significant gains in child knowledge of sexual abuse (Davis and Gidycz, 2000; Kenny and McEachern, 2000; Renk et al., 2002). However, children who learn to protect themselves solely through school-based programs have great difficulty in accepting the idea that someone they know and care for can harm them (Daro and Cohn Donnelly, 2002). Further, young children often misunderstand concepts of secrets and how to deal with ambiguous or confusing feelings that may relate to unsafe touching by older children or adults (Daro and Cohn Donnelly, 2002).

Sexual abuse prevention programs do, however, promote the safety of disclosure, and this lesson may be helpful in affecting future behavior. Research suggests that child participants in the programs retain increased awareness of safety and remember general safety rules, but they retain little knowledge about such educational concepts as who perpetrators can be, the different kinds of abuse, and the fact that sexual abuse, if it happens, is not their fault (Daro and Cohn Donnelly, 2002).

School-based sexual abuse education programs are found to achieve such objectives as teaching body safety skills and some CSA concepts to children (Kenny and McEachern, 2000; Rispen, Aleman, and Goudena, 1997). Laura Gibson and Harold Leitenberg (2000) studied the rates of CSA in a population of female college students to determine if there was any correlation between CSA and participation in a school-based prevention program during childhood. In a large but homogeneous sample ( $n = 825$ ), 62 percent of women reported having participated in a childhood program that used concepts of "good touch-bad touch" (Gibson and Leitenberg, 2000, p. 1118). Eight percent of participants who reported school-based participation also reported experiencing



CSA. In comparison, 16 percent of participants reported CSA but reported no participation in a school-based prevention program. The researchers concluded that early education about self-protection and CSA may have helped prevent CSA. Gibson and Leitenberg (2000) acknowledged their study to be limited by its retrospective design as well as the unclear effects of program participation on CSA occurrence. The nature of the sample (Caucasian female undergraduates) compromises the generalizability of the findings, because these women may have had other resiliencies not otherwise accounted for, and such factors may have contributed to their abilities to retain and employ safety concepts, regardless of school-based education. Because no research studies have examined how prevention programs effect CSA prevalence, it cannot be assumed that these prevention programs lower child risk of CSA (Davis and Gidycz, 2000; Gibson and Leitenberg, 2000).

Although these programs have dominated prevention efforts for at least 30 years, their effects are limited (Daro and Cohn Donnelly, 2002). Kimberly Renk and colleagues (2002) found that school-based prevention programs often avoid explicit anatomical terms, and such avoidance may make it difficult for children to describe sexual abuse experiences adequately. In addition, children usually participate in school-based programs before middle and high school sexual education (Renk et al., 2002). These early characterizations of sexual matters may frame them as wrong, bad, or scary.

Teaching self-protection and resistance behaviors to children may also increase their chances of severe harm and victimization. One study found that only one-quarter of offenders reported that they would have stopped the abuse if the child had used some form of resistance (Elliott et al., 1995). Many school-based prevention programs attempt to include families as educators, but most parents do not inform their children about sexual abuse (Renk et al., 2002). Parents who do talk to their children about self-protection may possess inadequate knowledge of CSA (Renk et al., 2002). As a result, these parents may provide explanations that are too ambiguous and confusing for their children to understand.

Researchers identify successful school-based prevention programs as those that: (1) provide children with opportunities to role-play, rehearse safety strategies, and practice responses; (2) present information that is tailored to developmental norms and cognitive abilities; (3) stress the need for emotional expression and safe disclosure; (4) include formal and extensive training components for parents and teachers; and (5) develop prevention programs that are integrated into the regular curriculum and that include after-school and discussion components (Daro and Cohn Donnelly, 2002; Davis and Gidycz, 2000; Kenny et al., 2008; MacIntyre and Carr, 2000; Renk et al., 2002).

## STOP IT NOW: PROVIDING ADULTS WITH TOOLS TO ADDRESS CSA

Founded in 1992, Stop It Now is an independent, national, nonprofit organization that has mounted a public health campaign to help adults prevent CSA (Chasan-Taber and Tabachnick, 1999; Pollard, 2007). The organization receives funding through federal grants as well as private contributions (Stop It Now, 2007). Stop It Now provides a telephone helpline, community-based programming, and a variety of Internet and print resources, as well as panel discussions that bring together various individuals who have experienced, perpetrated, or provided mental health treatment for CSA.

According to its 2005–2006 annual report, Stop It Now operates “the only confidential, national, toll-free Helpline (1-888-PREVENT) which offers support, information, and resources to adults who are concerned about the sexualized behaviors in themselves or people they know” (2007, p. 3). The helpline serves perpetrators and potential perpetrators by offering them confidential information on self-disclosure and mental health treatment.

Stop It Now has implemented community-based programs in Virginia, Georgia, Massachusetts, Minnesota, Philadelphia, Wisconsin, and several other countries (Stop It Now, 2007). In each community, Stop It Now conducts a needs assessment and establishes collaborative relationships with state health departments. It also provides other community education and training programs in the mental health field (Stop It Now, 2007). Depending on results of market research, Stop It Now launches statewide public service announcement campaigns that advertise the helpline and highlight themes of collective action to prevent CSA. Many of Stop It Now’s advertisements feature messages that confront the issue of CSA and challenge adults to hold themselves responsible for sexual harm caused in their communities.

The strategies and interventions used by Stop It Now were designed according to the Precede-Proceed framework (Chasan-Taber and Tabachnick, 1999). Developed by Lawrence Green and Marshall Kreuter (1999), Precede-Proceed is a planning model that uses educational and ecological approaches to diagnose challenges or areas where improvement is needed. The model attempts to facilitate organizations’ planning for health-promotion efforts. Precede-Proceed has guided the design of other successful public health campaigns, including those for smoking cessation, child car-safety seats, breast self-examination, breast-cancer screening, high blood pressure, injury control, and general community health (Chasan-Taber and Tabachnick, 1999). As applied by Stop It Now, the framework attempts to recontextualize CSA as a public health problem that can be prevented through proactive, community-

based monitoring and response. Prevention efforts focus on public perceptions and education about CSA, as well as on ecological factors that the organization identifies as contributing to or deterring CSA occurrence.

The targeting of CSA prevention efforts at adult caretakers, communities, and perpetrators (current and potential) stems from an ecological model proposed by Urie Bronfenbrenner (1977). According to Renk and colleagues (2002, p. 69), Bronfenbrenner views “the child’s environment as a series of nested and interconnected structures,” and his model indicates that “the child is at the center of the sphere of influence.” Bronfenbrenner’s model targets prevention efforts on the child’s immediate relationships and interrelationships among family members, teachers, physicians, and other adults with whom the child may come into contact. The model also targets social settings that may affect the child indirectly and “the cultural context in which all other systems are embedded [and which govern] the ideology behind how children should be treated and what they should be taught” (Renk et al., 2002, p. 70). The Stop It Now campaign in Virginia arguably uses the ecological “sphere of influence” (Renk et al., 2002, p. 69) to challenge adults on their perceptions about their responsibility for protecting children.

Some of the most recent and controversial public discussions about CSA have been triggered by the Stop It Now campaign in Virginia. Stop It Now billboards and posters in Richmond feature shadowy, lavender-toned photographs that show the large hand of an adult (apparently male) folded over the small, delicate hand of a child (Virginia Department of Health, n.d.*b*). The caption reads: “It doesn’t feel right when I see them together.” It is precisely this visceral subtlety that has evoked anxiety and outrage from a number of interest groups (Zaslow, 2007). The Virginia public service announcements have been the focus of national discussion, catching the attention of CNN, *The Wall Street Journal*, and Good Morning America (ABC News, 2007; CNN, 2007; Zaslow, 2007). It is reported that the Virginia Department of Health received more than 200 complaints from men about the campaign (Zaslow, 2007). The concerns are that Stop It Now, along with such other media ventures as the Dateline NBC series “To Catch a Predator,” are promoting widespread fear of men, especially men who take care of their children (ABC News, 2007; CNN, 2007; Zaslow, 2007). The Stop It Now advertisements in Virginia may inadvertently portray men as automatic predators. They also may serve to scare fathers and male caretakers from participating in their children’s lives, showing affection, or even joining in the efforts to prevent CSA. Further, the reactions from a number of interest groups may affect the campaign’s ability to meet its goals in each community.

In response to these criticisms, Peter Pollard (2007), Director of Public Education for Stop It Now, affirmed the father-child relationship as “one of the most effective means of protecting children from sexual abuse” (p. 2). He also highlighted Stop It Now’s commitment to the improvement of programs through critical self-evaluation and to considering criticisms as part of that evaluation (Pollard, 2007).

Chasan-Taber and Tabachnick (1999) evaluated the first two years of a Stop It Now campaign in Vermont that was implemented between 1995 and 1997. A 1995 baseline assessment determined that 55.5 percent participants in a random telephone survey ( $n = 200$ ) were unable to define CSA. In 1997, another random telephone survey was conducted with 200 Vermont residents; this time only 35.5 percent of participants were unable to define CSA. However, the percentage of residents (56 percent) in the 2-year evaluation who did not know warning signs of abuse was similar to the percentage found at baseline (55 percent). Chasan-Taber and Tabachnick (1999) also interviewed key decision makers and community leaders about their familiarity with Stop It Now’s programming and resources. These interviewees pointed to increases in public awareness of CSA. They also pointed to increases in public recognition of the idea that perpetrators deserve help and treatment. The evaluation reported that the Vermont Stop It Now helpline received 100 calls in its first year (1995), 141 in its second (1996), and 241 by September 1997 (Chasan-Taber and Tabachnick, 1999). During that period (1995–1997), calls from perpetrators represented 23.2 percent of those received by the helpline; 50.6 percent of calls came from people who knew a victim or an abuser; most callers knew both. The evaluation also reported relevant state statistics. Over 2 years, states attorneys’ offices across Vermont indicated that eight sexual offenders voluntarily reported their crimes to authorities, 11 adults reported perpetration of CSA to their clinicians, and caretaker inquiry resulted in the treatment of 39 juveniles for sexual behavior problems (Chasan-Taber and Tabachnick, 1999). The researchers acknowledged that the rates of self-reporting may not be caused by or correlated with the campaign (Chasan-Taber and Tabachnick, 1999).

The Virginia Department of Health also evaluated its programming through Stop It Now. The Virginia Department of Health (n.d.*a*) reported that its state helpline received 40 calls within a 5-month period. One-third of these calls came from callers seeking information about CSA, and 20 of the callers reported knowing both a suspected abuser and a suspected victim. Because callers remain anonymous, it is not possible to determine the helpline’s effects on the incidence of CSA. This evaluation is limited by its sample size

(40 calls within 5 months), which may not be sufficient to enable a reliable assessment of the effects of the advertisement of the helpline. The Virginia Department of Health (n.d.*a*) also conducted a randomized telephone survey of 500 state residents. Results indicate that individuals who were exposed to the radio and print advertisements reported increased awareness of CSA prevention; however, the evaluation does not report comparison percentages, and therefore, these results may not be a reliable assessment (Virginia Department of Health, n.d.*a*).

Based on this case evaluation, Stop It Now programs appear to be consistent with strategies of both public health and social connection models. Systemic understanding of CSA is illustrated in the mission of Stop It Now: “Stop It Now prevents the sexual abuse of children by mobilizing adults, families, and communities to take actions that protect children before they are harmed” (Stop It Now, 2008*a*). Stop It Now’s efforts notably address the vulnerabilities and resiliencies of children and CSA perpetrators with its helpline and use of market research to understand adult perceptions of the problem. Stop It Now uses public health strategies of surveillance and monitoring to tailor its programs to the communities it serves. Further, its use of media campaigns is intended to promote widespread dissemination of information on CSA and the multiple prevention opportunities that are available to adults. This article also determines that Stop It Now aims to promote strategies of a social connection model, although it is yet to be determined if the organization is successful at reducing stigmatization of child-adult relationships, especially in light of the Virginia campaign controversy and outrage by a number of male interest groups (ABC News, 2007; CNN, 2007; Zaslow, 2007). The efforts of Stop It Now, at very least, encourage collective responsibility for CSA, an understanding of ecological factors that contribute to the problem, and widespread participation by community members in efforts to protect children from sexual abuse.

## RECOMMENDATIONS

Their evaluation of Stop It Now led Chasan-Taber and Tabachnick (1999) to recommend that future prevention efforts should: (1) provide a forum in which those who have lived through abuse can tell their stories; (2) encourage children to learn about types of abuse and different effects of abuse on children; and (3) offer skills-based programs for adults who face situations of CSA, training them in such tasks as confronting suspicions, talking to family members, and seeking help in a way that minimizes the threat to the family system.

This article recommends that efforts explore and utilize public health and social connection models to better understand how they effectively contribute to CSA prevention. This article also recommends that prevention programs address the overwhelming empirical evidence that CSA perpetrators are most often men. Specifically, programs should avoid assertions and programming that stigmatize the relationships between male caretakers and children. Rather, prevention efforts should develop strategies that actively bring men into the prevention movement. This article also recommends fostering discourses that provide men with the opportunities to be considered nurturers and caretakers. Ultimately, such discourses should help reconnect men to their children.

*Open the Lines of Communication about CSA*

Renk and colleagues (2002) observe that most CSA prevention programs focus on engaging children and their mothers. This observation leads them to argue that prevention efforts should attempt to increase the participation of fathers and male intimate partners in CSA prevention education. Involving male and female caregivers in the sexual abuse education of their children may help to decrease the secrecy associated with abuse, increase social support, and promote the responsibility of adults in preventing CSA. Parents and teachers should be encouraged to talk to children about sexual abuse, to learn how to detect signs of abuse, and to promote self-esteem as well as emotional expression in children. Education efforts should ensure that children, parents, and professionals do not harbor the inaccurate notion that sexual abuse perpetrators tend primarily to be strangers. Rather, CSA prevention education should focus on the need for adults to be protective of and responsible for children (their own, child relatives, and children in their community). Further, the prevention of sexual abuse may require adults to understand and address their discomfort with certain topics, such as child sexuality, abuse, and family secrets.

Prevention efforts should also explore how children may strengthen their abilities to differentiate safe touches from ones that are not safe, regardless of whether they come from caregivers or strangers. Efforts also should encourage children to verbalize confusion or discomfort to youth and adults. Programs should help children to feel comfortable discussing with their caregivers the feelings and questions they may have about their own bodies. Opening the lines of communication about CSA may reduce some of the secrecy, shame, confusion, and stress that all parties (children, families, perpetrators, individuals at-risk for offending, and the public) associate with its occurrence.

*Promote Awareness of Social Constructs Related to Gender and Sexuality*

Community and school-based CSA prevention programs should be updated to address the root causes of CSA. Brian Oliver (2007) recommends that prevention programs educate parents, teachers, and school counselors about warning signs and risk factors. He also recommends that programs reach out to at-risk adolescents and adults, encouraging them to seek help before they abuse. Importantly, Oliver recommends that prevention programs should focus on altering perceptions of gendered sexual scripts as well as gendered assumptions about abusers and victims.

Janice Haaken and Sharon Lamb (2000) argue that societal sexism is largely to blame for the prevalence of sexual abuse in the United States. Renk and associates (2002) suggest that preventive strategies should include “differential socialization messages” (p. 76). Other researchers have argued that male children grow up with restricted messages about what kinds of emotional expressions are socially acceptable for men; some assert that social sanctions nearly exempt men from involvement in parenting and routine caretaking (Cohn, Finkelhor, and Holmes, 1985; Renk et al., 2002). A prevention strategy that promotes awareness of gender and sexuality constructs may serve to strengthen the relationship between the child and male caregiver. Such a strategy might advocate that male caregivers play an active role in child-rearing. It might also engender a community discussion of the continuum of child sexual abuse as well as of its effects on the development of sexual, gender, and parental identity. It might work to open communication by decreasing feelings of fear, guilt, and shame. Communication might also grow with an emphasis on prevention and social connection. In addition, the current review suggests that school-based, health education programs may be a useful medium for addressing sexuality, sexual curiosity, healthy relationships, cognitive distortions, and empathy, as well as risk and protective factors for all types of child maltreatment, not just sexual abuse.

*Emphasize the Magnitude of Social Connection in Public Messages and Intervention Strategies*

Research on perpetrators of CSA suggests that offenders tend to victimize children who appear to be socially isolated and vulnerable. Research on factors that moderate adverse outcomes of CSA for children suggests that family support is an important contributor to the resiliency of CSA victims. This article recommends that researchers explore protective factors that may help guard children against sexual abuse. Not only should the message of social

connection be brought to the public (Renk et al., 2002), but CSA prevention efforts should seek to promote a broad understanding of social connection. Research has yet to discover whether communities that actively work to promote social connection help protect children from sexual abuse and from CSA's negative sequelae.

Phil Rich (2006) argues that prevention efforts might rehabilitate social connection by adopting methods that differ from previous ones. Evaluation research does not clearly indicate that efforts by Stop It Now contribute to increased public awareness of CSA or to prevention. However, such large-scale public health campaigns are able to address the widespread problems on a variety of levels (family, community, and society). Public health and social connection models may be utilized to complement the almost-universal school-based programs. These efforts reinforce adult and community responsibility for CSA, encourage open communication about CSA, increase awareness of constructs of gender and sexuality, and expand public understanding of the magnitude of social connection. One important contributor to CSA prevention may be the private (family) and public endorsement of open communication to deter the secrecy, shame, taboo, and general misinformation that perpetuate the problem. Although these recommendations may undoubtedly prove challenging to implement in accordance with current policy, political and moral stances, and public thinking, they promote openness and social connection as both a public health response and prevention strategy for creating a safe context for children to grow up.

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## NOTES

<sup>1</sup>In this article, CSA refers to any sexual behavior or activity that a juvenile or adult caregiver perpetrates with a child. The term and its abbreviation, CSA, will be used as distinct from “child maltreatment,” which refers generally to child abuse, including physical, sexual, and psychological abuse, as well as neglect.

<sup>2</sup>This article uses the term “sequelae” to refer to negative outcomes for which individuals who have experienced CSA are at heightened risk. Such outcomes may include physical and psychological effects as well as any behaviors that may cause distress for the individual in his or her environment.

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# EMPLOYERS' USE OF LABOR MARKET INTERMEDIARIES (LMIs) IN FILLING LOWER-LEVEL JOBS AND IMPLICATIONS FOR LOWER-SKILLED LMI CLIENTS

*By Timothy P. Hilton*

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School of Social Service Administration

CHAIR: Susan Lambert, Ph.D., Associate Professor

The goal of this research is to examine roles labor market intermediaries (LMIs) serving lower-skilled workers play within firms' HR systems and implications for LMI clients. Focusing on hotels in downtown Chicago, this study explores three sets of factors thought to be related to firms' LMI-use: those pertaining to business strategy; those related to normative aspects of HR management; and those that reflect other general organizational characteristics. Data indicate that where HR managers are more educated, more aware of innovations in professional HR management, more involved in strategic planning initiatives within their firms, and have sufficient flexibility to design and adjust HR practices, they tend to develop similar HR systems aimed at attracting and retaining skilled employees by creating higher quality job opportunities and using targeted attraction practices, regardless of whether their firms employ a cost leadership or differentiation business strategy. HR leaders at these firms tend to use LMIs in a targeted manner, selecting only those that refer retainable and productive workers. While these firms are not necessarily more likely to use LMIs than other firms, lower-level jobs filled through LMI referrals tend to be of higher overall quality than those of other firms. Firms with less educated HR leaders who are less aware of and responsive to innovations in

HR management and lack the flexibility to design and adjust HR practices tend to use LMIs in an indiscriminant manner as a means of coping with high turnover.

#### ABOUT THE AUTHOR


TIMOTHY P. HILTON is an Assistant Professor and Program Director of the Bachelor of Social Work Program at Northern Michigan University. His research interests include labor market intermediaries serving low-income job seekers, welfare and work, and human resource management. In addition to his ongoing research related to his dissertation, Dr. Hilton is currently developing two new research projects, one focusing on employment prospects of individuals living in poverty within a rural area facing rapid job loss and the second identifying coping mechanisms of rural homeless populations.

# THE IMPACT OF PROVIDER CHARACTERISTICS ON THE QUALITY OF THE CLIENT-PROVIDER RELATIONSHIP IN MENTAL HEALTH SERVICES

*By Colleen A. Mahoney*

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Although there is a growing evidence base that supports the importance of the client-provider relationship for outcomes in community-based services for persons with serious mental illness, little research attention has been given to the precursors of this relationship. This study represents an attempt to identify provider-related factors that influence the interpersonal context of service delivery and pays particular attention to providers' patterns of thinking about challenging client behaviors. Specifically, it examines the impact of provider causal explanations, or attributions, for a common challenging client behavior, medication nonadherence, on the quality of the working relationship. Data were collected from 152 client-provider dyads from a large, urban community mental health clinic. Focal independent variables capturing aspects of providers' attributions for client medication nonadherence were derived from providers' written responses to a question eliciting reasons why clients may not take medications as prescribed. Using both a novel approach and a modified version of an established method of coding attributions, provider responses were rated to measure multiple dimensions of their attributional patterns. Bivariate, OLS regression, and HLM analytic strategies were used to examine the impact of these provider attribution patterns on the quality of the client-provider relationship.

Results indicated that client experience of the negative relationship was impacted by both the complexity and content of providers' attributions. Specifically, clients perceived less criticism and rejection when their providers generated a greater number of explanations for client medication nonadherence and when those explanations included mention of client beliefs about their illness and medication. Provider perception of the negative relationship was impacted by the dimensionality of provider attributions. That is, providers who generated causal explanations external to the client perceived less conflict and demoralization in their relationships with clients. Finally, provider perceptions of the positive relationship were impacted again by the content of their attributions. In this case, providers who acknowledged pragmatic impediments as possible causes of medication nonadherence perceived greater levels of satisfaction and connection in their relationships with clients. Together, these findings offer several implications for practice and future research. Most fundamentally, they suggest that training and supervision efforts targeting providers' thinking patterns may result in improving the quality of the interpersonal context in which services are delivered. Providers should be encouraged to think in more differentiated ways about why clients may engage in challenging behaviors and should be prompted to examine clients' environments for possible causal sources, paying particular attention to pragmatic and concrete realities in clients' lives. Furthermore, client beliefs about medication and mental illness should be acknowledged as providers' reasons about their potentially challenging behaviors. In addition to replicating the current findings, future studies should also examine the pathways by which provider causal explanations exert their influence on the quality of the helping relationship.

#### ABOUT THE AUTHOR

COLLEEN A. MAHONEY is currently an Assistant Professor at the School of Social Work, University of Wisconsin-Madison. Her research and teaching interests include serious mental illness, co-occurring disorders, mental health service delivery, and intensive community-based services such as Assertive Community Treatment, with a particular focus on the interpersonal context of these services.