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Editorial: How Far Do You Go?

How Far Do You Go?

Stephen M. Marson & Jerry Finn

Cheating in college! Literature on the subject is quite distressing and sadly cheating appears to be on the increase. We suspect that cheating in social work departments is no different than any other areas of study. We have two particularly terrible examples of academic dishonesty.

The first had to do with a quiz and the aftermath. A student who was sitting in the back of the classroom complained that she could have a higher grade if she cheated as two other students had. The (social work) professor asked the two students to visit his office. When the first one arrived, he naively asked about the possibility of cheating. She immediately broke into tears and claimed she didn't. She was merely handing "whiteout" to her friend who had asked to borrow it. When the second student came to visit, in the same naïve manner, the professor asked her about cheating. She was outraged and lost her temper in a manner unprecedented for a student. Although the professor was in the classroom, he saw no cheating and therefore had no firsthand evidence to pursue adjudication. However, he had an intuitive sense that cheating had occurred.

After the second student (the one with the temper) graduated, she obtained employment as the *only* social worker in a small rural hospital. During a complex review of the medical charts, the staff came to the horrendous conclusion that this hospital social worker had consistently fabricated a large number of social histories, progress notes, and so forth. In some cases, she was writing social histories and progress notes on patients she had never seen. Upon this realization, she was fired and told to leave the hospital premises *immediately* and never return. Although that happened ten years ago, that hospital will not accept field work students from the BSW program nor will they hire any of its graduates. In addition, few human service workers in this rural county are unaware of the story of the fabricated medical records. As a result, the former hospital social worker cannot obtain a professional position.

The second story is much more complex. Susan pushed to be placed in a field setting the social work program had never used in the past. The director of the field work accommodated her.

Early in the semester, she complained that it was a terrible experience because she was not seeing any clients. Through a series of complex arrangements, the student was removed from this placement and started with another agency. After she graduated, pieces of a complex puzzle emerged. A second social work student asked¹ Susan to gain her field placement at the first agency in order to procure mental health records of the second student's husband. The second student wanted to employ these confidential records for an upcoming divorce proceeding. Copies of the records were passed from one student to the other. When the deed was completed, Susan was able to switch her field placement.

Prior to any of this being uncovered, Susan was accepted into an MSW program with advanced standing status. At the same time, Susan had been requesting to purchase term papers from current social work majors and graduates. These term papers were to be used toward her MSW degree! After the discovery, the chair of the social work department contacted the MSW program and forwarded a series of certified affidavits regarding the mental health records. In addition, the MSW administrators learned of her alleged purchases of term papers. At least three lawyers were involved and, due to the complexity of the law, *nothing could be done*. To everyone's best knowledge, both of these characters are practicing social work.

Major questions constantly should haunt us about both of these situations. Do social work students who cheat in the process of learning also act in unethical manners in their professional practice? The first case suggests "yes." However, little support is found in the literature. The professor who was involved in both of these examples attempted to conduct a national survey of academic misconduct. No social work program would reply or allow their students to complete the survey – even though the same survey was employed in research for other academic programs. One comment was that "the IRB [Institutional Research Board] would not permit" the acquisition of such information.

The big question is this: What responsibilities do social work professors have to identify, prevent, and adjudicate cheating within our respective academic programs. We do not see this

¹ Probably for the exchange of money.

issue as “yes, we should address cheating” or “no, we shouldn’t,” but rather the intensity of our involvement. Or, stated more clearly, how far should professors go to prevent and address cheating?

Letters to the Editors

Dear Editors:

First, I would like to tell you how much I like the e-journal and hope that you will continue to have this available to the public. I am a clinical social worker, and my specialty is gerontology. Currently, I am also a candidate for a PhD in social work at Simmons College in Boston, MA.

You asked the question about splitting the journal into practice and academic/research sections. That idea might be helpful to some readers. However, if a research article is relevant to social work practice would people not read it if it were placed in the research section? I, personally, read everything, even if it is not in my particular area. I find there is a great crossover. Research articles should be "readable," and thus of interest to all practitioners.

Thank you for your contributions to social work knowledge.

Sincerely,
Elise Beaulieu, MSW, LICSW

Steve and Jerry,

Congratulations on another successful publication of the Journal. I remember the birth of this journal. I praise you for your willingness to make the Journal widely accessible. I found the article on dual relationships in rural practice particularly helpful. I have directed it to my students and rural colleagues in Eastern Kentucky. We have a huge problem getting people to use mental health services in our rural areas. Their concerns usually center on confidentiality.

Doug Burnham,
Professor (Retired), University of Eastern Kentucky

Can We Be Fair? Balancing the Personal with the Professional Response to Terrorism

Denise Ellis, Ph.D., C.S.W.
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Abstract

Given the recent terrorism events in the U.S. and the ongoing threat of additional acts, it is imperative that social workers consider the ethical implications that affect the ability to provide for clients, students, and ourselves. This paper examines the role of core values of the NASW Code of Ethics, personal values, fears, safety concerns, limitations and strengths as social workers practice in the new era of terrorism.

Keywords: Values and ethics, terrorism, September 11th, disaster, post-traumatic stress disorder (PTSD)

Introduction

Acts of terrorism have been in the nation's spotlight since 9/11. Terrorism impacts everyone either directly or indirectly. Social workers are human first and are not immune to the recent and ongoing events and threats of terrorism. They also experience the same fear, anger and personal safety concerns as the general population in response to dramatic images of violence, mayhem, death and destruction. Consequently, American values and beliefs based on equality, free speech, freedom to practice religion, and right to privacy have been called into question. While it is dangerous in other parts of the world, living in the U.S. has also become potentially dangerous. Neither race, ethnicity, educational or economic status, nor religion is a guarantee of safety in the U.S. (Ellis, 2004). As a result, there may be a gap for some social workers between their personal and professional responses. The highly emotionally charged atmosphere requires that social workers critically examine any bias or prejudice that may exist. Failure to do so would compromise practitioner effectiveness.

The profession of social work is guided by a Code of Ethics that parallels American values and provides a moral road map to enhance practice. The National Association of Social Work (NASW) urges an examination of a role for the United States in working in cooperation with other nations, to reduce inequity and wide discrepancies that contribute to social injustice and resentments that may in turn lead to conditions that spawn terrorism. Furthermore, they attempt to put some of these variables in perspective, and to prepare the profession for possible future attacks. NASW (2002) refers to a prediction by (Johnson, 2000) who suggests, "Given its wealth and power, the United States will be a prime recipient in the foreseeable future of all of the more expectable forms of blowback, particularly terrorist attacks against Americans in and out of the armed forces anywhere on earth, including within the United States" p. 223.

This paper examines the challenge for social workers to practice in an era of terrorism events in the U.S. and the challenge to balance our personal and professional responses. Terrorism is defined in this article as "the unlawful use of force and violence against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives" (FBI, 2001). Ethical considerations that affect social workers' ability to provide for us, clients directly and indirectly affected by terrorism, and students are also addressed. A review of research suggests a relationship between values and ethical principles. This paper will highlight the historical effects and current research on the effects of war and terrorism, social work values and ethical principles that guide practice. In addition, the responses of the professions of psychiatry, public health, education and social work are identified. This is followed by a discussion of the ethical implications of the core values in the Code of Ethics as they apply to service provision to people directly and indirectly affected by terrorism.

Historical Effects of War and Terrorism

Since the American Revolution the United States has been attacked four times. The attacks were the bombing of Pearl Harbor in 1941, the first bombing of the World Trade Center (WTC) in 1993, the Oklahoma City bombing in 1995 and the second bombing of the WTC in 2001. Both bombings of the WTC and the Oklahoma City bombing were carried out by individuals with no known ties to any government and were labeled as terrorist attacks. In contrast, the attack on Pearl Harbor was considered an act of war by the U.S. government. An act of war is an attack on one

country carried out by a government of another country. Terrorist attacks are acts implemented by individuals who appear to operate outside government channels, but who may have government ties.

During WWI and WWII, the majority of research on the effects of stress was conducted on military personnel, by the U.S. Army and the U.S. Navy, rather than on civilians. A review of historical literature covering the periods of WWI and WWII chronicled the reactions of American and British soldiers under the stress of combat (Appel & Beebe, 1946). War neurosis, operational fatigue, combat stress and shell shock were the initial terms used interchangeably for a range of symptoms that came to be known as Post Traumatic Stress Disorder (PTSD). Of the western nations involved in WWI, the British military were the furthest behind in understanding trauma. WWI British military authorities attempted to suppress reports of psychiatric casualties because of the demoralizing effects on the public (Showalter, 1985). Three hundred and six British soldiers exhibiting symptoms of shell shock, including confusion, and walking around dazed and listless, were subsequently executed for what would now be labeled PTSD. The executed soldiers were accused of being weak, inadequate and cowardly (UK National Workplace). Additional symptoms included, but were not limited to exhaustion, anxiety, fear, sleeplessness, irritability and aggressive behavior (Grinker & Spiegel, 1945).

Research conducted during and immediately following WWII provided additional information about the re-entry experiences and the impact of combat related stress for soldiers, their families, and the communities to which they returned. During this period, psychiatrists, rather than social workers played the major role in the provision of mental health services to armed forces personnel and their families, with the primary intervention being psychotherapy (Grinker & Spiegel, 1945). Since WWII, social work has increasingly assumed a central role in the provision of psychotherapy.

The syndrome of chronic trauma has evolved to include symptoms of anxiety, agitation, constant state of vigilance, intense fear, chronic apprehension of doom, nightmares, irritability and feeling of detachment (Herman, 1992; Straussner & Phillips, 2004). Additionally, those affected by PTSD commonly experience issues around basic trust and questioning of faith (Herman, 1992). It was not until 1980 that the American Psychiatric Association included 'post-traumatic stress

disorder' in its official manual of mental disorders (Herman, 1992; American Psychiatric Association, 1980).

Several parallels exist between the response of citizens during the next era, the Cold War and the post 9/11 era. First, during the Cold War era, when the threat of nuclear annihilation existed, the U.S. government, then as now, advised citizens to be prepared for an attack. A retired social work educator related her experience during this period. "Americans knew there was a threat, something to which we needed to be alert. However, although the government presented the threat as imminent, average Americans went on with their lives" (Personal communication). Second, public buildings of the time had air raid shelters, equipped with non-perishable food and other supplies, to be used in case of an attack. These shelters were the forerunners of 'safe rooms' that today's Americans were recently encouraged to prepare in their homes by the Dept. of Homeland Security. In addition to traditionally recommended supplies, duct tape and plastic sheeting have been added. Third, individuals and groups who were viewed as a threat to national security were targeted and discriminated against.

An explanation of recent targeting is based on the U.S. government conclusion and subsequent public awareness that Osama bin Laden and all nineteen hijackers who commandeered planes on 9/11 had the following characteristics: 1) they were Muslim males; 2) from the Middle East, (most from Saudi Arabia); and 3) were identified as members of Al Qaeda. Since 9/11, pictures have routinely been displayed of menacing looking men in turbans, often brandishing weapons. Those who fit the profile of suspected terrorists have been officially and selectively denounced, with the accompanying emotional response of moral revulsion (Ahmad, 2001). The difficulty is not knowing with certainty who is and is not engaged in terrorist activities. However, it is a short leap for the public, to view anyone with any of the above characteristics as suspicious if not guilty of terrorism.

Recent Research on the Effects of Terrorism in the U.S.

There is a paucity of data and information about the ongoing effects of terrorism on people in the U.S. prior to 9/11. This is primarily due to the extremely limited number of terrorist attacks that have occurred on U.S. soil.

World Trade Center Bombing 1993

This was the first attack on U.S. soil since the bombing of Pearl Harbor. One account of the experiences and impact of the World Trade Center bombing in 1993 on children in the immediate vicinity was discovered in the literature. Some children were stuck in an elevator in a nearby elementary school during the bombing. They later received crisis counseling. Webb (1994) noted that "school personnel tended to discount the impact of the response on children... [but] some parents later reported that their children continued to experience sleep disruptions, and that some were afraid to go on elevators" (p.15).

Oklahoma City Bombing

The major attack in terms of loss of life that occurred in the latter half of the last century was the Oklahoma City bombing in 1995. The Traumatic Stress Studies Program, of the (Department of Psychiatry of the Mount Sinai School of Medicine, 2004) concluded the following after a review of the research about the effects of the event and ongoing trauma on citizens directly involved:

- Survivors reported increased anxiety, depression, increased use of alcohol, stress and PTSD symptoms a year after the bombing (North, Nixon, Shariat, Mallonee, McMillen, Spitzanagel & Smith, 1999).
- "Two years after the bombing, 16% of children and adolescents who lived approximately 100 miles from Oklahoma City reported significant PTSD symptoms related to the event" (Pfefferbaum et al, 1999).
- In the Oklahoma City bombing "adults who sought mental health services had reactions of being nervous and being upset by how other people acted when the bombing occurred was predictive of PTSD" (Tucker, Dickson, Pfefferbaum, McDonald & Allen, 1997).

Moreover, they predicted that the community would function as a critical source of support and help those directly and indirectly affected to overcome symptoms associated with trauma. It was their belief that symptoms if present would lessen with time (Department of Psychiatry of the Mount Sinai School of Medicine, 2004).

9/11 Attacks

A review of the literature revealed limited results of any mental health studies on civilians who were at any of the Ground Zero sites. The New York City Department of Health and Mental health is conducting a long-term study on the health impact of 9/11 on the people who lived and worked in the area of the World Trade Center and emergency responders. Toward this end, they

have developed the World Trade Center Health Registry to identify and track the data. To date, 40,000 have registered (NYC Dept. of Health and Mental Health).

Bocanegra & Brickman (2002) conducted a study on 77 displaced Chinese workers in the vicinity of the World Trade Center complex. The results indicated, "One third of the sample was classified as at least moderately depressed, and 21% met diagnostic criteria for post-traumatic stress disorder; however, few had utilized mental health services (p. 55).

Psychiatry, Public Health, Nursing and Education Policy Responses

Psychiatry, public health professionals, education and nursing have all issued professional policy statements in response to recent terrorism events. Each addresses the impact, role and responsibilities on and of its members.

Psychiatry

Psychiatry developed a "Traumatic Stress Studies Program" which is housed in the Department of Psychiatry at the Mount Sinai School of Medicine. The program is designed to function as a resource for other professionals. The literature on psychiatry and terrorism also includes articles on, the neuro-psychiatric effects of domestic terrorism with chemical or biological agents (DiGiovanni, 1999) and the role of an 'on-line response to terrorism' (Kennedy, 2002).

Public Health

The public health profession views keeping people healthy as its primary function and has identified a role and strategy for its members in response to terrorism. The Board on Neuroscience and Behavioral Health of the Institute of Medicine, in addressing the role of the public health profession stressed that in order to fulfill their responsibility to the public, they will need to "Address the physical, psychological, and social needs that result from the range of terrorism events or hazards (conventional explosives, biological, radiological, chemical, nuclear attacks) will require universal preparedness by all systems responsible for the public's health" (Board on Neuroscience and Behavioral Health, Institute of Medicine, 2003 , p.3). In addition, public health professionals are expected to identify and track disease patterns (Johns Hopkins University, Civilian Biodefense Studies Center, 2001).

Nursing

The International Council of Nurses (2001) issued a position statement for nurses on Emergency Preparedness. In it they stress, "In the event of terrorist attacks nurses and other health professionals need to work with other groups and the public to address concerns and provide health services" (International Council of Nurses, 2001, p.1). Toward that end, nurses are expected to be prepared to "allay public concerns and fear of bioterrorism and identify feelings that they and others may be experiencing" (International Council of Nurses, 2001, p.2). An additional focus of intervention for nurses is the responsibility to familiarize them with bioterrorism, which includes the use of chemical and biological agents as weapons. Nurses and social workers face a similar dilemma of balancing their personal and professional responses to patients. Similar to the NASW Code of Ethics, the International Code of Ethics for Nurses clearly states, "nurses are ethically bound to provide care to all people" (ICN Code of Ethics, 2000).

Education

The Educators for Social Responsibility, a national organization of teachers in lower education, felt compelled as an organization to develop a list of guidelines and recommendations to help teachers address terrorism and war in the classroom. This response resulted partially from anger, fear and concerns expressed by students. The comprehensive list: 1) helps teachers intervene to help students cope with their feelings of rage, revenge and prejudice about the death of a relative or friend, and 2) proposes approaches to teaching elementary school children about the war and other violence in the world (Educators for Social Responsibility, 2003, p.7-8).

In a review of the literature, this author discovered an interdisciplinary committee of psychiatrists, social workers and public health professionals, formed to assess options for responses to terrorism. They assessed peer reviewed "trauma and disaster mental health studies and relevant data on consequences of and responses to terrorism"(Board on Neuroscience & Behavioral Health, 2003, p.2). Each of these professions has as its central mission, helping to enhance and improve some aspect of health. Working collaboratively will increase the ability of each profession to help people preserve and enhance physical and mental health in light of recent and ongoing threats of terrorism.

NASW Code of Ethics and Terrorism

The Code of Ethics provides ethical principles to help social workers answer who, what, when, where and how to guide our professional response to practice. The Delegate Conference of the American Association of Social Workers adopted the first Code of Ethics in 1947. The concept of social justice was not mentioned specifically until 1993, after the code underwent several revisions. The core values, which serve as the foundation of our work, include service, social justice, dignity and worth of the person, competence, integrity and competence.

An ever-growing list of social problems coupled with dramatic advances in technology and the development of new treatment strategies has resulted in refinement of the Code of Ethics and its core values. Domestic violence, HIV/AIDS, school shootings, and terrorism require social workers to constantly expand their knowledge base in order to remain current with these social problems. Currently, NASW does not have a binding policy statement on terrorism. This is puzzling since for one hundred years the social work profession has maintained a tradition of being in the vanguard of upholding and defending the rights of vulnerable populations and promoting social justice. Social work, similar to other helping professions needs to develop best practices for its members. Responses to terrorism may confront social workers with a variety of stressor's and place them in ethically difficult situations. It is anticipated that the social work profession, similar to other helping professions, will begin the process of determining what additional resources, tools and strategies the profession must have in response to terrorism. Some questions to be considered are, for example:

- Are the issues and implications of terrorism significantly different from other practice issues, and if so, do the traditional guidelines apply?
- How should social workers balance their personal and professional responses to the threat on ongoing terrorist attacks? Unlike other practice and political issues, their existence may hang in the balance.
- Who should decide what the best/most effective intervention is for working with individuals, groups and populations from regions thought to support terrorist beliefs and goals?
- When, if ever should social workers discontinue directly providing service to clients if they are having difficulty managing possible fears and prejudices?
- Where should social workers turn to for accurate, timely information about terrorism?
- What procedure should a social worker follow, if they suspect a client of involvement or support of terrorist activities?

Core Social Work Values

Service

The (NASW Code of Ethics, 1999) states that a "Social workers primary goal is to help people in need and to address social problems". In times of disaster (whether natural or manmade), and or terrorism, helping professionals can be counted on to help those experiencing trauma, to the best of their ability. In these situations, social workers provide crisis intervention, mental health counseling and other concrete services. The professional role is evident. However, the question remains as to what extent can service be provided to others when the helping professional may be struggling with his or her own personal need for comfort and safety concerns?

Research is currently being conducted to assess how social workers in various fields of practice have been functioning in the post 9/11 era. However, much of what is known is anecdotal and related by social workers in various fields of practice. For example, attitudinal changes were identified by a New York metropolitan area Critical Incident Stress Debriefing, who is also an emergency medical technician (EMT), with a long history of providing emergency services to victims of various types of disaster and trauma, including law enforcement, fire personnel and victims of 9/11. She indicated that "Terrorism affects everyone's life on a day-to-day basis". She admits that her attitude toward "Arab looking" men has changed since 9/11. She shared for example, that prior to 9/11, if she observed a group of "Arab looking" men, she wondered if they were going to be buying another convenience store? Post 9/11, she admits one thought is, "I wonder if they are terrorists, planning an attack" (Personal communication). She reports feeling troubled by what she realizes are stereotypical attitudes.

She has also observed a consequence of providing service on some debriefers. She noted that in her personal experience, some debriefers "keep their feelings in and let them out in very inappropriate ways and at inappropriate times." Several examples of behavior she noted in colleagues, particularly since 9/11 include: 1) having difficulty re-establishing boundaries between one's personal and professional responsibilities; 2) experiencing acute symptoms of sleep and appetite disturbance; 3) increased tension with co-workers; 4) constant state of vigilance; 5) being unwilling to accept or respond to co-worker concerns about apparent stress symptoms, and; 6) being unwilling to accept assistance from colleagues, family or friends.

A review of the literature has not yielded any published data identifying the impact of 9/11 personally and professionally on social workers who were at Ground Zero. We need to determine needs and experiences of the following social workers: 1) those who were living or working at or near Ground Zero; 2) those who provided service to clients directly and indirectly affected; 3) practitioners in other regions of the country; and 4) those in various fields of practice. Some questions to be explored are: have there been any changes in how service is provided, considering social workers are among the potential targets of terrorists just by living in the United States? Additionally, is it a challenge to "elevate service to others above self-interest" as the code further asserts?

Social Justice

The Code of Ethics challenges social workers to "strive to ensure equality of opportunity, access to needed information, services, resources, and meaningful participation in decision making for all people". During these turbulent times, people from vulnerable populations and from regions associated with terrorism are at increased risk of being the victims of discrimination and prejudice. The profession has traditionally championed the rights of those at risk and not able to speak for themselves. Toward this end, it has participated in the 'War on Poverty', 'War on Drugs', and most recently, the 'War on Terror'. In the case of the most recent 'war' social workers work to support individuals and or groups being discriminated against because they may be of Arab descent, from the Middle East, Muslim or may have characteristics perceived by the general population as similar. Additionally, social workers may work to support individuals or populations opposed to the U.S. government 'War on Terror' and or strategies to combat the 'war'.

Holody (2004) asserts that "...to maintain social work's relevance in a world that includes mass violence and the conditions that give rise to such acts by individuals, groups and nations, social work must reassess its values, define their relevance to changing conditions, and actively work to better the conditions of human life" (p. 187). Since its inception, the profession has worked to advance the rights of the oppressed. This history and the lessons learned provide a unique opportunity to reach out to and work with other helping professions in a concerted effort to bring about nuclear disarmament, peace and social justice that would benefit humanity. The profession does have an obligation to confront policies that we view as unjust, unfair and discriminatory.

Dignity and Worth of a Person

Social workers are committed to promoting each individual's right to be treated with dignity, respect and worth. Can social workers genuinely uphold this value and remain unbiased when working with individuals or populations, when fear, hostility or anger may be present? Social work professionals have a worldview based on acceptance and equality of all. However, until research suggests otherwise, there is no reason to think social workers would not experience a wide range of feelings, mirroring those of the general population. As practitioners it is imperative that we acknowledge and work through our feelings about possible terrorists and those who support the goals of terrorists. Other helping professionals must also struggle with conflicted feelings in their work with patients and clients. The (International Council of Nurses, 2001) affirms "In the aftermath of terror even health care professionals can feel bias, hatred, vengeance, and violence towards ethnic or religious groups that are associated with terrorism" p.2. Instances of social worker responses to feelings about terrorists have been identified as ranging from no feelings to anger, prejudice, fear and a need for revenge. These responses were identified as part of an ongoing research study being conducted by this researcher and through individual contacts with colleagues, particularly, those in the New York metropolitan area.

Social workers have the theory, skills and Code of Ethics to guide practice. One crucial question becomes what to do with our feelings. Reamer (2001) suggests "For many of us, the terrorism seems to have assaulted our values, as well as the human victims. Is it humanly possible for social workers to respect the dignity and worth of terrorists, or should we even be expected to?" p. 23. The answer it seems is still unfolding. As professionals, we have parallel instances of working with child molesters and abusers, all of whom elicit powerful feelings. It's not easy to respect and uphold the rights of terrorists. Social workers vary in their ability to accept their personal feelings about terrorists and terrorist attacks, while adhering to the tenets of the Code of Ethics. A critical difference that distinguishes our feelings about work with groups associated with terrorism is the knowledge that terrorists are dedicated to committing violence, and if necessary, murder of U.S. citizens to advance their objectives. From an ethical standpoint there should be no difference in the way social workers practice, whether or not they are at personal risk. It remains to be seen to what degree our professional responses are influenced by safety concerns and or

negative attitudes toward populations suspected of direct or indirect participation or support of ‘terrorist’ activities. Additional research in this area is needed, as social workers in the United States have little precedent for this ethical dilemma.

Importance of Human Relationships

Social workers are dedicated to the promotion of healthy human relationships and identification and facilitation of support systems for client systems. Helping individuals and groups locate resources in their communities is a critical approach in helping people respond to uncertainty and conflict resulting from disaster (Soliman, 1996). Communities can also be a tremendous source of support when coping with terrorism and the ongoing threats (Soliman & Rogge, 2002). Support systems are as important for social workers, as they are for our clients. In this era of uncertainty, related to ongoing threats of terrorism, social workers in all fields of practice must resist the urge to ‘go it alone’. Rapoport (1965) cautioned social workers that "in addition, the helping person needs to view himself as intervening in a social system—as part of a network of relationships—and not a single resource" p. 30. Reliance on colleagues, friends and family is critical.

The code states "Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations and communities" (NASW Code of Ethics). This particular value calls upon social workers to utilize our knowledge and work collectively to advocate for policies that: 1) demonstrate an understanding of the importance of human relationships, and 2) rely on non-militaristic approaches to national and international conflicts and threats to peace.

Integrity

This principle in the Code of Ethics is based on the assertion that "social workers must behave in a trustworthy manner". It is easy to conclude that this is the easiest of the core values to uphold. However, this may not always be so easy to achieve, when one considers the difficulty that may be encountered when mediating between individuals, groups, communities and or organizations that may have opposing viewpoints. The added element is possible existence of fears and safety concerns related to terrorism and those who support or engage in such activity. Ethical dilemmas related to integrity might arise, when, for example:

- A social worker is assigned to work on behalf of a client system which supports terrorist objectives.
- A social worker is at odds with stated or unstated agency policy regarding the treatment and or disposition of a client system.
- A faculty person has students discuss feelings of anger at those they believe are responsible for terrorist attacks, when they themselves share similar feelings.

Informal reports from some administrators indicate that "social work faculty seem reluctant to take charge and help students process their feelings" (Personal communication, 2004). Baseline data will be needed in this area, but in the meantime, faculties have an obligation to facilitate meaningful class discussions while functioning as honest and responsible role models. The intellectual process and direction are provided by the Code of Ethics when confronted with these dilemmas. However, a lingering question remains as to how social workers should manage their feelings through these unsettling times. It is said that 'the longest trip in the world is between your head and your heart' (Author unknown). Levy (2002) echoes this dilemma when she acknowledges "Professionally and personally, I don't think anyone ever gets used to being a victim of terror" (p. 5).

Competence

Social workers need to feel confident about their ability to help others in order to be effective. The (NASW Code of Ethics, 1999) encourages social workers to "continually strive to increase their professional knowledge and skills and to apply them in practice." Current standards for competence in various fields of practice need to be expanded to include terrorism's impact specifically, as opposed to other trauma work, which includes natural disaster (earthquakes, hurricanes) and technological disaster (nuclear plant accidents and chemical spills. The effects of terrorism would be expected to cause even the most skilled social worker to question ability and competence, as U.S. social workers have no frame of reference for this. The post 9/11 era provides an opportunity for social workers in the U.S. to draw from the experience of our colleagues on other continents that have decades of experience dealing with terrorism.

A negligible amount of information exists in the literature regarding competent practice and terrorism. The Red Cross, Salvation Army and International Critical Incident Foundation offer training for social workers and other helping professionals, to provide information and skills that

each organization deems necessary. To date, however, no national standards of competence have been identified.

Social Work Practice and Post 9/11 Era Realities

The following realities related to terrorism need to be remembered as social workers respond to client needs precipitated by 9/11 and ongoing threats of terrorism:

1. Populations who were at risk before 9/11 are still at risk. We can't forget these client systems or their needs. Addressing people's needs post 9/11 simply means that there is an added dimension to professional practice.
2. During times of disaster, these sources of communities and disaster relief organizations may become over-extended. Current government strategies to combat the 'War on Terror' have further exacerbated disproportionate resource availability.
3. Providing disaster relief services and ignoring warnings of one's own stress and possible burnout have adverse effects. Social workers have the knowledge, tools and skills necessary to help others. It is critical that we simultaneously take care of ourselves. We have an ethical responsibility to try and prevent becoming overwhelmed by symptoms of stress and burnout.
4. Social workers know intellectually that everyone ought to be treated equally. However, we may have feelings to the contrary. Those feelings need to be identified, examined and acknowledged.
5. We need to put our professional differences aside. Our differences revolve around debates about theoretical perspectives, approaches, which field of practice is more desirable, and last but not least, destructive battles about clinical versus other types of service provision.

Conclusion

Most of us have been touched in one way or another by the terrorist attacks. Our professional stance is shaped in large part by our individual values and beliefs about what is right and wrong and by notions of fairness. The NASW Code of Ethics serves as a moral compass as we navigate through the post 9/11 era. Questions and concerns about personal safety contribute to newly acquired feelings of being vulnerable and expendable. Ultimately, we must decide as a nation, how to live with our feelings and fears in the 21st century and preserve our integrity, dignity and civil liberties.

Because the U.S. has little experience with terrorist attacks on its shores, there is a lack of corresponding research in this area. Current exploration of the moral and ethical implications of terrorism for social work practice is in the infancy stage. If we are not squarely on a proactive path

and making our voices heard, we run an ever-increasing risk of becoming irrelevant in the search for peace and social justice.

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Dual Relationship Legitimization and Client Self-Determination

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Abstract

This paper is a discussion about the legitimization of non-sexual dual relationships in social work practice. Social work ethics and standards require social workers to be cognizant of dual relationships and boundary issues. What happens when the practice arena legitimizes dual relationship actions that ethically do not uphold professional social work standards? What ethical dilemmas does this have for social work practitioners and for their client's right to self-determination? This paper will explore these questions through the utilization of a case study example. Unless the practice arena remains vigilant in monitoring ethical standards of conduct, the helper role will become blurred with personal assumptions about what is right and wrong, and ultimately good.

Keywords: dual relationships, legitimization, helper role, boundaries, ethical dilemmas

Introduction

Ethics

Ethics can simply be described as two things (Markula Center for Applied Ethics, 2004). Ethics refers to standards of right and wrong, of what each of us ought to do usually in terms of rights and obligations, benefits, common good, least harm and social justice for all. Ethics also refers to the ongoing study and continued development of one's ethical standards. As a practitioner involved in a social work relationship, one ought to pursue, examine and reflect upon ones' beliefs and actions from a moral standpoint not only for oneself but also for the institutions and their moral direction that each person can and does have an impact on (Younggren, 2002).

Social Work Relationship

A social work relationship represents two relationships: a fiduciary relationship and a therapeutic relationship. The client places his/her confidence and trust in the social worker and

depends on the social worker's judgment or counsel (Pelligrino, Veatch & Langran, 1991). As a fiduciary, the social worker is expected to (1) practice with integrity and to act in accordance with her professional standards of conduct and (2) respect the inherent rights and dignity of the client (Black, 1991). As a fiduciary relationship is based on unequal power and responsibility, it is the social worker's obligation to resist abusing this power and to practice in an ethical manner (Kutchins, 1991).

The therapeutic aspect of the relationship means that clients who receive help are vulnerable to social worker influence (Kagel & Giebelhausen, 1994). A social work relationship is particularly vulnerable to non-sexual dual relationships because of the helper role.

Paper position and outline

This paper is a discussion about non-sexual dual relationships and the right to self-determination. The paper takes the view that the 'helper role' within social work practice is inadvertently legitimizing non-sexual dual relationships. This legitimization has the potential to jeopardize the client's right to self-determination. The practice of social work must insist upon ongoing study and development of ethical standards in order to recognize actions that promote dual-relationship development. The first step in the vision of an ethical practice is to recognize that the profession has become blind to potentially unethical actions in our practice.

The aim of the paper is twofold: (1) to alert social workers that 'helping' actions may not necessarily equate with ethical practice and (2) to recognize that actions that contribute to a non-sexual dual relationship can be a catalyst for a legitimization of this relationship within the practice arena.

The paper is comprised of the following descriptive parts: (1) the International Federation of Social Work's standard of conduct, (2) a definition of dual relationships, (3) an explanation of the right to self-determination, (4) a case study involving the promotion of action(s) that develop non-sexual dual relationships in the workplace and (5) an ethical debate of these action(s) based on the Markula Center of Applied Ethics ethical decision-making framework.

Social Work Conduct

In October 2004, the International Federation of Social Workers (IFSW) issued a new Ethical Principles and Standards Document (IFSW, 2004). In this document, social worker's

professional conduct must: (1) act with integrity. This includes not abusing the relationship of trust with the people using their services, recognizing the boundaries between personal and professional life, and not abusing their position for personal benefit or gain, (2) include an acknowledgement that they are responsible for their actions to the people they work with, their colleagues, their employers, the professional association and to the law, and that these accountabilities may conflict, (3) foster and engage in ethical debate with their colleagues and employers and take responsibility for making ethically informed decisions and (4) work to create conditions in employing agencies and in their countries where the principles of this statement (IFSW ethical document) and those of their own national code are discussed, evaluated and upheld (IFSW, 2004).

This professional standard of conduct represents a moral aspiration for all social workers. It asks that all social workers engage in ethically based relationships with people and within their workplaces that do not allow them to develop unethical alternative actions to practice.

Dual relationships

Ethical issues concerning dual relationships in the social work practice arena are the most challenging and problematic (Strom-Gottfried, 1999; Kagel & Giebelhausen, 1994). In its simplest definitional form, non-sexual dual relationships in social work practice are relationships that occur when a social worker assumes a second relationship with a client that may cause actual or potential conflicts between their professional duties and their social, religious or business relationships (Kagel & Giebelhausen, 1994; Reamer, 2001; Reilly, 2003). These second relationships may be ethical or unethical, problematic or non- problematic which is why the blurring between professional ethics and standards and practice sometimes occurs.

Reamer (2001) states that it is important for human service professionals to distinguish and to understand what is meant by a boundary crossing and a boundary violation when attempting to understand dual relationship issues. As the name suggests, a boundary violation happens when a social worker is involved in a dual relationship that is exploitative, coercive, manipulative or deceptive. Not only are boundary violations aggressive in nature, but a potential conflict of interest which could harm clients or colleagues is possible. Should a conflict of interest occur, the social worker could potentially be seen as prejudicial in her decision-making.

Dual relationships that are not exploitative, coercive, manipulative or deceptive with clients are seen as a boundary crossing. This type of crossing over between a professional relationship and into a second relationship has the potential to be either ethical or unethical or somewhere in between. Some of these 'crossings' may be more helpful than harmful and vice versa (Hartly, 2002).

Reamer (2003; 2001) has defined dual relationships within five central themes: (1) intimate relationships, (2) personal benefits, (3) emotional and dependency needs, (4) altruistic gestures, and (5) unanticipated circumstances. Actions within those five themes are listed in Table 1.

Table 1: Actions and Themes [Source: Reamer, 2003]

Dual Relationship Themes	Actions
Intimate Relationships	sexual relationships physical contact services to former lover intimate gestures
Personal Benefits	monetary gain good and services useful information
Emotional & Dependency Needs	extending relationships with clients promoting client dependence confusing personal & professional lives reversing roles with clients
Altruistic Gestures	performing favors providing nonprofessional services giving gifts being extraordinarily available
Unanticipated Circumstances	social & community events joint affiliations & memberships mutual acquaintances & friends

Many of the ethical complaints against social workers involve sexual dual relationships (Aguilar, Williams & Akin, 2004; Mittendorf & Shroeder, 2004). Not many practitioners, the institutions and the populations that they serve would fail to recognize the inherent harm and conflict of interest that involve some form of sexuality within a social worker-client relationship. However, not all practitioners, the institutions and the populations that they serve recognize the inherent harm and conflict of interest that can arise from non-sexual dual relationships (Pepper, 2004). Practitioners who do recognize their involvement in a dual relationship can experience

discomfort which may have negative effects on their personal and professional lives (Nigro, 2004). Have we as practitioners allowed those areas that are not as readily evident as sexual intimacy to become so muddled in a twilight zone of practice and place that we have forgotten their ethical importance? Whatever form dual relationships take, it is without question that most dual relationships inherently violate the belief in the worth and dignity of all humans. This belief forms the basis to the right for self-determination.

The Right of Self-Determination

According to the IFSW (2004), the social work profession's foundation rests on the belief that social workers should respect the inherent worth and dignity of all people. The right that underlies this belief is the right to self-determination and participation. Our professional conduct as social workers must reflect this belief and promote the right to self-determination.

The right to self-determination for everyone must be recognized and respected. Self-determination is a key aspect in a community's autonomy to control its own future and thus to grow and prosper (Foster, 2001). Self-determination is not only perceived to be a right of control in one's destiny but also in holistic terms, of one's health and survival and ultimately of one's community's health and survival (Tuhiwai Smith, 1999).

The United Nations International Covenant on Civil and Political Rights in Part 1, Article 1 of its declaration, recognizes that all people have the right to self-determination "by virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development" (1997). Everyone has a basic moral right to self-determination, to participation in their development and through that participation, to control over what happens to them (Tuhiwai Smith, 1999). All people must be viewed as capable of self-determination (Buckle, 1993) and as possessing an inherent right with regard to that capability.

Principles of human rights are fundamental to social work. The right to self-determination is a fundamental human right that the profession of social work adheres to. The right to self-determination should remind all of us that ethics has an important place in human affairs. Almond (1993) believes that self-determination is based on humanities commonalities, their needs and capacities. The commonalities among persons should be more important than their differences.

Case Study

I worked in a medium sized city in a government department in a special unit that worked with the vulnerable population of lone parent families. Most of these parents were female, between the ages of 16 years and 24 years who were on social assistance, had not completed high school and were without familial support. These youthful mothers were referred to the unit through various channels: (1) child protection workers, (2) long term ward (foster care) workers, (3) medical personnel (i.e. nurses, medical clinics, doctors), (4) relatives or friends, or (5) self-referral. Unless the referral was from a child protection worker, participation within our program was voluntary. The length of time in the program averaged one year. Some of the young mothers stayed with the program for 5 years or more, depending on their level of need and the number of pregnancies that they had. The workers often commented that the very nature of the helper role that had developed through time in the unit took on a pseudo big sister or mother role. We were encouraged to be involved with a client as much as our time allowed in relation to our perceived need of that client.

The unit program for the young mothers offered in-home parenting education and support (i.e. how to mix formula, bathing children), support through facilitation of parent support groups, transportation to medical appointments and any other appointments that the social worker deemed necessary (i.e. purchasing food, food bank pick up) advocacy in the areas of housing, financing, medical appointments, bus ticket allocation, partner relationships and teacher-parent meetings for school-age children. Depending on the worker's determined need of the client, a worker might see the client once a month, once every 2 weeks, once a week, and sometimes in a crisis, every day until the crisis was resolved. Some clients telephoned every day for various reasons, but often for support and socialization.

Meeting clients in one's office was discouraged for reasons of confidentiality, particularly around adoption information. There were interview rooms in the building specifically for meeting clients. Most staff did not utilize these rooms as most of their contact with clients was in-home, in the hospital, in transportation (cars), grocery stores or restaurants.

The social workers in the unit were also involved in the social lives of these mothers. This involvement took various forms such as attendance at graduation ceremonies and birthday parties, bringing gifts to the hospital in celebration of a new baby, taking the mother and child out for lunch

(occasionally) or coffee (often) as a form of social support (i.e., acceptance, role modeling behavior in a restaurant, friendship gesture). The expenses incurred through the invitations for coffee (or lunch) were reimbursed through the workplace. Sometimes clients offered to take workers out for coffee, which was occasionally accepted.

Social workers were not encouraged to give the clients their home numbers. However, clients could access workers after hours and on weekends by calling a mobile crisis unit that could connect with the worker. Clients were able to access staff telephone addresses and addresses through the telephone book. Occasionally a client would telephone a worker or turn up at their home. Although this didn't happen often, when it did, the worker felt compelled (due to the intense nature of the worker-client relationship) to communicate with the client on the telephone or to invite them into their homes for a brief chat.

At one point in time, the unit developed and facilitated a grief support group for young mothers who had placed their child or children in an adoptive home. This support group took place in one of the social worker's home. The session often lasted an afternoon with refreshments as part of the session. The two social workers who facilitated the session and the clients (ages 15 to 20) became very close to one another. Some of these girls were also the worker's clients so were involved with the workers outside of the support group. The workplace unit enthusiastically endorsed this support group.

Social workers often received cards, photographs, letters and small gifts from clients as tokens of appreciation and friendship. These gestures of appreciation were proudly displayed on desks and on wall boards not only as remembrances of a helping role that was appreciated but also of friendships that had been formed.

Ethical Decision-Making Framework

Let's examine whether or not some of the actions (from the case study), particularly emphasizing the action of facilitating a support group in a social worker's home, were ethical and contributed to dual relationships, according to the Markula Center for Applied Ethics (2004) framework for ethical decision-making. This framework is comprised of five steps: (1) recognize a moral issue, (2) get the facts, (3) evaluate the alternative actions from various moral perspectives, (4) make a decision and (5) act, then reflect on the decision later. Questions concerning ethics and

those actions that may contribute to non-sexual dual relationships in social work practice ask how we ought to act or conduct ourselves. As social workers, in accordance with IFSW standards of conduct, are our actions right or wrong?

Recognize a moral issue

Was there something wrong personally, interpersonally or socially in the worker client relationship described in the case study? The social workers could not be described as intentionally conducting themselves in a manner that they would describe as wrong but was it perhaps, albeit more gently stated, not quite right. Being involved in non-sexual dual relationships that are altruistic in nature such as giving gifts, attending social events and being extraordinarily available are often intended, at least from the worker's perspective, to be helpful in supporting the worker client relationship. However, clients may see these altruistic behaviors as an indication of a worker who is a friend or even perceived as a familial support person.

Social workers supporting clients as a group in their homes could be seen from a client's perspective as confusing or blurring of personal and professional lives and as an extension of another relationship beyond the worker client relationship. Social workers may be promoting client dependency through these kinds of actions and the potential for conflict-of-interest situations to occur.

The workplace reimbursement of funds spent on 'socializing' in restaurants in order to 'promote and enhance the client-worker relationship', in essence, officially recognized this socializing behavior as legitimate and indirectly promoted further actions of this nature. In essence, social workers were supported through the workplace to conduct themselves in a manner that was supportive of non-sexual dual relationships.

Get the Facts

Who is at risk of vulnerability and has more to lose: the social worker, the workplace or the clients? All three parties are at risk of vulnerability. Even though due to benevolent motivation, the social worker is vulnerable to further breaches of professional standards of conduct because she has become blind to ethically questionable actions within her practice. The workplace is vulnerable to institutionalizing some forms of non-sexual dual relationships because of the continued legitimization of actions that contribute to the development of dual relationships

between social workers and clients. Both the social workers and the workplace support some form of non-sexual dual relationships because no one recognizes these behaviors as inherently wrong. Genuine motivation to help is not inherently wrong, but rather should be a stimulus for professional behavior.

The client is at risk of increased vulnerability because a second relationship with their social worker crosses a boundary between the professional helper role and the client, creating a potential place of dependency and a threat to the right of self-determination.

The social worker and the workplace are at risk of losing or blurring the meaning of those professional standards of conduct that set social workers apart and unique from other helping professions. Unless social workers remain vigilant in maintaining their professional standards, those standards lose their intrinsic value for the profession. Our integrity as professionals in a helping role is at risk. We have something very special to lose.

Clients, such as youthful single mothers, are vulnerable before the client worker relationship exists. The social worker relationship by its very fiduciary and therapeutic nature places these clients in a vulnerable place. These clients are at risk of increased on-going vulnerability. It is painfully obvious that the client is most at risk of vulnerability and has the most to lose: their right to self-determination.

What options (actions) do the social workers from the case study have? If we examine the example of the grief support group in a worker's home, several options become readily apparent. The support group location could have been moved to a neutral location i.e., a community center. The workplace (from an agency support rather than from a specific worker support) could have supported the group with a contribution of refreshments, space and childcare. Social workers, other than the client's workers, or those workers outside of the unit, could have facilitated the group.

Evaluate the Alternative Actions from Various Moral Perspectives

The Utility Perspective

The utility perspective focuses on the consequences that actions (or policies) have on the well-being of all persons directly or indirectly affected by the action or policy. We would ask ourselves as social workers, what action will produce the most *good and do the least harm*? Of any two actions, the most ethical one will produce the greatest balance of benefits over harms.

The reader may feel that the client's sense of well-being in the worker's home would not have been affected. But what would a client have to say? Clients may not feel that they have a voice with regard to location of services or if asked, would agree to the location feeling the social worker had more knowledge of these things. Some clients may have felt uncomfortable, awkward or unsure of their role with the workers or conversely felt closer to the workers and believed they were more in need of help than they originally had thought they were. Did some of the clients believe that the social workers were truly becoming very close friends?

Very confidential and painful experiences were shared in the group. Did a home environment mean something different to each girl? Were those meanings (individual girl's perceptions) compatible with what a home meant to the workers? Did the home location make some of the girls sad or unhappy because of their familial background experience? Would having the support group in a community center have raised the same questions of ethical concern?

The Rights Perspective

The rights perspective recognizes that everyone must be *treated with dignity and must respect the rights of a person* who is seen as capable of making her decisions with regard to her own destiny. A right to self-determination is recognized as a moral right within the rights perspective. The social workers unquestionably treated the grieving mothers with dignity and respect. But if the reader looks deeper into the situation, the clients, grieving the loss of a child and some still children themselves, were placed in a position of increased risk for emotional dependency and confused personal and professional relationships, because of the location of the group. This location, and the 'choice' about going to a group at this location, indirectly threatens the dignity and respect of these young mothers, and their ability to make decisions with regard to their own destiny. Both the location and the 'choice' of going to this location represent serious boundary issues. An action is morally right when clients have voluntarily given their permission and have been given the necessary knowledge (that supports their right to self-determination) to make this decision.

The Justice Perspective

The justice perspective focuses on how *fairly or unfairly* our actions distribute benefits and burdens among the members of the group. In our example, the social workers would have

endeavored to treat everyone in the group in a fair manner. Is the action of having a support group in a social worker home capable of fairly treating (i.e. grief counseling) everyone in a fair manner in light of how this action potentially burdens vulnerable clients with actions that contribute to dual relationships? Some of these clients may have been more vulnerable than other members of the group. An action is morally right when we treat all clients fairly and in the same manner.

The Common Good Perspective

The common good perspective looks at society as comprised of individuals whose own good is inextricably tied to the good of the whole. This perspective looks at the option that will promote the *common good* and help everyone to participate and share in society's goods. Does the home location have anything to do with the common good? It may have everything to do with the common good. What may harm one can damage the whole. A client who is harmed in some way from meeting at a social worker's home has brought harm to the whole group. The common good is advanced through ethical action.

Make a Decision

The reader may have come to the conclusion that the action of having the support group in a community center rather than a social worker home would: (1) *produce the most good and do the least harm*, (2) *treat everyone with dignity and respect their right of self-determination*, (3) *would treat everyone fairly*, (4) *promote the common good* and (5) *develop moral virtues in all of us*. This action is the right thing to do.

Act, then Reflect on the Decision Later

Once an action is taken (i.e., to have the support group in a community center), then it is necessary to conduct an evaluation of how that action of choosing a community center for the support group worked out for all concerned. Social work must continually evaluate their actions, in order to improve and develop a reflective practice which is based on professional standards of conduct.

Reflective practice means looking back at ourselves in a certain situation and looking at how certain actions have affected us and how we have affected others through those actions (Burns & Bulman, 2000). Reflection forces all of us to attend to our feelings and to examine our moral beliefs in conjunction with our professional standards of conduct about what is right and wrong,

and ultimately good. With reflection, we can analyze our actions in the workplace and decide if we will react differently if faced with a similar situation in the future.

Conclusion

The reader may disagree or agree with some or all of the ethical debate around the case study, or even for the need for such an ethical debate to take place (Zur, 1999). The point is that ethical debates with colleagues and employers are not taking place in some workplaces and should be. Are social workers aware that 'helping' actions (based on personal assumptions about what is right and wrong) may not necessarily be equated with professional ethical practice? Is the practice arena contributing to the legitimization of dual relationship actions?

Ethics is about standards of right and wrong with regard to our actions in terms of the common good, virtues, benefits and fairness and the recognized rights of all humans. It is also about the continual examination and study of our moral beliefs and moral conduct. An ethical practitioner does not have to do whatever the workplace accepts and supports. The fact that there is no definitive agreement on all issues among all people supports the need for on-going ethical debate.

Not all actions which can contribute to a non-sexual dual relationship between social workers and clients are inherently unethical or potentially harmful. Locating a support group in a worker's home is not inherently unethical, but it is certainly potentially harmful. Some actions such as attending a birthday or giving a present in celebration of the birth of a child may be more ambiguous in one's ethical interpretation of them. For these types of actions, it is especially important to be cognizant of their potential to develop into a second relationship with a client or to create dependency.

First, actions that can contribute to potential non-sexual dual relationships must be recognized, and second, these actions must be thoughtfully examined and reasons for courses of action documented prior to actualization (Reamer, 2001). Ensuring client safety from non-sexual dual relationship harm and respecting their right to self-determination is a primary consideration for all social workers. Ensuring worker professionalism and safety from ethics complaints and possible lawsuits is a primary consideration for the profession.

Practice arenas which support actions that may contribute to non-sexual dual relationships are in danger of legitimizing these actions. Over time, no matter what actions were genuinely initiated because they were seen as helpful (i.e., regularly taking a client out for coffee), if legitimized, will become an institutionalized workplace standard of conduct. This standard of conduct jeopardizes social work's foundation which is built upon the client's right to self-determination.

Lest we forget, standards of conduct and ethical action must not be forgotten. It is too easy to become blind to the inherent harm and conflict of interest in non-sexual dual relationships and in that blindness, lose the vision of the dignity and worth of all humans.

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Is Self-Determination Still Important? What Experienced Mental Health Social Workers Are Saying

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Abstract

This study investigated the attitudes of 320 seasoned mental health social workers toward the social work value of self-determination. Social workers were asked to rate the importance of self-determination in their daily practice, both as a guiding value and in actual practice and were asked to describe, in relation to their practice history, any changes they had experienced in the importance of the value. The majority of participants responded that they thought more about self-determination now than in the past. Surprisingly, they also reported being relatively untroubled when practice situations conflicted with the value of self-determination, such as when a client was in need of involuntary treatment interventions. Participants provided rich information about why they believed changes had occurred in the way they thought of self-determination and how they implemented self-determination in practice with mental health clients.

Keywords: self-determination, mental health practice, ethical dilemmas

Background

Self-determination (defined here as the condition in which a person's behavior comes from his or her own wishes, desires and decisions) has been an influential, if sometimes controversial concept in social work practice since the profession's beginnings. Similarly, since the beginnings of the country, Americans have struggled with the emphasis and protection that individual liberties could and should have while simultaneously maximizing the general welfare. Self-determination as a concept is similar to the ideas of liberty and the pursuit of happiness that appear in the Declaration of Independence, one of the first American documents. This early emergence of self-determination is consistent with Freedberg's (1989) assertion that the roots of the concept reach back to the Enlightenment. As perennial as the ideas of self-determination, freedom and liberty are

themselves, so is the competition and tension surrounding them in a society that equally values social welfare, general safety, protection and maintenance of the community. In other words, the struggle to work out an acceptable balance between the sometimes mutually exclusive goals of personal liberty and societal well-being is a source of dissonance for our legal system and, indeed, society at large. This struggle is especially important when considering the impact of postmodernist trends in thinking about and reexamining ethics (Hugman, 2003).

This same struggle is played out in the mental health service delivery system between the rights of individual consumers to refuse or accept treatment and the rights of communities to feel safe physically, psychologically and aesthetically. The task of negotiating about this larger struggle falls to mental health practitioners, in our often multiple (and sometimes mutually exclusive) roles as consumer advocate, family advocate, risk manager, agency employee, and community citizen. The current research tapped the experiences of seasoned mental health social workers to explore self-determination's place in their current practice and their own practice wisdom in dealing with self-determination's more troubling manifestations. The research is important because the way social workers *think and feel* about self-determination is an essential component of what they *do* or *do not do* when operationalizing the concept. Additionally, social work practice can be complex and values that are intended to guide practice can also serve as important touchstones for professional exploration. The consequences of living and practicing in conflict with one's values can result in burn out and professional dissonance, which have implications for both the practitioner's and the client's quality of life (Taylor & Bentley, 2005).

Self-Determination Defined

The NASW Code of Ethics (1999) calls self-determination an "ethical responsibility to clients" and groups it with other client areas such as, informed consent, competence, cultural competence and social diversity, conflicts of interest and privacy and confidentiality. The core value that self-determination is generally placed under in the Code of Ethics is "dignity and worth of the person." Self-determination has received mention in each Code of Ethics in social work's history and most recently is given the following attention:

Social workers respect and promote the right of clients' self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit client's right to

self-determination when, in the social worker's professional judgment, client's actions or potential actions pose a serious, foreseeable, and imminent risk to themselves and others (NASW, 1999).

The current research builds upon McDermott's definition of self-determination as "that condition in which an agent's behavior emanates from his [sic] own wishes, choices and decisions" (McDermott, 1975, p. 3).

Social workers throughout the history of the profession have offered varying definitions of self-determination, as well as lengthy and differing opinions about its usefulness as a guiding value in social work practice. The debate about self-determination tends to center on whether or not the concept should be more "practitioner-driven" such as when a social worker makes therapeutic calls about what is good for a client (see Perlman, 1975); or more "client-driven," with a focus on client choice, when the client makes their own decision about what is best despite the risk of failure (see McDermott, 1975). It can be argued that this client-driven understanding of self-determination is compatible with social work's current emphasis on collaborative styles of practice like empowerment practice, and the strengths perspective.

The work of Frederic Reamer in the area of values and ethics has greatly contributed to the understanding of the topic in social work literature. Reamer's (1979, 1980, 1982ab, 1983, 1985, 1986, 1987ab, 1992, 1995ab, 1996, 1997, 1998abc, 2000) work is important as he has addressed issues such as the client's right to competent and ethical treatment, ethics under managed care, ethical consultation ethics committees and ethics audits for social work, dealing with the impaired social worker, informed consent and other diverse topics such as bioethics in social work and the use of modern technology. Reamer's work, to carve out the issues of professional social work values and ethics as a legitimate area of dialog and discussion, sets the stage for the actual, hands-on *study* of how values and ethics are used to guide real-life social work intervention.

Marcia Abramson (1981, 1984, 1985, 1989, 1991, 1996a, 1996b) is another strong contributor to the literature on ethics and values, in particular, her work about paternalism and autonomy. She has also written about the use of influence by social workers—a topic that is directly relevant to the current subject matter. Abramson's work speaks to the day- to-day realities of social work practice when decisions are difficult to make and live comfortably with. Abramson focuses her examination of ethics to specific areas of social work practice such as the use of

influence in adult protective services (1991), and ethical dilemmas inherent in hospital discharge planning (1981). Abramson calls the use of influence a largely understated area in social work practice.

Beneficence and Paternalism.

Congress (1999) makes the point that values make more sense when studied in pairs instead of in isolation. Accordingly, when studying self-determination, it is useful to refer to the competing value position of beneficence or paternalism, which tends to parallel Perlman's (1975) earlier understanding of a more practitioner-driven model of self-determination. Abramson (1989) defines paternalism as "a form of beneficence in which the helping person's concepts of benefits and harms differ from those of the client, and the helper's concepts prevail" (p. 389). Murdach (1996) has more recently offered the concept of beneficence as an appropriate value stance for social workers. She defines it as acting for the good of a consumer when they cannot or *will not* act for themselves. She asserts that social workers have been too quick to reject beneficence and its related concept of paternalism and have perhaps been inappropriately preoccupied with self-determination.

While some social work and allied authors have pointed out the problematic presence of paternalism in mental health practice (Bentley, 1993; Chamberlin, 1998; Wilk, 1994), others have defended the use of paternalism when consumers cannot or will not act in their own best interest (Murdach, 1996; Rosenson, 1993). All of this debate about paternalism and beneficence versus self-determination has caused some social work authors to call into question the utility of the concept for social work at all (Rothman, 1989; Rothman, Smith, Nakashima, Paterson, & Mustin, 1996).

After exploring the literature about issues of self-determination, it becomes clear that there are many diverse understandings of the topic but not that much in the way of empirical evaluation of what social workers really make of it. In short, much of what we know of self-determination comes from theoretical discussion of the topic and from its presence in the value base and conversation of social workers. This leads to the question: How real is the value of self-determination in the practice lives of seasoned social workers?

Methodology

Self-determination was one area of inquiry in a larger study in 2002 designed to investigate issues of professional dissonance, or the collision of values and job tasks in social work practice.

Sample

A systematic random sampling technique was used to recruit 750 participants who were listed in the *Register of Clinical Social Workers*, 11th Edition (NASW, 2001). The National Association of Social Workers (NASW), the professional organization that publishes the *Register*, is the largest professional social work organization with 155,000 members (Gibelman & Schervish, 1997). Social workers listed in the *Register* tend to have been working a long time, often as social workers in private practice. A conscious decision was made to sample these social workers since they have had more of an opportunity to explore their views on self-determination over time. Of the 6290 names listed in the 2001 *Register*, 33 international names were subtracted leaving a total of 6257 eligible names. The systematic random sampling technique first included narrowing the national pool to include only those who had a self-described mental health modality. From this pool, 1450 social workers listed described a major modality as mental health or mental disorders. Every other eligible name was selected until the end of the *Register* was reached, then every third name was selected in order to yield 750 names. A total of 320 usable surveys were returned which related to a response rate of 44.4%.

Instrumentation

An instrument was created for the purposes of this study. Copies of the instrument can be obtained from the author. The instrument, designed for the professional dissonance study, assessed social workers' endorsement of the existence of professional dissonance by surveying them about their feelings and experiences of involuntary treatment and self-determination over their careers (See Taylor & Bentley, 2005). The instrument was pilot-tested with an interdisciplinary group of mental health professionals working in the psychiatric pavilion of a large medical center. The four professionals were asked to answer the items and identify any that were unclear or problematic, thereby helping to ensure face validity. A panel of seasoned social work researchers also reviewed the instrument prior to data collection.

Only the results of the self-determination portion of the instrument are described here. Respondents were provided with the following definition of self-determination: "Self-

determination refers to the condition in which a person's behavior comes from his or her own wishes, choices and decisions." Three Likert-type questions prompted respondents to give information about how "important" and how "useful" they believed the ethical principle of self-determination to be in their daily social work practice. They were also asked to describe "how troubled" they feel when a situation such as providing involuntary treatment conflicts with self-determination. A fourth question asked if they thought of self-determination "more, less or the same" as they did when first practicing social work. A final open-ended question prompted respondents to "describe in a few words" what had changed in their attitudes about self-determination, if a change had indeed occurred.

Data analysis

Data from the Likert-type items was coded and analyzed using the SPSS-10 statistical package. Data from the open-ended questions were typed verbatim into corresponding individual data files, separated by question number and labeled with their respective participant identification numbers. The researcher printed one copy. An open-coding technique was utilized in order to identify patterns in the responses (Strauss & Corbin, 1998). From these patterns, categories and subcategories were identified to group the responses through the use of key words and similar themes (Colorado State University, 2002). Responses were then placed into the appropriate category based on key words and themes and counted.

Important Findings

Demographics

Of the 320 social workers participating in the study, 62.8 % (n = 201) were female, 36.8% (n = 117) were male and 2 participants failed to indicate their gender. The majority of the participants (91.6%, n = 293) identified themselves as Caucasian or White. In addition, 2.2% (n = 7) identified themselves as African American or Black, 1.6 % (n = 5) as Asian, 1.3% (n = 4) Latino/Latina and 1.9% (n = 6) identified as bi-ethnic. Five participants declined to identify their ethnicity. Participants brought many years of practice experience to this study with a mean number of years past their MSW of 25 (md =25). In addition to their lengthy practice experience, most of the participants appeared to have quite a bit of life experience as the average age reported was 56 (md = 56). Participants ranged in age from 30 years old to 80 years old and 12 (3.8%) respondents

declined to reveal their age at all. While the use of the *Clinical Register* insured that participants had a long history in the field and a fairly mature chronological age, it may also have resulted in a less representational sample of social workers in the areas of race and gender.

Importance of Self-Determination

Results indicate that both the importance and utility of self-determination were heartily endorsed by the majority of participants. Self-determination was rated as “very important” by 226 (70.6%). In fact, 97.5% of all respondents rated self-determination as “important” or “very important” in their daily practice. Interestingly, for all of the endorsement of self-determination, participants did not indicate a high level of distress when practice situations “seem at odds with the principle of self-determination.” In fact, only 15 participants (5%) found this “very troubling,” with only 35 (10.9%) responding that this was “somewhat troubling.” One-hundred and twelve (35%) found these situations “troubling.” The rest of participants, (N = 145, 45.3%) endorsed this item with a 1, “not at all troubling,” or a 2 on the Likert scale.

While participants were not greatly “troubled” by practice situations that conflicted with self-determination, this did not mean that participants did not think about self-determination anymore. In fact, only 30 participants (9.4%) reported they thought about self-determination when making practice decisions “less now” than when new social workers. By contrast, 143 participants (44.7%) reported thinking about it “more,” while roughly the same number (N = 140, 43.8%) think about it “the same” as when they began practicing. In summary, the majority of participants endorsed self-determination as “important” or “very important,” reported conflicts in practice situations with self-determination as “troubling,” and indicated they either think about it “more now,” or the “same” as when they were new social workers. The open-ended self-determination questions allowed participants to provide detail to their responses on self-determination.

Open-ended Question: Self-Determination Over Time

Participants who had experienced a change in how much they thought of self-determination when making practice decisions were prompted to explain in a few words what they felt had caused the change. Responses were again typed verbatim by the researcher into a computer data file and examined for similarities. Responses were also coded as “more” “less” or “no change” depending on respondent answers to that question. Open-ended responses to the self-determination

“change” question fell into four fairly distinct categories. Most frequently, experience, maturity and growth appeared to be the largest factor in change. Accordingly, this first category was named “Practice and Life Experience.” Examples of responses in this category included statements such as: “As my practice goes on I have dealt with more people in different situations and realize each of us is unique. I do as much as I can so people can make as many decisions as possible,” and “Experience has taught me that judgment can be fallible,” and, “less angst over conflict than when ‘new’ social worker.”

A second category emerged that contained responses describing how changes in jobs and clients served had caused a change in thinking about self-determination. For example: “Now the population is mostly adult there are fewer times of conflict” and “I am working with a more functional client population at present.” This second category was termed “Job/Client Change.” The third category again parallels the responses to involuntary treatment in that respondents reported they had changed by watching the realities of mental illness, especially mental illness that goes untreated and was termed “Reality of Mental Illness.” An example of responses in this category is:

Once a young boy had tried to kill himself. He was adamant he didn’t need hospitalization. I sent him to our locked ward anyway. Later he was released, his family grateful he was alive. Two years later he did commit suicide...I had whole family in grief counseling.

Other responses in this category include, “I have encountered situations when treatment is critical,” “people do not usually ‘self-determine’ themselves to become mentally ill” and, “I don’t believe they should languish in their illness.”

An interesting trend noted in a final category of responses was the tendency of the respondent to philosophize a bit about the state of self-determination in our profession today, or the best way to implement it in contemporary practice situations. These respondents, as indicated in the sample responses in Table 1, rarely used the first person as did the respondents in other categories: “Self-determination[is] a must so long as a person can make informed decision and exercise judgment based on reality. With independence comes responsibility, including social responsibility,” “I may be more practical. I may not “band my head” as much,” “I make fewer excuses for my mistakes and others... If social work practice is not used to provide the best care

for our patients we burn or never grow.” These answers were coded as “Practice Philosophy” (See Table 1)

Table 1, Sample Category Coding: Self-Determination Change

Category	Response
Practice and Life Experience	My own personal maturation I am more mature as a therapist Experience (30 years) Experience has made the difference The older I get the more I realize how little impact treatment modalities have compared to the client’s will to change. Experience and practice have given me a better understanding of the concept and more strategies to deal with it.
Job/Client Change	Previous practice setting...many clients were court-mandated I am working with adults who are healthier I am working with a more functional client population
Reality of Mental Illness	Clearer the harm people can inflict on self and others Dynamics of illness itself More experience with people who are unable to make rational decisions I see the horrific consequences that can result... In my opinion, people do not usually “self-determine” themselves to become mentally ill.
Practice Philosophy	I see the concept eroding before my eyes. Self-determination relies on the availability of psychological emotional and medical support. Energy flows where attention goes Excuses to avoid change have clouded both change process and adult/positive decisions

A total of 175 participants (54.6%) gave open-ended responses to this question, a number that roughly matches the 173 participants who responded they had experienced a change in self-determination over the years. Of these, the largest number of responses represented category one, “Practice and Life Experience” (N= 63, 36%). Category four, “Practice Philosophy” had 44 responses (25.14%), while category 2, “Job/Client Change” contained 26 (14.86%) and category 3, “Reality of Mental Illness” had 32 responses (18.29%).

Discussion and Recommendations for Future Inquiry

One of the main contributions of the current study is the subject matter. Previous research (Rothman, 1989) has called for increased empirical inquiry in the area of social work values and especially their operationalization in everyday practice. While there is a large body of excellent, empirical thought about self-determination (see Reamer, 1992, 1983, 1982a, 1982b, 1979), there is less actual study-based research on this topic. This study was especially important because it

utilized the viewpoints of practitioners who had an average of 25 years of experience in the field. In this way, the importance of self-determination across a lifetime of practice was affirmed. Similarly, the richest data were evident in the open-ended responses of participants about how their ideas of self-determination had changed over time. Through the answers to these questions, we see how social workers have evolved in their practice and the practice wisdom evident in these responses speaks to the largely untapped resource of our own experience to guide one another's practice, especially in difficult situations.

One limitation of the current study is the sampling frame. The *Clinical Register*, while enabling the researcher to capture seasoned social workers, may not include those social workers "in the trenches" in public mental health service delivery with reluctant consumers due to the high proportion of listees who are in private practice. A future study should focus on capturing this group in order to move the discussion of self-determination out of the realm of private practice where the majority of clients may be more motivated internally to pursue help.

Another possible limitation of the study deals with threats to instrument validity resulting from the issues of social desirability and self-serving bias. After all, as a group, social workers are heavily socialized to value self-determination. Saying that you think about self-determination a lot, and more now than in the past, even, is a decidedly "social work" response. Future inquiries into social workers' attitudes towards self-determination should pay close attention to the potential for social desirability and self-serving bias in self-reports. Direct ways of measuring social workers' use of self-determination in practice would be a logical step for future inquiries.

In conclusion, self-determination is still considered very important by seasoned social workers and is thought about even more--or at least the same-- today as when they were new social workers. While they report being relatively serene when practice situations conflict with self-determination, they have insight into the ways their views about it have changed over the years. Capturing the ways our cardinal values are incorporated into everyday social work practice is an important area for social work research as it has implications for educating future social workers, protecting sensitive practice with clients, and maintaining the practice longevity and vitality of those in the profession.

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Ethics Complaints in Social Work Practice: A Rural–Urban Comparison

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Abstract

A common theme in rural social work is that ethical concerns of confidentiality and dual relationships are greater than in urban communities. This study compared rural and urban social workers' reported ethics violations and found complaint profiles for rural and urban social workers to be similar.

Keyterms: Professional Ethics, Rural Social Work, Ethics Complaints, Dual Relationships, Confidentiality, Licensing

Introduction

There has been much discussion about the special ethical challenges faced by social workers who practice in rural settings (Boisen and Bosh, 2005; Ginsberg, 1998; Gumpert and Black, 2005; Miller, 1998; Strom-Gottfried, 2005; Watkins, 2004). A recurrent theme is how rural social workers manage confidentiality and dual relationships given that they are integral members of their small communities. The National Association of Social Workers appropriately summarizes the key issues in their policy statement on Rural Social Work.

Small communities pose challenges to confidentiality, particularly when relatively few professional social workers interact with providers and community members who may have limited understanding of professional ethics. ...Ethical practice in rural areas requires special attention to dual relationship issues. Few other settings expose social workers more to the risk of violating the NASW Code of Ethics' admonition that social workers are to take steps to protect clients and are responsible for setting clear, appropriate and culturally sensitive boundaries (NASW, 2003).

Rural social workers must achieve a delicate ethical balance between two areas of the NASW Code of Ethics, specifically, “The Code is relevant to all social workers and social work students regardless of their professional functions, the settings in which they work, or the populations they serve” and “... setting clear and culturally sensitive boundaries” (NASW, 1999). This balance is so difficult to achieve because in rural practice “professional distance” can present a significant barrier to establishing trust and working with the community (NASW, 2003). Human behavior in small towns and rural communities is characterized by face-to-face relationships between individuals and with institutions (Ginsberg, 2005) and impersonal approaches are seen as culturally insensitive.

Yet, while we are well aware of the ethical challenges faced by social workers in rural settings, we know little about how well they are coping with these challenges. Given that rural social workers appear to be at greater ethical risk than their counterparts in other communities in the areas of confidentiality and dual relationships, we might expect to see more reports of violations in these areas. Analyzing these reports may be useful in understanding the extent of the risk and preparing rural social workers to practice more ethically.

Currently, there is a great deal of discussion of risk but little empirical evidence of social worker behavior relating to this risk (Croxton, Jayaratne, and Mattison, 2002; Miller, 1998). This study reports on data from the Texas State Board of Social Worker Examiners (TSBSWE) and examines the relationship between ethics complaints against social workers in rural communities and those against social workers from other types of communities.

Review of Literature

The rural social work environment has been compared to a “fishbowl” (Farley, Griffiths, Skidmore, and Thackeray, 1982) in which every action is subject to public observation and judgment. Rural communities operate on a highly personalized basis (Ginsberg, 1998) in which the closeness of people (NASW, 2003) is an important issue for social work practice. Social Workers become part of the community system and their actions and affiliations are important factors in how they are evaluated by the local community (Ginsberg, 2005). To be effective, social workers must take time to learn and adapt to the cultural norms of their communities, including becoming known by establishing personal relationships (Ginsberg, 1998).

In the close-knit culture of the rural community social workers are challenged to adapt their practice in ways that are both effective and ethical. As professionals, social workers are usually educated in methods and models that are not well adapted to rural environments (Daley and Avant, 1999; Ginsberg, 1998; NASW, 2003). The emphasis on formal professional relationships conveyed through social work education and professional ethics are often viewed as inappropriate or distant. Rural communities, which value personal relationships, tend to see professional distance as either rude or culturally insensitive, and this presents a barrier to effective social work. Given the realities of rural life, social workers usually find themselves maintaining a delicate balance between the expectations of the profession and those of the community.

Ethical vulnerability for rural social workers appears most pronounced in the areas of confidentiality and dual relationships. Strom-Gottfried (2005) highlights several areas in which social workers in rural communities may be at ethical risk. These include confidentiality, dual relationships and conflicts of interest, competence, and anonymity and self-disclosure. Confidentiality issues present potential risk based on the community having common knowledge of the problem, overlapping relationships causing confusion about who knows what, community and family pressure to share information, and receiving confidential information from informal sources. Dual relationships present a difficult issue because of the lack of social distance and intersecting or overlapping relationships. Davenport and Davenport (1995) also identify the ethical dilemmas of confidentiality and dual relationships as issues for rural social workers. Specifically, they discuss the importance of maintaining confidentiality while enlisting natural helpers and potential business relationships with clients as challenges for rural social workers.

NASW (2003) highlights the ethical concerns related to confidentiality and dual relationships that confront rural social workers and calls for research to better inform the social work profession on these issues. Ginsberg (1998) states that the challenges of confidentiality and dual relationships in rural communities are such that social workers must adapt what they have learned to adjust successfully to the rural community.

Burkemper (2005) raises a number of ethical challenges that may confront rural social work practitioners. These include boundary dilemmas (dual relationships), confidentiality, fees and bartering, and cultural and practice competence. Among the confidentiality issues she raises are

informed consent, sharing information with other professional and agencies, visibility of the office location and procedures. Watkins (2004) indicates that confidentiality may generate a potential conflict of values, especially for rural social workers working with natural helping networks, where the exchange of information is an expected part of the helping process. Fenby (1980) and Riggs and Kugel (1980) both mentions maintaining confidentiality as an important consideration for social work practitioners in rural communities.

An opposing viewpoint is presented by Croxton, Jayaratne, and Mattison (2002). They surveyed 3,062 members of NASW possessing the MSW and who were identified as being in direct practice. Their results indicate little difference between rural and urban social workers with respect to beliefs and behaviors about client confidentiality.

Boisen and Bosch (2005) believe that the social isolation of rural residents creates a need for interdependence and generates difficulty for social workers in making a clear demarcation between personal and professional relationships. They also indicate that dual relationships are seen as more acceptable in rural communities. Their research concludes that rural social workers require an increased awareness of dual relationships. They indicate that boundary maintenance is the social worker's responsibility, and because social workers must be engaged in rural mores, dual relationships must be approached with caution. Rural social workers must have a plan for dealing with dual relationships, and training on dual relationships must be a part of formal education for social workers practicing in rural areas.

Miller (1998) believes that dual relationships are an ethical issue for rural social workers and adds that dual relationships are hard to avoid because social workers are quite involved in their communities and the options for service provision are limited. She suggests that engaging in dual relationships is a beneficial part of the helping process for rural social workers. Watkins (2004) indicates that dual relationships may also present a potential ethical problem based on preexisting relationships that the worker may have with community members. His position is that as social work professionalized and adapted to an urban model based on secondary relationships, it developed an emphasis on confidentiality and discouraged dual relations. Rural communities were less committed to the formalized service model and remained more strongly tied to traditional, informal helping networks, thus creating a potential source of ethical conflict for social workers in

rural settings. Croxton, Jayaratne, and Mattison (2002) found significant differences between rural and urban social workers in both practice beliefs and behaviors in their survey. Their results with regard to dual relationships indicate that more rural social workers consider dual relationships appropriate and enter in them with greater frequency than urban social workers.

Methods

To examine the ethical challenges of rural social workers, data on ethics complaints that were filed with the Texas State Board of Social Work Examiners (TSBSWE) from 1995 to 2003 was collected. This data on alleged violations of the code of ethics and state law yielded broad based information on social worker behavior related to ethical practice.

The eight-year reporting period yielded a total of 594 complaint cases against individual social workers. Frequently, each complaint alleged violations of multiple sections the ethical code and licensing law. Each of these alleged violations was identified and coded. The case data also specified the community of residence of each social worker. It should be noted that the data base only contained data relating to ethics complaints and not to the validity or disposition of those complaints.

The Code of Ethics and administrative rules employed by the Texas State Board of Social Worker Examiners (Texas Administrative Code, 2005) is similar to, but not identical to the NASW Code of Ethics (NASW, 1999) Standard 1 which addresses social workers' ethical responsibility to clients. Because the primary purpose of social work licensing is protection of the public, the Texas regulations and rules do not cover social worker conduct beyond that relating to clients. Ethics complaints may be filed by anyone who believes that social workers have violated either the TSBSWE Code of Ethics or any specific administrative rule related to conduct.

Once the case data was collected some recoding of data was necessary to put it into a format for analysis. First, the information on the specific complaints that were alleged had to be coded. Violations identified in the data base were specific to sections of the TSBSWE Code of Ethics and administrative rules. Reclassification of these complaints into categories that were more general in nature and more commonly used in the literature was necessary to facilitate analysis, interpretation of the data, and general understanding of the findings. Second, to determine the

context of practice for the social workers, their communities of residence had to be identified as rural or urban. This required recoding of address data.

Data regarding alleged ethics violations were reclassified into categories adapted from Strom-Gottfried's (2000) study of NASW ethics violations. This classification was useful in that it included categories that contained commonalities and were more generally applicable than the specifics of the Texas Code. The classification used had nine categories: *Boundary Violations*, *Poor Practice*, *Competence*, *Record Keeping*, *Honesty*, *Confidentiality*, *Informed Consent*, *Reimbursement*, and *Conflicts of Interest*. Some of the alleged ethics violations in this data did not match any of these categories, as they related to very specific aspects of the Texas law such as the requirement for licensure and were excluded from the study. After reclassification of the data, a total of 1389 alleged violations were identified from the 594 cases.

Social workers' community of residence was determined by using zip code data. Using the individual social workers' zip codes, the population of their community was determined using data from the Texas Almanac (County - ZIP Code Database, 2005; Dallas Morning News, 1997). Based on population data and the United States Department of Agriculture's listing of rural counties (National Association of Counties, 2005) the community of residence was classified as rural or urban. This method of classification is based on that of the US Census Bureau and is suggested by the work of Olaveson, Conway, and Shaver (2004) and Daley and Avant (2004). The resultant data were analyzed using an SPSS statistical program and descriptive statistics for the data were computed.

Results

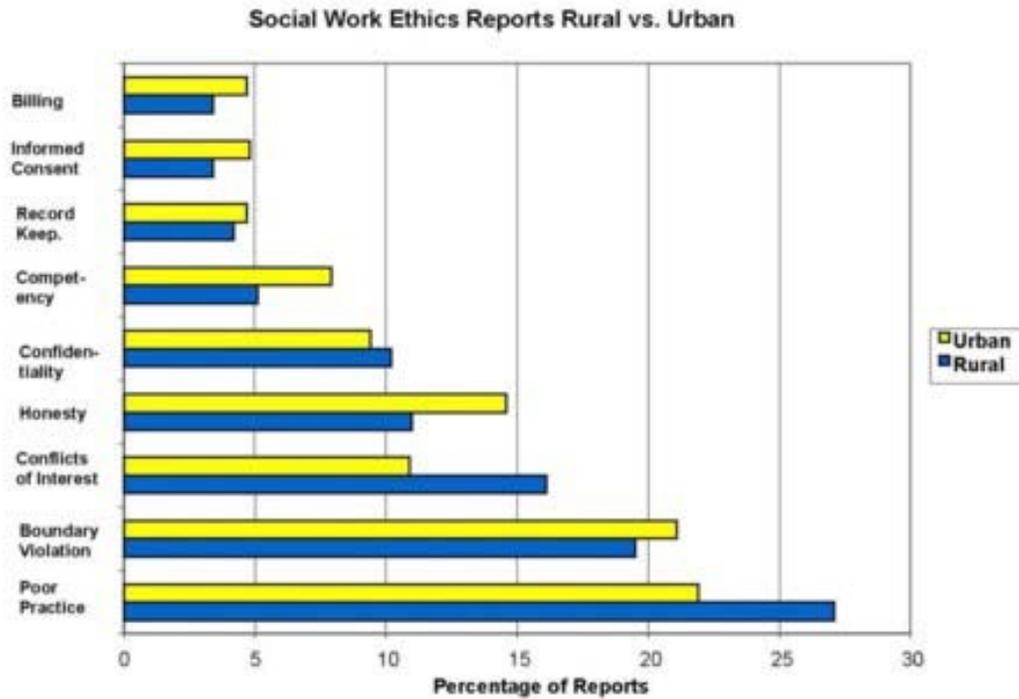
In 2003, the Texas State Board of Social Worker Examiners licensed approximately 23,500 social workers, and during the reporting period complaints were received only about 2.5 percent of this number. Annually this is only about 3.2 per thousand social workers who are alleged to have ethical violations per year. The 594 individuals who were reported for violations were alleged to have violated 1,389 sections of the State Code of Ethics or Administrative Code that corresponded with the NASW Code of Ethics. Thus, on average, each report identified 2.3 areas of violation.

Based on the large number of complaints retrieved from the data base, the number of ethics complaints filed against social workers in rural communities was remarkably low. Of the 1,389 alleged violations, only 118 (8.5%) were filed against rural social workers, while 1,271 (91.5%) were filed against urban social workers. The rate for ethics complaints did not appear to differ for rural and urban social workers, as 9.3% of the social workers licensed in Texas lived in rural and 90.7% lived in urban areas.

As indicated by this data there was a relative scarcity of social workers in rural communities. There are 254 counties in Texas, 196 of which are classified as rural (Dallas Morning News, 1997; National Association of Counties, 2005). The rural counties contain approximately 15% of the state's 21 million plus population (Texas State Data Center, 2005). However, in 36 counties, there were no resident social workers, and 68 counties had five or less social workers. In the rural counties that did have social workers 54.3% were licensed at the BSW or pre-professional level (Social Work Associate).

The data were broken down by community of residence to make a rural-urban comparison across the alleged category of violations. The bar graph in Figure1 illustrates the rural-urban comparison in ethics complaints by category and Table1 summarizes these results in terms of specific percentages.

Figure 1



It is interesting to find that the ethics category *poor practice* was the most frequently cited category of complaint for rural social workers. *Poor practice* refers to failure to meet accepted standards for client care such as evaluation of clients' progress, appropriate use of supervision, and making appropriate referrals. *Poor practice* was listed in 27.1% of rural complaints versus only 21.9% of those for urban social workers. The difference in percentages of the total reports for each group of 5.2% in this category was the largest in the study.

Table 1
Category of Ethics Violation by Residence

	Rural		Urban	
	%	N	%	N
Poor practice	27.1	32	21.9	278
Boundary Violations	19.5	23	21.1	268
Conflicts of Interest	16.1	19	10.9	139
Honesty	11	13	14.6	185
Confidentiality	10.2	12	9.4	119
Competency	5.1	6	7.9	101
Record Keeping	4.2	5	4.7	60
Informed Consent	3.4	4	4.8	61
Billing	3.4	4	4.7	60
TOTAL	100	118	100	1,271

The literature review had led us to expect that citations for confidentiality and dual relationships would be higher for rural social workers. *Boundary violations* include inappropriate and potentially harmful personal, social, and/or business relationships with clients. This category has two subgroups, dual relationships and sexual relationships.

Indeed, boundary violations, which include dual relationships, were the second most commonly identified ethics report for rural social workers at 19.5% of the total citations. Boundary violations also ranked as the second most frequent report for urban social workers with 21.1% of the reports. Further examination of the *boundary violation* category revealed that there was an approximately even split in this category for rural social workers, with 11 (47.8%) citations for *dual relationships* and 12 (52.2%) citations for *sexual relationships*. For urban social workers there was a greater difference, with 170 (63.4%) reports for *dual relationships* and 98 (36.6%) reports of *sexual relationships*.

Therefore, the data would suggest that *dual relationship* related issues represent a greater concern for urban social workers than they do for rural social workers. This is the opposite of what the literature would lead us to expect. Yet almost two-thirds of the reports of boundary violations

for urban social workers are for *dual relationships* versus a little less than one-half for rural social workers.

Reports of *confidentiality violations* were less than expected given the attention paid to this issue in the literature. These complaints represented only 10.2% total citations for rural social workers. *Confidentiality violations* were only the fifth most frequently reported type of ethics citation for both rural and urban social workers. The percentage of complaints for *confidentiality violations* by urban social workers was very close to that for rural social workers at 9.4%. Thus, the rate for confidentiality complaints was only minimally higher for rural social workers and appears very consistent with that for urban social workers.

The category of ethics complaint that ranked third in frequency for rural social workers was *conflict of interest*, with 16.4% the citations. This category ranked fourth for urban social workers at 10.9% of the total complaints. Two types of behavior were evident in this category: *exploitation* or placing the interest of others (including the social worker) over the interest of the client, and *discrimination* in the form of a prejudicial denial of service.

The complaint category that ranked fourth in frequency for rural and third for urban social workers was *honesty*. This category accounted for 11.0% of the citations for rural and 14.6% of the citations for urban social workers. This category included reports for allegedly engaging fraudulent, deceitful, or misleading acts affecting a client.

The five highest ranked categories of complaints account for 83.9% of the total citations for rural and 77.9% of the total citations for urban social workers. Given the small numbers of complaints about rural social workers in the remaining four categories, the percentages and rankings for those complaints may be a little less reliable and informative. *Competency* citations ranked sixth overall at 5.1% for rural social workers versus 7.9% for urban social workers. This category included practicing within the limits of the social workers' knowledge and skill, and issues related to impairment of the practitioner due to physical or mental health, the use of medication, drugs or alcohol. The remaining three categories *record keeping*, *informed consent*, and *reimbursement* accounted for very small percentages of the reports. Citations in this area require social workers to maintain accurate up-to-date service records, fully inform clients of all aspects of the services offered, and to seek reimbursement only for services actually rendered. The

report rate for each of these categories for both rural and urban social workers ranged from 3.4% to 4.8%.

The licensing profile of the social workers alleged to have committed ethics violations differed markedly between rural and urban communities. In rural communities, social workers licensed at the BSW level had the highest percentage of complaints at 44.7%, while social workers licensed for independent practice accounted for 30.3% and MSW licensed social workers for 15.7%. Reports for urban social workers reflected complaints against those licensed for independent practice at 52.6%, MSW licensees at 23.3%, and BSW licensees at 15.4%. This data may simply reflect the differing compositions of the social work community in rural and urban areas in which rural communities tend to have larger proportions of BSW social workers and urban communities' greater proportions of MSWs and those licensed for independent practice (Daley and Avant, 1999).

It is important, for several reasons, to be cautious in making broad generalizations based on the results of this study. First, the data used in this study was retrieved from the social work licensing entity of only one state and the ethics violations reported may be idiosyncratic to that state. Second, the data reflect reports of alleged violations not adjudicated findings of violations. Thus, the extent to which these allegations are valid is not known. Third, the citations recorded for a complaint involve interpretation and assessment both when received by TSBSWE and when classified into categories for analysis by the researchers. Fourth, the small number of alleged violations for rural social workers in some categories makes interpretation of the percentages and rankings of those violation categories difficult. For example, the variation just of one or two reports in some categories could make a large difference in the percentages for rural social workers. Fifth, the data does not lend itself for tests of statistical significance to assess differences between rural and urban social workers, since many individuals had multiple reports, affecting the independence of the complaints. Thus, the results reported are descriptive and should be evaluated in that context.

Discussion

Analysis of ethics complaints submitted to the Texas State Board of Social Worker Examiners suggests that while the ethical issues of confidentiality and dual relationships may represent significant challenges for rural social workers, the challenges are handled at least as well

as those faced by their urban counterparts. Clearly the “fishbowl” environment of rural life creates a greater potential for ethical risk for rural social workers in both of these categories. But heightened risk does not equate to ethical violations, the critical piece is how the risk is managed. Ethical challenges are confronted and overcome every day by all social workers, and it appears that despite the heightened risk, rural social workers are measuring up to the challenge. Our data offers no insight into how they are doing this, but it is an interesting question for future research.

The data from our study indicates a similarity in profile between ethics citations for rural and urban social workers that is greater than is normally acknowledged in the literature. Rural and urban social workers demonstrated no statistically significant differences on the categories of ethics citation reported. In addition, the rank order for each of these categories were parallel in most respects, and the percentages of the total complaints for each category were comparable for both groups, further indicating rural and urban consistency.

It might be argued that our findings are an artifact of the rural tendency to handle things informally within the community, thus reducing reports of ethical violations. This does not appear to be the case because the rates of reporting for alleged ethics violations, both rural and urban, are in direct proportion to their membership among licensed social workers.

While the study did not find great differences between rural and urban social workers in reported ethics violations, we should not lose sight of the practical fact that almost 30% of the ethics complaints alleged against rural social workers related to either boundary or confidentiality violations. Thus, the rural social work literature appropriately raises these key issues for practice and education. Perhaps it is the attention to the ethical risks of rural practice that makes social workers better prepared to recognize and attend to these issues in their practice.

Ethics complaints regarding poor practice were the most common ethics allegations against rural social workers and represented over one fourth of the reports. This finding represents another substantial area of concern regarding ethical practice. The poor practice category contains allegations that social workers did not meet accepted standards for client care such as: making proper assessments, using supervision appropriately, and making suitable referrals. While the issue of poor practice is not as keenly highlighted in the literature, it is not entirely surprising either. The *poor practice* category that was used in our study appears to correspond more closely to a concept

identified as competency in the rural social work literature. While our study did include a competence category, it was less focused on to competent practice behaviors than upon worker impairment and practicing within the formal preparation the social worker.

Behavioral aspects of social worker practice and competence are identified as a source of ethical risk to rural social workers by a number of authors. Strom-Gottfried (2005) believes that rural social workers may be presented with responsibilities and situations exceeding their level or area of competence and these situations would traditionally indicate making a referral in densely populated communities. However, referrals might not be a viable option in a rural community either because of availability or distance. The rural social worker must then confront the decision of whether the client may benefit more from marginally competent service than no service at all. Croxton, Jayaratne, and Mattison (2002) also indicate that the broadened responsibilities of rural social workers put them in situations where they must provide service despite limitations or leave clients to receive no services. Burkemper (2005) cites the difficulties rural social workers face in obtaining supervision and in accessing continuing professional education. Ginsberg (1998) suggests that rural social workers function with more independence from supervision because of the scarcity of social workers available to provide ready supervision.

Each of these factors may lead to poor practice allegations being the most frequent for rural social workers. Geographic distance and communication issues may create a self-reliance that may ultimately result in barriers to using supervision either appropriately or effectively. The desire to help in a rural community where appropriate referral sources are not practical options may also lead social workers to delve into areas where their preparation is limited. One might also postulate that these circumstances, the likelihood of successful outcomes would be lower. Croxton, Jayaratne, and Mattison (2002) do report that rural social workers were more likely to report unsuccessfully outcomes with recently terminated clients. Perhaps frustrations over unsuccessful outcomes led to more reports of poor practice in our study.

Conflict of interest allegations for rural social workers were also notably higher than those for urban social workers. Reports in this category consisted of behaviors related to discriminatory treatment of the client and placing the interests of others over those of the client. There was a strong relationship conflict of interest and boundary violation complaints, as in 43.7% of the cases

both allegations were reported. In these cases, conflict of interest and boundary violation allegations likely refer to different aspects of the same behavior. In instances where discriminatory treatment was alleged, the closeness of the rural community may play an important role. The close-knit atmosphere of rural life may make it more likely that the social worker knows or knows of the client and/or the client's family. Given this preexisting knowledge, it may be more likely for the social worker to prejudge a client, or for the client to believe that he or she is being prejudged.

Allegations related to honesty alleged social workers engaged in fraud or deceit with clients. Although this was the fourth most frequent ethics report for rural social workers, the rate of reporting was lower than that for urban social workers. Perhaps the informal networks and communication systems in rural communities served as a deterrent to dishonest behavior. In other words, a person's reputation in rural America tends to be well known and be given great weight. Once the word got out that a social worker was not to be trusted, it would be hard to work with clients and colleagues, and it would be difficult to be effective. Four other categories of ethics complaint had so few reports that the data is not of practical use.

Perhaps the most striking finding of difference between rural and urban social workers lies in the distribution and the composition of the labor force. Rural social workers comprise only 9.3% of the licensed social workers yet serve 15% of the population. Based on the number of rural counties in Texas, the geographic area that these rural social workers must serve is enormous and must be viewed as significant factor in service delivery. Rural social workers are more likely to be licensed at the baccalaureate level (Daley and Avant, 1999), and are less likely to have the MSW or be licensed for independent practice. This is the case with our population as 54.3% of the rural social workers were licensed at the BSW or pre-professional level. Moreover, the percentage of rural social workers who are licensed as associates without a social work degree is twice that found in urban counties. Thus, based on the logistics of service delivery, the relative scarcity of social workers, and their preparation as baccalaureate generalists, it is not surprising that rural social workers are frequently thrust into situations in which advanced or specialized services are needed and resources for referral may be difficult, if not impractical to access. Practically speaking, in rural areas BSW social workers are often asked to perform the types of tasks usually assigned to MSWs in urban settings. In the environmental context of rural social work, the ethical decision

to serve clients, perhaps on the fringes of professional competence, or do nothing is a serious one that appears to confront rural social workers with some frequency and bears further exploration.

Conclusions

Discussions about the ethical challenges of rural social work have raised the question of whether there may be a rural code for social work practice (Boisen and Bosh, 2005). This study of alleged ethics complaints for rural and urban social workers strongly suggests that there is not such a rural code, as our data did not indicate great differences between the two groups. Rural social workers may, indeed face higher ethical risk in some areas than their urban colleagues, but they appear to have found a way to manage that risk within a common code of ethics. An important question for future research is to identify the strategies used by rural social workers in their risk management.

These findings do appear to raise questions concerning some widely held assumptions about the differences in rural and urban social work practice, particularly in the areas of confidentiality and dual relationships. While confidentiality and dual relationships have received the greatest emphasis in the rural literature, it was ethical allegations regarding poor practice that were reported with the greatest frequency in our study. It does appear that the scarcity of rural social workers and available supervision and referral resources may contribute to the greater frequency for reports of poor practice. However, ethical social work practice is an extremely complex matter and additional research is needed to further clarify more specifically how these issues play out in practice.

This study may indicate that we need to make revisions in ethics education and training for the social work profession in rural communities by focusing on the areas of greatest risk for complaints. The profession may need to strengthen its emphasis on ethical practice in rural settings, particularly with regard to the effective use of supervision and the use of referral. This may require discussing strategies for strengthening supervision and improving communication linkages, perhaps by using technology. It may focus on developing networks of referral sources external to the community that may be utilized when appropriate. Clearly ethics training for rural social work must also continue to address the challenges of confidentiality and dual relationships.

The shortage of social worker in rural communities is a challenge that the profession needs to address (Daley and Avant, 1999; NASW 2003). Otherwise, not only will rural social workers continue to be faced with the troubling ethical dilemmas about the services they provide, but many services might continue to be provided by non-professionals who may not subscribe to any ethical code.

In the final analysis, it seems that the differences between rural and urban social workers play out more subtly than our data could capture. We would be well served to remember Ginsberg's (2005, p. 4-5) perspective that "Perhaps the first important principle is that social work with rural populations and in rural areas is, ideally, simply good social work that reflects and considers the environment in which practice takes place". Our challenge for the future is to identify ways in which good social work can be adapted to the rural environment to strengthen practice.

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Ethical Decision-Making Among Hospital Social Workers

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Abstract

The purpose of this study was to examine ethical decision-making among hospital social workers. The primary intent was to examine the extent to which social workers in health care identify an ethical dilemma, provide a rationale for the basis of their decision, and subsequently follow a process for ethical resolution. A pattern that emerged was reliance on rules and laws rather than using systematic frameworks. The findings suggest the need to understand ethical decision-making as part of a thoughtful, ongoing process.

Keywords: Ethical Decision-making; Medical social workers; Ethical resolution paradigms; Frameworks for ethical resolution

Introduction

The concept of ethics in health care is not new. Since the days of Hippocrates, medical ethics have been concerned with the ethical obligation of health care professionals in meeting the needs of the sick and injured (Beauchamp & Childress, 1994). However, impressive technological developments in medicine, the rapid emergence of managed care in the delivery and reimbursement of health care costs and expanding information systems have contributed to the increased frequency and complexity of bioethical dilemmas for all health care professionals, including social workers (Blumenfield & Lowe, 1987).

Several factors have had an impact on the growing frequency of ethical dilemmas in health care. While scientific developments in medicine have offered expanded opportunities for treatment choices and the potential for longer life, they have additionally created ethical dilemmas involving issues related to quality of life, informed consent, end-of-life decision-making including the provision for or withdrawal of life support, access to health care, and resource allocation (Blumenfield & Lowe, 1987; Cossom, 1992; Manning, 1997; Reamer, 1998). These developments

have raised questions for social workers as to what should be done in life-or-death situations, who should decide, and what criteria should be used in the decision-making process (Blumenfield & Lowe, 1987). Social work in today's health care environment not only requires an awareness of the clinical and ethical concerns that arise in practice, but it demands a demonstration of a reasoned response toward ethical analysis and decision-making.

Literature Review

Advancements in medical technology and related ethical issues and questions affect social work practice on a daily basis. Traditionally, the function of hospital social work focused on the development of a viable post hospital plan to meet the medical and social service needs of patients (Blumenfield & Lowe, 1987; Cummings & Cockerham, 1997). Current hospital social work also requires grappling with issues related to patient autonomy, confidentiality, refusal of services, and informed consent as well as assisting families in decision-making about treatment and quality of life (Csikai & Sales, 1998; Manning, 1997). These issues often present the social worker with the task of initiating ethical discussion and deliberation and demonstrating a level of ethical competence which is best approached using a reasoned process for ethical resolution (Reamer, 1998).

Additional ethical dilemmas in health care stem from the cost containment measures currently affecting reimbursement for hospitals. The prominence of managed care as a primary means to control cost and health care delivery has raised new ethical dilemmas for social workers. Concerns of confidentiality, conflicts of interest, client abandonment, and negligent care (Strom-Gottfried, 1998) present difficult choices for social workers when confronted with the need to comply with managed care guidelines. Often social workers believe that compliance with managed care requirements can result in ethical problems related to compromises in quality of care and in potential violation of ethical standards in social work (Reamer, 1997).

Moreover, further reductions in hospital stays, less than adequate discharge plans, disposition problems and delayed discharges create many ethical conflicts for social workers' attempting to balance the competing needs of client best interest and responsibilities to the health care organization, the third-party payer, the medical staff and the patient's family members (Abramson, 1981; Cummings & Cockerham, 1997). As these ethical issues in health care continue

to challenge social workers professionally, the processes and strategies for ethical resolution need to be studied and clarified in order to understand the resolution options used by social workers to address ethical issues. What remains as an area in research is, once an ethical dilemma is identified, what rationale is used to make the decision that a situation is an ethical one and what processes are used to facilitate resolution of the dilemma. It is the intent of this research to go beyond the identification of an ethical dilemma and to test a model of decision-making developed for this study to understand what social workers do to attempt to reach the optimal solution to the ethical quandary.

Ethical decision-making

Ethical decision-making is contingent upon a number of factors. The first step in decision-making is recognizing that a practice situation has competing values, obligations, or principles, which for the purposes of this study will serve as the definition of an ethical dilemma. Once the ethical issue is recognized, the second step is understanding the rationale used by practitioners to determine the presence of an ethical dilemma which can involve a variety of responses to the identified ethical dilemmas.

The third step in ethical decision-making is the resolution process used to facilitate ethical outcomes. The resolution process can encompass a variety of ways social workers resolve ethical dilemmas. What is considered an optimal approach is one that establishes the ethical facts, possible alternatives available, applies ethical theory and principles and considers consequences of different courses of action for resolution (Hebert, 1996; Reamer, 1990). Understanding how practitioners identify the presence of an ethical dilemma and how they make decisions regarding the resolution of the ethical dilemma provides the conceptual underpinnings for this study.

The ethical decision-making process rests largely on the ability of a practitioner to recognize that an ethical dilemma exists in a given practice situation. Recognizing that a situation has competing values, principles and obligations helps to separate the ethical components from practice or nonethical components (Reamer, 1990). Identifying the ethical components of a situation also serves to reduce the tendency of social workers to see ethical issues as merely practice problems which lead to resolution strategies based on practice techniques rather than on sound ethical inquiry (Joseph, 1989).

The identification of ethical dilemmas can also be influenced by practitioners who rely on personal value preferences or on an ordinary morality screen that is based on intuitive levels of thinking rather than on a reflection of ethical principles, theories, or codes of ethics (Foster, Sharp, Scesny, McClellan & Cotman, 1993). A personalized moral sense is rooted in an individual's belief of what is right or wrong rather than on moral rules or principles. As a result, certain practice situations will not be perceived as involving conflicting moral issues (Goldstein, 1987). For example, a belief system that does not accept euthanasia of any kind would not view situations involving end-of-life decision-making as an ethical quandary.

Practitioners who tend to follow rules, agency policy, or legal obligations may find themselves unwilling to identify and subsequently unwilling to act upon ethical dilemmas (Kugelman-Jaffee, 1990). Often agency policy, obligations, and even organizational work roles in the agency may influence the priorities that a practitioner will consider in identifying ethical dilemmas (Mattison, 2000). Organizational rules and constraints frequently make a social worker's obligations unclear as to whom the social worker has primary obligation: the client or the agency (Abramson, 1981). For practitioners in health care social work where the focus is on medicine rather than on social work, the influence of the organization can be problematic in relationship to the complex ethical issues emerging in health care (Abramson, 1990; Abramson & Beck Black, 1985; Foster et al., 1993; Reamer, 1985).

For social workers grappling with the magnitude of contemporary ethical challenges in health care, a reasoned reflective approach to identifying ethical dilemmas is critically important. Identifying ethical dilemmas in terms of competing values, principles, and obligations provides an ethical rationale for initiating the next step toward ethical issues in terms of value tensions, competing obligations and ethical principles which foster a systematic approach to determining a course of action for achieving the best possible solution for resolution.

Ethical decision-making may be approached by practitioners in a number of ways. The reliance of social workers to resolve ethical dilemmas from an intuitive sense rooted in their own internalized ethical code may lead to biased solutions that rest generally on a practitioner's own personal values. Decision-making based on moralistic beliefs of practitioners is viewed as a

subjective ethical decision-making style that is not grounded in a careful consideration of the fundamental moral issues of the situation (Foster et al., 1993; Goldmeier, 1984).

Similarly, ethical decision-making that is based on rules, organizational influences, or legal obligations that guide ethical analysis may also result in a practitioner's favoring different priorities a bias which can lead to different courses of action for ethical resolution. Reliance on rules, obligations, or agency policy reflects an ethical-decision-making style that attempts to resolve ethical dilemmas through the use of technical skills rather than through reasoned ethical inquiry (Joseph, 1991).

Because of the tendency of social workers to resolve ethical dilemmas either by reliance on their own individualized ethical styles or by adherence to agency policy, rules or legal obligations, several social work researchers have proposed resolution paradigms as a way to formalize and clarify the reasoning that needs to occur for appropriate ethical decision-making (Abramson, 1981; Blumenfield & Lowe, 1987; Loewenberg & Dolgoff, 1996; Mattison, 2000; Reamer, 1990). These models for ethical decision-making have been developed as a method to analyze ethical issues, to establish the ethically relevant facts and to determine what needs to be addressed for adequate resolution of a moral quandary (Hebert, 1996; Manning, 1997). While each resolution model emphasizes a different aspect of decision-making, all the models offer some general commonalties such as identifying the ethically relevant facts, determining a decision-making process, identifying relevant value issues and examining the various alternatives and options in order ultimately to select a plan of action. These common features offer ways to organize the various dimensions of ethical analysis and to guide practitioners toward practical resolutions that are sensible and insightful (Hebert, 1996; Mattison, 2000). While these models are not intended to be simple formulas or technical tools to be applied for ethical resolution, they are ways to provide rationale for making choices (Abramson, 1981; Mattison, 1994).

Ethical decision-making influences

The process of ethical decision-making may be influenced by a number of factors such as internationalization of social work values, education, and experience in social work, prior ethics training and professional identification. The presence of these factors may guide a practitioner toward a decision-making process that is based on an examination of the value conflicts present,

the establishment of the ethically relevant facts, the consideration of ethical theory, principles and codes of ethics and the examination of all possible alternatives and options available to resolve the ethical dilemma.

A key component to ethical decision-making is the identification of the value conflicts present in a situation. Ethical problems and dilemmas that occur have a value-based component that includes issues such as client autonomy, confidentiality and distribution of resources (Watt, 1992). These value conflicts are often the most problematic for social workers particularly when faced with determining which value should be considered primary among competing interests. Competing obligations often raise questions such as, are there primary obligations to self-determination or are there situations where disclosure of confidential information is justified (Mattison, 2000). Often these value conflicts involve choosing among courses of action where none of the options or alternatives appear to offer a satisfactory resolution.

The question of whether social workers understand how to use values in professional practice and how these values influence the ethical dimensions of practice remains largely unanswered. Despite the importance of social work values to professional practice and to the existing empirical study on values and the impact of social work education on values assimilation (Abbott, 1988; Varley, 1963), little research has been focused on the internalization of social work values and its influence on ethical decisions. As ethical dilemmas are typically defined in terms of competing values, the internalization of professional values should lead a social worker to identify readily ethical issues when confronted with conflicting values and use those conflicting values as a way to initiate ethical discussion and deliberation.

As values are an integral part of social work education, the educational background of practitioners may also influence the use of a decision-making process. Consequently, the educational background of practitioners has been examined as a possible correlate in previous studies on ethics and social work practice (Dobrin, 1988; Mattison, 1994; Watt, 1992). At least one researcher has suggested that education not only improves practice skills but that graduate education can also improve the ethical skills needed for ethical decision-making (Dobrin, 1988). Dobrin's suggestion (1988) is that years of formal social work education, exposure to systematic

learning, and participation in the educational process may lead practitioners to develop principled ethical judgments based on resolution paradigms.

Coupled with a practitioner's education background, the years of experience in social work practice may also influence the use of a process for ethical decision-making. Experience in social work has been suggested as a possible factor that increases knowledge about the multiple issues that come into play with ethical dilemmas (Congress, 1986), a suggestion implying that more experience equals an improved use of a process of ethical decision-making.

Preparedness in ethical analysis and decision-making through prior training in ethics, ethical theory, and ethical principles has also been found to improve competence in ethical deliberation (Foster et al., 1993; Joseph & Conrad, 1989). Prior education and training in ethics increase a social worker's awareness of the moral components of situations and provide a framework to help practitioners analyze and resolve ethical conflicts in practice (Foster et al., 1993, Joseph & Conrad, 1989; Watt, 1992). Previous studies have demonstrated that social workers without prior ethics training report a lack of preparedness to resolve ethical dilemmas and lack a general ability to make decisions based on the ethical content of the dilemmas, thus relying on personal rather than professional ethics for guidance (Kugelman-Jaffee, 1990; Felkenes, 1980; Mattison, 1994).

A worker's professional identification with the social work profession may be a final factor that influences the use of an ethical decision-making process. Organizational influences have been demonstrated to affect the ethical decision-making ability of practitioners (Congress, 1986; Kugelman-Jaffee, 1990; Walden, Wolock & Demone, 1991). The organizational setting can influence health care workers to adopt professional roles consistent with the hospital organization thus fostering an attitude risking a loss of identity with respect to professional disciplines (Chambliss, 1996). At least one researcher found that practitioners will identify with concrete organizational policy first when they regard professional obligations as too abstract to be useful in practice (Felkenes, 1980). When ethical decision-making and the organization have been studied empirically, researchers found that those who rely on organizational rules deliberate somewhat differently on ethical issues than do those practitioners who use ethical principles to guide their decision-making (Kugelman-Jaffee, 1990). Thus, the challenge for hospital based social workers,

where the primary organizational emphasis is on medicine, is to maintain their professional identification which can lead to ethically informed positions and to increased quality in the provision of social work services. Further maintenance of professional identity which begins during the educational process is fostered through professional organization memberships, attendance at social work sponsored conferences, participation in social work meetings and maintenance of appropriate licensure and/or certification. A continued sense of professional connection to social work allows for a more fully integrated professional identity that fosters a greater commitment to the social work profession rather than to the values of the employing organization (Compton & Galaway, 1984). A continued commitment to the profession may influence a practitioners' ability to demonstrate ethical skills and use a reasoned process for ethical resolution rather than to rely on organizational authority or power held by others in a multidisciplinary setting (Kugelman-Jaffee, 1990).

In general, the literature indicates that social workers have learned content on the recognition of ethical dilemmas but have not learned to apply ethical skill to difficult decisions or are lacking in the knowledge of the use of a formalized process for ethical decision-making.

Method

The purpose of this study was to assess ethical decision-making among hospital social workers. The dependent variables were the extent to which social workers in hospital settings identify the presence of ethical dilemmas, the rationale used to determine their decision, and the extent to which a decision-making process is used to resolve ethical dilemmas in health care. Independent variables in this study included the internalization of Social Work Values (as measured through Abbott's 1998, Professional Opinion Scale) educational background, experience in social work, prior training in ethics and professional identification. Additional demographic variables such as age and gender as well as employment variables of current job position, location of hospital (urban/rural), type of hospital (medical/surgical, rehabilitation or pediatric), presence of a formal social work department and size and structure of the social work department were included as variables. A descriptive survey design was used for this study. An anonymous mailed questionnaire was sent to a random sample of Directors of Social work in acute care, medical surgical hospitals affiliated with the American Hospital Association.

Population and Sample

The study population was hospital based social workers practicing in acute care hospitals that were affiliated with the American Hospital Association (AHA), excluded from the study were hospitals that did not belong to the AHA. For the purposes of this study, an acute care hospital was defined as a general medical surgical hospital with a primary mission to meet the urgent health care needs of seriously ill and hospitalized patients. The Directors contacted for the study sample were selected using a random list of one thousand hospitals affiliated with the AHA. The list was purchased by the researcher through American Medical Information, Inc. The requested membership list of 1,000 hospitals generated 800 usable addresses of acute care hospitals across the country. The research package was mailed to the Directors of Social Work with the request to have two members of the department complete the survey instrument. The director may or may not have personally completed the survey. The cover letter instructions were provided to the Director stating that they could include themselves in the selection of staff to complete the surveys. This non-probability method of relying on available subjects (Babbie, 1986) following the simple random selection of AHA member hospitals is characterized as an accidental, self-selected sample and is recognized as a limitation of the study. The selection of two respondents from the department as a representative number of social workers is based upon the AHA statistical information. This information reflected that the largest percentage of hospitals have a total number of hospital beds between 100 and 199, therefore requiring two or more social work staff. Additionally, smaller hospitals (those with fewer than 100 beds) which make up approximately 44 percent of all hospitals in the AHA listing typically have smaller social work departments than larger teaching hospitals that generally have social work staff assigned to specialty areas or clinics accounting for larger departments.

The research package was mailed to 800 acute care hospitals throughout the country. A total of 282 questionnaires were returned; forty-three questionnaires were not included in the data analysis as they were completed by non-social work professionals, thus the total number of usable surveys was reduced to 239 which represented a 15% response rate. Of the 239 responses used for data analysis, 36% of the hospitals returned one survey, 32% returned two surveys. This non-

probability sampling plan and low response rate does not allow for generalization beyond the parameters of the study sample.

Instruments

The survey instrument included three sections. Section I contained four case scenarios which asked respondents to indicate whether the case represented an ethical dilemma, how they chose their answer, and what process would be used to resolve an ethical dilemma. Section II contained the standardized measure, the Professional Opinion Scale (Abbott, 1988). Section III contained demographic data that included gender, age, size of the department responsible for social work, location of the hospital, and type of hospital. In addition, information regarding the respondent's educational background, years of experience, prior ethics training, and professional identity was also collected.

Dependent Variable

There are three components of the dependent variable, namely ethical competence. Ethical competence is further defined as the ability to identify an ethical dilemma, the rationale used to determine the presence of an ethical dilemma, and the process used for ethical resolution.

The recognition of an ethical dilemma was measured through the use of four case scenarios designed to reflect two cases representing advances in medical technology and two cases depicting issues of cost containment in health care.

Previous studies reviewed in the literature showed use of a variety of case scenarios that depicted various practice situations containing ethical dilemmas. Some studies had selected cases that represented situations such as medical truth-telling, but none of the studies used vignettes related specifically to this study: the issues of advancing medical technology and the issues arising out of the cost containment efforts currently faced in health care. The decision to develop original case vignettes based on actual hospital practice situations resulted from a review of the literature that indicated that contemporary hospital practice was concerned with issues of advancing medical technology and cost containment issues (Csikai & Sales, 1998; Manning, 1997).

Vignettes

Vignette one was constructed to depict the conflicts inherent in end-of-life decision-making and the withdrawal of life support. The issue centered on the request of a spouse to disconnect life

support for his wife who had suffered a paralyzing brain stem stroke. The advanced medical technology that included life support measures, such as mechanical respiration, tube feeding, and a special hospital bed to prevent skin breakdown were the only means of keeping this woman alive following this usually fatal type of stroke. There was no written advance directive or health care power of attorney and an unwillingness on the part of the physician to withdraw life support as the patient's wishes could not be communicated. This case represents conflicts over the emerging societal issue of the right- die and personal, professional, and organizational values.

Vignette two highlighted the tension between upholding confidentiality, informed consent, and duty to warn in order to protect an infant. The issue of holding in confidence the information obtained in the delivery of professional services (NASW, 1996) and the decision to share the confidence for protection of life, raised questions of who the client is in situations involving HIV and AIDS (Abramson, 1990). The ethical tension also reflected the need to balance competing principles while systematically analyzing the justification for choosing one principle (confidentiality) over another (Duty to warn) (Abramson, 1990). This case raised issues over what to do when medical technology was available to a newborn who may have been exposed to HIV in utero but was not given the opportunity to utilize advance medical treatment and care.

Vignette three addressed competing commitments made to the employing organization versus commitment to clients as delineated in the Code of Ethics (NASW, 1996). Conflicts between a social workers' professional obligations and organizational policies were a part of this dilemma that highlighted the strain between two competing obligations. Additional tensions included the allocation of scarce resources in the form of bed availability in a neonatal intensive care unit and the continued economic viability of an organization in providing care for a patient no longer in need of acute care hospitalization.

Vignette four reflected current marketplace values that conflict with professional values in a managed care environment. The case depicted the conflict between allocation of resources and distributive justice and quality of life. This situation also illustrates the complexity of discharge planning in an environment that is affected by fiscal constraints and cost containment issues (Abramson, 1981; Conrad, 1988). It raises several questions regarding to whom the social worker has primary obligation: the patient, the hospital, or to the third-party payer (Abramson, 1981).

To establish reliability and validity of the case scenarios, in July 1999, the researcher mailed the cases to a sample of ten social work educators with expertise in ethics with a letter explaining the purposes of the research. Each educator was asked to indicate whether the case depicted an ethical dilemma and whether he/she could identify the value conflicts inherent in each case. To provide additional input into the review of the cases, one educator also shared the cases with two colleagues, one with medical social work experience and one with experience in child welfare. Each reviewer identified competing values inherent in the cases, identifying value conflicts such as self-determination and end-of-life decision-making (Vignette One), informed consent and protection of others against harm (Vignette Two), quality of life and rationing and conflicts arising in meeting the NASW Code of Ethics standards (Vignette Three), and conflicts in professional obligations arising between scarce resources and quality of life (Vignette Four). All cases were deemed as representing ethical dilemmas and all reviewers agreed on the competing values in each of the ethical dilemmas.

Independent Variables

Social Work Values

The 40-item version of the Professional Opinion Scale (Abbott, 1988) was used to measure the independent variable of internalization of social work values. The goal of this instrument is to measure respondent concurrence with the underlying ideology or value base of social work (Abbott, 1988). The selection of the Professional Opinion Scale was based on the instrument's measurement of consistency with social work values and the ease of administration to large numbers of people. The 40-item version of the Professional Opinion Scale is based upon the 121-item version developed in 1988 and is arranged as a 5-point Likert-type scale with responses ranging from strongly agree to strongly disagree. Higher scores indicate greater consistency with social work values. The content of the Professional Opinion Scale comprises items reflecting the variety of public social policy issues identified by members of NASW to assess the degree of commitment to four basic social work values: respect for basic rights, sense of social responsibility, commitment to individual freedom, and support of self-determination (Abbott, 1988). The four values of the Professional Opinion Scale were initially identified in a 1988 exploratory factor analysis with Abbott's 1998 study reaffirming the relevance of the Professional Opinion Scale as

a viable instrument for assessing commitment to social work values (Abbott, 2000). The 1998 version of the scale reflected the reassignment of several items to different factors that resulted in a forty-item scale (Abbott, 2000). The 1998 confirmatory factor analysis provided evident that the four factors (value dimensions) are valid and reaffirms the reliability of the 1988 generated factors (Abbott, 2000). The forty items comprising the four Professional Opinion Scale value dimensions resulted in the following reliability scores: Factor One: Respect for Basic Rights, Cronbach Alpha reliability, .7680; Factor Two: Support for Self-Determination, Cronbach Alpha reliability, .6806; Factor Three: Sense of Social responsibility, Cronbach Alpha reliability, .7609; and Factor Four: Commitment to Individual Freedom, Cronbach Alpha reliability, .7947.

Education

Educational background in social work was measured by asking respondents to identify their highest academic degree. This information indicated to the researcher when the respondent was exposed to course work on ethics, an indication supporting the previous research that suggests graduate education provides preparation to handle ethical issues (Dobrin, 1988; Watt 1992). The Education Index will result in a single score ranging from 0-3 (0 = no response, 1 = BSW degree, 2 = MSW degree, 3 = Ph.D./DSW).

Experience in Social Work

Respondents were asked to identify their number of years' experience in social work and their number of years' experience in hospital social work. The data was presented as the actual years reported for both social work experience and health care social work experience.

Prior Ethics Training

Information pertaining to prior ethics training was measured to examine the relationship prior exposure to ethics content has on practitioners' ability to recognize ethical dilemmas, and to follow a process for ethical resolution. Respondents were asked to identify what ethical training they had received in terms of social work values, ethical decision-making models, professional codes of ethics, ethical principles and theories, and the date such training was received. The inclusion of these questions related to ethics training and its date are intended to evaluate when such training occurred.

For purposes of data analysis, the responses to ethics training were coded using the Ethics Training Index developed for this study based on the research that suggests prior ethics training is a positive factor in ethical decision-making (Joseph & Conrad, 1989). The Ethics Training Index used a Yes/No scoring format for each of the four questions related to social work values, decision-making models, codes of ethics, and ethical principles and theories with *Yes* being 1, and *No* being 0 with a range of scores from 0-4. Higher scores reflect increased ethics training.

Professional Identity

Respondents were asked whether they belonged to professional organizations such as the National Association of Social Workers (NASW) or the Society for Social Work Leadership in Health Care (SSWLHC). Additionally, they were asked if s/he holds a state license and/or certification, ACSW or other professional social work membership. Questions about attendance at regular social work meetings and attendance at NASW or social work sponsored conferences were also included. The responses to the questions were coded using the Professional Identity Index developed for this study to assess the extent to which respondents maintain a professional identity to social work. The Professional Identity Index assigned a 1 to indicate a *Yes* answer or a 0 for a *No* answer for State Licensure or certification, each membership in a professional organization, and each type of social work sponsored conference. The assignment of a *Yes/No* format related largely to the absence of any supporting literature that suggests additional professional memberships or attendance at professional conferences is of greater value than another. Higher scores suggest increased professional identity.

Additionally demographic and employment related variables were also measured to examine their relationship on practitioner ability to recognize an ethical dilemma, the rationale used for recognition, and the extent to which a process was used for ethical decision-making. The employment related variables were current job position, location (urban/rural) and type of hospital (medical/surgical, rehabilitation or pediatric), presence of a formal social work department or department responsible for social, and size and structure of the social work department. Respondents were asked to identify their age and gender. This section provided the identifying characteristics of the social workers' participating in the study. Demographic and employment related questions were located at the end of the instrument to minimize respondent fatigue as the

questions are presumed to be less demanding than the assessment of the ethical dilemma, resolution process, internalization of social work values, prior training in ethics, professional identity and social work education and experience.

Furthermore, identification of contemporary ethical issues in practice was assessed to see whether practitioners' perceptions of ethical dilemmas are consistent with the current literature. Respondents were asked to list what they perceive to be the current ethical issues in today's hospital social work practice. The responses were grouped around similar themes.

Pilot Study

A pilot study of the survey was administered to social workers practicing in ten acute care hospitals. The pilot study completed in December 1999 consisted of a sample of hospital based social workers located in acute care hospitals, three in Pennsylvania, two in New York, and one each in Texas, Vermont, Mississippi, Montana, and California. Thirty surveys were mailed with a letter of explanation about the study, a consent form, and a self-addressed stamped envelope for returning the questionnaire. The pilot study yielded a 63% response rate and helped to assess the amount of time needed to complete the instrument and the readability of the items. No questions were identified as problematic for the respondents. Respondents were asked for comments about the questionnaire; this feedback included three responses that indicated the survey was lengthy, one respondent who commented that the vignettes made her think about the issues, another noted that the answers were in the context of the moment but in actual practice would take more time to examine the issues. Based upon the results of the pilot study and feedback received, no changes were made to the survey instrument.

Data Collection

The research package was mailed in March 2000 and consisted of two copies of the study questionnaire, a letter of explanation about the study, and informed consent form and a self-addressed stamped envelope for returning the survey instruments. A code number for tracking purposes only was assigned to the survey instruments to monitor returns. Two mailings were included in this study: the original questionnaire and one follow-up notice to all participants to thank them for participation and to serve as a reminder to complete the survey. The follow-up notice was intended to increase response rate and was sent out two weeks after the initial mailing

(Babbie, 1986). In addition, the name and telephone number of the researcher was included in the survey packet for respondents to contact if they had any questions. Approximately five respondents did contact the researcher to clarify questions regarding completing the survey. Two respondents questioned completion of the instrument when there was only one social worker in the hospital. One respondent inquired as to whether the survey should be completed when there were no social workers in the hospital; one hospital director telephoned to say that staffing was a problem in their facility, and they would be unable to complete the survey; and four respondents requested the survey findings and enclosed a business card for the researcher to follow-up with sending the completed survey results. Additional follow up included contact with five hospital social work directors regarding the selection of participants to complete the questionnaire. Two directors indicated that the questionnaire was presented at a staff meeting and volunteers were asked to complete and return the survey; one director indicated there was one social worker on staff and that person replied and returned the other survey uncompleted; one respondent completed the survey as the director and gave the other to the only MSW on staff; and one respondent was selected as she had additional training in ethics and served as the ethics liaison in the hospital. Prior to the pilot study, the research study was approved by the Institutional Review Board at Marywood University, which has established review procedures for the use of human subjects in research before undertaking this study.

Data Analysis

Respondents were asked to indicate whether each case vignette represented an ethical dilemma. *Yes* and *No* responses to this question were scored as 1 or 0 respectively. Scores for all vignettes were summed: based on the total score, respondents with higher scores exhibited greater competence in identifying ethical dilemmas. Face validity of both the case scenarios and scoring system was achieved by using a panel of three social work educators and a panel of ethics educators who reviewed all cases and determined each case represented an ethical dilemma.

The respondents were also asked to explain briefly in an open-ended narrative format what rationale they used in determining the ethical issues at work in each vignette. These responses were scored to a single category according to a coding scheme that includes five categories of possible responses: 0= no response; 1= rationale based on personal preference or feelings; 2= a skill-based

rationale based on agency policy or legal obligations to be followed; 3= a rationale that identified one side of the value conflict; 4= a rationale base on some elements of ethical analysis; or 5= a rationale grounded in ethical theory, principles or codes of ethics. Responses for each vignette were given a single score, a range of 0-5, with the higher the score reflecting greater competence in the use of a rationale grounded in ethical principles and values. Face validity of both the question asked, the rationale used in identification of an ethical dilemma and the Rationale Classification Index, the scoring system, was achieved by using three social work educators.

The respondents were also asked to select one of the four case scenarios that they believed represented an ethical dilemma and to explain in narrative form the ethical issues and the process used to resolve them. The responses to the vignette selected by the respondent were coded using the Resolution Process Index (RPI) developed for this study to reflect the extent to which respondents follow a process for ethical resolution. The coding index for the resolution process included five categories of possible responses: 0= no response; 1= avoids any attempt at conflict resolution; 2= bases resolution on personal values or on practice skills; 3= bases resolution on rules, agency policy or legal obligations; 4= bases resolution on identification of the value conflict and limited use of tools of ethical analysis; 5= bases resolution on ethical analytic techniques. The answer provided received a single score based on the Resolution Process Index. The higher the score from the Resolution Process Index, the greater the use of a systematic process for ethical resolution. Face validity of the question asked, the process used and the Ethical Resolution Index, the scoring system, was achieved using three social work educators.

Additionally, inter-rater reliability measures were used to assess the level of agreement between two separate judges to establish reliability of the Rationale Classification Index. The inter-rater reliability was completed by both the researcher and an MSW clinician with experience in health care social work, home health and mental health counseling. All responses were reviewed and coded twice by the researcher and coded by the MSW clinician. Two rationale responses were found to be different from the researcher's original score and the one assigned by the clinician. Both cases were reviewed again by both judges and agreement was found on the scoring, with one case retaining its original score and one case changed to reflect a more skill base response.

Inter-rater reliability measures were used by the researcher to assess the level of agreement between two separate judges using the Ethical Resolution Index. As with the other narrative responses the researcher scored the cases on two occasions and the MSW clinician also scored the resolution process reported by the respondents. The results of this inter-rater reliability showed a 100 percent agreement in the scoring using the Resolution Process Index.

Initially the three primary research questions were evaluated using frequency distributions to group responses. Descriptive statistics were also computed for the Ethical Identification Index, the Rationale Classification Index, and the Resolution Process Index. Pearson's Product Correlation and Spearman's Correlation were used to assess the individual hypotheses of the study. Finally, a regression analysis was used to evaluate the relationship between identification of an ethical dilemma, and the process used for ethical decision-making and internalization of social work values, educational background, years of experience, prior ethics training, and professional identification.

Results

The majority of the respondents were employed in urban (52%), medical surgical (94.6%), non-teaching hospitals with a formal social work department with four or fewer staff members (46%). The findings indicated that most of the respondents are female (87%) averaging 41 years. Most of the respondents indicated they are staff social workers (62%), having a Master of Social Work degree. On the average, the respondents indicated they have at least thirteen years of social work experience and an average of nine years of hospital social work experience.

Two cases out of four were most often reported as ethical dilemmas. More medical cases (94.6%) were identified as ethical dilemmas than cost containment cases. However, the responses from study participants suggest dilemmas involving self-determination, confidentiality and decision whether or not to intervene in patients' lives when faced with end-of-life decisions are readily recognized as ethical conundrums. Situations that reflect the need for organizational economic viability along with the expectation to adhere to institutional regulations appear to be routinized into practice as issues to be resolved through concrete discharge planning efforts. Additionally, as most respondents did not perceive cases of cost containment as an ethical dilemma, they obviously did not select these cases for which to propose a process for ethical

resolution. Most of the respondents typically selected cases that depicted ethical tensions such as decisions to prolong or end life, or disclosure of confidential information for ethical resolution. The difference found in the identification of ethical dilemmas is consistent with what practitioners currently identify as ethical quandaries. Ethical conflicts have been identified by practitioners as those that involve termination of life sustaining treatment, and patient's autonomy or self-determination rather than issues pertaining to managed care initiatives although these issues are confronting social workers with increased frequency in medical settings (Holland & Kilpatrick, 1991; Kugelman-Jaffee, 1991; Landau, 2000).

When asked to give a rationale for determining the ethical dilemma, respondents used a rules-based rationale over 50% of the time to both the cost containment cases and for one of the medical cases. For the other medical case, one third of the respondents used a rules-based approach and one-third identified at least one side of the value conflict. This rules-based approach is one that sees ethical dilemmas as conflicts between rules, policy or law. By way of example, this approach in confronting end-of-life decision-making would view the ethical conflicts as those involving legal aspects of decision-making capacity versus proper execution of an advance directive as required by state law and hospital policy. With this approach, the competing ethical imperative is the conflict between legal definitions of decision-making capacity versus the legal aspects of living wills or health care proxy.

Most (69%) of the respondents selected one of the medical technology cases when asked to propose a resolution process. The ethical decision-making process used by respondents (54.4%) was based more on skills and rules than on a systematic ethical process.

The relationships between the independent variables and the dependent variable identification of an ethical dilemma were not significant. The rationale used to determine the presence of an ethical dilemma, internalization of social work values ($r=137, p=.03$), experience in social work ($r=129, p=.04$), and professional identity ($r=146, p=.02$) were found to be correlated. These findings indicate that when a person has internalized social work values, more years of experience and a greater identification with the profession, a higher rationale process is used for identifying an ethical dilemma. The process used for ethical resolution did not differ for

respondents whether they identified one or all cases as ethical dilemmas. The majority of respondents used the same process, one that was rules based for ethical resolution.

A stepwise linear regression analysis identified those variables that were significant predictors of the rationale used for identifying ethical dilemmas and the use of a process for ethical decision-making. For the rationale used, professional identity was identified as a significant predictor ($R=148$, $R^2=0.22$). Prior ethics training was the only variable that was identified as a predictor of the use of a process for ethical decision-making ($R=137$, $R^2=.019$).

Additional findings revealed a significant difference between the two types of cases used in the case scenarios. Specifically, fewer responses were found in the cost containment case than expected and more in the medical case observed than expected in identifying the ethical dilemmas ($X^2=119.933$, $p=.000$). Further analysis using a post hoc analysis ($F=19.303$, $p<.000$) revealed a difference in the rationale used by respondents and the ability to identify cases as ethical dilemmas. Those respondents using a higher rationale process identified more cases as ethical ones. Although the variance explained by the variables is small these findings are substantive in understanding the role of professional identity and prior ethics training in ethical decision-making thus warranting further research in this area.

Respondents provided additional insight into the types of ethical concerns in hospital practice. Medical technology issues specific to end-of-life decision-making remain the most problematic followed by cost containment concerns related to third party payers and reimbursement strategies.

Discussion

In view of the tendency of health care practitioners to rely on rule-based approaches for identifying and resolving ethical dilemmas, a tendency which suggests other aspects of resolution paradigms may be ignored; the profession must consider the need to adopt a framework for identifying, gathering, and assessing the information necessary to make informed ethical decisions. Although there are several resolution paradigms available (Abramson, 1981 ;Abramson, 1983; Blumenfield & Lowe, 1987; Levy, 1993; Loewenberg & Dolgoff, 1996; Mattison, 2000; Reamer, 1990), support of a framework to be used for ethical decision-making can aid in understanding and defining the critical issues involved, those individuals affected by the decision-making, and

possible courses of action to take, the relevant state or federal guidelines that, taken together, can lead to improved ethical decision-making.

Social work as a profession needs to recognize that while there has been a recent emphasis on ethics education, more needs to be done to assess its effectiveness in practice. How ethics training is provided in professional education, what methods of instruction are utilized, and how this education is actually applied in practice will offer insight into how the CSWE mandates to integrate ethics into education is actually carried out.

Policy initiatives within the hospital setting can include development of informal discussions to highlight ethical quandaries to guide staff struggling with ethical dilemmas. Rotating staff participation on interdisciplinary ethics committees and forums through educational programs available to staff may foster development of skill in ethical analysis and decision-making. Those more experienced colleagues who demonstrated greater ethical reasoning in this study need to draw on both practice wisdom and experiences in the successful and unsuccessful resolution of ethical dilemmas with their less experienced colleagues. Policy development may include assignment of professional mentors to balance the obligations between ethical practice and the concerns with preventing negligence and malpractice.

Future research that measures social workers' tendencies to favor rules, policy and legalistic choices of action in identifying and resolving ethical dilemmas can offer insight into the ways these preferences factor into the ethical decision-making process. The tendency to fall back on external sources when attempting to resolve value conflicts suggests that additional research is needed as to the type of content and methods of instruction on ethics is presented in the social work curricula and in on going continuing education.

It would be useful to see whether the values of self-determination and confidentiality are as well defined and recognized as the study findings suggest and why social work values related to broader social issues and organizational policy such as cost containment and economic viability are less recognized and not so well understood.

Additional research may need to examine whether the primary dilemmas identified in this study are representative of the dilemmas faced by hospital social workers. Future study could

include comparisons of the perspectives of other health care professionals and social workers regarding their perceptions of what the major ethical dilemmas are in health care.

Limitations

Results of this study must be considered in relationship to the limitations of survey research.

How the study sample was similar to samples reported in the literature, consideration must include the issue of sampling techniques and the potential for selection bias. This study used a random sample of acute care hospitals affiliated with the American Hospital Association (AHA) which excluded any hospitals that do not maintain membership in the AHA, an exclusion restricting generalizability to all acute care hospitals. Furthermore, the low response rate (15%) and the self-selection of respondents to participate in the study must all be taken into consideration when examining the study findings', therefore, generalizability cannot be made beyond the parameters of the self-selected sample. The concern of selection bias does pose a threat to the internal and external validity of the study. One such threat is that as the subjects were drawn from the membership list of the AHA, it is possible that these subjects may have an unidentified characteristic (i.e., access to ethics training through AHA publications, seminars, or communications) that nonaffiliated hospitals may not have. Such a characteristic may impact upon the dependent variables of identification of an ethical dilemma, use of a rationale and the process used in ethical resolution. The study sample when compared to sample selection in the existing literature, previous studies have utilized a purposive non-probability sample (Beckerman, 1991; Kugelman-Jaffee, 1990; Landau, 2000). Sample size in the research has been reported as twenty, thirty-two and seventy-three subjects. This study included two hundred thirty-nine respondents; therefore, the sample size is larger.

Also, the instrument, despite being tested for content validity but not for reliability or for construct validity, and the cases reviewed by a panel of experts may not have been sensitive enough to capture some of the differences among the respondents. Future research might build on the findings of this study to refine a testing instrument designed to measure social workers' ability to identify and resolve ethical dilemmas.

An additional limitation recognizes these results reflect only what participants say they do in practice not what they actually do when confronted with an ethical dilemma.

Conclusions

The prevalence of ethical challenges in health care confront practitioners today at an accelerated rate. Ethical dilemmas resulting from improved health care technology and the economic pressures of managed care have led to changes in practice and to a need to understand ethical decision-making as part of a thoughtful, ongoing process. Therefore, understanding the process which influences the outcome is as important as the action taken. Knowing what tendencies and influences that factor into how a case is deemed as an ethical one and, ultimately, how it is resolved is an important part of social work practice and a first step in promoting ethical competence. Social workers, like other professionals in health care, are influenced by the medical-legal environment in which they practice. Understanding the role and relationship of the law and ethics related risk and malpractice is becoming more important for practice. Better identification and understanding of social workers' tendencies toward favoring rules, policy, or legalistic choices is a step toward recognizing how these factors impact on ethical decision-making. Similarly, recognizing these tendencies in practice can offer opportunities for enhanced efforts in considering courses of action that would balance both ethical and legal obligations and improve the decision-making process for all involved.

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A Model for Ethical Decision-Making: The Context of Ethics

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Abstract

This paper presents a model for ethical decision-making that is easy to teach, easy to remember, and easy to use. The model defines life, choice, and relationship as the three elements that comprise the context necessary for an ethical decision to present, and the paper proposes that maximizing each element is the best possible resolution to an ethical dilemma. The model proposes that further resolution of ethical dilemmas is impossible.

Keywords: social work ethics; ethical decision-making; ethical models; ethical context; context of ethics

Introduction

Social Work is a profession based in values and ethics, yet the NASW Code of Ethics gives relatively little guidance in resolving ethical dilemmas. When two or more ethical principles are in conflict, the Code of Ethics provides little guidance on how to proceed, and with so many principles, the possibility of two or more coming into conflict is great. Texts on ethics frequently discuss dilemmas from multiple perspectives but provide little direction about how to resolve the dilemmas, leaving the reader wondering which view is most likely to produce an ethical decision. The problem is not helped by the circumstance that ethics, as a branch of philosophy, has no external mechanism for determining correctness; philosophical systems necessarily rest on untestable propositions (Pojman, 2001). While there may be value in exploring many different points of view about ethical decision-making, it seems useful to develop a simple ethical system that can be easily taught and more importantly, easily applied in the field. This paper is an attempt to develop such a system.

Literature Review

Several writers (e.g., Abels, 2001; Loewenberg, Dolgoff, and Harrington, 2000; Reamer, 1990, Robison and Reeser, 2000; and Rhodes, 1991) have written about ethical issues for social workers. Many acknowledge the difficulty of making ethical decisions and of developing useful ethical systems. Rhodes (1991) says that difficult cases “contribute to the sense that understanding ethical issues in some rational, systematic way is impossible” (p. 2). Rhodes (1991) goes on to say that social workers have “received little useful help in making ethical decisions” (p. 19). Abels (2001) says, “Ethics within the profession seem unsettled, and unsettling” (p.4). She further observes, “Conflict frequently arises among reasonable individuals about what is right or moral” (Abels, 2001, p. 4). Robison and Reeser (2000) acknowledge that “appealing to the Code of Ethics does not give us sufficient guidance in difficult cases” (p. 45), and Loewenberg, Dolgoff, and Harrington (2000) acknowledge that social workers often cannot honor the values to which they are committed.

These writers proceed to provide guidance for ethical decision-making. Reamer (1990) provides six guidelines that prioritize some ethical principles over others. Loewenberg, Dolgoff, and Harrington (2000) provide an “Ethical Principle Screen” that orders seven ethical principles in a hierarchy. Rhodes (1991) argues for a “kind of informed relativism” (p. 45) that engages in dialog and that considers the context in which ethical decisions are made. She provides a list of questions to guide ethical decision-making. Robison and Reeser (2000) also provide a list of principles and questions to guide ethical decision-making. Abels (2001) challenges the profession to develop an empirical base that would permit review of other professional decisions. This idea appears consistent with Rawls’ (1999) idea that a proper ethical principle can be determined by the consensus of a group of disinterested individuals.

Limitations of These Approaches

While each of these approaches has merit, each has limitations. Ethical decisions must sometimes be made quickly, and opportunities to work through several steps, to seek consultation, or to engage in dialog are sometimes impractical if not impossible. There appears to be little that would commend one system over another. In fact, Rhodes (1991) specifically criticizes Reamer (1982) for not giving “compelling reasons for accepting his account rather than some other” (p.

17). Rawls', Rhodes', and Abels' approaches rest on the assumption that what is right may be properly determined by consensus. If ethics is nothing other than consensus, it is no wonder that social workers are confused. Since different groups may arrive at different consensuses, ethical behavior can shift dramatically from place to place and from time to time. The limitations of time consumption, complexity, and necessity of consultation are difficult—if not impossible—to overcome. In the real world of social work education and social work practice, students and practitioners need an approach to ethical decision-making that is easy to understand, is easy to apply, and that does not require consultation. However, the approach must not trade breadth for convenience: It must provide adequate breadth to cover situations social workers actually encounter.

An Extremely Brief Introduction to Ethical Thought

Ethical thinkers are often divided into two camps: teleologists, or relativists—who believe that what is right is determined by the consequences of the decision—and deontologists, or absolutists—who believe that what is right is not determined by consequences but that instead, certain actions are inherently right or wrong (Reamer, 1990). These two camps reflect the difference between ends and means or between outcome and process. The former argue that a decision is ethical if it produces a good result while the latter argue that a result cannot truly be good unless it is achieved through good processes.

The former view, teleology, is further divided into two major schools: egoism and utilitarianism. Egoism argues that people should pursue their own self-interests and that good will be accomplished when they do so. Utilitarianism argues that an action is right if it promotes the maximum good. Both egoism and utilitarianism are concerned with end results, but the former is concerned with end results for each individual while the latter is concerned with end results for as many individuals as possible.

Critique of Ethical Thought

Because they are philosophical systems, there is no external way to validate any of these approaches to ethical decision-making (Gödel, 1992), and each can be criticized on numerous grounds. The weaknesses in those systems are the motivation for the proposed model.

One weakness of the deontological approach appears when good principles lead to bad outcomes. For example, telling the truth can lead to great harm if individuals who have evil intent use that truth to find and kill innocent people. It seems hard to claim that one has acted ethically by reporting on the location of individuals who are hiding from a genocidal regime. We somehow want our ethical principles to lead to desired outcomes, and when they don't, we intuitively question the principles.

Another weakness of the deontological approach appears when two or more ethical principles conflict with each other, which is, by definition, an ethical dilemma. The presence of two or more ethical principles creates the possibility of dilemmas. A desire to behave in accordance with right principles cannot be fulfilled if two principles conflict with each other. If both principles are right, and one must choose one or the other, one cannot behave ethically because ethical behavior has already been defined as behavior that is consistent with the conflicting principles. This problem can be addressed, (see, e.g., Reamer, 1990) by developing prioritized lists of ethical principles with the guidance to adhere to the principles in order of priority. Nevertheless, the more principles on the list, the greater the potential for conflict among them.

The teleological approach can appear to ignore principles and to allow any process that leads to good outcomes. From a teleological perspective, individual actions are justified if they produce desired results for the individual, and group actions are justified if they produce desired results for the majority. The teleological perspective would support stealing to feed the hungry, lying to achieve personal gain, and subjugation of a minority to support economic advantages for the majority. This perspective tends to ignore rights of minorities, and it appears to hold that methods are justified by their results.

Neither perspective addresses the fundamental question about what constitutes good, and it is in the effort to decide what is good that we need guidance. Ironically, or perhaps it is a paradox, attempting to define what is good appears similar to the challenge in deontology of deciding what the universal principles are. How, then, should we proceed?

A New Model

I propose an approach to ethical decision-making that attempts to reduce choices to a set that is necessary and sufficient. In its simplest form, this approach has three values and one principle. It can therefore be easily taught, easily understood, and easily used.

Consistent with Reamer (1999) and with Loewenberg, Dolgoff, and Harrington (2000), it appears that prioritizing values or ethical principles can help resolve ethical dilemmas. Because an ethical dilemma is, by definition, a conflict between two or more values or principles, it follows that the fewer values and principles there are, the lower the possibility of an ethical dilemma.

I propose that a small set of elements constitutes the context in which ethical decisions are made. These three elements are life, choice, and relationship. Only the living can make ethical decisions, so life is a necessary part of the context. Ethical decisions involve choices about behaviors in relationships with other people. Therefore, choice and relationship are also essential elements of the context. Together, life, choice, and relationship form the context in which an ethical decision is made, and they therefore provide the values necessary for an ethical decision. While it is tempting to arrange these three elements in hierarchical order, I propose that doing so is artificial, unnecessary, and counterproductive. Further, since all three are necessary for ethical decision-making, elimination of anyone removes the possibility of an ethical decision.

Some authors (e.g., Reamer, 1990) propose that ethical principles must be hierarchically organized, but I reject that argument on the grounds that all three elements I have proposed are necessary for an ethical dilemma to exist and that arranging them hierarchically introduces as many problems as it solves. For example, asserting that life is the most important provides no guidance when one must choose between lives, and it would allow third parties to make life-or-death choices for others. I submit that these three contextual elements constitute the heart of ethical dilemmas and that only by treating all three as necessary and equal parts of the context can we develop a system to guide us.

According to Festinger (1957), when an individual holds two inconsistent beliefs, psychological discomfort results. The discomfort is in proportion to the strength of the beliefs. Individuals seek to reduce the discomfort by changing one of the beliefs. I concur with Festinger that the inconsistent beliefs that constitute an ethical dilemma produce discomfort, but I submit that an additional element contributes to the distress, and that is the belief that the dilemma can be

resolved. Technically, the dilemma can be resolved by changing one of the beliefs that produces the dilemma but attempting to change a belief that one's social group considers to be right produces its own cognitive dissonance. Attempting to resolve an ethical dilemma by prioritizing one value over another is ineffective because although doing so may reduce the distress—in effect by changing the intensity with which one holds a belief and thereby by reducing the dissonance—it does not eliminate the dissonance because the two beliefs remain inconsistent. Our belief that unresolvable conflicts can be resolved contributes to our distress, and unless one of the ethical principles that creates the dilemma can be changed, the best we can do is to accept that the dilemma is unresolvable. By giving each principle equal weight and accepting that the conflict cannot be resolved, we can reduce the distress. We must learn to accept that there is no resolution to a genuine dilemma. Because all three contextual elements are essential, any situation that requires one to be sacrificed for another cannot be ethically resolved. Therefore, when an ethical dilemma exists, the best one can do is to maximize all three elements of the context, and this is the one overriding ethical principle in the proposed model. And this leads to the crux of the ethical system I propose: No individual may ethically violate the context. Context, as stated, includes life, choice, and relationship. For one to make decisions regarding the life, choice, or relationship of another violates the ethical context.

Before explaining, some definitions may be helpful. Maximizing means to maintain as much as possible without compromising any of the three elements. To maximize life means to support life and its processes. To maximize choice means to acknowledge available options and to allow free selection from among them. To maximize relationship means to communicate in ways that promote continued communication. Relationship is the voluntary interaction between two individuals. It includes the spoken and unspoken rules about that interaction. Relationship is part of context because the ethical dimensions of choices that exist outside of relationships are immaterial. For example, if I had no living relatives, no friends, and lived off the land in the great north woods, how much I ate, drank, cursed, and engaged in autoeroticism would be of little consequence. I am proposing that choices independent of relationships do not contain an ethical component.

Now it is necessary to explain how choices may be ethically made. The nature of the relationship determines what is ethical, and the nature of the relationship may be properly determined only by open, voluntary negotiation. This open, voluntary, negotiation requires truth-telling, not as its own value or ethical principle but as a necessary ingredient for free choice to be exercised. Choices made without knowledge of truth cannot be free, and choices that are not free can hardly be called choices. Openness involves honest disclosure of information, thoughts, and feelings about the issue at hand. Voluntariness involves the capacity to give or withhold consent for participation in the relationship and in the negotiation.

Individuals may voluntarily enter into unequal relationships. When they do, the person who has greater power must accept greater responsibility for maintaining the context: life, choice, and relationship. This is the situation for professional social workers. Because the professional relationship is inherently unequal, the social worker has greater responsibility to assure that the life, the choice, and the relationship with the other are maintained. Having said that, it is also important to say that the social worker does not give up the right to life, choice, and relationship. A social worker who determines that her life, choice, or relationship is unreasonably compromised in relationship with a client may properly renegotiate the relationship, and if necessary, end the relationship, after appropriate but unsuccessful good-faith negotiations. The contextual element of choice would require the social worker in that situation to maximize the choices of the client by exploring alternatives for service and by facilitating appropriate referrals.

Summary

In summary then, are the following elements of the proposed ethical system.

- Life, choice, and relationship are contextual elements in which ethical decisions are made.
- Any situation that requires one element of the context to be sacrificed for another cannot be ethically resolved.
- The best possible solution to a conflict among the contextual elements is to maximize each element.
- No individual may ethically violate the context of another.
- The nature of a relationship determines what is ethical within that relationship.
- The nature of the relationship may only be properly determined by open, voluntary negotiation.

Application

Social workers can use the proposed system in daily practice. As they enter into helping relationships, they can openly negotiate the terms of those relationships and maximize the choices of both parties. As the encounter dilemmas, they can identify the elements of life, choice, and relationships that interact to produce the dilemmas. After they recognize the elements creating the dilemma, they can decide how to maximize each element. They can also teach the model to clients who encounter ethical dilemmas of their own.

Social contract theory (Rousseau, 1762) provides the necessary guidance to apply the above system on a larger scale. Social contract theory holds that participation in society requires the sacrifice of some individual freedoms if society is to function. The society as a whole can appropriately and ethically develop processes to respond to the problems that arise when individuals behave unethically, i.e., violate the context of another. Through democratic processes, members of society can establish laws that balance the interests of individuals with each other and between individuals and the society. They can establish courts to interpret and apply the laws, and they can create justice systems to enforce the laws as they are interpreted by the courts. By maximizing life, choice, and relationships, legislatures and courts can promote a more ethical society.

An example may be useful to illustrate application of the approach.

Linda works in a community mental health agency. Juan, who is 16 years old, is one of her clients. Juan's mother, Carmen, brought him to the center with concerns about his moodiness, which Linda has described as anger and depression. Linda is also concerned about Juan's risky behaviors such as alcohol and marijuana use and associating with other teens who carry weapons and commit crimes such as armed robbery. Linda views herself as caught in an ethical dilemma among her duty to protect Juan, her responsibility to fulfill her commitment to Carmen to address his anger and depression, and her obligation to maintain Juan's confidentiality.

The proposed model identifies three elements that are relevant to the situation—the potential threat to Juan's life if he continues dangerous behaviors, the nature of her relationships with Juan and with Carmen, and the right each person has to make informed choices. Use of the model would require Linda to discuss these factors with Juan and with Carmen. Through

discussion, each individual would clarify the nature of their relationships, and each would clarify the choices that each one has in the current situation. Juan would understand that Linda has a duty both to him and to his mother, and Carmen would understand that Linda has a duty both to her and to Juan. Linda would have the opportunity to clarify Juan's and Carmen's expectations for confidentiality and for protecting Juan from potential dangers. Through these discussions, each person would gain additional information about the elements that create the context, and each would have the opportunity to make informed choices about how to continue. Without the discussion, none of the participants can make an adequately informed choice, which would violate the proposed model. The choices that each individual might make are limitless, but for the sake of continuing the illustration, consider that Juan might decide that he does not want treatment if there is any possibility that his mother will find out about his risky behaviors, Carmen might decide that Linda's primary duty is to help her parent Juan, and Linda might decide that she cannot adequately fulfill the expectations that both Juan and Carmen have for the professional relationship. The dilemma would then be clear, and she might decide either not to continue treatment because she cannot accept the terms of the relationship or she might decide to negotiate with Carmen and with Juan to find acceptable terms. Either outcome is consistent with the model, i.e., either outcome maximizes life, choice, and relationship.

Conclusion

Because ethical questions are philosophical questions, there can be no ultimate answers. Although the proposed model has weaknesses inherent in any philosophical system, it offers some advantages over other systems. By reducing the number of values to three, it reduces the opportunity for conflicting values. If the argument that these three constitute the context in which ethical decisions are made, they are necessary and sufficient. By reducing the number of values that must be considered to the smallest possible number, it brings clarity to situations that are less clear when attempting to manage larger numbers of conflicting values. By reducing the number of values to three and the guiding principle to one, it reduces the amount of information that must be recalled implementing the decision-making model. And because of its simplicity, it is easier to teach and to use than those models that incorporate more elements.

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