

## An Editorial Comment: A Question to Clinical Social Workers About 9/11

I had a conversation with a social worker from Oklahoma City between 1996 and before September 11, 2001. We discussed the April 19, 1995, truck bomb that exploded at the Federal Building in Oklahoma City, killing 168 people, injuring more than 700 people, and causing structural damage to 25 buildings. The focus of our discussion was on the impact of the news media. A hypothesis was developed: the constant barrage of media interviews inhibit an individual's ability to recover from the trauma. The media (mostly news reporters) will not allow the subject to rest.

With both my parents dead, I don't have reporters coming to me on a weekly basis asking me how I feel about it. I have been able to go on with my life. Oklahoma and Twin Towers victims are not permitted to grieve in peace. It gets worse for the Twin Tower victims. One can purchase commemorative plates, rings, and statues symbolizing the remembrance of the tragedy. One can purchase jewelry made from the wreckage. If the victims get a piece of the proceeds from the commercialization, are they emotionally helped or hurt?

Victims of such major traumatic events are afforded *no* respite. Their lives seem to require them to constantly reflect on the tragedy. They are *not afforded* an opportunity to "let go."

I watched both my parents die of cancer. It was a terrible experience, but I have recovered. Occasionally, I think of my parents and feel sad, but I am able to move on. I can do this in peace. I wonder how I could continue my life, if someone was

constantly reminding me (and I don't need reminding) that my parents are dead? "Well, your parents are now dead, how do you feel about that, Steve?" I don't think that I could cope with the constant barrage of questions and commercialization of my experience.

I am interested in sharing your vision with subscribers of *The Journal of Social Work Values and Ethics*. If you are interested in sharing your opinion, complete my 4-item questionnaire which can be found at: <https://www.surveymonkey.com/s/LJWJROD>

Thanks!

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Editor

# Guidelines for Practitioners: A Social Work Perspective on Discharging the Duty to Protect

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## Abstract

In situations in which a client is deemed to present a serious risk of violence to another, a responsibility arises for the counselor to use reasonable care to shield the anticipated victim from such danger. Guidelines are provided to assist social workers in ethical practice in “duty to protect” situations while avoiding malpractice.

Keywords: duty to protect, social work, ethical mental health practice, ethical dilemma, client danger to third parties

## 1. Introduction

The Tarasoff doctrine directs that when the therapist determines, or ought to determine, that the client presents a serious danger of violence to a third party, an obligation arises “to exercise reasonable care to protect the foreseeable victim from that danger” (Tarasoff v. Regents of the University of

California 345, 1976). When a *duty to protect* issue arises in practice, social workers may experience ambivalence and uncertainty with respect to the need to reconcile and integrate the professional ethics of confidentiality and legal mandates of the duty to protect. This article reviews a brief history of the Tarasoff decision. The Tarasoff duty to protect standard and the ensuing uncertainty about the standard’s meaning and application based on inconsistent court opinions will be explored. Social workers’ ethical obligations are addressed as they relate to the duty to protect standard. Finally, guidelines are set forth to assist social workers in ethical practice in duty to protect situations while avoiding malpractice. Typically, in the mental health arena, the duty to protect issue arises either in a hospital/clinic setting or a clinician’s office. This article addresses duty to protect issues that arise in mental health treatment in a clinician’s office. Duty

to protect issues related to clients with communicable diseases, such as HIV or AIDS, or with genetic conditions, are not addressed.

## **2. The Tarasoff Case**

In autumn 1968, Prosenjit Poddar became acquainted with Tatiana Tarasoff at the University of California (Herbert, 2002), and initiated romantic overtures as he believed she was his intended. Poddar asked for Tarasoff's hand in marriage, and Tarasoff rejected the proposal. Fuming, Poddar returned home to his roommate and expressed a desire to kill Tarasoff (Tarasoff v. Regents of the University of California 1974).

Tarasoff left for Brazil in the summer of 1969. After her departure and upon a friend's suggestion, Poddar accessed mental health counseling and assistance through the University. In late summer 1969, Poddar was engaged in counseling with a psychologist, Dr. Lawrence Moore. Poddar revealed to Moore that he planned to murder a girl when she returned from Brazil (Herbert, 2002).

The psychologist sent a letter to the campus police chief and relayed his concern that Poddar had significant mental health problems and posed a danger. Subsequently, Poddar was picked up by campus police. However, the campus police became convinced that he was lucid and no longer a danger to Tarasoff. The officers obtained Poddar's assurance that he would maintain physical distance from Tatiana, and subsequently released him from custody (Tarasoff v. Regents of the University of California 1974).

Poddar stopped seeing Dr. Moore. In late October 1969, Poddar traveled to Tarasoff's home, stabbed her to death, and then called the police to report the killing. Poddar was arrested. Tarasoff's parents brought suit and named the university health service and the campus police as defendants. The consequent court decision on this legal action resulted in what is recognized as the Tarasoff standard (Tarasoff v. Regents of the University of California 1976).

## **3. The Tarasoff Standard and Confusion that Followed**

The standard is best articulated by the Tarasoff court.

When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. In sum, the therapist owes a legal duty not only to his patient, but also to his patient's would-be victim (Tarasoff v. Regents of the University of California 345, 1976).

Confusion arises in a number of areas. One area of uncertainty stems from the fact that there were two Tarasoff court rulings. Succinctly stated, in the first Tarasoff ruling, in 1974, the California Supreme Court stated that therapists have a duty to warn prospective victims (Tarasoff v. Regents of the University of California, 1974). A later court decision and what is often called the Tarasoff II ruling, issued by the California Supreme Court, instructs that therapists have a duty to protect prospective victims

(Tarasoff v. Regents of the University of California, 1976). Thus, the legal standard in Tarasoff II moves beyond a counselor's duty to warn to encompass and mandate a duty to protect third parties if the client presents a serious, foreseeable danger of violence to another (Kagel & Kopels, 1994).

Court decisions that followed Tarasoff II were perplexing because of their inconsistency and unpredictability (Kachigian & Felthous, 2004). For instance, in Davis v. Lhim (1983), a patient released from a state hospital subsequently shot and killed his mother. Although there was no past record of violence, the plaintiff's expert witness described him as likely to engage in violence. The plaintiff's sole piece of tangible proof was a notation made in a hospital record documenting that the patient had made threats toward his mother. This documentation occurred two years prior to the mother's death (Kermani & Drob, 1987). The court reasoned that if the treating psychiatrist had reviewed past records, the patient's mother could have been identified as a foreseeable victim. The court adopted the Tarasoff reasoning and held that a psychiatrist owes a duty of reasonable care to a person who is foreseeably endangered by his patient. The court found the psychiatrist negligent for not reviewing a previous record on the patient. This decision in Davis v. Lhim (1983) was later reversed in Canon v. Thumudo (1988) on other grounds, specifically, with reasoning by the Michigan Supreme Court that the psychiatrist's determination that the patient should not be involuntarily hospitalized fell within a scope of immunity from tort liability (p. 698).

In the pursuit of professional clarity and the hope for judicial predictability, protective

disclosure statutes (legislation that attempted to define Tarasoff's duty to protect standard) were passed in 23 states by 2004 (Kachigian & Felthous, 2004). Research reflects that state courts have taken diverse approaches in interpreting their respective protective disclosure statutes, and that only in a few cases did courts construe the statutes to limit the duties owed to third parties (p. 272). Some indicate that there has been a discernable trend to limit the scope of the clinician's Tarasoff II duty to protect in both court cases and through the use of protective disclosure state statutes, which explicitly codify both the duty and how to discharge the duty (Walcott, Cerundolo, & Beck, 2001).

Conversely, some jurisdictions do not mandate a duty to protect. For instance, Florida's statute is permissive and indicates that a confidential communication between the licensed or certified mental health worker and the patient or client is confidential, and *may* be waived, when "there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society..." and the licensed professional communicates the information "only to the potential victim, appropriate family member, or ...other appropriate authorities" (Fla. Ann. Stat. 491.0147, 1991). Florida's Court of Appeal in Green v. Ross (1997) held that the permissive language of this statute did not create an affirmative duty to warn, and as a result, no cause of action for failure to warn could be brought against a mental health worker. In so holding, the court relied upon a prior Florida appellate decision, Boynton v. Burglass (1991), which affirmed the dismissal of a plaintiff's complaint for failure to state a cause of action against a psychiatrist under an alleged duty to warn.

The appellate court in Boynton v. Burglass, along with other factors, construed the language of Fla. Stat. 455.2415 (pertaining to psychiatrists) to be permissive in that psychiatrists “may disclose patient communications....” Consequently, no duty to warn arose on which to base a cause of action against the psychiatrist. Thus, the Florida statute permits but does not require breaching of confidentiality to protect a third party from harm.

The Texas Health and Safety Code language on duty to warn is similar to the Florida statute as the language is permissive allowing professional disclosure of confidential information to warn a third party of a patient’s danger to them (611.004). Similarly, Texas courts have declined to construe a duty to warn from their permissive statutory language that a professional “may disclose confidential information...” (Thapar v. Zezulka, 1999; 611.004). Accordingly, in a minority of jurisdictions, there is no affirmative duty to warn or protect, and the disclosure to protect a third party is permissive.

Additionally, social workers should be aware of whether a shield law exists in their jurisdiction that protects the professional, good-faith discloser from liability. For instance, in Texas, the permissive disclosure statute does not shield mental health professionals from civil liability for good faith disclosures when threats are made by a client against another (Barbee, Combs, Ekleberry, & Villalobos, 2007). For this reason, among others, Texas courts have declined to mandate a duty to protect, since no protection from civil liability is provided to mental health professionals when breaching confidentiality under duty to protect circumstances (p. 21).

Because of these differences in state law, clinicians are well-advised to be knowledgeable about the relevant statutes and case law in their states (Kachigian & Felthous, 2004). Additionally, the advice and counsel of a local attorney who is familiar with the relevant duty to protect law is helpful and necessary in providing a full contextual understanding of the law in one’s jurisdiction.

#### **4. Social Work Confidentiality and Duty to Protect**

Social workers are held to a “constellation of core values” (National Association of Social Workers [NASW], 2008, preamble). These core values are service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. Inherent in these core values is confidentiality for the client. The Code assists in the ethical practice of social work by providing “broad ethical principles that reflect the profession’s core values and establish a set of specific ethical standards that should be used to help guide ethical practice” (NASW, purpose).

Pursuant to the duty to protect, confidentiality must sometimes be breached to protect third parties. Support for the obligation to comply with specific legal obligations which on limited occasions surpass the client’s primary interest is found in the Code (NASW, 2008). Clients’ interests are most important when considering an ethical dilemma. However, in limited circumstances, the duty to the client may be superseded by specific legal obligations and clients should be so advised (Privacy & Confidentiality).

The Code instructs that respect and promotion of self-determination of clients is primary, while noting that social workers may limit this right to self-determination “when, in the social workers’ professional judgment, clients’ actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others” (Sec. 1.02). Specifically, the Privacy and Confidentiality section of the Code, under ethical responsibilities to clients indicates that

Social workers should protect the confidentiality of all information obtained in the course of the professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person (Sec. 1.07c). ...Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent (1.07d). ...Social workers should discuss with clients... the nature of confidentiality and limitations of clients’ right to confidentiality... [and explain] where disclosure of confidential information may be legally required ... (1.07e).

Significantly, social workers are allowed to breach client confidentiality in order to

comply with laws, court orders, or to prevent serious, foreseeable, and imminent harm to an identifiable third person pursuant to the NASW Code of Ethics. In addition to the serious threat of danger made by the client, most states now require the third party be identifiable, before the therapist can be said to have a duty to this victim. This is consistent with the language in the NASW Code of Ethics.

To breathe life into social work’s ethical code, Dabby, Faisal, Holliman, Karliner, Pearl, & Silverman (2008) review the literature that supports ethics as activity or discourse. These authors cite Goldstein (1998) who sees ethical social work practice as an art and “...like any art, ethical and moral understanding is best learned through the experience of human relationships and its many variations” (p. 242-243). The authors encourage social workers to see themselves as artists who “create with clients, colleagues, environments, and experiences,” and that this view is perhaps more empowering than one of implementers of policy and codes (Dabby, Faisal, Holliman, Karliner, Pearl & Silverman, 2008). This perspective assists in expanding the vision of ethical practice in duty to protect situations.

## **5. Need for Guidelines**

Trends show an increase in the number of lawsuits filed against social workers in the past 25 years (Surface, 2005). Certainly, the fact that a lawsuit is filed does not mean that the complaining party prevails, or that the case ever comes to trial. It behooves social workers to be aware and knowledgeable about their liability exposure from third parties as a result of the Tarasoff II duty to protect. Social workers may find

themselves in a dilemma balancing the duty to protect third parties with the ethical duty of confidentiality in order to maintain trust and therapeutic relationships with clients (Zavez, 2005). Research from a related profession is instructive. Pabian, Welfel, and Beebe (2009) polled 1,000 psychologists, receiving 300 usable responses, on their knowledge of Tarasoff laws in their states. This research found that most psychologists (76.4%) had misunderstandings about their respective state's laws, believing that a legal duty to warn arose when it did not, or believing that a warning was their only legal recourse when other protective options less detrimental to client privacy were permissible.

The varying state law on the duty to protect, the potential legal exposure, and the need for professional clarity in duty to protect situations suggest the need for guidelines to assist social workers in ethical practice.

## **6. Guidelines for Ethical Practice**

It is important for social work practitioners to understand that in order for a plaintiff to prevail in court when a lawsuit based on negligence is filed against a mental health professional, the plaintiff must show a duty, a breach of duty, that the breach caused an injury, and damages resulted (Fulero, 1988) from the injury. The breach of a *Tarasoff* duty will be judged by "the standard of the reasonable professional in the community under the circumstances" (p. 186).

The duty to protect has been defined by Parry and Drogin (2007) as the "duty of a therapist or mental health facility to take affirmative steps to prevent an overtly dangerous patient from harming a third

party" (p. 438). Reamer (2006) indicates certain conditions should be satisfied before confidential information is used to protect another. The social worker should have evidence that 1) the client poses a threat of violence to a third person; 2) significant risk exists that the violence will occur; 3) the violent act is imminent or likely to occur in the near future; and, 4) the potential victim is identifiable. However, as to the last condition, some jurisdictions differ on whether the victim must be identifiable.

The four conditions provide a general overview of when the duty to protect is triggered, and confidential information can be used to protect a third party. To provide more specificity for social workers seeking to protect their clients, themselves, and discharge the duty to potential third parties, guidelines are set forth to assist in this process. Previous work in this area by Costa and Altekruze (1994) resulted in guidelines for counselors regarding the duty to protect. With the author's permission, these guidelines have been researched, added to, expanded, updated, and tailored for social workers. The following guidelines should be considered within a deeply contextual understanding of the client and the client's treatment needs.

### **6.2. Guidelines for Social Workers in Discharging the Duty to Protect**

1. Become and stay knowledgeable in the state and federal statutory and case law related to duty to protect in your jurisdiction. Becoming knowledgeable in the pertinent jurisdictional law is vital since the law varies by state and is continually evolving. Thus, it is imperative to know what the law is in the jurisdiction in which practice occurs. For instance, some jurisdictions differ on

whether the potential victim must be identifiable before a duty is triggered. In a minority of jurisdictions, there is no affirmative duty to warn or protect, and a disclosure to protect a third party by the social worker is permissive. For instance, some authors in the counseling field assert that there is a legitimate case to be made in Texas that mental health professionals should not violate confidentiality under any circumstances to protect another, unless it falls under the mandatory child abuse or positive HIV reporting law (Barbee, Combs, Ekleberry & Villalobos, 2007). An alternative social work viewpoint considers the client's interests and those of third parties who may be injured or killed - in conjunction with the NASW Code of Ethics' values and ethical standards. In addition to state law and legal counsel, the NASW Code of Ethics provides direction on reconciling ethical dilemmas, and clinical consultation provides support and assistance in making necessary, ethical decisions.

Thus, knowing the specific legal mandates will be critical in determining what action, if any, is required. The onus is on the social worker to stay knowledgeable in the current and relevant jurisdictional law with respect to duty to protect (Chaimowitz, Glancy & Blackburn, 2000).

2. Plan ahead through consultation and supervision using your knowledge of duty to protect law in your jurisdiction. Seek the input of colleagues, retained attorneys, and other professionals who have expertise in strategizing and dealing with the protection of clients, potential 3rd parties who may be or are in danger, and oneself, as a professional social worker. Seek out guidelines and standards implemented from the jurisdiction of practice regarding duty to

protect, and the advice of local counsel familiar with the duty to protect law in the particular jurisdiction. Independent practitioners may join together to retain an attorney for such consultation prior to an actual duty to protect dilemma arising.

3. Develop a protocol, using the consultations noted above, that outlines how you will proceed if the client threatens to harm someone. Maintain an up-to-date understanding of managing violent patients (Roth, 1987), and include this in the protocol. Use the protocol developed to be able to identify issues, options, and needed information when urgent decisions must be made (Isaacs, 1997).

4. Acquire and review past treatment records. This is an important clinical practice, and one that can provide protection to the client and social worker.

5. Practice within your areas of expertise, and select clients carefully. Determine which presenting problems are best referred to another practitioner, and how you will make these decisions in your practice.

6. Obtain informed consent in writing before initiating the treatment process and explain exceptions to confidentiality, in writing and verbally. Informed consent is the legal standard for medical and other related treatments that requires a patient's decisions to be "competent, voluntary, and knowledgeable" (Parry & Drogin, ABA, 2007). Thus, the consent form should state what the client is consenting to, that the client has asked questions about anything they do not understand, that the client understands the scope of consent, and that the client is making a competent and knowledgeable decision in signing the consent form.

7. Obtain professional liability insurance. Seek and carry sufficient professional insurance. Verify and understand what is and is not covered in the liability insurance policy to be an informed consumer.

8. Access appropriate consultation (Fulero, S.M., 1988) when the duty to protect is triggered. The consultation must include clinical issues (Walcott, Cerundolo, & Beck, 2001) and should incorporate Appelbaum's (1985) suggested three step procedure of assessment of danger, formulating a treatment plan, and ensuring the treatment plan is implemented.

First, assess dangerousness as accurately as possible which involves such considerations such as past threats of violence, a past history of violent behavior, current threats to harm others, accessibility of weapons, relationship with the intended victim, membership in a group that condones violence, and lack of adherence to treatment. (Steinberg, Duggal, & Ogrodniczuk, 2008). The counselor must remain up-to-date with current, effective practices in assessing dangerousness (Simon, 1987; Harris & Rice, 1997).

Second, formulate an individualized treatment plan which involves determining which options are appropriate for the client and situation. Part of the treatment plan is determining whether the patient should be hospitalized as a danger to others. This can be done voluntarily by the client, or involuntarily through the court system. By initiating civil commitment proceedings (involuntary hospitalization) the burden of decision-making is shifted to the court (Mills, Sullivan, & Eth, 1987). Some in psychiatry believe, "It is difficult if not impossible to envision a clinically realistic

situation requiring a warning in which involuntary commitment is not also called for, as the levels of danger that are conditions for the two actions are indistinguishable" (Gutheil, 1995). However, one study showed that about half of the clients were hospitalized after the Tarasoff II notification for protection occurred (McNiel, Binder & Forrest, 1998). These findings suggest that a different interpretation was made by clinicians for civil commitment and for a Tarasoff II duty to protect third parties (p. 1100). This California study also suggests that of the clients who made threats that resulted in notification, half had records of arrest and of these "31% (N=70) had arrests for violent crimes and 21% (N=49) for drug-related offenses" (p.1098, para 9). Mental health courts that exist in some jurisdictions may be an option (Lamb & Weinberger, 2008). Others options include assuring that a psychiatrist reviews current medication or prescribes any needed medication for the patient since changing medications, beginning medications, or increasing the dosage may be appropriate. Additionally, the frequency of appointments may be increased, and the client referred to a structured program. (Steinberg, Duggal, & Ogrodniczuk, 2008).

The treatment plan should include warning the intended victim and/or his relatives. It may include warning friends or others likely to apprise the victim of the danger. Notify the police, and take whatever steps are reasonably necessary. Again, the need to be knowledgeable about jurisdictional law and consult with legal counsel is critical. For instance, in Texas, the professional *may* disclose confidential information to medical or law enforcement personnel if the professional determines there is a probability of imminent physical injury by

the patient to others (Tex. Health & Safety Code Sec. 611.004, 2009). There is no authorization in this Texas statute to disclose confidential information to the victim or the victim's family.

The preceding is not meant to be an exhaustive listing of individualized treatment options. Each client and client situation must be individually considered within the context of best treatment practices, the NASW Code of Ethics and jurisdictional law.

Third, ensure the client treatment plan is implemented (Steinberg, Duggal, & Ogrodniczuk, 2008). It may be necessary for the social worker to take multiple actions quickly.

9. Engage the client in the needed protective action when possible. This is actually a part of formulating the treatment plan; however, it warrants singular attention due to its importance. When it is apparent to the counselor that harm is imminent to a third party, a duty to protect becomes imperative. (Presuming the jurisdictional law mandates a duty to protect.) Explain this duty and involve the client in the process of protecting the third party when appropriate. A strengths-based approach may be useful when engaging the client (Rapp, 1998). Consider warning with the client present (Walcott, Cerundolo, & Beck, 2001). Avoid surprising clients with third party warnings when possible. Some suggest involving the client in the notification process which may have a therapeutic effect for the client, and on the therapeutic relationship (Walcott, Cerundolo, & Beck, 2001 citing Wulsin, Bursztain, & Gutheil, 1983). At least one group of psychotherapists assert that having the client

provide the Tarasoff protective warning is the best alternative option (Ginsberg, 2004 citing Wulsin, Bursztain, & Gutheil, 1983). In such a situation, the social worker should be present with the client, for instance, in a conference call during the actual notification. However, remember that the social worker's duty to warn the third party is paramount and should occur whether the client assists or not. In addition, "obtaining the permission of the client (written or taped) to warn the intended victim removes any violation of confidentiality" (Fulero, 1988).

10. Discharge the duty to protect by implementing the protocol with contemporaneous consultation and legal advice. Since each client situation is different, the protocol will need to be individualized to each client and the threatened third party in conformity with the jurisdictional law. Inform your supervisor, attorney, law enforcement, and the intended victim or others who may need to protect the intended victim.

11. Document thoroughly (Fulero, 1988) all the information conveyed to a client about the clinician's duty to warn a foreseeable third party about harm or violence directed towards them. Document a mental status exam, verbatim statements and behavior of the client from which you determine the client is a threat to a third party. Explain clinical choices in writing, and why one option was chosen over another. Document related consultations and professional actions to protect your client and the third party. Document in a timely fashion, and avoid over-documentation in crisis situations. Also, avoid anticipatory documentation, which is documenting what the social worker anticipates will occur, as this negatively

impacts professional credibility in the event of legal action. Proper and thorough documentation serves as protection from liability. If a case is litigated, courts will review whether the social worker acted reasonably and took proper actions to prevent harm.

Thorough records are critical to document that the therapist understood the nature of the situation and that reasonable steps were taken in light of the facts. Consultation provides evidence of professional consensus about the action taken. A therapist is not liable for a negative outcome unless his or her actions fall below the expected standard of care (p. 186).

12. Be self-aware and use self care. A social worker may hesitate to seek legal advice or inform third parties. As a result, the professional may be erroneously concerned about breaching client confidentiality if not knowledgeable about the limits of confidentiality. Additionally, the professional may inflexibly and incorrectly place a higher priority on client confidentiality than on a third party's need for protection. A helping professional may utilize what Racker (1968) has characterized as a manic defense, feeling they can and should manage the threatening client on their own without outside help or guidance (Steinberg, Duggal, & Ogrodiczuk, 2008). The professional may become so preoccupied by the threats of harm to a third party that the client's treatment suffers. Practical and counter-transference ramifications of the threat must be dealt with if the client and social worker are to maintain a treatment relationship (p.17).

The above guidelines provide a basic structure and strategy in preparing for and resolving the duty to protect dilemma (Costa & Altekruze, 1994). Notable for social workers, is the advice of Steinberg, Duggal & Ogrodiczuk (2008) that

the anxiety, financial cost, and potential guilt and grief involved in not appropriately seeking legal advice when a threat is followed by a physical attack or even murder exceed out of all proportion whatever discomfort and cost may be incurred by seeking legal advice and appropriately informing third parties (p.15).

## 7. Conclusion

The Tarasoff doctrine instructs that when a therapist determines, or pursuant to professional standards ought to determine, that the client presents a serious risk of violence to another, the therapist "incurs an obligation to use reasonable care to protect the intended victim against such danger". The Tarasoff doctrine known as the duty to protect standard, and its interpretation has caused practitioners uncertainty about the standard's meaning and application. The challenges have been complicated by varying court decisions and statutes in different jurisdictions. The language and obligations set forth by the NASW Code of Ethics provide a duty to protect exception to the imperative of confidentiality. Guidelines are offered to assist social workers in ethical practice in duty to protect situations. Some key suggestions are to understand the jurisdictional law, plan ahead through legal consultation, develop a protocol, limit practice to areas of expertise, be selective about clients, acquire and

review past records, obtain the client's informed consent, obtain professional liability insurance, involve the client in the decision to protect when possible, discharge the duty to protect by implementing the protocol developed, document, and be self-aware. Maintaining a current understanding of the law is critical as the law is ever evolving. Discharging the duty to protect can be a life altering decision for the client and an intended victim; accordingly, informed preparation, appropriate guidance and consultation, critical thinking, and ethical action are paramount.

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# Conscientious Objection in Social Work: Rights vs. Responsibilities

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## Abstract

This paper reports on a national study that explored the complexity surrounding ethical conflicts related to conscientious objection in social work. Specific focus was on the extent to which practitioners have a right to remove themselves from professional services and situations that conflict with a religious or moral worldview.

Key Words: Conscientious objection, value conflicts, duty to treat, Code of Ethics, health care legislation

## 1. Introduction

A hallmark of a true profession is the presence of a code of ethics (Greenwood, 1957; Reamer, 2006; Wilensky, 1964). Although social work has several codes of ethics, the code most subscribed to, and that contains the most comprehensive statement of ethical standards, is the National Association of Social Worker's (NASW) Code of Ethics (Reamer, 2006). The NASW code sets out guidelines and responsibilities that consolidate the values and ethical behavior underlying the profession. In some ways, the code provides specificity with regard to ethical conduct; in other ways, the code has been deemed too broad

(Loewenberg, 1988).

In recent years, a number of professions have modified their codes to address specific emergent ethical and legal issues. One area that has resulted in code changes for a number of health-related professions relates to conscientious objection (CO) and the rights of professionals to opt out of 'duty to treat' obligations as a result of conflicts with religious or moral convictions (Anderson, Bishop, Darragh, Gray, & Poland, 2006).

This paper reports on a national study that explored the complexity surrounding ethical conflicts related to CO in social work. In general, research questions focused on the ethical obligations of social workers when faced with conflicts between personal and professional values, such as the extent to which practitioners have a right to remove themselves from professional services and situations that conflict with a religious or moral worldview. An Internet-based survey was used to reach a broad spectrum of social workers (n = 3300) across the United States.

## 2. Clarification of Terms

A conscience clause (also termed objector legislation, noncompliance clause,

opt-out clause, refusal clause, and/or religious exemption) is a policy statement or provision, typically related to health care, which exempts professionals from providing health-related services that are found to be personally, morally, or religiously objectionable. These provisions, drawn from philosophical, legal, and theological perspectives (Anderson, Bishop, Darragh, Gray, & Poland, 2006) may be expressed in a number of different ways-- for example, a physician who refuses to prescribe birth control to unmarried women, or a pharmacist who refuses to dispense ECPs (emergency contraceptive pills). The most familiar illustration of CO is refusal to perform military service on grounds of freedom of thought, conscience, or religion. CO has been extended to various health professions, allowing professionals to "opt out" of participating in health-related services that are found to be objectionable. For the purposes of this paper, the focus will be on the ethical dimensions surrounding CO in social work.

The definition of *social worker* has been the subject of considerable debate. For this study, the term *social worker* will be defined as a graduate of a social work education program at the bachelor's or master's degree level who uses his/her knowledge and skills to provide social services for clients (Gibelman & Sweifach, 2008). Although social workers share in common a belief in and commitment to the principles of the profession's *Code of Ethics*, personal beliefs are quite diverse. Some social workers are politically liberal, and others are conservative. Some are devoutly religious, and others are atheists. Nevertheless, adherence to the *Code of Ethics* should distinguish social workers from other professional groups in regard to compatible beliefs and actions between professional and personal behaviors (Gibelman & Sweifach, 2008).

Since the inception of the profession, social workers have clung religiously to professional values; "we seem to cling to them intuitively, out of faith, as a symbol of humanitarianism" (Vigilante, 1974). The profession's deep value-based roots serve as the foundation of the profession's mission, the relationships social workers have with clients and society, methods of interventions used, and for resolving ethical dilemmas (Reamer, 2006a). Some suggest that social workers are the defenders of social morality (Glasser, 1984). The NASW Code of Ethics, in addition to providing guidelines and responsibilities for ethical conduct, serves as the basis for the general public's expectations of professional conduct for social workers (Strom-Gottfried, 2003). The Council on Social Work Education mandates that every MSW and BSW program infuse values and ethics throughout the curriculum (Council on Social Work Education, 2004).

Commentators suggest that clashes between personal and professional values are inevitable (Reamer, 2006a). The conflict emanates from the clash between two or more values, each of which can be substantiated as morally correct and ethically grounded (Linzer, 1999; Mattison, 2000; Rokeach, 1973). Although social workers are admonished to limit the influence of personal values on professional practice, commentators suggest that for some social workers, especially those for whom their personal worldview is fundamentally religious or informed by a particular moral order, putting aside values regarded as immutable is an especially difficult challenge (Linzer, 1995; Spano & Koenig, 2008). Discrepant opinions permeate the literature with regard to the actions that professionals ought to take when personal and professional values collide. Some of the literature suggests that when conflicts between personal and professional values develop, social workers must suspend

their personal values. “To be a professional practitioner is to give up some of one’s autonomy and to relinquish some of one’s rights as a freely, functioning being” (Levy, 1976, p. 113). One writer suggests that “in conflicts between personal values and professional values, the professional is duty-bound to uphold professional values. Upholding professional values represents ethical action” (Linzer, 1999, p. 28). Pumphreys (1959) stated that new recruits to social work must accept the profession’s values before being considered bona fide professionals.

Other opinions within the literature suggest that there is not necessarily one set of values to which all social workers subscribe (Guy, 1985; Timms, 1983). Commentators explain that the application of any code of ethics’ provisions involves a certain degree of interpretation and judgment (Franklin, Harris, & Allen-Mearns, 2006). For example, the NASW Code of Ethics states that the social worker’s primary responsibility is to promote the well-being of clients. The National Association of Christian Social Workers (NACSW) endorses this principle, but emphasizes that loyalty owed to a client is secondary to harm to self or others (Ressler, 1997).

The literature explains that what is “best” for the client may be left to how “best” is translated by the worker. A social worker who believes that a fetus is a living being, may be compelled to act differently from a colleague who believes that life begins after birth (Loewenberg, 1988). The choice is not usually between one good option and one bad; each option typically contains both positive and negative attributes (Dolgoff, Loewenberg, & Harrington, 2008). Commentators suggest that at the most general level, there is most likely agreement on a common value base. However, when dealing with values on an

action or practical level, this unanimity fades (Loewenberg, 1988).

For centuries, ethicists and philosophers have struggled to establish guidelines for choosing among competing values (Reamer, 1982). Commentators have proposed models for resolving value conflicts and ethical dilemmas [see for example Levy’s (1976) ‘classification of values’; Mattison’s (1994) ‘framework to analyze ethical dilemmas’; and Dolgoff, Loewenberg, & Harrington’s (2008) ‘hierarchies of ethical principles’]. Many of these models are best used to analyze dilemmas when professional values conflict with other professional values. Few models focus on resolving conflicts between personal moral/religious worldviews, and the code of ethics (Spano & Koenig, 2007). Despite these guides, models, and ethical codes, practitioners continue to contend with dissonance when faced with a choice between two values, both of which can be substantiated as right and good.

In part, a profession is defined by its code of ethics. Professional codes of ethics are guidelines that reflect the moral ideals and values of a profession, as well as required attitudes and conduct. In general, professional codes of ethics are based on universal moral principles such as justice, autonomy, beneficence, veracity, fidelity, respect for persons, and nonmaleficence (avoiding harm).

### **3. Duty to Treat**

The ‘duty to treat’ is grounded in several moral principles. Its origins can be found in medicine’s Hippocratic Oath and other ethical writings. It obliges the professional to use skill and judgment to benefit the patient. The obligations are centered around principles of beneficence, nonmaleficence, and autonomy. Beneficence is expressed as the moral obligation to

promote the welfare, health, and wellbeing of others (Beauchamp & Childress, 2001; Schroeter, 2008). The principle asserts an obligation to help others further their unique interests. The principle of nonmaleficence requires that harm is not inflicted upon others; it derives from the maxim *primum nil nocere* (first do no harm). This principle asserts an obligation to consider the possible harm that an intervention might cause. The principle of autonomy derives from the Greek *autos* and *nomos*, meaning self-rule. The principle refers to the rights of an individual to be treated in accordance with his/her own decisions and goals. The principle asserts an obligation to support self-determination and the respect of personal preferences.

Although there are some philosophical differences among the various ethical codes of health professions, there is general theoretical consistency in how these principles are conceptualized. For example, the Code of Ethics for Nurses, which combines beneficence and nonmaleficence, articulates that the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient, including the right of competent patients to determine what will be done with their own bodies (ANA, 2001). For the American Pharmacists Association's (APhA) Code of Ethics, beneficence is quite pronounced; the code states that "a pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner." The principle of nonmaleficence requires that pharmacists refrain from acting in ways that could potentially harm or injure others and they "have a duty to maintain knowledge and abilities as new medication, devices, and technologies become available and health information advances" (APhA, 1994).

Although these standards of care are seemingly clear and self-evident, application

is highly interpretive. For example, the principle of nonmaleficence (do no harm), can be viewed in abortion cases as doing no harm to an unborn child. A clinician working with a gay client may interpret restorative therapy as a "beneficent" way of improving a client's wellbeing.

#### **4. Non Compliance Clauses**

The first conscience clause was the "Church Amendment" which was enacted shortly after *Roe v. Wade* in 1973 as a response to the supreme court's decision to legalize abortion. This amendment states that public officials may not require individuals or agencies that receive public funds to provide or assist in abortions or sterilization procedures if doing so is contrary to personal moral or religious beliefs. By 1978, almost every state had implemented some variant of conscience clause legislation (Feder, 2005).

#### **5. Methodology**

Drawing from the accumulating literature on CO in professions such as medicine, pharmacy, and nursing (e.g., Anderson, Bishop, Darragh, Gray, & Poland, 2006; Curlin, Lawrence, Chin, & Lantos, 2007; Wernow, 2008; Wilson, 2008), a survey instrument was constructed to examine perceptions and opinions of respondents about social workers who wish to "opt-out" of duty to treat obligations. Exempt status was received for conducting the research through the Albert Einstein School of Medicine's internal review board. The survey was developed using Survey Monkey, a web-based platform for conducting surveys. All responses were anonymous, and no method of tracking individual identity was utilized; as a result, informed consent was waived.

A database of social work administrators was created using staff directories from social work agency

websites. Each administrator was asked to forward a cover letter, soliciting participation, and a survey link to personnel at his/her agency. The cover letter invited respondents to forward the survey link to colleagues. This is a mechanism similar to convenience and snowball sampling (Babbie, 2001) or word-of-mouth communication, termed in the literature as the “pass-along” approach (Norman & Russell, 2006). In addition, a survey link was posted on an array of social work-based web pages (e.g., NASW, Facebook, social work blogs), inviting users to participate in the survey.

Prior to conducting the study, a draft survey was sent to a pilot group of social workers to evaluate the face and content validity of the instrument. The social workers were alumni at the University where the researchers work. Respondents taking the pilot test did not remain eligible to participate in the actual study. Suggested changes were incorporated into the final version of the survey.

Of the 3,300 surveys sent, 2,650 surveys were successfully delivered electronically; 650 bounced back as undeliverable. Of the successful transmissions, 923 of those surveyed returned completed useable questionnaires for an overall 35% response rate.

## **5.1 Instrument**

The questionnaire opened with a case revolving around a gay couple interested in adopting a child. At the center of the case was a social worker who was charged with conducting a home visit to assess adoption suitability. After realizing that the couple was gay, the social worker requested to be removed from the case, citing moral opposition. The first section of the questionnaire referred to the case and asked respondents their opinion about personal and professional value conflicts. The second section of the questionnaire

asked respondents to reflect on ethical or religious conflicts personally experienced within their own past practice experiences. The third section of the questionnaire asked respondents to identify their views on an array of contemporary ethical issues such as stem cell research, first trimester abortion, gender re-assignment surgery, contraception, and others. The fourth section of the survey asked respondents about their own personal religious practices, as well as their ideological and political views. The final section focused on general socio-demographic areas.

In addition to multiple choice and likert-scale response items, several open-ended questions were included to better understand how respondents feel about CO within social work. Analyses were conducted to compare demographic sub-groups in terms of their religiosity, age, income marital status, sexual orientation, gender, moral attitudes, and political orientation.

## **5.2 Data Analysis and Measures**

Data analysis was conducted using SPSS version 16.0. Means, standard deviations, frequencies, and percentages were used to generate descriptive results. A significance level of .05 was used for all inferential statistics. To establish the significance between variables, both nonparametric (chi squares) and parametric (t-tests, ANOVAs, and Pearson product moment correlation coefficients) tests were conducted. Several indices were constructed from survey items. Each index was dichotomized at the mean. Each index was comprised of items with five ordinal categories, all logically compatible. For each scale, items were re-coded to maintain consistency in direction and clarity of interpretation with the other scales. Responses were dichotomized as high or low based on original rating scales, with

high to low corresponding with “important” to “unimportant,” “agree” to “disagree,” “often” to “rarely.” A Cronbach’s alpha was conducted to assess the reliability of the indices. Cronbach’s alphas were all above .70.

## 6. Findings

Of the respondents who indicated their gender, 75.7% were female, 23.6% were male, and .7% indicated other. This ratio is consistent with other data on the human services labor force, which reflects a growing trend of feminization (Bureau of Labor Statistics, 2003; Gibelman & Schervish, 1997). The mean age of the sample was 48 years old. The mean annual family income was approximately \$75,000.00.

The vast majority of respondents self-identified as White (84%), 5% African American, 3.5% Latino, and 7.5% other. In regard to marital status, 67.5% of

respondents indicated they were married or living with a partner, 2.6% were widowed, 10.8% were divorced or separated, and 19.1% were single. With regard to sexual orientation, 83% indicated that they were heterosexual; 11.4% indicated gay/lesbian, 3.8% indicated bisexual; 0.4% indicated that they were questioning/unsure. Thus, the sample was primarily white, near 50 years old, middle class, heterosexual, and female.

Of the respondents who answered the question about religion, 42.5% indicated that they were Christian; 24.7% indicated Jewish, 6% indicated Unitarian, 19% indicated Agnostic or “no religion.” Other religions, all 1.5% or less, included: Hindu, Islam, Mormon, Sikh, Buddhist, Bahai, and Atheist. In regard to highest degree obtained, 3.5% hold the BSW as their highest degree, 81.9% the MSW, 11.9% a PhD or DSW, and 2.7% other. Respondents provided their state of residence. Table 1 shows their geographic distribution.

**Table 1**

Table 1. Geographic Distribution of Respondents (n=788)

Re-Coded Region	Sample Representation
Region I and II = Northeast	40% (n=324)
Region III and IV = South	18% (n=142)
Region V and VI = Mid and Southwest	18% (n=146)
Region VII and VIII = Central and North Central	6% (n=44)
Region IX and X = West	17% (n=132)

### 6.1 Professional Characteristics

Respondents are an experienced group of social workers. The vast majority (69.1%) reported having ten or more years of work experience in the social work profession. Only 6.3% reported having 0-5

years of experience. A primary function of direct service was indicated by 35.6% of respondents. An additional 18.2% of respondents indicated that their primary function is in private practice, the majority of whom provide direct services. Only 7.6% of respondents reported working in

executive (senior) management, and another 15.1% reported their primary function to be middle management. Such findings mirror those of other labor force studies of social workers (see, for example, Gibelman & Schervish, 1997). The majority of respondents work full-time (75.3%), 18.9% work part time, and 5.8% indicated that they are unemployed or retired.

## 6.2 Religious, Moral, and Socio-Political views

According to the moral views scale, the respondents of this study do not tend to object to contemporary moral issues such as abortion, stem-cell research, euthanasia, and same-sex marriage. The religiosity scale suggests that respondents fall along a wide continuum of religiousness. According to the socio-political scale, respondents lean more toward liberal political and social views than conservative (see Table 2).

**Table 2**

Table 2 . Moral views, religiosity, and socio-political scales

	Description of scale	# of items	n	a	Mean (SD)	Potential Score Range	Interpretation of scale	
							LOW	HIGH
Moral Views Scale	Moral or religious objections to controversial issues (e.g., same sex marriage, abortion, etc.).	11	733	.86	1.13 (.57)	1 to 3	Less moral or religious objection	Greater moral or religious objection
Religiosity Scale	Religious Practices (e.g., religious service attendance, adherence to religious laws, and rituals, etc.).	5	733	.89	2.03 (.63)	1 to 3	Less religiosity	Greater religiosity
Social Political Scale	Social and Political Views (e.g. how would you describe your political views, your views on social issues; your views on economic issues).	5	733	.84	1.3 (.52)	1 to 3	More Liberal Views	More Conservative Views

## 6.3 Conscientious Objection

Respondents (n=905) were asked a series of attitudinal questions about CO within the social work profession. The large majority of respondents (n=714; 79%) believe that social workers “ought to work with all clients regardless of whether the social worker has a religious/moral objection to the client's issue.” Over 71% (n=642) of respondents believe that “opting out” of working with a client as a result of a religious or moral objection is not acceptable.

Over two thirds (69%; n=624) of respondents indicated that state clauses that protect health care providers, such as doctors, nurses, and pharmacists, from adverse consequences that may arise from

refusing to attend to client issues that violate their moral or religious conscience, should not apply to social workers. Respondents were also asked whether these types of clauses ought to apply to nurses and pharmacists. With regard to nurses, approximately 60% (n=542) felt that nurses should not have the right to refuse a patient’s request even if the request is inconsistent with the nurse’s beliefs (e.g., assisting in an abortion or organ retrieval), and 71% (n=645) felt that pharmacists should not have the right to refuse a patient’s request (e.g., contraception prescription, day-after pill). A substantial proportion of the sample expressed strong views regarding “opting-out” in social work (see table 3).

**Table 3**

Table 3. Views about opting out in social work

	Somewhat agree %	Strongly agree %	n
Social workers who are unable to move past moral/religious issues of conscience ought to consider another profession.	13	56	640
Social workers who opt-out of working with a client as a result of a conscientious objection, ought to be reprimanded in some way.	20	28	136
Social workers should learn to work with all clients regardless of whether he/she has a religious or moral objection to the client (client's issue).	26	53	717

n=905

Pearson's Linear Correlations were used to measure the relationships between conservatism and "opt-out" views. The two indices (religious/moral, social/political) showed strong correlation ( $r=.72$  &  $.61$  respectively,  $p=.005$ ), suggesting that conservatism and support for 'opting out' are correlated. Very weak or no correlation was observed between religious practice and 'opt-out' views ( $r=.12$ ,  $p=.65$ ), suggesting that religious practice does not have a decisive influence on "opt-out" views.

#### **6.4 Experience with moral/religious conflict**

By and large, this study's respondents have experienced challenges to

religious/moral beliefs, but have not chosen to remove themselves from these cases (93%,  $n=841$ ). Just under a third of respondents (31%,  $n=280$ ) have chosen not to work with a client for reasons other than religious objection. Whereas 11% of respondents ( $n=99$ ) have chosen not to work with a client because of a religious/moral objection, 93.2% of these respondents ranked high on the moral views scale (indicating strong objection to the index of controversial issues). In general, open-ended comments were disproportionately negative in tone, critical of opting out in social work (see table 4).

**Table 4**

Table 4. Open-ended comments about opting out in social work

If a social worker's religious beliefs make it impossible to function ethically, he needs to reconsider his choices. He should immediately be removed from the case and his supervisor needs to be clear about agency expectations.
Social Workers should not discriminate no matter what their personal feelings. This is part of our code of ethics.
Social workers that can not separate personal/professional values, need to find a profession that does not require them to deny their own sense of morality or ethics and that does not put them in a position to offend, oppress, discriminate against vulnerable populations.
If social workers cannot extend compassion to all they serve, they should reconsider their profession.
Social Work is about working with these populations. The people who want a clause are not social workers.

## 7. Limitations

There are a few limitations in this study that must be discussed. A modified convenience sampling method was used to collect the data. It is possible that this method led to a self-selection bias; that is, the study may have attracted only those social workers who have an interest in CO. Furthermore, reliability of self-reported attitudes are subject to the respondents' inclination to promote a favorable opinion of the social work profession. Finally, the use of a web-based online survey might result in obtaining a biased sample, as it unintentionally excludes potential participants who lack access to or comfort with the Internet.

## 8. Discussion

This study explored the complexity surrounding CO in social work. The large majority of this study's respondents believe that when personal moral/religious values conflict with professional duties, social workers are obligated to side with professional values; almost two thirds of respondents do not believe that "opting out" of working with a client because of a religious or moral objection is acceptable.

Although in many states, health care workers who choose the path of CO are protected, the respondents of this study appear to suggest that social workers should not be afforded these same protections.

Commentators suggest that social work is one of the most value-based professions (Mattison, 2000; Noble & King, 1981; Osmo & Landau, 2003; Reamer, 2006; Timms, 1983). The respondents of this study agree with the literature. When asked to rank social work on a scale from 1 to 10 (high) with regard to how value-based they feel the profession is compared with other professions, 75% ranked social work 7 or higher. Perhaps the strong opinions regarding "opting out" expressed by the respondents of this study may result, in part, from an identification with social work's strong value base. Another tangential explanation is that social workers are committed to diversity, tolerance, and inclusion (Hodge, 2007), accepting these values as part of a professional oath. When engaged in professional activities, perhaps social workers feel that one's professional oath should override personal moral or religious allegiances.

Although respondents feel strongly

about the necessity of separating religious/moral values from professional duties, less than half believe that workers ought to be fired (46%; n=421), or reprimanded (45%, n=407) for refusing to serve those found to be morally or religiously repugnant.

## 9. Implications

Research shows that Americans overwhelmingly oppose laws that would allow religious or moral interests of health care providers to come between them and their health care needs (ACLU, 2002; RHTP, 2000). It appears that social workers share this belief, in that more than two thirds of respondents believe that laws protecting some health care providers should not extend to social workers.

Health care professions appear to be mixed about opt out laws. For pharmacists, each state has different regulatory policies. There are only a few states that require pharmacists to dispense every lawful prescription. New Jersey is the only state that explicitly prohibits pharmacists from opting out of filling prescriptions solely on moral, religious, or ethical grounds (Beal & Cappiello, 2008). Eleven states have laws that protect a pharmacist from any adverse action that may result from refusing to fill prescriptions based on a religious or moral objection (NCSL, 2009). The American Pharmacists Association (APhA) recognizes an individual pharmacist's right to conscientious refusal (APhA, 2008). Commentators have advised that in recent years, there is a growing list of pharmacists who have chosen to opt out of dispensing medication on grounds of moral or religious objection (Grady, 2006; Sonfield 2004).

With regard to physicians, several states have laws that protect health care providers from any adverse consequences that may arise from refusal to participate in medical services that violate their

conscience (Curlin, Lawrence, Chin, & Lantos, 2007). Principle VI of the AMA's (2006) Code of Medical Ethics states: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve..." According to the literature, ongoing debates among physicians continue about CO in medicine (Curlin, Lawrence, Chin, & Lantos, 2007).

The American Nurses Association states that nurses have a right to refuse to participate in cases, although they have an obligation to detail information about health-related options which are available (Sonfield, 2004). According to the literature, nurses must ensure that any CO relates to a procedure and not to a particular patient.

According to the NASW Code of Ethics, social workers are expected to "act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, or mental or physical disability" (p. 27). The code of ethics also states that the "social worker's primary responsibility is to promote the well-being of clients" (NASW, 1999, 1, 1.01). Commentators explain that when clients' behaviors and practices conflict with a social worker's personal morals or religious beliefs, the social worker may be in need of peer support, supervision, or values clarification training to responsibly serve clients (Aronstein & Thompson, 1998; Ryan & Rowe, 1988).

Should the code be more specific? In general, commentators suggest that historically, codes of ethics were written in general terms; contemporary codes tend to be more specific. With greater specificity, however, comes a greater chance for conflict (Dolgoft, Loewenberg, & Harrington, 2009). Some commentators suggest that the core

values of the profession are too generalized and non-specific, and as a result they do not offer sufficient behavioral guidance (Jayartne, Croxton, & Mattison, 1997; Loewenberg, 1988). Congress (1999), on the other hand, explains that a code of ethics must be general.

For now, a great deal of variability exists in the way social work values and the NASW Code are interpreted and applied. Some commentators suggest that at a generalized level, personal and religious beliefs may have a more profound impact on practice than professional values (Faver, 1986; Kassel & Kane, 1980; Loewenberg, 1988). This, however, appears to run counter to key principles articulated in the NASW Code of Ethics, which advocates giving precedence to ethical duties and professional obligations over personal interests. Opting out does appear to be acceptable within other professions, although tight guidelines exist. For social work, however, which is “among the most value based of all professions” (Reamer, 2006, p. 4), the question remains unsettled as to whether CO has a place.

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# Mental Health Stigma: Society, Individuals, and the Profession

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## Abstract

Mental health stigma operates in society, is internalized by individuals, and is attributed by health professionals. This ethics-laden issue acts as a barrier to individuals who may seek or engage in treatment services. The dimensions, theory, and epistemology of mental health stigma have several implications for the social work profession.

**Key Terms:** Mental Health, Psychiatric Conditions, Stigma, Treatment Engagement, Social Work Ethics

## 1. Introduction

In 2001, the World Health Organization (WHO) reported that an estimated 25 percent of the worldwide population is affected by a mental or behavioral disorder at some time during their lives. This mental and behavioral health issue is believed to contribute to 12

percent of the worldwide burden of disease and is projected to increase to 15 percent by the year 2020 (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003). Within the United States, mental and behavioral health conditions affect approximately 57 million adults (National Institute of Mental Health [NIMH], 2006). Despite the high prevalence of these conditions, recognized treatments have shown effectiveness in mitigating the problem and improving individual functioning in society. Nonetheless, research suggests that (1) individuals who are in need of care often do not seek services, and (2) those that begin receiving care frequently do not complete the recommended treatment plan (Corrigan, 2004). For example, it has been estimated that less than 40 percent of individuals with severe mental illnesses receive consistent mental health treatment throughout the year (Kessler, Berglund, Bruce, Koch, Laska, Leaf, et al, 2001).

There are several potential reasons for why, given a high prevalence of mental health and drug use conditions, there is

much less participation in treatment. Plausible explanations may include (1) that those with mental health or drug use conditions are disabled enough by their condition that they are not able to seek treatment, or (2) that they are not able to identify their own condition and therefore do not seek needed services. Despite these viable options, there is another particular explanation that is evident throughout the literature. The U.S. Surgeon General (1999) and the WHO (2001) cite stigma as a key barrier to successful treatment engagement, including seeking and sustaining participation in services. The problem of stigma is widespread, but it often manifests in several different forms. There are also varying ways in which it develops in society, which all have implications for social work – both macro and micro-focused practice.

In order to understand how stigma interferes in the lives of individuals with mental health and drug use conditions, it is essential to examine current definitions, theory, and research in this area. The definitions and dimensions of stigma are a basis for understanding the theory and epistemology of the three main ‘levels’ of stigma (social stigma, self-stigma, and health professional stigma).

## **2. Stigma Definitions & Dimensions**

The most established definition regarding stigma is written by Erving Goffman (1963) in his seminal work: *Stigma: Notes on the Management of Spoiled Identity*. Goffman (1963) states that stigma is “an attribute that is deeply discrediting” that reduces someone “from a whole and usual person to a tainted, discounted one” (p. 3). The stigmatized, thus, are perceived as having a “spoiled identity” (Goffman, 1963, p. 3). In the

social work literature, Dudley (2000), working from Goffman’s initial conceptualization, defined stigma as stereotypes or negative views attributed to a person or groups of people when their characteristics or behaviors are viewed as different from or inferior to societal norms. Due to its use in social work literature, Dudley’s (2000) definition provides an excellent stance from which to develop an understanding of stigma.

It is important to recognize that most conceptualizations of stigma do not focus specifically on mental health or drug use disorders (e.g., Crocker, Major, & Steele, 1998; Goffman, 1963). Stigma is relevant in other contexts such as towards individuals of varied backgrounds including race, gender, and sexual orientation. Thus, it is important to provide a definition of mental disorders, which also include drug use disorders, so that it can be understood in relationship to stigma. While each mental health and drug use disorder has a precise definition, the often cited and widely used Diagnostic and Statistical Manual of Mental Disorders (4th Ed., Text Revision [DSM-IV-TR]; American Psychiatric Association [APA], 2000) offers a specific definition of mental disorder which will be used to provide meaning to the concept. In this text, a mental disorder is a “clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom,” which results from “a manifestation of a behavioral, psychological, or biological dysfunction in the individual” (APA, 2000, p. xxxi). While this definition provides a consistent base from which to begin understanding how stigma impacts individuals with mental health and drug use disorders, it is important to recognize the inherent danger in relying

too heavily on specific mental health diagnoses as precise definitions (Corrigan, 2007), which is why the term is being used just as a basis for understanding in this context.

The next important step is to understand the constructs underlying the concept of stigma. These constructs detail the multiple pathways through which stigma can develop. Building from Goffman's initial conceptualization, Jones and colleagues (1984) identified six dimensions of stigma. These include concealability, course, disruptiveness, peril, origin, and aesthetics (Feldman & Crandall, 2007; Jones et al, 1984). In addition, Corrigan and colleagues (2001; 2000) identified dimensions of stability, controllability, and pity. It is important to understand that these dimensions can either present independently or simultaneously to create stigma. Further, stigma is more than a combination of these elements impacting each person as an individual, since stigma is believed to be common in the structural framework of society (Feldman & Crandall, 2007).

The first dimension of stigma is *peril* – otherwise known as dangerousness. *Peril* is often considered an important aspect in stigma development, and it is frequently cited in the research literature (Corrigan, et al, 2001; Feldman & Crandall, 2007; Angermeyer & Matschinger, 1996). In this instance, the general public perceives those with mental disorders as frightening, unpredictable, and strange (Lundberg, Hansson, Wentz, & Bjorkman, 2007). Corrigan (2004) also suggests that fear and discomfort arise as a result of the social cues attributed to individuals. Social cues can be evidenced by psychiatric symptoms, awkward physical appearance or social-skills, and through labels (Corrigan, 2004; Link, Cullen, Frank, & Wozniak, 1987; Corrigan, 2007). This particular issue highlights the dimension of *aesthetics* or the

displeasing nature of mental disorders (Jones, et al, 1984). When society attributes, upon a person or group of people, perceived behaviors that do not adhere to the expected social norms, discomfort can be created. This often leads to the generalization of the connection between abnormal behavior and mental illness, which may result in labeling and avoidance. This also may be why society continues to avoid those with mental and behavioral disorders whenever possible (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003).

Another dimension of stigma that is often discussed in the research on stigma is *origin*. As in the definition provided earlier, mental and behavioral disorders are often believed to, at least in-part; develop from biological and genetic factors – i.e., *origin* (APA, 2000). This has direct implications for the dimension of *controllability* (Corrigan, et al, 2001). Within this dimension, it is often believed in society that mental and behavioral disorders are personally controllable and if individuals cannot get better on their own, they are seen to lack personal effort (Crocker, 1996), are blamed for their condition, and seen as personally responsible (Corrigan, et al, 2001).

A recent report by Feldman and Crandall (2007), found that individuals with disorders such as pedophilia and cocaine dependence were much more stigmatized than those with disorders such as post-traumatic stress disorder. This supports the *controllability* hypothesis in which pedophilia and cocaine dependence could be viewed as more controllable in society than a disorder believed to be caused by a traumatic experience (PTSD). It also supports the *pity* dimension, in which disorders that are pitied to a greater degree are often less stigmatized (Corrigan, et al, 2000; Corrigan, et al, 2001). In this case, individuals within a culture or society may

have more sympathy for disorders that are perceived as less controllable (Corrigan, et al, 2001).

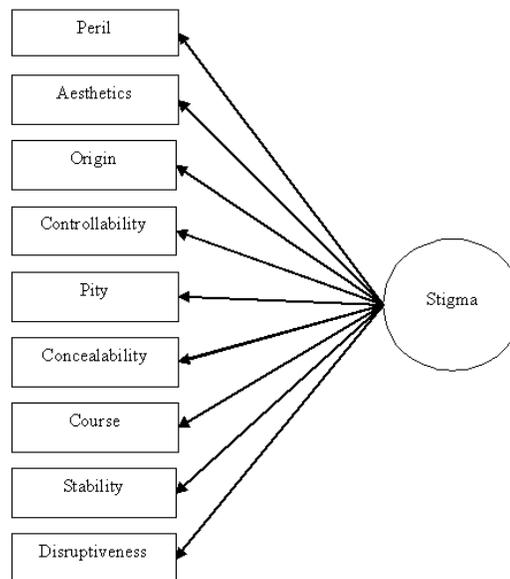
*Concealability*, or visibility of the illness, is a dimension of stigma that parallels *controllability*, but also provides other insight into the stigmatization of mental and behavioral disorders. Crocker (1996) suggests that stigmatized attributes such as race can be easily identified, and are less concealable, allowing society to differentiate and stigmatize based on the visibility of the person. This is supported by research that shows that society attributes more stigmatizing stereotypes towards disorders such as schizophrenia, which generally have more visible symptoms, compared to others such as major depression (Angermeyer & Matschinger, 2005; Lundberg, et al, 2007).

The final three dimensions, *course*, *stability*, and *disruptiveness*, also may have some similarities among each other and compared to the others presented. *Course* and *stability* question how likely the person with the disability is to recover and/or benefit from treatment (Corrigan, et al, 2001; Jones, et al, 1984). Further the *disruptiveness* dimension assesses how much a mental or behavioral disorder may impact relationships or success in society. While disorders are frequently associated with an increased risk for poverty, lower socioeconomic status and lower levels of education (Kohn, Dohrenwend, & Mirotznik, 1998), the stability and disruptiveness of the conditions have implications as to whether an individual will be able to hold down a successful job and engage in healthy relationships, as evidenced by differences in stigma based on social class status. This demonstrates that if disorders are less disruptive, in which case they may be perceived as more stable, they are also less stigmatized (Corrigan, et al, 2001). This also expresses that some

flexibility exists within each type of mental or behavioral disorder, as each diagnosed person is not stigmatized to the same extent (Crocker, 1999). Figure 1 depicts stigma as a latent variable constructed from the dimensions discussed above.

**Figure 1**

*Figure 1: The dimensions of stigma*



### **3. Levels of Stigma: Theory & Epistemology**

Illustrating the constructs underlying the formation of stigma helps us understand three specific levels of stigma – social stigma, self-stigma, and professional stigma. In this context, ‘levels’ does not refer to a hierarchy of importance for these varied stigmas, but rather to represent different social fields of stigma that can be differentiated from each other. In addition, further definition and theory behind these three ‘levels’ of stigma must be presented. First, stigmatized attitudes and beliefs towards individuals with mental health and drug use disorders are often in the form of social stigma, which is structural within the

general public. Second, social stigma, or even the perception that social stigma exists, can become internalized by a person resulting in what is often called self-stigma. Finally, another, less studied level of stigma is that which is held among health professionals toward their clients. Since health professionals are part of the general public, their attitudes may in part reflect social stigma; however, their unique roles and responsibility to 'help' may create a specific barrier. The following theories are presented as an aid to understanding how each 'level' of stigma may develop in society.

### *Social Stigma*

The first, and most frequently discussed, 'level' is social stigma. Social stigma is structural in society and can create barriers for persons with a mental or behavioral disorder. Structural means that stigma is a belief held by a large faction of society in which persons with the stigmatized condition are less equal or are part of an inferior group. In this context, stigma is embedded in the social framework to create inferiority. This belief system may result in unequal access to treatment services or the creation of policies that disproportionately and differentially affect the population. Social stigma can also cause disparities in access to basic services and needs such as renting an apartment.

Several distinct schools of thought have contributed to the understanding of how social stigma develops and plays out in society. Unfortunately, to this point, social work has offered limited contributions to this literature. Nonetheless, one of the leading disciplines of stigma research has been social psychology. Stigma development in most social psychology research focuses on social identity resulting from cognitive, behavioral, and affective processes (Yang, Kleinman, Link, Phelan, Lee, & Good, 2007). Researchers in social

psychology often suggest that there are three specific models of public stigmatization. These include socio-cultural, motivational, and social cognitive models (Crocker & Lutsky, 1986; Corrigan, 1998; Corrigan, et al, 2001). The socio-cultural model suggests that stigma develops to justify social injustices (Crocker & Lutsky, 1986). For instance, this may occur as a way for society to identify and label individuals with mental and behavioral illnesses as unequal. Second, the motivational model focuses on the basic psychological needs of individuals (Crocker & Lutsky, 1986). One example of this model may be that since persons with mental and behavioral disorders are often in lower socio-economic groups, they are inferior. Finally, the social cognitive model attempts to make sense of basic society using a cognitive framework (Corrigan, 1998), such that a person with a mental disorder would be labeled in one category and differentiated from non-ill persons.

Most psychologists including Corrigan and colleagues (2001) prefer the social cognitive model to explain and understand the concept of stigma. One such understanding of this perspective – Attribution Theory – is related to three specific dimensions of stigma including stability, controllability, and pity (Corrigan, et al, 2001) that were discussed earlier. Using this framework, a recent study by these researchers found that the public often stigmatizes mental and behavioral disorders to a greater degree than physical disorders. In addition, this research found stigma variability based on the public's "attributions." For example, cocaine dependence was perceived as the most controllable whereas 'mental retardation' was seen as least stable and both therefore received the most severe ratings in their corresponding stigma category (Corrigan, et al, 2001). These findings suggest that

combinations of attributions may signify varying levels of stigmatized beliefs.

Sociologists have also heavily contributed to the stigma literature. These theories have generally been seen through the lens of social interaction and social regard. The first of these theorists was Goffman (1963) who believed that individuals move between more or less 'stigmatized' categories depending on their knowledge and disclosure of their stigmatizing condition. These socially constructed categories parallel Lemert's (2000) discussion on social reaction theory. In this theory, two social categories of deviance are created including primary deviance, believing that people with mental and behavioral disorders are not acting within the norms of society, and secondary deviance, deviance that develops after society stigmatizes a person or group. Similarly, research demonstrating that higher levels of stigmatization are attributed towards individuals with more "severe" disorders (Angermeyer & Matschinger, 2005) also resembles these hierarchical categories and the disruptiveness and stability dimensions of stigma.

Furthermore, Link and Phelan clearly illustrated the view of sociology towards stigma in their article titled *Conceptualizing Stigma* (2001). Link and Phelan (2001) argue that stigma is the co-occurrence of several components including labeling, stereotyping, separation, status loss, and discrimination. First, labeling develops as a result of a social selection process to determine which differences matter in society. Differences such as race are easily identifiable and allow society to categorize people into groups. The same scenario may occur when society reacts to the untreated outward symptoms of several severe mental illnesses; i.e., Schizophrenia. Labels connect a person, or group of people, to a set of undesirable characteristics, which

can then be stereotyped. This labeling and stereotyping process gives rise to separation. Society does not want to be associated with unattractive characteristics and thus hierarchical categories are created. Once these categories develop, the groups who have the most undesirable characteristics may become victims of status loss and discrimination. The entire process is accompanied by significant embarrassment by the individuals themselves and by those associated with them (Link & Phelan, 2001).

While social psychology and sociology are the primary contributors to the stigma literature, other disciplines have provided insight as well. Communications, Anthropology, and Ethnography all favor theories that revolve around threat. In Communications literature, stigma is the result of an "us versus them" approach (Brashers, 2008). For example, the use of specific in-group language can reinforce in-group belongingness as well as promote out-group differentiation (Brashers, 2008). This is referenced in research on peer group relationships such that youth often rate interactions with their same-age peers more positively than with older adults (whether family members or not) (Giles, Noels, Williams, Ota, Lim, Ng, et. al., 2003). This can also be applied to those with mental disorders in that individuals in the out-group (mental disorders) are perceived less favorably than the non-ill in-group.

Anthropology and Ethnography also prefer the identity model. From this perspective, the focus is on the impact of stigma within the lived experience of each person. Stigma may impact persons with mental illnesses through their social network, including how it exists in the structures of lived experiences such as employment, relationships, and status. Further, the impact of stigma is a response to threat, which may be a natural or tactical self-preservation strategy. However, it only

worsens the suffering of the stigmatized person (Yang, et al, 2007). It is important to note again that while many disciplines have been leaders in social stigma theory, social work-specific literature has been mostly void of discussion on this topic. This is particularly unusual, since stigma is an obvious factor that impacts the lives of social work clients on a daily basis.

### *Self-Stigma*

Crocker (1999) demonstrates that stigma is not only held among others in society but can also be internalized by the person with the condition. Thus, the continued impact of social/public stigma can influence an individual to feel guilty and inadequate about his or her condition (Corrigan, 2004). In addition, the collective representations of meaning in society – including shared values, beliefs, and ideologies – can act in place of direct public/social stigma in these situations (Crocker & Quinn, 2002). These collective representations include historical, political, and economic factors (Corrigan, Markowitz, and Watson, 2004). Thus, in self-stigma, the knowledge that stigma is present within society, can have an impact on an individual even if that person has not been directly stigmatized. This impact can have a deleterious effect on a person's self-esteem and self-efficacy, which may lead to altered behavioral presentation (Corrigan, 2007). Nonetheless, Crocker (1999) highlights that individuals are able to internalize stigma differently based on their given situations. This suggests that personal self-esteem may or may not be as affected by stigma depending on individual coping mechanisms (Crocker & Major, 1989).

Similarly, other theories have provided insight into the idea of self-stigma. In modified labeling theory, the expectations of becoming stigmatized, in addition to actually being stigmatized, are factors that influence psychosocial well-being (Link,

Cullen, Struening, Shrout, & Dohrenwend, 1989). In this context, it is primarily the fear of being labeled that causes the individual to feel stigmatized. Similarly, Weiner (1995) proposed that stigmatized beliefs provoke an emotional response. This can be interpreted from the standpoint of the afflicted individual, such that he or she may feel stigmatized and respond emotionally with embarrassment, isolation, or anger.

### *Health Professional Stigma*

It may seem unlikely that social workers and other health professionals would carry stigmatized beliefs towards clients; especially those whom they know are affected by a variety of barriers to treatment engagement. Nonetheless, recent literature is beginning to document the initial impact of health professional stigma (Nordt, Rössler, & Lauber, 2006; Volmer, Mäesalu, & Bell, 2008). While limited evidence exists specifically on social worker attitudes, pharmacy students who desire more social distance towards individuals with Schizophrenia are also less willing to provide them medications counseling (Volmer, et al, 2008). In addition, one Swiss study (psychiatrists, nurses, and psychologists) found that mental health professionals did not differ from the general public on their desired social distance from individuals with mental health conditions (Nordt, et al, 2006). Other studies have also come to similar conclusions (Lauber, et al, 2006; Tsao, Tummala, & Roberts, 2008; Sriram & Jabbarpour, 2005; Ücok, Polat, Sartorius, Erkoc, & Atakli, 2004). Clients have also reported feeling 'labeled' and 'marginalized' by health professionals (Liggins & Hatcher, 2005). Individuals with mental illnesses may not even receive equivalent care (compared to non-mentally ill patients) in general health settings once health professionals become aware of their mental health conditions (Desai, Rosenheck, Druss, & Perlin, 2002).

Theory on health professional stigma is very limited, but some literature does provide insight into its possible development. In one way, stigma by health professionals may develop very much the same as the social stigma evident in the general public. Social workers may develop their own biases from their upbringing or even from burnout in their own working roles, particularly when working with individuals who have severe and persistent mental illnesses (Acker & Lawrence, 2009). Nonetheless, some indications suggest that health professional stigma may also develop in a unique way. For instance, social workers and other health professionals, similar to persons in the general public, experience their own mental health and drug use problems and often have friends or family members who experience these same issues (Siebert, 2004; Fewell, King, & Weinstein, 1993). Individuals may also self-select into a helping profession due in part to these experiences (Stanley, Manthorpe, & White, 2007). When social workers and other health professionals deal with mental health and drug use problems they may experience burnout and/or become more or less likely to recognize similar problems among their clients (Siebert, 2003). Some research suggests that mental health conditions are more prevalent among helping professionals than in the general public (Schemhammer, 2005). This problem has also been shown to impair professional social work practice behaviors (Siebert, 2004; Sherman, 1996). For example, Siebert (2003) found that social workers who used marijuana were less likely to recognize marijuana use as a problem among their clients.

The counter-transference that can develop as a result of personal experiences or behaviors may impact clients who may be vulnerable when participating in treatment and may not have the appropriate resources

to determine when they are not being treated adequately (Siebert, 2004; Hepworth, Rooney, & Larsen, 2002; Rayner, Allen, & Johnson, 2005). Clients may also be disenfranchised by the treatment process and become more likely to end current treatment and less likely to seek treatment in the future. This creates a barrier to the overall well-being of individuals by preventing adequate treatment, but it also may impact the acknowledgement of their disorder. Overall, health professionals may not provide adequate intervention, early detection, or community referral options for individuals with mental or behavioral disorders (Gassman, Demone, & Albilal, 2001; Tam, Schmidt, & Weisner, 1996), because of their own stigmatizing beliefs and personal histories (Siebert, 2004; 2005).

#### **4. Implications for Social Work**

While it is apparent that stigma (all three levels) impacts individuals' lives, there are also several implications for stigma and health professionals. These implications are placed into context within social work practice, education, policy, and research. In practice, social workers make up between 60-70 percent of mental health professionals in the United States (Proctor, 2004). While their roles may vary in different countries, they can nonetheless be important participants in mitigating stigma across the world. Since social workers often provide gatekeeping and triage functions in their roles, they are among the first to be in contact with individuals with psychiatric conditions (Hall, et al, 2000). Their attitudes and treatment preferences in practice settings can thus either promote or disenfranchise treatment seeking among their clients.

Social workers may be able to address issues of stigma within themselves by recognizing and embracing values and

personal biases. This may be a difficult transformation that requires significant personal work and/or therapy. They may also be able to work with their clients on issues of stigma through their treatment provisions, triage roles, and outreach efforts. Nonetheless, the National Association of Social Workers (NASW) Code of Ethics mandates that professionals promote self-determination, client rights, self-realization, empowerment, social justice, and the dignity and worth of every person (National Association of Social Workers [NASW], 1999). These specific professional values pointedly call social workers to work to mitigate their own levels of stigma and work with others to dispel levels of social stigma and self-stigma.

While social workers have the opportunity to work with individuals, they also work with families. One additional way social workers may seek to mitigate social stigma on a micro-level is via the family. Family therapy may help relatives understand psychiatric conditions and how they can help/support the afflicted individual (Lefley, 1989). Some research suggests that more attention to families of individuals with mental health conditions is needed (Thornicroft, Brohan, Kassam, & Lewis-Holmes, 2008). If social workers are able to support an individual's support system (family), it may help improve treatment seeking and treatment engagement for that person. Several studies have demonstrated the positive impact between family interventions and treatment engagement by the afflicted individual (Copello, Velleman, & Templeton, 2005; Adeponle, Thombs, Adelekan, & Kirmayer, 2009; Glynn, Cohen, Dixon & Niv, 2006). While this does not replace group work or individual work with a particular client, families may be among the most stigmatizing groups towards the afflicted person (Lee, Lee, Chiu, & Kleinman, 2005), and improved efforts

towards the family system may be helpful.

On a macro level, social workers can also be instrumental in leading larger targeted educational efforts aimed at reducing stigma. Targeted programs have shown effectiveness in challenging misconceptions, improving attitudes, and reducing social distance (Thornton & Wahl, 1996; Esters, et al, 1998; Corrigan, et al, 2001). One such program, lead by the network of the World Psychiatric Association, has focused on individuals that impact the larger structural attitudes of stigma such as medical personnel, police officers, and journalists (Thornicroft, et al, 2008). Large macro-level stigma campaigns that can be facilitated by social workers include public advertisements, targeted educational efforts, and advocacy for agency change. Occasionally, other systematic changes need to accompany these targeted efforts (Pinfold, Huxley, Thornicroft, Farmer, Toulmin, & Graham, 2003), but they have shown effectiveness and are important in mitigating stigma around the world. Nonetheless, more interventions and strategies must be developed to mitigate stigma in society.

Another important way to impact stigma is by educating individuals that have an opportunity to make a difference – i.e., *social work education*. For instance, when individuals have contact with those with mental illnesses, stigma can be diminished (Corrigan, et al, 2001). This may be the result of stereotypical beliefs about psychiatric conditions that are consistent with dimensions of stigma such as dangerousness or aesthetics (see, Jones, et al, 1984). Exposing social workers to these population groups may increase their willingness to treat the afflicted clients. This can be implemented through the field practicum experience at the undergraduate and graduate level. Education on stigma also fits into the practice sequences (macro-

and micro- level), elective courses on substance abuse, and clinical diagnosis and assessment courses. Nonetheless, Bina and colleagues (2008) found that improving the knowledge and education of social workers about clients with drug use conditions will increase their interest in working with that population in practice. Furthermore, social work educational research has demonstrated that training social workers improves the likelihood that they will intervene, assess, and provide treatment for persons in an afflicted population, seek employment in that area, and feel confident and competent about their work (Amodeo, 2000).

Stigma is a global issue, and efforts to mitigate stigma through policy may be another effective strategy. On the macro-level, social workers can be very influential in advocating for policy change. Corrigan and colleagues (2001) suggest that policy change is one of the three strategies to mitigate stigma in society. For instance, stigma may impact lawmakers and permeate throughout government. One of the most important reasons why mental health care is not adequate is due to a lack of resources. In this case, it appears that economic factors may play a role in access to treatment. However, there is also a low priority placed on mental health within government and other funding bodies to support services (Knapp, Funk, Curran, Prince, Grigg, & McDavid, 2006). The WHO (2003) showed that while neuropsychiatric conditions make up 13 percent of the global burden of disease, only a median 2 percent of health care budgets in countries around the world are appropriated for mental illness. The lack of governmental support combined with the lack of support from other funding bodies (insurance companies) can in part be attributed to stigma (Knapp, et al, 2006). The debate about mental health parity in the United States is another example. Insurance companies in the U.S. have traditionally not

funded mental health treatment to the same degree as general physical health illnesses (U.S. Surgeon General, 1999), which promotes that devaluation of mental illness in society. These disparate policies also act as a barrier to afflicted individuals and their ability to access social work services. Social workers and other policy makers can advocate for change in society. Social workers can be specifically instrumental in this process as they often serve disadvantaged populations such as those with mental illnesses, and should work to assist with the needs of their clients.

Social workers, as social scientists, are in position to develop research programs that seek to understand and influence stigma. More research is needed to understand the impact of different cultural traditions, attitudes, values, and beliefs on stigma, as it may vary between and within countries. This is also true among health professionals and their attitudes towards treating individuals in their community. As social scientists that practice and conduct research with different client populations, social workers have the ability to measure stigma among not only different race/ethnicity groups, but also in relation to individuals' sexual orientation, gender, and age. In addition, limited research has specifically addressed the dimensions of stigma as discussed in the theoretical literature (Corrigan, et al, 2000; Jones, et al, 1984). More precise measures are needed to adequately assess stigma, across its varying dimensions and levels. The use of current stigma-related measures such as the *Psychiatric Disability Attribution Questionnaire* (Corrigan, et al, 2001) and the development of alternative scales to measure health professional stigma are needed to address dimensions of stigma across all three levels simultaneously. Also, larger studies of health professional stigma are needed, to understand how the attitudes

of health professionals, and specifically social workers, influence treatment engagement and access.

## 5. Conclusions

Mental health conditions are pervasive around the world. In addition, the burden of these conditions is expected to grow over the next 20 years (Mathers & Loncar, 2006). Unfortunately, few individuals receive the psychiatric treatment they need, as individuals often do not seek services and frequently do not remain in care once they begin. The WHO (2001) has suggested that stigma is one of the largest barriers to treatment engagement, even though treatment has shown to be effective, even in low income countries (Patel, et al, 2007). While stigma remains evident in society, within individuals themselves, and among health professionals, the ethical problem of health professional stigma places an additional barrier on clients who seek needed mental health services.

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# Dissonance Between Personal and Professional Values: Resolution of an Ethical Dilemma

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## Abstract

Conflicts between personal and professional values are common in social work practice. This article highlights a personal narrative of a social worker's journey to resolve one such ethical dilemma. The author describes the process of personal reflection and confrontation of long-standing beliefs and the implications for social work practice.

*Key Words:* ethical dilemma, social work values, dignity and worth of the person, feminism, dilemma resolution.

## 1. Introduction

Often, in the course of practice, social workers encounter situations that bring them face to face with a conflict between their personal values and the values of the profession. The National Association of Social Workers' Code of Ethics (NASW, 1999) has identified six core values and ethical principles that guide social workers'

professional behaviors. These core values and their ethical principles are:

- *Service.* Social workers' primary goal is to help people in need and to address social problems.
- *Social justice.* Social workers challenge social injustice.
- *Dignity and worth of the person.* Social workers respect the inherent dignity and worth of the person.
- *Importance of human relationships.* Social workers recognize the central importance of human relationships.
- *Integrity.* Social workers behave in a trustworthy manner.
- *Competence.* Social workers practice within their area of competence and develop and enhance their professional expertise.

These values and principles compel the social worker to commit to practice in a manner that safeguards the client's rights to privacy and self-determination and to be treated with dignity and respect. These

principles do not differentiate between types of clients or client behaviors that are deemed worthy of ethical consideration. The social worker, who practices and lives the ethical standards of the profession, is compelled to apply these principles to practice with all clients. This process is facilitated when there is congruence between the worker's personal and professional values. Cormier, Nurius and Osborn (2009) argue that "when personal values of helpers are consistent with professional standards of conduct, helpers are more likely to interact genuinely and credibly with clients and other professionals" (p. 32). What happens when the social worker faces a situation where there is a clash of competing values, such as personal values and professional ones? Ideally one would prefer that there be a high level of congruence between the two. Nonetheless, the reality often is that we bring into our practice our own personal core values, beliefs and biases, shaped through our life experiences. We ascribe a high level of importance to our personal values and life experiences that may, at times, create dissonance with our social work values.

The NASW Code of Ethics (1999) guides social workers to respect the intrinsic dignity and worth of clients and to treat each person in a caring and respectful manner. Translated into practice, this principle means that social workers must respect the intrinsic worth and dignity of their clients and demonstrate unconditional acceptance of their client's personhood. Thus, they should avoid judgmental attitudes that may frame the client with pejorative or dehumanizing labels. However, there are times in the course of practice when we are faced with clients whose behaviors and attitudes collide with our personal values. In such cases, what actions do we take to help us

differentiate between the wrongness of a person's actions and the worth of the individual? How do we avoid passing judgment on an individual whose behavior is unacceptable at best and heinous at worst? If we aspire to respect the intrinsic worth and dignity of all clients, how do we then judge a behavior as "good" or "bad" without using that behavior to frame the entire worth of an individual? As Zastrow and Kirst-Ashman (2007) indicate, social workers at various levels of professional development and throughout their careers must face situations in which there may be no perfect solution for the clash of conflicting ethical principles. In such cases it is important that we learn to work through the conflict in a manner that is congruent with the values and ethics of our profession. However, as Doyle, Miller, and Mirza (2009) suggest, a code of ethics does not prescribe specific actions for ethical decision-making.

The purpose of this article is to describe a case of dissonance between personal feminist values and social work values that compelled a social worker (EC) to confront an ethical dilemma, and prompted a process of resolution through critical thinking, personal exploration, reflection, self-discovery and supervision. Although effective models of ethical decision-making provide a framework to help social workers resolve ethical dilemmas (Cormier et al., 2009; Mattison, 2000), there is a paucity of literature, perhaps due to the complex nature of this issue, which has addressed the specific process and factors that influence a social worker's decision-making method (Doyle et al., 2009). Therefore, this article uses a personal narrative to illuminate those overarching factors that contributed to a conflict between personal and professional values, and the resolution of the conflict. The outcome of

this process was an increased awareness of biases and judgmental attitudes that might otherwise have gone undiscovered. This course of action was critical in allowing this social worker to grow and develop personally and professionally and become a more effective helper.

## **2. Feminist Theory**

As will be shown throughout the narrative, this journey begins with a personal history that valued feminism and flourished with the author's practice with victims of domestic violence and sexual assault. Feminist values have fundamentally shaped both my self and my world views. Thus a discussion of this underpinning perspective in general, and specifically related to domestic and sexual violence, is necessary. On a societal level, the foundation of feminist theory suggests that multiple forces exist that place women in a subordinate position to men. Women are viewed as physically, intellectually, emotionally and sexually less capable than their male counterparts (Crawley, Foley & Shehan, 2008; Ruth, 1998). While there are multiple perspectives within feminist theory (Saulnier, 1996), this basic premise guides the thoughts and behavior of each gender. From this ideology it follows that a feminist is one who questions and challenges the belief that men are more capable than women, and thus, values gender equality.

In the field of domestic violence and sexual assault, practice frameworks and models stem from a feminist perspective (McPhail, Busch, Kulkarni & Rice, 2007). Feminist theory in this field suggests that physical and sexual violence tactics are used to control women and to maintain the power differential that exists between men and women. As Brownmiller (1975) suggests,

one such tactic is rape. Moreover, Dworkin (1989) notes that women's fear of violence overrides a basic freedom that is afforded to men—freedom of movement. She goes on to argue that “we must recognize that freedom of movement is a precondition for freedom of anything else. It comes before freedom of speech in importance because without it freedom of speech cannot in fact exist.” (Dworkin, 1989, p.16). Consequently, the fear of rape is a tactic that limits women's freedom. The intrinsic injustice of this tactic, together with the author's (EC) work with rape survivors, contributed to a personal belief that those who subjugated and perpetrated sexual violence against women were less worthy and deserving human beings; a belief that engendered intense levels of anger towards these offenders. This view would be at the center of the ethical dilemma the author was about to face.

## **3. Practice Dilemma**

My first field placement during my Masters of Social Work (MSW) education appeared to have all the qualities of a perfect position. It had everything I was looking for: a focus on human rights, along with opportunities to learn about program development, policy and community organizing. I moved through my first project with ease and felt competent in the application of what I had learned. When it came time to determine my second project, my enthusiasm turned into ambivalence, which stemmed from the realization that I was being confronted by a serious conflict between my personal and professional values.

This conflict occurred during a meeting with my MSW field instructor, the identified individual who links the course content to field application; and the Policy

Director, the person who would oversee my tasks on a project related to policy and community organizing. The conversation started with a discussion about my previous experience and what I wanted to gain through the new placement. I expressed a strong desire to be assigned a project that was related to women's issues, during the implementation of which I would gain policy skills. The Policy Director said, "Well, nothing is really going on at the state level with any women's issues right now, but there is a policy project working with mothers. How does that sound?" From this brief description, it sounded as if it were related to women's issues. I wondered to myself, "If I am going to be working with mothers, the people in society who have experienced what our culture terms the defining moment of womanhood, how could it not be a women's issue?" She described the project as one in which I would be working in the state capital with a group of mothers whose sons had been placed on the public sex offender registry. This group was advocating for legislative changes to the state's policy governing the required registration of sex offenders. Immediately, I understood the complexity of the moment. I was drawn to the project for the opportunity to be involved with state policy initiatives and work on behalf of women (i.e. mothers); however, I realized that in working with sex offenders, some of my deeply held personal values and beliefs might come into conflict. Although it was not clear to me then, soon I realized that my hesitancy to engage in this task stemmed from the discord between my personal feminist values and social work values. On the one hand, I strongly believe in a woman's right to equality and to live free of fear and oppression, and, on the other hand, I adhere to professional social work value of respect for the dignity and worth of

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all persons. This involves the provision of services to people in need, while elevating service to others above self-interest (NASW, 1999). However, in this situation I was being called to advocate on behalf of those whom I judged to be the ultimate perpetrators of fear and oppression upon women: sex offenders. Although I did not know it at the time, this clash of values would force me to confront personal beliefs and would send me on a path of discovery, growth and self-awareness, and ultimately, resolution of the dilemma.

According to Banks (2001; 2006), ethical dilemmas in social work practice occur when the social worker is faced with having to choose between "two equally unwelcomed alternatives which may involve a conflict of moral principles and it is not clear which choice will be the right one" (p. 11). According to Banks, a defining characteristic of an ethical dilemma is that there may seem to be no solution. This contrasts with Banks view of an "ethical problem", where the social worker, although facing a difficult decision, seems to have a clear notion of the decision to be made.

Banks (2001) suggests that ethical dilemmas in social work practice generally revolve around three main issues: (1) individual rights and welfare, (2) public welfare, and (3) inequality and structural oppression. It was this third type of issue, inequality and structural oppression that would ultimately underscore the case that I was facing. However, two other key social work values and principles clearly resonated in my consciousness, these were: the value of service that guides social workers to help people in need and elevate social-interest above self-interest, and the value of respecting the inherent worth and dignity of every person (NASW, 1999). As I contemplated the alternatives I became

increasingly aware that this assignment also included elements of social justice and social change on behalf of oppressed individuals or groups. Banks (2001) further proposes that as part of this issue it is the social workers' responsibility to strive to change policy that supports such oppression.

Based on Banks' definition of "ethical dilemma" I found myself facing what I thought to be two unwelcomed alternatives. The first alternative entailed accepting the task of working with the sex offenders, which would betray my feminist principles of promoting equality for women and the right to live free of fear and oppression. The second alternative was to refuse to work with this population. Yet, by engaging in such refusal I believed I would be betraying the social work values of service, respect for the inherent worth and dignity of individuals, and challenging social injustice and oppression.

Although a code of ethics may provide guidance around expectations for ethical conduct and individual responsibility, it does not provide clear steps for the resolution of ethical conflicts or dilemmas. Several ethical decision-making models have been formulated to help social work practitioners facing ethical dilemmas (see Cormier, Nurius, & Osborn, 2009; Mattison, 2000). A summary of the key elements of these models that were particularly helpful working through this case included: (1) organizing background information and details to clearly describe the issue at hand, (2) considering the ethical principles that bear on the case and separating those from my own personal values or other professional standards, (3) examining conflicts and tensions, both internally and externally, that I experienced throughout the process, (4) identifying possible alternatives and reflecting on the

consequences and projected outcomes of such, (5) selecting and implementing the preferred choice of action, and (6) finally, assessing the outcome and possible implications of the resolution.

Since the process of ethical decision-making is generally laden with tension, conflict, and some level of abstraction it is suggested that social workers, particularly those at the beginning stages of their career, seek consultation and supervision that will help them work through the steps delineated above. In this case supervision was particularly helpful along two lines. First, it helped to navigate the ethical decision-making process, with particular focus on consideration of the ethical principles involved, recognition of tensions created by the dilemma between personal and professional values, and the ultimate resolution of the conflict. Second, supervision provided an opportunity to examine, and begin the process of reframing, long-standing judgmental and biased attitudes and perspectives that underscored my reluctance to work with sex offenders.

#### **4. A Journey to My Past**

It has been suggested that out of our early childhood experiences we begin to form the core beliefs and values that influence the way we judge ourselves, others and the world-at-large (J. Beck, 1995). As I reflected on my past, it was during the early latency phase of my childhood that I began to recognize a difference in the way men and women's social roles were defined in my family. As the only girl with three older brothers, it became apparent to me at a young age that I was not allowed to do "what the boys did". My family held traditional roles for women; roles that led

most women in my family to set goals only related to domesticity. Women were expected to marry and have children, and there was a clear expectation that they would remain in the home to raise their children. This attitude restricted the freedom of movement for the women in my family and left little room for a career or individual goals outside of the home. Along with the traditional roles came the stereotypical beliefs that women were the weaker of the sexes and men were expected to be the decision-makers for their families. The implicit and explicit messages that I received underscored the view that women were limited in their capacity to achieve and succeed beyond their domesticity; they were judged based on their gender, not for their abilities.

As I became more cognizant of the status of women in my family, I developed an overwhelming sense of frustration and anger. Throughout my adolescent and teenage years, this anger intensified as I immersed myself in feminist readings. I felt a strong sense of injustice and inequality about the limited options available to me, to all the women before me, and to all the young girls coming into my family after me. My anger, fueled by a sense of injustice, is what led me to the profession of social work: I wanted to make changes in the quality of life for girls and women. Mueller and Leidig (1976) note that, throughout the women's movement, the expression of anger was prevalent and used as a motivator for prosocial change to help overcome women's sense of powerlessness (see also Cox, et al., 2004). Consciousness-raising groups excavated the sources of women's anger, which included: women's reliance on men for economic stability; women's experiences of objectification and social put-downs, which judged women based solely on their

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gender; and the physical disparity that exists between the sexes, making women fear for their physical and sexual safety. Gradually, I began to realize that the targets of my anger were those policies or entities that systematically placed women in positions of powerlessness, which contributed to unjust treatment and further fueled women's abuse and fear. In my mind, sex offenders personified this notion.

My experiences in the field at two domestic violence and sexual assault shelters reinforced the sources of my anger. The women I served lived in constant fear of their perpetrators. Stories of severe abuse solidified my beliefs that men who abuse and objectify women represented society's subjugation of women by men. These men emotionally, physically and sexually control women. The stories I heard greatly impacted my beliefs regarding offenders and perpetrators of violence against women. I directed my anger towards these men, and at the extreme end of my reproach were sex offenders. To me, they encompassed all of these control tactics. I blamed sex offenders for the fear that I, and most women, live under. My dislike for this group carried into my MSW field education placement questionnaire, where I noted that I would not take a placement working with sex offenders. At the time, based on the views that I had internalized from my experience with domestic violence and sexual assault survivors, I felt it was appropriate for me to withdraw from any professional contact with a group of people I felt I could not serve adequately. In essence, I did not want to provide services to this population.

"So, do you want to work on this project?" the Policy Director asked. At the time, my intuition told me to turn it down; however, I knew it would be critical for my career to have the policy experience the

assignment would offer. In the end, I pushed my poignancy and disappointment aside and accepted the project. Immediately I began to experience the internal conflict that arises between contending values. Glassman (1992) suggests that feminist social workers experience conflicts between their personal values as feminists and the ethics and values of the social work profession. For example, social work values encourage the practitioner to consider and respect the cultural milieu and context of the client's world. However, when that cultural context involves an unfair, patriarchal system, a feminist worker may have to defy that value by encouraging the client to evaluate and challenge the oppressive nature of such a system. Glassman (1992) advocates for self-reflection and dialogue to resolve the conflicts that arise between feminist and professional values. On one hand, I strongly believed in the feminist value of upholding a woman's right to live without the fear of abuse or assault. On the other hand, I also felt a sense of commitment to the social work values of providing help to those in need and raising service to others above self-interest, as well as upholding the inherent dignity and worth of every human being. I later realized that, as it often is with ethical dilemmas, this conflict was only one aspect of a more complex situation.

During the first meeting about this project, the women in the group shared their sons' stories, including the events that caused them to be on the registry, their court cases and their experiences as publicly-registered sex offenders. These young men would be placed on the registry for 25 years, or life, following their convictions for crimes that, although not excusable, involved a mistake they made prior to adulthood. These mothers felt that the punishment was too severe for the offense

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committed. As I reflected on the inequity the women expressed, I experienced a similar feeling of anger as I felt in my past, but this time it was ignited by the stories of injustice these families were relating. What impacted me most was the multitude of stigmatizing experiences these young offenders had faced. Many of them had been called names such as "monster" or "predator"; furthermore, they had been shunned by some of their peers and the community. As the women told these stories, I reflected on times when I had mentally labeled perpetrators and offenders with similar names, not having fully realized the pain that these dehumanizing words were now causing for these young men and their families.

The descriptive terms I had used to dehumanize sex offenders appeared to stem from the anger I felt growing up, which was rooted in my view of how women were perceived within my family and by society at large. Anger, as described by Fitzgibbons (1986) is, "a strong feeling of displeasure and antagonism aroused by a sense of injury or wrong" (p. 629), and is a general human response when an individual's needs go unmet. When my family set limitations around goals I wanted to set for my life, I believed that they were denying me my right to be treated equitably. A. Beck (1999) furthers the discussion on anger by noting that, when one feels angry, one establishes a cognitive us versus them dichotomy in order to blame someone for the wrongdoing. Upon further introspection, I began to realize that sex offenders were the ultimate offenders against women: the "enemy". By using stigmatizing and pejorative labels, whether consciously or unconsciously, I blamed and framed them in derogatory terms. Once the label had been placed, I began to perceive these individuals as inherently bad and I

judged them only by their criminal actions (Meier & Robinson, 2004). In retrospect, I realize that I had stripped them of any inherent worth or dignity. A. Beck (1999) suggests that, “the more extreme the undesirable derogatory adjectives, the less human the out-grouper appears and the easier it is to aggress against him or her with impunity” (p.154). I consciously labeled sex offenders and held them in the category of “undesirable” human beings. They became an object of my hostility.

Now, as I was faced with the task of advocating on behalf of individuals who had committed sexual offenses against women, I would need to overcome my anger and hostility, and confront the derogatory views with which I framed the total personhood of these individuals. I also recognized that I would need to work to engender a more balanced and realistic perspective of these individuals. In my field placement, I found myself challenging old beliefs about sex offenders. Although not condoning their behavior or offense, and maintaining a strong sense of empathy for their victims, I worked to adopt a wider perspective that would allow me to appreciate the individual human worth of each person and, in some cases, understand their own history of victimization. My experiences at the domestic violence and sexual assault shelters provided a perspective on the issue that spoke to my personal experiences of being a woman and the fear in which I lived. My experience at this placement showed me the offender side of the issue, which spoke to my passion to eradicate social injustices and provided me the opportunity to do an in-depth evaluation and reframing of the narrow and disparaging views I held towards sex offenders. At this moment in time I was facing an ethical dilemma fueled by the conflict between the social work value of

upholding the dignity and worth of the person and my personal beliefs. I wrestled with the question of whether a feminist social worker could advocate on behalf of sex offenders.

The conflict between my feminist and social work values hinged upon my inability to separate the intrinsic value of the individual from his or her behaviors. I was unable to see that, regardless of the specific behavior, (i.e. sex offenses that were committed) there is always a person that has the same dignity and worth as everyone else. I realized that, similar to the survivors that they have victimized, perpetrators of sexual offenses have often been subjected to harmful and hurtful experiences. Although the rates vary, a number of studies have reported that individuals who exhibit a history of sexual offenses show higher prevalence rates than non-offender populations of having been sexually abused as children (Dhawan & Marshall, 1996; Romano & De Luca, 1997; Seghorn, Boucher, & Prentky, 1987; Weeks & Widom, 1998) Following their study of 147 sex offenders, Coxe and Holmes (2001) also indicated that, although the factors that impact the dynamics of being both a victim as well as an offender are complicated, and no direct cause-effect can be inferred, there is the suggestion of a relationship between early history of being sexually abused as a child and later sexual perpetration as an adult. Severson (1994) writes that practitioners who work with offenders must have a different perception of these clients: “It demands a rethinking of the concept of victim” (p. 452), and even further, that all individuals, regardless of their behaviors, are worthy of the profession’s skills and knowledge in improving their social functioning and quality of life.

Human rights-based approaches to the treatment of sex offenders are founded on a core value that respects the dignity of all human beings (Connolly & Ward, 2008; Ward & Connolly, 2008). This value suggests that freedom and well-being of offenders, their victims, and the community are equally important for healthy communities. The Good Lives Model (Ward & Stewart, 2003) and the Offender Practice Framework (Ward & Connolly, 2008) are grounded in human rights philosophy and seek to ensure that offenders can identify and acquire the skills necessary to live a life that is meaningful to them, while at the same time respects the needs and rights of others. These models guide social work practitioners in the process of treatment and rehabilitation. During assessment and treatment, social workers must be cognizant that offenders are rights-holders, meaning that they deserve the same level of dignity and service as any other client. With this right, social workers must also realize that offenders are duty-bearers, meaning that they must respect and appreciate the needs and rights of others (Connolly & Ward, 2008).

While human rights perspectives have informed practice within the prison system, there has been little attention to human rights with regards to community reintegration and the freedom and well being of offenders upon their release from prison (Connolly & Ward, 2008). The goal of community reintegration is to afford offenders the right to redeem their criminal behaviors with a belief that they have the capacity to change. However, current policies such as sex offender registration appear to place more weight on the rights of the community, and deprive the offender of the opportunity for change. Ward & Connolly (2008) suggest that this

deprivation of human rights will result in the offender being unable to respect the rights of others. Offenders will resent the lack of dignity exhibited towards them, which decreases their ability to reintegrate into the community and increases the chances for re-offense.

Under a human-rights perspective, social workers must focus on the freedom and well-being of offenders throughout the assessment and treatment phases with sex offenders. Human rights can be ensured by focusing on respectful interactions with the offender, using the ethics of the profession to include them in the treatment process, and allowing for self-determination where possible (Connolly & Ward, 2008). Taking a constructive, humanistic approach to work with sex offenders is required for respecting their dignity, and allowing for freedom and well-being for a meaningful life, and successful community reintegration.

## **5. A New Self-Awareness**

My upbringing and field placement revealed to me the limitations that we place on ourselves and others when judgments are made based on narrow and simplistic perspectives of individuals. Now, through the process of self-reflection, I recognized that I had become judgmental. I internalized the judgmental behavior that I had experienced within my family, which placed limitations upon me, and I used that experience to blame and dehumanize those who, in my view, perpetrated oppression upon women. Through this process of self-awareness, I recognized that if I were to engage in the ethical practice of social work, I would have to bring about a fundamental change in some of my beliefs and values. I needed to find a resolution to the dilemma presented by these contending values and

also to find ways to express my anger in healthier and more pro-social ways.

Ultimately, my field placement experience forced me to confront my biases and prejudices and to become more congruent with social work values. Moreover, since I had also become judgmental of my family, I worked to rationally reframe those long-standing beliefs. I realized that my family did not intend to damage or limit me personally by imposing traditional gender roles upon me. They were simply reliving and recreating generational scenarios and rules that informed them as to how men and women should be and what paths in lives they should pursue. I learned that they had replicated historical societal structures that perpetuated men's domination of women that shaped their perceptions of the role of women. As hurtful and limiting as these perspectives were, I was able to recognize that my family meant no harm. I also learned that anger can be used prosocially to overcome and advocate for change, such as it has in the women's movement or how it has motivated service on behalf of those who suffer injustice (Ellis & Tafrate, 1997; Glassman, 1992).

As Dolgoff, Loewenberg, and Harrington (2005) suggest, ethical decision-making is not a prescriptive endeavor, but rather often involves a complex process of reflection on multiple factors impinging upon the situation. In this case the process involved identifying and reframing deeply held personal beliefs and values that clashed with my professional values. I recognized that some of my views and beliefs towards sex offenders were narrow and pejorative. However, I also realized that my feminist values of advocating for women's equality and their right to live free of fear did not preclude me from advocating against

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injustice and unfairness. Through a process that involved self-reflection, professional guidance and supervision, I was able to confront and resolve the dilemma between my personal and professional values in a manner that allowed me to evolve into a more competent and ethical social worker, and also to resolve longstanding feelings of anger.

When facing ethical dilemmas, social workers are encouraged to consult with colleagues, supervisors, and the professional organization as they may be of help in the process of ethical decision-making and resolution of the conflict (Cormier et al., 2009; Landau, 1999; Mattison, 2000). Gray (2007) suggests that ethical decision-making is a process that revolves around critical thinking, whereby supervisees learn to integrate their knowledge and experience and apply it to their practice. In this process the role of a supervisor is to challenge and encourage supervisees to critically reflect on the dilemma at hand by identifying conflicting values, understanding the ethical issues present, recognizing the moral implications of their action, acknowledging their responsibility in making ethical choices, and identifying and selecting a course of action (Christie, 2009). Often throughout this process the supervisee becomes aware of, and engages in, an examination of important beliefs outside the realm of immediate awareness.

In the case presented, supervision was an integral part of working through the ethical-decision making process. Furthermore, as a result of the critical analysis and self-reflection that such a process demanded, it led me to confront and reframe long-standing biases I held towards sex offenders. That process, in turn, sent me through a journey to revisit past experiences

and uncover deeply held beliefs and attitudes that were the root of my anger. Furthermore, reading the literature regarding anger, and consequently writing about the topic, helped me navigate through this ethical dilemma and emerge with a more open perspective.

## **6. Conclusions and Practice Implications**

What started as a critical moment in a social work internship led to a greater appreciation for the ethics and values of the profession. Through the guidance and support offered through supervision and professional development, which included a process of self-reflection and critical thinking, the eventual resolution of this ethical dilemma evolved. The implications of this journey emphasize the role of self-awareness and the need for social workers to be cognizant of their personal values, and how these values may conflict with those of the profession. Therefore, social work education, whether provided through formal courses or continuing education, should stress the ongoing development of self-awareness and the recognition of our own biases. Furthermore, social workers benefit from understanding that growth occurs when these conflicts are acknowledged, explored, and resolved. When conflict between competing values arises, personal core beliefs may highlight biases and prejudice attitudes that underlie the dilemma. Ultimately, social workers must be aware that, if these conflicts go unresolved, their practice with clients will be affected. Most importantly, the profession has mechanisms in place that are designed to guide its practitioners in their exploration and resolution of these conflicts. A number of decision-making models are available that

provide social workers with a framework to guide them in the resolution of ethical conflicts (Cormier et al., 2009; Kenyon, 1999; Mattison, 2000). Furthermore, social workers at all stages of professional development (but more so for those in the beginning stages of their career) should have a solid support network consisting of supervision and colleagues to help them navigate through situations in which they may face ethical conflicts. To the extent possible, social workers should use these mechanisms to explore and resolve conflicts between their personal and professional selves.

Drawing from their research with social workers in the field of domestic violence and sexual assault, McPhail, et. al. (2007) suggest a diversion from an entirely feminist model for practice, “Feminist practitioners no longer have to feel conflicted, disloyal, or constricted by the feminist model as it embraces a more complex understanding of violence without sacrificing the vital importance of a gendered analysis of power, control, and violence” (p. 839). Among many recommendations for changes to the standard feminist model, these authors recommend that feminist practitioners can use feminist theories and models as the foundation of their work, while at the same time using additional theories and models to explain, assess, and intervene in domestic-violence and sexual assault situations. As is reinforced by this exploration of the author’s ethical dilemma, McPhail et al. (2007) note that an ideological shift is critical when adapting these new theories and models; the identity of the perpetrator is no longer the focus; the behavior that creates and maintains such violence is. To this social worker, that knowledge was critical in resolving the dilemma between competing

personal and professional values and moving beyond such conflict into a more genuine form of ethical practice.

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## Book Review

Norwood, F. (2009). *The Maintenance of Life: Preventing Social Death through Euthanasia Talk and End-of-Life Care – Lessons from The Netherlands*. Durham, NC: Carolina Academic Press.

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*The Maintenance of Life* is an anthropological study on the practice of euthanasia in the Netherlands. Study data was collected over 15 months through direct observation and in-depth interviews of patients, families, and doctors. The data was interpreted relative to the historical and cultural context that gave rise to the legalization of euthanasia. The results were used to lend insight into the challenges of legalizing euthanasia in the United States.

The book begins by defining social death as being precipitated by a loss in one's physical capacity to engage in activities and relationships that inform social identity, enhance self worth, and sustain life meaning. In this case, social death is attributed to physical deterioration that occurs near the end of life.

Norwood found that patients most often struggled with the inability to do errands, live independently, control urine incontinence, and engage in social relationships. The significance of these losses was punctuated by patient efforts to sustain capacity to engage in relationships by avoiding pain medications that compromised mental alertness.

The process of euthanasia relies heavily on the Dutch tradition of "overleg," or dialogue. Overleg allows for active participation in social life through which social connection is facilitated and collaboration in decision-making occurs. In the case of euthanasia, the patient's *huisarts*

is responsible for overseeing a five-step process defined by "euthanasia talk."

The patient is responsible for (1) initiating the request for euthanasia that must be (2) submitted in writing by the patient. If the patient meets the criteria for euthanasia, the *huisarts* (3) will ask another *huisarts* to evaluate the patient for a second opinion. Then (4) a date is set for euthanasia upon which (5) euthanasia occurs. This process may be cancelled at any time by the patient or the *huisarts* as the content of euthanasia talk evolves.

The patient's primary *huisarts* may delay (or end) the process if there is an absence of family involvement or unresolved family conflict, the patient does not have a terminal illness with unbearable pain, or the patient shows signs of mental illness and/or suicidal thoughts. The patient may end the process and often does so before getting to the third step.

Based on this and other research, Norwood found that the majority of patients did not follow through with euthanasia, in part, as a result of the therapeutic effect of euthanasia talk.

Euthanasia talk gave patients the opportunity to increase their social engagement and life quality. Patients were able to shape life meaning, strengthen family bonds, and gain the peace of knowing what to expect at the end of life.

The author also explored the potential for euthanasia to be used inappropriately. These cases included instances in which pain medication was administered when “medically indicated,” life-prolonging treatments were withheld/withdrawn, and euthanasia was provided when the patient was too impaired to give consent (p. 89). However, close scrutiny of euthanasia deaths partially depended on the accuracy of voluntary reporting by the *huisarts*.

There were compelling narratives by *huisarts*, patients, and family members who experienced the euthanasia process. Social workers would likely appreciate the revelation of personal insights imbedded in these accounts. However, being an anthropological study, this material was largely overshadowed by a broader focus on the technical details of the study, results and sociopolitical context of the Netherlands.

The author concluded by summarizing how culture shaped the policies and practice of euthanasia in the Netherlands. There was some discussion about how the United States could address the issue of euthanasia,

but Norwood cautioned that the Dutch process would not be feasible in the United States given different cultural norms, health care funding, and service network for end-of-life care.

For example, patients at the end of life are at risk for social death. Without the opportunity to engage in euthanasia talk, patients must process alone whether to end their suffering with suicide being the only option. (Norwood cautioned that suicide introduced the potential for a failed attempt, which was less likely to occur with euthanasia.) Nevertheless, social workers must uphold the law despite patient needs to process or access such resources.

Altogether, this book is a masterful illustration of how one country successfully integrated euthanasia into the system of health care. Although bound by culture, it provides an excellent starting point for anyone interested in exploring how the United States might respond to the demand for euthanasia. It also alludes to the ethical challenges faced by social workers responsible for patient care.

## Book Review

Hunter, S. (2011). *Lesbian and gay couples: Lives, issues, and practice*. IL: Lyceum Books, Inc.

Reviewed by Shawn D. King, Ph.D., MSW, LISW

Author Dr. Ski Hunter has held a full faculty position at the University of Texas at Arlington since 1984. Dr. Hunter earned her Ph.D. in Social Work from The Ohio State University, a Master of Social Work from San Diego State University, and a Master of Science degree in Psychology from North Texas State University. She has received numerous academic and community service achievement awards. She is the author of more than five books and numerous articles that outline affirmative practice with lesbian, gay, bisexual and transgender individuals. The subjects of her books have addressed social work practice with midlife and older LGBT adults, coming out and disclosure issues, and practice issues for those who work to serve them.

In the author's most recent book, which is the focus of this review, the aim is clearly focused and directed to the current issues that face lesbian and gay couples. The author gives demographic information that is very up-to-date and informative about the gay and lesbian couple population. She clearly outlines a conceptual approach to her work in this book. She uses the introduction to discuss both heterosexism and the use of a postmodern and queer theory framework throughout the chapters. Furthermore, the author states that the aim is to give the intended reader better insight and understanding of how lesbian and gay couples process current gay marriage issues. The author points out that her aim is to inform practice, focusing on practice issues for lesbian and gay couples, and outlines the

various practice interventions that have potential to be effective in resolving those issues.

One of the biggest strengths of this book is the use of past research to inform and define the unique issues that have been found to be important for lesbian and gay couples. Additionally, the demographic information presented in the introduction reveals the most current statistics that we have for this population. The author devotes chapters to couple relationship satisfaction, sexual intimacy, and breakups. She also addresses intimate partner violence, grief, and bereavement from the lens of lesbian and gay couples. The author aims to inform the intended reader of the differences and similarities between lesbian and gay couples and heterosexual couples on issues related to courtship, dating, and various approaches to having children.

The intended readership for this book includes those individuals who want to better understand lesbian and gay couples and practitioners who work with them. The information presented specifically in chapters five and six gives the intended practitioner very good insight into important aspects from a psychosocial perspective when providing social services to this population. For instance, in chapters five and six, the author addresses points of social values and ethics with the importance of not assuming that all issues brought to lesbian and gay couple situations center on sexual orientation or identity. Instead, the author

suggests that practitioners ask the couple to define themselves, thereby adhering to a more client-centered and strengths based perspective. Furthermore, in chapter six the author discusses the importance of practitioners being knowledgeable about the unique ways that heterosexism affects lesbian and gay relationships. The author suggests using consultation when needed to help identify the focus of interventions and to also contact organizations such as PFLAG when needed for further resources. The author further gives important insight into gender role issues for lesbian and gay couples and the way that heterosexism and societal practices become barriers within these relationships. This reviewer found this information very important and insightful.

The book covers the chapter topics with great insight and backing from other scholars and research. Each chapter ends with a practice vignette that can be used to further practice the information that was presented in the chapter. In chapter one, courtship networks of lesbians give very important information. The chapter does not go as far in detail for gay male couples, and this may be due to the lack of research for gay couples. For instance, do courtship networks exist for gay couples as they do for lesbian couples, and to what extent? And, are these networks different or similar from those of lesbians?

In chapter two, which outlines the ways in which lesbians and gays have children, the author discusses how lesbian couples create their families and the effects on lesbians who have children, such as the division of labor discussion and how that affects these couples. This is important and great information for anyone, including practitioners, to better understand the unique aspects of the relationship of these couples. In comparison, there is only a small piece on gay male couples, and this again may be due

to the lack of research and knowledge that scholars have in this area. This chapter has a great section on disclosure to children and the effects on teens and how they are more affected by same-sex parents than younger children and what is believed to be the reasons why. This reviewer found that to be very important information for the intended reader. This reviewer, being a scholar in LGBT social issues, understands the importance of the disclosure or “coming out” process. In chapter seven this author discusses “coming out” and provides valuable and important guidelines for these issues with lesbian and gay couples. For instance, the author puts forth the importance of not forcing individuals to disclose, but instead help them to make decisions after careful consideration. The information presented in this chapter also includes information about interracial couples and their unique experiences with not only heterosexism but also racism. This gives the intended reader greater insight into working with interracial lesbian and gay couples. In the same chapter, the author discusses the death of a partner, the stages of grief, counseling models, and general techniques and interventions for working with the surviving partner. As throughout the book up to this point, these sections lack the unique aspects experienced by the lesbian or gay survivor. Instead, these sections read in general terms about the topics found in many books on grief and bereavement.

The author concludes with chapters eight and nine. Chapter eight gives the intended reader more insight into practice intervention approaches that reduce heterosexism that is internalized by lesbian and gay couples. The author discusses liberation practice, feminist and pro-feminist practice, and affirmative practice. The use of gay affirmative practice is considered by several scholars to be a promising approach

for those who struggle with self-acceptance and to reduce the effects of internalized heterosexism. In the same chapter, the author discusses social support and the need to create bonds with others, what scholars and this author refer to as “family of choice.” The author goes on to cite research that points out that lesbian and gay couples need social support networks consisting of eight to twelve people. The final chapter on same-sex marriage provides several important issues surrounding marriage for these couples, including the effect on children of lesbian and gay couples, the lack of a legal system to protect couples who break up, and the response to the current gay marriage climate in the United States from

different perspectives within gay communities.

Overall, this book provides relevant and important information for anyone who wants to better understand the effects of heterosexism on the lives of lesbian and gay couples. It provides information that establishes, while being members of a specific defined population, the unique and differing problems that lesbian and gay couples bring to social services and practice. This book offers the intended reader more insight into the heterogenic nature of lesbian and gay couples and the need to approach practice and services with this understanding in order to provide ethical practice.

## Book Review

Fox, R. (2011). *The use of self: The essence of professional education*, Chicago: Lyceum Books Inc.

**Reviewed by** Veronica L. Hardy, PhD, LCSW  
University of North Carolina at Pembroke

*The Use of Self: The Essence of Professional Education* (2011) provides insight into the process of creative teaching pedagogy. The author, Dr. Raymond Fox, is currently a professor within the Graduate School of Social Service at Fordham University. For approximately fifteen years, he has been actively involved in conveying information about teaching methods and curriculum through workshops and seminars for university faculty. Furthermore, he has several publications to his credit, including scholarly journal articles, book chapters, and three books. To develop this current text, Fox has drawn from his experience in professional education to communicate the benefits of self-awareness and the use of diverse teaching techniques in the classroom environment. As a result, the book is divided into three parts that address the themes of teaching and learning in relation to self-awareness, the process of teaching, and methods that can promote reflection amongst students.

Part One of this writing speaks to the fluidity of teaching and how the educator can integrate the roles of self and practitioner into transactions with students. This is encouraged through evaluation, modeling, and allowing “teachable moments” (p. 14) that promote a student’s deeper engagement with the content. Fox further connects the classroom process as the means for students to transition into professional practice with clients. Next, Part Two provides educators with insight on how to enable students to function as professional

practitioners. In addition, Part Three provides a combination of six applied techniques that promote personal reflection, interrelation with classmates, and interaction with clients. The techniques are: journaling, movies, storytelling, case/critical incident, photography and art, and role playing.

The author provides multiple examples of teaching strategies that reflect the educational goals. For example, as social work includes several types of writing, such as process recordings and journaling, Fox describes methods that are student-centered, enhance self-awareness, and incorporate the professional knowledge base. Overall, writing is noted as a reflective technique that addresses the course learning objectives. Next, the case method is used to promote critical thinking and engage the student with experiences related to professional practice. The author addresses case selections that are consistent with “students’ level of development” (p. 127). The case method should engage students in skills such as problem-solving, reflection, and application. As a result, this text outlines methods that educators can apply in the classroom and through course assignments to enhance students’ ability to recognize factors impacting clients, analyzing various systems, and applying theoretical knowledge.

In conclusion, *The Use of Self: The Essence of Professional Education*, has several strengths that can contribute to facilitating a reflective learning experience for students.

For example, the author stresses the transfer of knowledge between classroom learning and professional practice. Furthermore, he encourages the integration of experiential learning opportunities into the teaching pedagogy through six methods that promote activity and reflection. Based on the information and applicable strategies noted throughout this text, it is recommended that this book be used for training of faculty regarding teaching pedagogy, course development, and methods of assessing student growth within the social work profession.

## Book Review

Wymer, W. & Grau, S. L. (2011). *Connected Causes: Online Marketing Strategies for Nonprofit Organizations*. Chicago, Illinois: Lyceum Books, Inc.

Reviewed by Dr. Ottis Murray  
University of North Carolina at Pembroke

According to the National Center for Charitable Statistics (<http://nccs.urban.org>), there are more than 1.5 million nonprofit organizations in the United States. Given the rapidly changing world of nonprofits and the increasing, numerous challenges facing these organizations (e.g., recruiting for volunteers, seeking new and sustaining current donors, informing stakeholders), an online marketing strategy and online presence is essential. This book seeks to assist nonprofit managers in developing the necessary skills to effectively evaluate, plan, and use online tools to bridge potential marketing gaps by developing an online response and alternative.

Dr. Walter Wymer, Professor of Marketing at the University of Lethbridge in Alberta, Canada, has co-authored or collaborated on nine books about nonprofits, ranging from marketing communication and nonprofit/business sector collaboration to nonprofit marketing and volunteerism marketing. He is widely published and a respected scholar in the field. Co-author Dr. Stacy Grau, Associate Professor of Professional Practice in Marketing at Texas Christian University, has focused on strategic planning and brand building efforts for nonprofits in addition to teaching in the Neeley School of Business at TCU.

The book is well organized; each chapter begins with a brief *overview* and concludes with *lessons learned* and suggestions for *further reading*. In ten well-written,

information packed chapters, the reader is introduced to the potential of online strategic marketing and completes the journey with digital insights and current research. The book is replete with interesting illustrations of online applications; for example, *Texting to save Haiti*. In January 2010, a 7.0 earthquake destroyed the town of Port au Prince. The Red Cross began a texting campaign that was publicized across a wide variety of media (e.g., local and national news, ESPN). The Text HAITI to 90999 campaign raised \$36 million. The power of online tools and social networking is becoming more readily apparent.

I basically divided the book into two sections. Section one (Chapters 1-5) focuses on nonprofit “branding,” the importance of website design and use of social media and the importance of a content strategy, and a discussion of “digital technology tools” (e.g., blogs, wikis, social networks, podcasting, widgets). The significance of “branding” was illustrated by the Obama Campaign for President, in which social media was used and the campaign raised 65 percent of the \$150 million from online contributors. And as the authors point out, the average donation was \$80.00. The obvious lesson: “do not underestimate the power of everyday people to give; small amounts add up.”

The book contains a variety of useful worksheets, ranging from website assessment and analysis to pointers for

visual and content design. These will prove very helpful for the nonprofit manager or organization in planning and evaluating key elements of an online marketing strategy. I was impressed with the specific discussions of online tools; they were sufficient in detail to inform, but not overwhelm, the reader. The format generally provides a description of the online tool, followed by its possible application and then an evaluation of its potential usefulness. I found this to be an important resource for developing or updating an online presence, as well as in designing a proactive online marketing strategy.

I found it easy and sometimes useful to jump to chapters that caught my eye (e.g., *Online Advocacy and Activism*), and I could comfortably fall back to previous chapters (e.g., *Social Media Content Strategy*) for a description and discussion of the more foundational aspects of planning, strategy, and technical aspects of various online technologies.

Section two (Chapters 6-9) addresses some specific nonprofit challenges (e.g., online fund-raising, volunteer recruitment, advocacy, activism, and public relations). I found these chapters to be very comprehensive and enlightening. For example, in a discussion of the “online volunteer recruitment efforts,” the importance and role of volunteers is covered, as well as a summary of insights for the development of a volunteer program. The authors discuss various motivations for and benefits of volunteering, which leads to an assessment of online approaches that may be successful in terms of creating a website to aid in recruiting, training, and retaining volunteers.

In my previous life, over 20 years, I worked for nonprofits. As I recall, defining who we

were, marketing services, recruiting volunteers, informing stakeholders and various publics, and constantly seeking resources created considerable stress on the organization and staff. Unfortunately, many of our efforts were generally trial-and-error; consequently, there were many unsuccessful endeavors at great expense in terms of time, energy, and scarce resources.

Today, online tools provide a powerful resource for nonprofits to more efficiently and effectively accomplish these and many additional tasks. But sadly, the availability and use of online tools, without critical assessment and strategic planning, may actually undermine the nonprofit’s mission and organizational goals. This book provides critical information to help avoid a trial-and-error strategy. It is not a simple process; adopting all the available online tools will not result in a successful marketing strategy. Careful assessment, planning, and ongoing evaluation are critical to success.

This book provides a very measured, clear, concise, and thorough examination of the important elements that should be considered and well-planned prior to the implementation of an online marketing strategy. The authors have created a valuable resource to aid in this investigation and strategic planning. The book helps the nonprofit manager understand the usefulness and potential value of various online tools (both positive and negative, given certain environments/challenges). This, along with the worksheets, numerous examples and questions, and rich details, provides a very timely and extremely useful asset for the nonprofit manager and his or her organization. Additionally, this book would be a useful text in courses related to community development, fund-raising, advocacy, social activism, volunteerism,

social work, nonprofit management, social movements, and social entrepreneurship.

I am reminded of Roger Maris of the New York Yankees baseball team. In 1961, he hit 61 home runs, breaking Babe Ruth's record of 60 home runs in a single season. Roger was quoted as saying, "you hit home runs not by chance, but by preparation." Wymer and Grau's book will help nonprofits prepare to hit those home runs in the field of online marketing.

## Book Review

Brashier, Ralph C. 2010 *Mastering Elder Law*. Durham, NC: Carolina Academic Press.

Reviewed by Stephen M. Marson, Ph.D., Editor

As a gerontologist and forensic social worker, I was quite pleased to receive *Mastering Elder Law* to review. Although Brashier does not explicitly express his intended audience, it is obvious that he intended his work to be used by law students and lawyers. I believe that Carolina Academic Press did not understand that they could capture a larger audience with this work. Although there is some legalese scattered throughout the book, there is not enough to deter gerontological social workers—particularly nursing home social workers—from purchasing it to include within their libraries. Simply stated, this is easy to read for nonlawyers. In addition, several other key strengths are notable.

First, I have read *many* books that have “Elder Law” in the title. The major weakness of all of these volumes is the timeliness. Laws change. This reality is a clear expectation for lawyers, but not gerontological practitioners. Thus, virtually all books addressing elder law have a very short shelf life. Brashier’s work is the clear exception. He is able to keep the reader timely by offering web pages that offer greater information and updates on legal standards. Not only is this a great benefit to readers of *The Journal of Social Work Values and Ethics*, it should benefit lawyers, also.

Second, a common colloquial expression within social work practice is, “there is the law and then—there is *the law*.” The harsh reality is our legal system is not blind. Although judges, lawyers, and legislatures make efforts to be fair, oftentimes our legal

system is unbalanced. Everyone *is not* treated in the same manner, laws are sometimes *not* enforced, professionals can violate laws *without getting caught*, and most importantly, the cost (financial and personal) for addressing these clear concerns is problematic. In the end, nothing is done. This commentary is not new information to any reader of this review. What is new is that Brashier employs this perspective as a theme in many sections of his work. He commonly warns the reader that just because a statute is in the book, it doesn’t mean that it will be enforced. A clear discussion of this theme can be seen on page 42, where the legal aspects of “the least restrictive alternative” are addressed. In addition, Brashier reports that courts are motivated to dispose of cases as quickly as possible—not much time to think for the social worker who has not planned in advance. Social workers must be prepared to have the energy to advocate!

Third, court actions are not always consistent with what social workers are taught and what they have read in their textbooks. In addition, the law in general, may not always be parallel to social work values and ethics. Entry level social workers might find themselves paralyzed with shock in the practice arena, but reading Brashier will prepare practitioners for the expected. He does a good job of providing case scenarios in which court outcomes are contrary to the social worker’s value/ethical expectations (see page 31 for an example).

For gerontological social workers, chapter 6’s section on Social Security will not

include any new information. I suspect that social workers might know more about Social Security regulations than the average lawyer. Chapter 6's section on retirement and pension programs is clearly worth reading. I could not find information in chapter 7 (Supplemental Security Income), chapter 8 (Medicare), and chapter 9 (Medicare) that is not thoroughly known by most practicing gerontologists.

The major weakness of the book might be its major strength. Throughout my reading, Brashier would capture my undivided attention on a critical issue of law. Here, he would note that each state addressed the topic in a unique manner. While reading, I found myself becoming frustrated. I asked myself, "Why can't he create a table that lists each state and the manner the topic is addressed for each respective jurisdiction?" I have seen this type of table in other books. In reflection after I completed the book, two issues emerged. First, laws change. There is

no guarantee that a table of state laws and regulations would be accurate after publication.

Commonly, Brashier fails to offer a URL to assist. Frankly, social workers would not know where to seek out current and correct information. Second, Brashier's intended audience includes legal professionals. They will have no problem seeking out up-to-date information. For social workers, the lack of specific information regarding jurisdictional statutes is the only weakness of this book. For legal professionals, there is no problem.

In general, when compared to other books addressing elder law, Brashier's work is clearly a cut above. He writes in a manner that is understandable by social work practitioners. I strongly recommend academic libraries that have a social work specialty include this volume. In addition, this is a particularly good reference piece to include within a nursing home library.

## Book Review

Siddharth, K. (2009). *Sex trafficking: Inside the business of modern day slavery*. New York: Columbia University Press.

Reviewed by Paige E. Fossum  
University of South Dakota, Sioux Falls, South Dakota

Siddharth Kara visited Slovenia during college, where he witnessed immense poverty, insurmountable strife, and the predisposition to human trafficking. Though he continued on to receive his Masters in Business Administration from Harvard University, he could not forget the painful stories of Slovenian sexual crimes. He began a journey to understand the origins of sex trafficking and human slavery. This expedition led to sixteen different countries and hundreds of interviews with individuals and families involved in the industry. His goal was defined on this trip: to abolish sex trafficking and all other forms of contemporary slavery. Kara wrote this book as a call to action for individuals, governments, and organizations to realize the origins, tragedies, and potential solutions for the current crisis of human trafficking worldwide.

As he dangerously enters brothels in the depths of the Nigerian mountains or the streets of India, he takes the reader along. This is not an easy trip, as the stories are filled with rape, abuse, and murder. The testimonies are graphic, detailed, and horrifying. Yet they serve as the greatest call to action. The reader cannot remain unaffected by the suffering that individuals and families endure at the hands of traffickers. Kara does more than respectfully

narrate the stories of the individuals. He explains the reasons trafficking exists while outlining his own solutions for eradicating it. Kara's rhetoric holds the reader while his experience enlightens. Whereas his overarching goal is not necessarily attainable through reading this book, there are steps any reader can take. Even the smallest gestures could help, such as sharing the book or discussing trafficking with friends, family, and co-workers.

The first chapter of this book provides a thorough orientation on trafficking today and goes beyond a mere definition. The author outlines the "*Anatomy of Sex Trafficking*," including the steps of acquisition, movement, and exploitation. Kara illustrates the immense profit made by slave owners and traders today and argues that the supply of slaves is facilitated through economic globalization and the proliferation of Western capitalism. The vastly unequal wealth distribution that has left millions living with less than \$2 per day, the erosion of social programs, and the disappearing freedoms for humans in certain desolate countries all contribute to the ease of trafficking. Kara shows the utter disdain in many countries where sex slaves are recruited for the notion of equal rights for women. He also shows the failures of law enforcement to prosecute the criminals or

protect the victims. In fact, in many of the countries Kara visited, the police were either bribed by or involved in the brothels themselves.

The middle section of his book details the places where trafficking exists. He explains his visits to India and Nepal, where the youngest girls are valued the most, families send their daughters off to work and never hear from them again, and there are few places that help victims if one ever escapes. Next he discusses Italy and Western Europe, where pimps are called protectors, police are often the main clients, and the crimes are organized within an intricate system of interracial gangs. In Moldova and the former Soviet Union, false job opportunities are used to entice young women, and often the sheer poverty makes families so desperate they will believe nearly any artificial pretense. Moreover, the ease of travel between the European Union assists traffickers in moving their victims. Women are often lured into false marriages, and child beggars are forced to lie in the streets of Albania and the Balkans. Kara also describes his visit to Thailand and the Mekong sub-region, which he describes as a “giant brothel.” In the United States, trafficking is not as prevalent as other countries, yet Kara takes time explaining that victims are moved quickly and often within the United States.

Some of Kara’s research endeavors consisted of staking out along borders or watching boats in harbors. Those estimates are not reliable and might mislead some readers. Although accurate estimates are hard to achieve in an underground crime, better methods can be utilized and would improve parts of this work. Furthermore, the vast amount of information on each country is astounding. His knowledge, combined with local resources, could be used to create country-specific literature to assist in eradicating human trafficking.

Kara mentions that good Samaritans and neighbors have been vital in saving many victims from desperate situations. By having this background information, citizens across the world will become more aware of the problem and learn how to help. Moreover, social workers who are working with youth, women, and immigrants should be well-educated in trafficking worldwide to assist those who have experienced this trauma. Social work educators may use this book to expand student awareness of these global injustices, while practitioners may find this book as good preventative medicine against increased sex trafficking in the United States. As more people go on this journey with Kara, the knowledge of this problem will expand, and hopefully as others feel called to action, the youth in this world will no longer become victims.

## Letters to the Editor

*Journal of Social Work Values and Ethics*  
Fall 2011, Volume 8, No. 2

Dear Editor,

Thank you for sending the Spring 2011 edition of the *Journal of Social Work Values and Ethics*. I have benefitted a lot from previous editions and found the articles very educating. I am a doctoral student in the department of counseling psychology and social work.

I like to appreciate you and your team for your good work through this medium.

Compliments of the Easter Season to you all.

Mrs. Angella Idonije  
Principal Assistant Registrar  
Igbinedion University, Okada  
Nigeria

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Steve,

After too many years, I am finally retired. Your work on assuring that the JSWVE is sent to members of the SOCWORK list is very much appreciated. While I am retired, I still take great pride and satisfaction about being a social worker. It is important to me to continue my learning through the journal and the work of others. Thank you so much for your work, professionalism, humor, and pride in the profession of social work.

Michael L. Comini, long-time member of  
SOCWORK