



Journal of Social Work Values and Ethics, Volume 11, Number 2, 2014
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Editorial: TERM PAPER CONTEST!

Stephen M. Marson, Ph.D., Editor

In celebration of 15 years of *The Journal of Social Work Values and Ethics*, we proudly announce our second term paper contest! The term papers will be collected by the JSWVE editorial board and judged by a board of professionals *not* associated with JSWVE. Winning papers will be published in the Fall 2015 issue.

Details for the contest are listed below.

1. Must have a central theme of social work values or social work ethics
2. Must be written as an MSW or BSW student (student may have graduated)
3. Must be nominated by a faculty member (the nominating professor's name will be published)
4. Must follow the general manuscript submission guidelines found at <http://www.jswve.org/images/PDFs/jswvemanuscriptformat1207.pdf>
5. Must be in APA citation style (except NO headers, NO footers, and NO page numbers)
6. Submission deadline: **May 15, 2015 noon**. No entries will be accepted after that time.
7. Paper must be submitted by email to smarson@nc.rr.com with a copy sent to donnadandennisv@gmail.com
8. Winning term papers will be published in *The Journal of Social Work Values and Ethics* in the fall issues of 2015.
9. Judges will be professionals who are NOT associated with the JSWVE editorial board
10. Judging criteria will include:
 - Critical Thinking Skills (15 points)
 - Relevance to Theme of Social Work Values and Ethics (15 points)
 - Relevance to Social Work Students, Practitioners, and/or Academics (15 points)
 - Coverage of Topic (15 points)
 - Use of Relevant, Scholarly Citations (10 points)
 - Coherence (flow of ideas, organization) (10 points)
 - Quality of writing – spelling, grammar, coherence (10 points)
 - Originality of the presentation (10 points)

The judges will be members of the North Carolina NASW Chapter Committee on Social Work Values and Ethics and the NASW (DC) Committee on Social Work Values and Ethics.

Ageism and Future Cohorts of Elderly: Implications for Social Work

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Journal of Social Work Values and Ethics, Volume 11, Number 2 (2014)
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Abstract

In the field of prejudice and discrimination studies, an emphasis has been on racism and sexism, with comparatively little attention to understanding of ageism. This fact is alarming, particularly in the context of the growing population of older adults around the globe. This article provides a review of evidence of ageism among members of helping professions. The author expresses concern and develops an argument that ageism will increase as Baby Boomers reach retirement years. Implications for social work are then discussed.

Keywords: Ageism, aging, older adults, gerontological social work, baby boomers

1. Introduction

Ageism is a difficult concept to identify and study due to its multidimensionality. Ageism is usually associated with inferior treatment of older adults, which will be the scope of this article. However, it should be mentioned that ageism can be directed against any group of people, when age is taken as a major attitude-determining factor (Butler, 1969). Ageist attitudes and beliefs often times may evolve into behavioural manifestations, resulting in discrimination and social exclusion of a particular group of people based on their age, negatively impacting well-being and quality of life of the stigmatized persons (Corrigan, 2004).

Therefore, ageism is an important phenomenon to address in social work clinical, educational, and research settings.

While racism and sexism, in the areas of prejudice and discrimination, have been extensively researched, comparatively little attention has been devoted to ageism (Nelson, 2011). That being said, the growing population of older adults has stimulated an increasing interest in ageism over the last few decades (Wilkinson & Ferraro, 2002). Although the exact extent of ageism remains unknown, there is evidence that it transcends culture (Cuddy, Norton, & Fiske, 2005; Rust & See, 2010; Thornstam, 2006). Moreover, a number of studies reported an alarming connection between ageism and other types of prejudicial attitudes and discrimination, such as sexism (Anderson & Hun, 2008; Harbison, 2008; Hard Clarke & Griffin, 2008), as well as the connection between ageism and various forms of abuse (Aosved & Long, 2006; Baa et al., 2010). Furthermore, it is disconcerting that ageism exists among members of helping professions (Acktoy-Stolarz, 2008; Bianchini, 2000; Klein, 2007; Ray, Raciti, & Ford, 1985; Rosowsky, 2005), including social workers (Allen, Cherry, & Palmore, 2009; Bianchini, 2000; Kane, 2007). These findings will be discussed later in greater detail.

The purpose of this paper is to provide an overview of ageism across several helping professions, and to invite the community of social work

professionals to join a debate on ageism in its various forms as an important social justice issue. The author first defines the phenomenon of ageism, reviews its origins and manifestations, and then presents evidence of ageism within the general population and members of helping professions. The author shares a concern in relation to the future of ageism in the context of the “baby boom” generation and the anticipated ageist manifestations that will occur as the Boomers continue to reach retirement age.

2. Defining the Phenomenon of Ageism

Wilkinson and Ferraro (2002) define ageism as widely accepted discrimination against older people, based on the belief that aging makes people less attractive, intelligent, sexual, and productive. Examining the construct of ageism and ableism, Angus and Reeves (2006) argued that old age, like impairment, is not a biological given but is socially constructed, both conceptually and materially. They claimed that ageism and ableism are similar in that each one is a system of oppression.

Defining ageism solely in terms of discrimination and oppression is not quite accurate; however, neither term implies that ageism is only about old age. Defining ageism as a system of oppression against older adults does not leave much ground for broad discussion. For example, ageism can result in pro-social benefits for the elderly. Among these are subsidized fares in public transportation and housing, special membership discounts, and amenity provisions. A more inclusive definition of ageism, therefore, is necessary to account for multidimensionality of this social phenomenon.

According to Butler (1969) who coined the term, ageism refers to stereotyping, bias, and/or discrimination of individuals based on their chronological age. Therefore, ageism can be relevant to any age group, even though it is often used in relation to older adults (Marshall, 2007). Moreover, it is important to differentiate between ageist stereotypes or beliefs, prejudicial attitudes about age, and age-based discrimination.

As Corrigan (2004) noted, stereotypes are normal features of the way humans perceive the world. Additionally, stereotypes function as efficient means of categorizing information about social groups (Corrigan, 2004). Not all stereotypes of aging are negative in nature. This explains the notion of ‘positive ageism’, which attributes positive qualities to people of a particular chronological age, for example, the belief that wisdom is the province of the elderly. While some stereotypes may be based on realistic characteristics of an age group, the stereotypes might not apply indiscriminately to members of the group. Nelson (2011) argued that all stereotypes about social groups are incorrect by their very nature, because they erroneously assume a homogeneity among humans that simply does not exist (p. 37).

In contrast to stereotypes, which are beliefs, or unfavorable attitudes (Deacon, 2006), prejudice is fundamentally a cognitive and affective response that often leads to discriminatory reactions (Corrigan, 2004). However, stigma and prejudice should not be defined in terms of discrimination (Deacon, 2006). Deacon (2006) noted that discrimination is only one negative effect of stigma. Others include status loss, internalization, and failure to take advantage of social, economic and healthcare opportunities because of expected stigma. Therefore, negative stereotypes, prejudice, and discrimination may rob people of important life opportunities that are essential for achieving life goals (Corrigan, 2004). With these considerations in mind, ageism should be defined as a multi-dimensional concept, which incorporates ageist stereotypes (both positive and negative beliefs), prejudicial or stigmatizing attitudes, and age-based discrimination (Marshall, 2007).

In this paper, ageism is discussed in the context of older adults. The research on ageism has helped to uncover not only the blatant forms of this phenomenon, but the subtle, implicit social manifestations of ageism (Wilkinson & Ferraro, 2002). For instance, Rosowsky (2005) commented that both overt and subtle expressions of ageism equally affect individuals and systems, both formal and informal. In this vein, Nelson (2011) argued

that in the United States ageism has become institutionalized, meaning that society allows, accepts, and even condones the stereotyping of older adults. As public policies reflect societal attitudes, pervasive age stigmatization results in structural ageism. Longino (2005) asserts that limitations in social, economic, and healthcare services gradually begin to reflect institutionalized stigmatization. These and other manifestations of ageism will be presented in several empirical studies that appear further in this paper.

3. Research on Origins of Ageism

Scholars have reported findings, consistent with the notion that ageism, similarly to other stereotyping thinking, is an automatic function of human social perception (Duncan & Schaller, 2009; Nosek, Banaji, & Greenwald, 2002; Perdue & Gurtman, 1990). As an example, Duncan and Schaller (2009) conducted an experiment with a sample of 88 undergraduate students in a Canadian university and concluded that the study provided evidence indicating that implicit prejudices against older adults could partly result from the operation of disease-avoidance mechanisms. However, Devine (1989, in Nelson, 2011) in her research argued that, although activation of stereotypes is automatic, the influence is environmental in that the learning history, the value system, and the motivation to override the automatic activation impact the resultant attitude and behavior of the perceiver.

Additionally, Nelson (2011) provided another explanation of the origins of ageism suggesting that ageism is an outcome of the recent historical developments. He noted that during the era of communal life young people did not harbor prejudices against older people. In fact, older people enjoyed respect and privileged status of decision-makers, owing to societal perception of them as sources of wisdom and important information. Nelson mentioned two events that have changed the personae of older people: 1) the advent of the printing press, which took away the unique status of older people as the sole repository of information; and 2) the industrial revolution and its requirement for a young, mobile workforce, one that

moved long distances from older family members and required less emotional support previously provided by elders in the family. The decreasing mutual support eventually created the phenomenon that is known today as the generational gap.

Some scholars have emphasized cultural origins of ageism. Since the beginning of 21st century, the new mantra of the “successful”, “resourceful”, “healthy”, “positive” aging has been reflecting anti-aging societal values and aspirations to reduce age-affective losses (Bayer, 2005; Longino, 2005; Rosowsky, 2005). Bayer (2005) argued that, although ‘positive’ aging could serve to counter age-related prejudice and discrimination, it is basically oriented towards youth retention, rather than aging well. Similarly, Rosowsky (2005) noted that “the whole concept of anti-aging has little to do with achieving the best possible old age. Instead, the social messages call for an extension of youth until it meets death, thereby avoiding old age altogether.” (p. 55)

Nelson (2011) illustrated how culturally biased, ageist messages are delivered through movies, television, magazines and advertisers, using an example of birthday cards for mature people with pity, derogatory or grieving messages. Longino (2005) referred to this phenomenon as cultural ageism and described it as an attitude embedded in a type of consumerism that celebrates a beautiful body, thus berating the physical characteristics of the aging. Bayer (2005) referred to this as a cultural battle against aging, stimulated by cultural insecurities and fears related to aging. Nelson (2011) added that a tremendous anxiety associated with aging process is the result of stereotypical perceptions of old age as a time of lost independency, freedom, health and attractiveness, respect and financial ability that all culminate in death.

Some empirical evidence (Martens et al., 2005; Greenberg, Schimel, & Landau, 2004) and theoretical conceptualization (Greenberg, Schimel, & Mertens, 2002) support the utility of the terror management theory (Greenberg, Pyszczynsky, & Solomon, 1986) in understanding of the meaning and purpose of our existence, which serves as a buffer against anxiety of our own mortality.

According to terror management theory (TMT), older adults are a reminder of our own mortality, which can explain anxiety associated with them. By blaming those who are aging and treating elders with pity, anger, irritation, or patronizing speech, young people are affirming their right to eternal youth, thus never growing old, which only happens to the elderly.

4. Is There Such Thing as Ageism? Evidence of Pan-Cultural Ageism

With the concept of ageism defined and its origins generally understood, the next important issue relates to prevalence of ageism in the contemporary world. To date, however, large-scale epidemiological studies on ageism are limited; therefore, only two studies (Cuddy, Norton, & Fiske, 2005; Thornstam, 2006) will be reviewed in this section. Other qualitative and quantitative works were conducted with convenience samples and provided mixed accounts on ageism in various countries.

Palmore (2004) conducted a cross-sectional study, administrated through a specially developed instrument, Ageism Survey, with satisfactory reliability and validity. The researcher used convenience samples of older people in the United States (N = 152) and in Canada (N = 375). The researcher noted gender and education as the common sample traits. Regarding age as a trait, the Canadians were younger than the Americans. The results showed that ageism is perceived as widespread by most respondents in both countries, though it is reported more often in Canada than in the United States (91 percent vs. 84 percent respectively). The most frequently reported incidents included hearing derogative joke about the aging; receiving greeting cards that demeaned the elderly; and observing incidents of age discrimination.

In a quantitative study of 140 Canadian undergraduate students, Palmore, Rust, and See (2010) confirmed the generally negative beliefs about aging among Canadians. Contrary to these findings, Linberts and June (2006), in a quantitative, quasi-experimental study at an American university, reported no evidence of ageism neither

among young nor older students (N = 87). However, both studies used convenience samples, resulting in limited generalizability of the findings.

Cuddy, Norton and Fiske (2005) conducted a large-scale, international study to learn about the prevalence of ageism and whether elderly stereotyping is unique to the American culture. The researchers collected data from six international countries, and concluded that elderly stereotypes are consistent across cultures. The authors referred to that finding as a pan-cultural ageism, whereby society views old people as having low status and being non-competitive.

Interestingly, findings from a recent Turkish study (Yilmaz, Kisa, & Zeyneloglu, 2011) discovered different findings. The authors conducted a cross-sectional study of a random sample of students in a Turkish university (N = 378) and concluded that students' views of older adults are generally positive. This study is rare in that indicators of ageism are few. On the contrary, a vast majority of the studies, particularly large-scale projects, do suggest that ageism exists in various countries.

Thornstam (2006) conducted a large-scale study in Sweden based on the data from postal surveys sent randomly to 3,000 people between the ages of 15 to 85 (response rate of 69 percent). Using a dichotomous scale of correct/incorrect, respondents rated statements that measured positive and negative attitudes toward the elderly. Although ageism varies in its manifestations, Thornstam concluded that ageism is prevalent in Sweden. Resulting from his study, Thornstam created a typology consisting of four attitudinal variations of responses to older adults (Type 1, Type 2, Type 3, and Type 4). Twelve percent of the respondents comprise the Consistently Negative group (Type 1) and reported negative attitudes regarding the role of the elderly in society. Twenty two percent (22 percent) belong to the Pity Positive group (Type 2) and expressed negative beliefs about the elderly. An additional orientation of Type 2 places restrictions on the role of older people in society. The No Fuzz group (Type 3), or 30 percent of the participants generally held positive images of older people and reported no pro-old image of their role in

in society. The Consistently Positive group (Type 4) accounts for 36 percent of the respondents and holds positive beliefs about older people and their collective role in society.

Despite the mixed data presented in this section, large-scale studies based on random samples revealed existence of ageism in the general population around the globe. The next section presents studies on intersectionality of ageism, or the co-existence of ageism with other forms of oppression.

5. Correlates of Ageism, Sexism, and Other Prejudicial Attitudes and Behaviors

A number of scholars have reported correlates of ageism and other prejudicial attitudes and behaviors. For example, Rupp, Vodanovich and Credé (2005) as well as Thornstam (2006) reported aged-gendered correlation of ageism, meaning that being younger, as well as being male seemed to increase the probability of having prejudices toward older persons.

Hard Clarke and Griffin (2008) referred to the aged-gender correlation of ageist attitudes and manifestations based on membership in different gender groups as gendered ageism. In their qualitative study of 44 women in the United States, Hard Clarke and Griffin described beauty work as a response to ageism, and argued that acquisition of visible signs of aging resulted in social invisibility, causing women to mask their chronological age through the use of beauty work. The study theorizes that women's experiences of aging and ageism are deeply rooted in their appearances and in the ageist, sexist perceptions of older women's bodies.

Anderson and Hun (2008) reviewed Ohio newspaper obituaries (N = 400), which covered a thirty-year period and concluded that photographs provided for deceased women and for older adults were more likely to be age-inaccurate than those of men and young people. Furthermore, the findings revealed that society's bias toward youthful appearance has increased over time, particularly in the case of older women.

In a Canadian study that examined ageism and sexism in the lives of older women experiencing spousal abuse, Harbison (2008) studied the women's needs to persist in these relationships. She argued that failure to address differences between older and younger women's needs stems from the ignored effects of the ageism and age-based oppression embedded in age relations with old people. In this vein, a quantitative study conducted in the United States focused on 492 male and 506 female college students in Illinois and revealed the interrelatedness of rape myth acceptance, racism, sexism, homophobia, classism, ageism, and religious intolerance (Aosved & Long, 2006).

In their Canadian study, Baa et al. (2010) examined proclivity of elder abuse by young adults enrolled in a post-secondary institution, using a convenience sample of university students (N = 206), who completed questionnaires on attitudes towards older persons. Results indicated that students' attitudes were correlated with elder abuse. When compared to middle-aged adults, young adults exhibited higher levels of ageist attitudes toward older persons. When compared with physical abuse factors, psychological abuse appeared stronger.

The review of the studies on intersectionality of ageism in the general public suggests that ageism exists across the globe and relates to other oppressions. One may wonder whether the picture varies when it comes to helping professionals, such as doctors, nurses, social workers, psychiatrists, and psychologists, the professionals who are guided by the highest ideals and ethical standards.

The following section presents a body of evidence that relates to the prevalence of ageism in research, clinical practice, and education within these disciplines, including social work.

6. Ageism in Research, Clinical Practice, and Education among Helping Professions

According to Nelson (2011), general under-interest in aging issues could be interpreted as a manifestation of ageism. Limited interest in

aging is documented by Bayer and Tadd (2000) who investigated whether research protocols submitted to the local research ethics committee contained unjustified upper age limits of participant's age and how the committee dealt with that fact. The authors reported that of 225 studies whose protocols were reviewed, 65 examined topics or conditions that automatically excluded elderly people. In 85 studies the age restriction was inappropriate and unnecessary without any justification provided. Moreover, the ethics review committee failed to highlight what could be construed as ageism.

In clinical practice, one would assume that social workers are prepared and perhaps predisposed to providing quality care absent of stereotypical beliefs toward those in need. Unfortunately, a reality test reveals mixed evidence on existence ageism in helping professions. For instance, Dobbs et al. (2008) in ethnographic study of stigma and ageism in assisted living settings/residential care facility, analyzed qualitative interviews and observational data from residents, families, and staff (N = 309). The researchers suggested that prejudiced images of the old as frail, dependent, and incapable of socialization could be enhanced or reduced within the residential care settings. In short, the authors reported evidence of stigma and ageism.

Similarly, Kane and Kane (2005) argued that actions of ageism is highly possible in health care settings, as well as in long-term care, or nursing homes. In their study, they revealed that ageism is more pronounced in long-term facilities than in hospitals. Quite often, however, subtle bias is common in both settings.

From the perspectives of geography and space, Petersen and Warburton (2012) compared residential care facilities and retirement villages in Australia. The researchers collected interview data from stakeholders; however, the study omitted details regarding the sample and methodology. The authors concluded that built-in environments in residential settings for older adults sustained stereotypes of older people as either ageless or dependent. Moreover, spaces designed for older people

reinforced historical legacies of separation from the community. In effect, built-in environments dually functioned as a cause and effect of ageism.

Other scholars conducted studies of different groups health professionals, revealing ageist attitudes and behaviors among these groups. For example, Klein (2007) conducted a qualitative doctoral dissertation study describing the experiences of gerontology occupational therapists (N = 16) in Canada. Participants described working with older adults as an enjoyable experience, which offered variety, intellectual challenge, and satisfaction. Just the same, the work of these professionals was often assigned lower status. Ageism that appeared to influence their abilities to be valued in the work setting is a challenge that gerontology therapists have often encountered. Klein reported that ageism appeared to be socially produced in response to the discourses related to rehabilitation and independence in the profession, as well as in public and professional attitudes toward the elderly.

Several studies have provided evidence of ageism in mental health services. For example, in a study by Ray, Raciti, and Ford (1985), psychiatrists reported to demonstrate a variety of negative attitudes toward older patients. The study suggested that certain personal characteristics of psychiatrists (female gender, psychoanalytic theoretical orientation and certification by the American Board of Psychiatry and Neurology) were associated with pronounced negative attitudes. Interestingly, Lynd-Stevenson and Pigram (1993) measured four facets of ageism: 1) attitudes to the elderly, 2) attitudes to the ageing process, 3) stereotypes of capability and 4) stereotypes of sociability in psychology students (N = 95) and found that ageism was not rampant among the students. While the majority viewed the capacity of old people somewhat negatively, they tended to have a positive social outlook and to hold positive attitudes toward the elderly. However, it is important to note that the students expressed ambivalence about themselves growing old.

In their literature review on ageism in the mental health arena, Robb, Chem and Haley (2002) found a limited number of studies on age

bias among mental health providers. Interestingly, they noted that in conversations about the aging and mental health, the two attributes were important factors for limiting access to services for the elderly. Considerable evidence does suggest differential medical treatment for older adults in areas such as physician–patient interaction, use of screening procedures, and treatment of varied medical problems. It must be noted, however, that clear evidence pointing to age bias, as a key factor, is needed. Other studies have also suggested that age discrimination has an adverse affect on general health and well being of seniors (Acktoy-Stolarz, 2008). Scharf, Phillipson, Kingston and Smith (2001) argued that one effect is social exclusion and institutional disengagement of seniors. They concluded that systematic disengagement contributes to the marginalization of seniors in terms of outsiders' perceptions of them.

One may wonder what the evidence reveals about the prevalence of ageism among social workers. Allen, Cherry, and Palmore (2009) focused on self-reported ageism in undergraduate and graduate social work students and among social service providers in managed care facilities. Findings indicated that people of varying educational and occupational backgrounds in social services admitted to positive ageism. In this study, practitioners in nursing home settings reported higher positive and lower negative ageist behaviours when compared to practitioners in other settings and the students.

Kane (2007) explored perceptions of elders among undergraduate criminal justice (N = 116) and social work (N = 112) students in the United States. The results of this cross-sectional study generally revealed moderate ageist attitudes among the participants. Of particular importance, the study noted that criminal justice students are less likely than social work students to possess positive attitudes towards elderly. The findings concerning criminal justice students are consistent with the results of the Israeli case study in the field of jurisprudential gerontology. Specifically, Doron (2012) reported that, contrary to the common perception of objectivity of legal decisions, judges often

constructed socio-judicial narratives embellished by personal bias and prejudices against old age.

Bianchini (2000) explored elder-related knowledge and attitudes of social work and nursing students (N = 159) at the University of Calgary and reported acceptable levels of age stereotyping; however, some of the responses are disconcerting. For example, a common agreement among the students is that teenage suicide is more tragic than elder suicide, and that older people should not be allowed to renew their driver licenses. The author concluded that nursing students, as well as those in social work are in need of adequate preparation in the field of gerontology.

The question that begs exploration pertains to the under-interest in studies on age bias within the various helping professions, especially when there is evidence of age-based differential treatment and limitation access to services for older adults. Schoenberg and Lewis (2005) suggested that using cultural lens on ageism might explain ageism in health care settings in that ageist attitudes manifested by members of helping professions “emerge from generalized negative cultural attitudes about aging. When placed within a success = cure, and fiscally concerned environment, ageism is perpetual.” (p. 90)

Social workers and other helping professionals behave as humans do; they are not free from prejudicial beliefs. Moreover, this beliefs could potentially seep into way social workers treat older clients, as well as how they approach gerontological practice and the extent to which they value their clinical practice with older adults.

Another argument relates to a problem of limited training of health and mental health professionals in gerontology. Rosowsky (2005) summarized reasons for under-interest of clinical professionals, including social workers, physicians, psychologists, psychiatrists and nurse professionals. Stated bluntly, gerontology is not chic; old people are not an interesting and exciting population with which to work. Old people have poor prognoses and tend to respond unfavorably to treatment. It is painful to work with old people as this time is one of deterioration and futile interventions. Consistent

with Nelson's (2011) general comment on stereotypes, Rosowsky noted that given the under-interest in gerontological specializations across disciplines, the largest issue for the growing population of elderly could be the relative scarcity of providers of the treatment and services the elderly requires.

7. Ageism and Future Cohorts of Elderly

Given the relative under-interest in ageism and limited understanding of this disturbing phenomenon in our society, as well as in the helping professions, there is a concern that negative manifestations of ageism will continue to dominate and that growing numbers of retiring Baby Boomers will face age-related stigmatization, which has begun. For instance, in a recent marketing book by Smith and Clurman (2007) titled *Generation Ageless: How Baby Boomers are Changing the Way We Live Today... and They're Just Started*, the authors describe and endorse the following stereotypical perception of the Boomers:

... Boomers don't accept limits, so it's no surprise that they have long been confrontational, polarizing, and uncompromising. And they see no reason to start compromising now. Their take-no-prisoners style looks to be working, albeit with the occasional set back every now and then. (p. xxix)

Phillipson, Leach, Money, and Biggs (2007) conducted a review of research and media to identify social and cultural constructions of the Baby Boomers. Boomers are depicted as bringing new lifestyles and attitudes to ageing and retirement; heralding economic disaster; or placing fresh burdens on health and social care services. The article provided a critical analysis of the Boomers as a 'problem generation'.

One can see the increasingly negative attitude toward Baby Boomers in media and public research through assigning catastrophic characteristics to aging of Boomers in such negative terms as 'apocalyptic demography', 'demographic imperative', 'impossible burden', 'age tsunami', or

'age storm' that will "crash on the shoals of business" (Longino, 2005, p. 80) and shrink dramatically social security assets of the nations. In other words, Baby Boomers are perceived as a threat to society.

Longino (2005, p. 81) asked an important question: "Is this scary story motivated by ageism?" His response is that the apocalyptic picture of the future is indeed ageist, "because it objectifies people who are aging and treats them as though they are all alike." As Nelson (2011) pointed out, older adults comprise a highly heterogeneous group, which assumes that a group shares a common personality characteristic. Such assumptions represent stereotyping.

A positive view on aging Baby Boomers, which is less popular than the 'scary story', highlights the high education and income levels among people of retirement age, speculating that these trends will partially offset the societal burden of the Boomers as they reach retirement (Longino, 2005). Similar to the negative perspective, this positive view is impacted by stereotypes. Rosowsky (2005) depicted this positive view in the following words:

Historically, many of this cohort have been heavy consumers of health and support services and have relied upon professional expertise and specialized services. They have cut their milk teeth on technological advances and are remarkable self-advocates and informed consumers. (p. 57)

Higher education status and relatively good health could possibly contribute to greater work retention of many Baby Boomers, which could possibly support reduction of structural ageism in the society (Longino, 2005). According to Binstock (2005), workplace ageism has been gradually eroding. However, he argued that negative portrayals of older people in society remain stable, regardless of older people's contributions to the society. In his empirical study, Thornstam (2006) suggested that some respondents believed that pro-seniors workplace policies and public attitudes might be

unjustified: “Why coddle the well-to-do elderly?” (p. 56) Thornstam interpreted this as a possible rivalry or sense of competition that younger people feel toward well-to-do older people, provoking jealousy and negative attitudes. This is consistent with the study of Cuddy et al. (2005) who found that older groups portrayed as competent, ambitious, and equally competitive with mainstream society are regarded by the younger public as less warm and likable.

Others have suggested that the growing demographic pool of the Boomers and “successful aging” could contribute to a flourishing market once it is oriented to serve the Boomers (Smith & Clurman, 2007). Longino (2005) speculated that anti-aging goodies and services could increase the probability of improving Boomers’ image in the society, resulting in positive imagery of older people as healthy, happy and younger looking. However, the question remains as to the extinction of ageism. Longino (2005) warns that:

One would logically expect that with the retirement and continued aging of the baby boom, our images of aging are likely to change for the better. Wrinkles will certainly seem more “normal.” On the other hand, marketing trends are usually directed to flatter the customer. When the customer is older, such flattery may arise from cultural aging... This cultural theme may persist as the median age of the nation climbs in the twenty first century. If it does, then a pernicious cultural ageism will persist. (p. 83)

In this vein, Angus and Reeve (2006) warned that aging-well initiatives, based on individualism and self-responsibility and existing power relations between those who age well and those who do not, will continue to inform ageist stereotypes. This would mean that advocacy for the poor and the frail may continue to be challenging (Longino, 2005), signifying a profound stigmatization and neglect of those who fail to aging successfully, healthy and well.

How will society relate to older adults who

are unhealthy and perhaps in need of financial, physical, social, emotional and medical support for their daily living? How will younger generations portray this cohort? How will society treat those who are labeled ‘non-successfully aged’? Will they remain undervalued? These questions raise the importance of extinguishing ageism in its various manifestations. A number of strategies to engage in anti-ageism action will be discussed in the following section.

8. Acting to Reduce Ageism: Implications for Social Work

Scholars have suggested a number of initiatives to reduce ageism in contemporary society. Butler (2005) asserts, “It is time to rally for the inclusion of ageism among the issues promoted by those individuals and organizations devoted to the protection and extension of human rights.” (p. 86)

Efforts to increase the status of older adults will help to reduce ageist attitudes prevalent in society (Nelson, 2011). To do so, Petersen and Warburton (2012) recommended the development of responsive urban residences to prevent the marginalization of elderly from the community. This approach would connect the young with the old and begin to normalize what it means to grow old. Additionally, school programs should promote the message that old age is nothing to fear, or to be embarrassed about (Nelson, 2011). Aging is part of life’s cycle.

Rosowsky (2005) advocates for improved education and training in the field of gerontology. In her opinion, good professional preparation can counterbalance false beliefs. On the other hand, inadequate training allows ageist attitudes to flourish, thus increasing the tendency to neglect the needs of the elderly.

Further, it is crucial that social workers question their attitudes toward the aging. It is difficult to admit that helping professionals may engage in stereotyping, hold prejudicial beliefs, or practice age-related discrimination. However, if we, today’s social workers deny this reality, we run the risk of compromising our ethical standards

of practice; jeopardizing the integrity of the profession, and potentially under-serving our clients. Encouraging self-awareness will temper personal biases and improve ethical conduct. Without question, thousands of social workers, over the next two decades, will serve older clients within their caseloads, regardless of their specialization or professional interests. Are we prepared and self-aware?

Unfortunately, the reality of ageist stereotypes cannot be entirely prevented. With this in mind, the profession of social work must promote the dignity of growing old. Practitioners must combat discrimination wherever and whenever it occurs. Most important, social workers must convey the message that sensitivity begins at the personal level. We must lead by example. For this reason, it is imperative that we understand the complexities of ageism and endorse better educational programs in gerontological social work, as well as in clinical and research settings.

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Political Diversity Among Social Work Students

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Journal of Social Work Values and Ethics, Volume 11, Number 2 (2014)

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Abstract

This article explores the political ideologies of graduate social work students and examines whether political views differ based on political party, religious affiliation, or other demographic characteristics. Results of surveys completed by 127 MSW students reveal that most are moderate or liberal. Political views do differ on sense of social responsibility based on political party and on respect for basic rights based on religious affiliation. No evidence was found that religious affiliation or political ideology changed during students' time in the educational program.

Keywords: Political ideology; Political diversity; Social work student attitudes; Religion and political views.

1. Introduction

Diversity and social justice are typically thought of within the social work profession as concepts indicating value, interest, respect, and inclusion of a wide range of views, experiences, and realities. Both are rich areas of exploration, discussion, and study in social work and in social work education. In recent years, however, there have been objections to the profession's focus on diversity and social justice, with claims that diversity and social justice are politicized terms referring to particular social policy positions (National Association of Scholars [NAS], 2007). Some have asserted that the focus on diversity and social justice within social work education programs results in social work students being silenced in terms of expressing their personal opinions and beliefs

(Balch, 2008). Most objections seem embedded with the assumption that social work is, by definition, a liberal profession, and that the value-base and ethical underpinnings of the profession mean that all social work students are required to be liberal, as well. In fact, however, whether or to what extent social work is a liberal profession or that social work students are expected to be liberal are relatively unexplored areas.

Little empirical data are available about the political ideology of social workers, and what does exist is somewhat contradictory. Even less is known about the political ideology of social work students. Exploration of the self-reported political views of social work students is needed to inform discussions about the assumed liberalism of the profession as well as to respond to allegations that social work education programs force students to adopt particular political stances. The current study examined the political views and beliefs of graduate social work students in terms of the liberal-conservative ideological continuum, explored whether their beliefs differed based on demographic characteristics, and examined whether beliefs differed between students entering and exiting a social work education program.

2. Background and Context

Council on Social Work Education (CSWE) accreditation standards explicitly require that social work education programs prepare students to "engage diversity and difference in practice" (CSWE, 2008, p. 4) and "advance human rights and social and economic justice" (CSWE, 2008, p. 5). Similarly, National Association of

Social Workers (NASW) Code of Ethics states that “social workers promote social justice and social change with and on behalf of clients”... [and]... “are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice” (NASW, 2012, Preamble, para. 2).

The NASW Code of Ethics (2012) provides a useful conceptual framework for understanding the terms diversity and social justice as used in the social work profession. The Code of Ethics describes the value of diversity as relating to cultural competency and social diversity. This is explained as recognizing the strengths that exist in cultures, providing services that are sensitive to differences among people and cultural groups, and seeking to understand social diversity “with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability” (NASW, 2012, Ethical Standards, item c). Similarly, the Code of Ethics provides a conceptual definition for social justice, stating

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people... Social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice... Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people. (NASW, 2012, Ethical Principles, para. 3)

The National Association of Scholars, in its objection to NASW and CSWE positions on diversity and social justice, has stated that NASW Code of Ethics standards regarding promoting social justice represent “partisan declarations... about policy” (NAS, 2007, p. 2-3) and that CSWE accreditation standards are “ideologically loaded and mandating political advocacy and action” (NAS, 2007, p. 7). Will (2007) argued that “in 1997, the National Association of Social Workers

(NASW) adopted a surreptitious political agenda in the form of a new code of ethics [by] enjoining social workers to advocate for social justice” (para. 3). In a 2008 letter to the Deputy Secretary of the Department of Health and Human Services, NAS President Stephen Balch stated that “one CSWE prerequisite for graduation is that social work students must endorse and even lobby for a particular set of ideological, social, and political positions [and that] in order to succeed in a social work program, students are forced to keep silent about their personal opinions or beliefs” (Balch, 2008, p. 2).

The terms diversity and social justice have been broadly used and there is lack of agreement about what exactly is meant by the terms. While no specific definitions have been offered by NAS, it is clear that they object to the focus on these issues by the social work profession. The concerns expressed by the NAS and others are primarily presented as concern for respecting the individual beliefs of social workers and social work students, particularly in regard to political and religious views. The objections appear to be based on the belief that social work values and ethical principles related to diversity and social justice serve to constrain the voice of conservative and/or religious social work students. If true, this would imply that social work not only is a liberal profession, but more importantly, a profession unaccepting of non-liberal or conservative views, and that social work education programs coerce students into following or adopting liberal views. Similarly, the objections would seem to imply that religious individuals automatically have different political opinions on areas of interest to social work than non-religious individuals, and that the profession will be non-accepting of the views of religious students.

Past research has called into question the assumption that all social workers hold liberal views on social, political, and religious issues or that conservative or religious views among social workers are unwelcome. Actually, prior research has indicated that there is considerable variation in political ideology and religious views among social workers (Hodge, 2003; Rosenwald, 2006;

Rosenwald & Hyde, 2006; Sheridan, Bullis, Adcock, Berlin, & Miller, 1992). For example, Rosenwald (2006) reported that 40.6% of the licensed social worker participants in his study were liberal and 34.4% were moderate. Just over half (55.2%) of Rosenwald's sample ranked themselves "left of center" (liberal) compared to 10.4% who ranked themselves "right of center" (conservative). Sheridan et al. (1992) found that about a third of social workers reported a belief in a personal God and over a third believed in a transcendent or divine dimension in nature. Only 9% of the Sheridan et al. sample believed that notions of God were only human imagination. Smith-Osborne and Rosenwald (2009) reported that 83% of a 2003 sample of licensed social workers reported a religious affiliation, and that the "average strength of religious affiliation level endorsed was 'fairly strongly religious or spiritual'" (p. 397). Smith-Osborne and Rosenwald also found that "strength of religious/spiritual affiliation was not significantly correlated with...political ideology...nor with beliefs about liberal ideological requirements for the profession" (p. 399).

The current exploratory study was intended to expand on the knowledge base related to political diversity among social work professionals. Specifically, the study was intended to examine the nature of social work students' political opinions and to examine whether their political views differed based on political party, religious affiliation, or other demographic factors. Results contribute to the exploration of diversity in student opinions, add to an understanding of how diversity and difference are managed in social work education programs, and inform discussions about the potential impact of social work education on students' views.

3. Methods

3.1 Design and Procedures

A survey design was used to investigate the political views of graduate social work students, to examine whether their views differed based on religious affiliation or other demographic characteristics, and to examine whether views differed between students who were just beginning their

social work education program and those who were into the advanced coursework portion of the social work program. Most students entering the particular Master of Social Work (MSW) program where the study was conducted had very little, if any, prior social work education as few had undergraduate degrees in social work. Many did, however, have varying degrees of social work practice experience as a result of prior employment or volunteer work. All students in the program were surveyed during a single academic year. Entering (1st year) students were surveyed during a new student orientation event. Continuing (2nd and 3rd year) students were surveyed in a required advanced year class. All continuing students had completed their foundation practice and policy coursework at the time of the survey.

A written questionnaire was used to collect responses. The questionnaire was divided into sections related to topical areas and asked about students' views on a range of social issues. Only responses related to political views were included in the current study. All surveys were completed in hard copy. Participants were advised that the completion of the survey was voluntary, and were advised to not include any identifying information on the questionnaire. Informed consent was provided prior to administration of the questionnaire. The research was reviewed and approved by the University Institutional Review Board prior to the study being conducted.

3.2 Sample Characteristics

The sample was made up of Master of Social Work (MSW) students in one social work program in a politically and socially conservative region (McGhee & Krimm, 2012) of a liberal-leaning (solidly Democratic) western state (Jones, 2009). The sample included 1st, 2nd, and 3rd year MSW students, thereby including students who were in the foundation and advanced portions of their academic program. A total of 127 responses were received. With an 88.2% response rate, results are believed to be highly reflective of student views at the point in time during which they completed the survey.

Survey respondents were predominantly female (83.5%). Just over half (52.8%) were between the ages of 25 and 34 years. Approximately a quarter (26%) were younger than 25 years old and nearly a quarter (20.5%) were age 35 or older. Over two-thirds of the students reported either Hispanic (36.2%) or White (33.1%) ethnic identifications. The remaining one-third included Asian (11.8%), African American (7.9%), Native American (2.4%), and Other (6.3%) ethnic identifications. Students were equally divided between being in the beginning (foundation) portion of their academic program (48.8%) and the concluding (advanced) portion of their academic program (51.2%). Survey respondents were demographically reflective of students in the program as a whole.

Participants were asked to report on their political party affiliation and their religious affiliation. In terms of political party affiliation, over half (55.9%) indicated they were Democrat. In comparison, approximately a fifth of participants identified themselves either as Republican (9.4%) or Independent (7.9%). Another fifth (19.7%) indicated they had no political party affiliation and 2.4% indicated another political party including Libertarian, Green, and Other. In terms of religious affiliation, the vast majority (78.9%) reported a religious affiliation. Over a quarter (26.6%) of participants indicated they were Catholic, 10.9% were Protestant, 5.5% were Evangelical Christian, and 35.9% were some other religious affiliation. Other religious affiliations identified included Jewish, Muslim, Hindu, Buddhist, and Other. Only 16.4% of participants indicated they had no religious affiliation, with 7.0% reporting they were Atheist and 9.4% reporting they were Agnostic.

3.3 Instrumentation

Political ideology was measured using an existing instrument, the Professional Opinion Scale (POS) (Abbott, 2003). The POS, originally developed in 1988 and revised in 1998, was constructed based on NASW Public Policy Statements and was designed to be a measure of commitment to social work values (Abbott, 2003). The NASW

policy statements are consistent with the social work value-base and reflect a “philosophy committed to social action, social justice, human rights, client self-determination, and a general commitment to social responsibility” (Abbott, 2003, p. 646).

Rosenwald (2006) used the POS to measure political ideology among licensed social workers and indicated the instrument “appeared to be the most comprehensive and reliable scale that gauged political ideology by examining policy statements linked to the social work profession” (p. 121). The POS has good evidence of internal reliability, with a Cronbach alpha of .85 (Rosenwald & Hyde, 2006). Embedded within the POS are four value dimension subscales intended to measure different elements of the social work value-base. These subscales include Support for Self-Determination, Sense of Social Responsibility, Commitment to Individual Freedom, and Respect for Basic Rights. The subscales have been found to have acceptable levels of reliability, with Cronbach alphas of .68, .76, .79, and .77, respectively (Abbott, 2003). In the current study acceptable levels of reliability were found for three of the four subscales with Cronbach alphas of .70 for Support for Self-Determination, .70 for Sense of Social Responsibility, and .73 for Respect for Basic Rights. A lower alpha coefficient of .53 was found, however, for Commitment to Individual Freedom in the current study. This may have been due to an error in instrument construction by which only 38 of the 40 items of the POS were included on the questionnaire. The failure to include these two items represents a limitation to the study and decreases the strength of comparison of study results with prior research.

The current study combined the POS items (38 of 40) with an additional 12 items. Three of the additional items were from prior research and 9 items were newly added for this study. With the inclusion of all items, a total of 50 political views statements were included on the questionnaire. Individual items were scored on a five-point Likert scale with participants indicating their level of agreement with each statement (strongly agree to

strongly disagree). Reverse coding was conducted on relevant items during data analysis to result in a score of 1 representing a conservative political viewpoint and a score of 5 representing a liberal political viewpoint for each item.

4. Results

4.1 Political Views

Evaluation of the political ideology of participants was conducted four ways. First, participants' responses on individual items were computed. Secondly, total POS scores using

answers on the 38 POS items were calculated. Thirdly, the four value dimension subscales of the POS were examined. Finally, overall scores of participants' ideology using all 50 items related to political views was computed.

Mean scores and standard deviations for each individual survey item, accounting for reverse scoring, are reported in Table 1. Table 1 also identifies the items making up each of the POS subscales. Mean scores on each item could range from 1 to 5, with lower scores indicating conservative views and higher scores indicating liberal views.

Table 1: Means and Standard Deviations for Professional Opinion Scale + Twelve Items (N = 127)

Item	M	SD
<i>Support for Self-Determination Subscale</i>		
Women should have the right to use abortion services if they choose.	4.28	.96
Confidential family planning/birth control should be available to all adolescents.	4.15	.88
Family planning services should be available to individuals regardless of income.	4.55	.71
Older persons should be sustained to the extent possible in their own environments.	3.61	1.20
The child in adoption proceedings should be the primary client.	4.06	.90
A family may be defined as two or more individuals who consider themselves a family and who assume protective, caring obligations to one another.	4.27	.89
When they are old enough, children should have the right to choose their religion, including the option to choose none.	4.42	.84
Counseling should be required for women who ask for abortions.	3.40	1.20
Couples should decide for themselves whether they want to become parents.	4.47	.73
Terminal (dying) individuals have a right to be informed of their prognoses.	4.60	.65
<i>Sense of Social Responsibility Subscale</i>		
There should be a guaranteed minimum income for everyone.	3.34	1.20
The federal government has invested too much money in the poor.	4.10	.90
The government should NOT redistribute the wealth.	3.70	1.10
The government should provide a comprehensive system of insurance protecting against loss of income because of disability.	4.05	.79
Unemployment benefits should be extended, especially in areas hit by economic disaster.	4.10	.90
The gap between poverty and affluence should be reduced through measures directed at redistribution of income.	3.57	.97
Efforts should be made to increase voting among minorities.	4.38	.75
Local governments should be monitored on the enforcement of civil rights statutes.	4.05	.83
The government should have primary responsibility for helping the community accept a returning criminal offender.	3.25	1.20

Table 1: Means and Standard Deviations for Professional Opinion Scale + Twelve Items (N = 127), continued

Item	M	SD
“No-knock” entry, which allows the police entrance without a search warrant, encourages police to violate the rights of individuals.	3.75	1.20
Commitment to Individual Freedom Subscale		
All direct-income benefits to welfare recipients should be in the form of cash.	2.24	.87
The employed should have more government assistance than the unemployed.	3.44	.95
Welfare mothers should be discouraged from having more children.	3.21	1.20
Capital punishment should be abolished.	2.94	1.18
The death penalty is an important means for discouraging criminal activity.	3.59	1.19
Welfare workers should keep files on those clients suspected of fraud.	2.35	1.13
It would be better to give welfare recipients vouchers or goods rather than cash.	2.54	1.08
The FBI (government) should keep files on individuals with minority political affiliation.	3.80	1.07
Corporal punishment is an important means of discipline for aggressive, acting-out children.	3.94	1.07
Respect for Basic Rights Subscale		
Retirement at age 65 should be mandatory.	3.81	1.00
The mandatory retirement age protects society from the incompetency of the elderly.	4.00	.92
Mandatory retirement based on age should be eliminated.	3.56	1.01
Seniors/elderly require only minimum mental health services.	4.15	.87
Only medical personnel should be involved in life and death treatment decisions.	4.22	.87
Pregnant adolescents should be excluded from regular school.	4.42	.87
Juveniles do not need to be provided with legal counsel in juvenile courts.	4.60	.64
Abduction by parents who do not have custody should be viewed as a family, not a legal, matter.	4.04	.93
The government should not subsidize family-planning programs.	3.65	1.03
Additional Questions		
Faith-based delivery of social services is an effective method of helping people in need.	2.41	.91
Special laws for the protection of lesbians’ and gay men’s equal rights are not necessary.	4.24	.96
Social services should be provided to illegal immigrants.	2.24	1.16
Mandatory sterilization is acceptable to prevent pregnancy among the severely mentally disabled.	3.90	1.16
Mandatory sterilization is acceptable to prevent pregnancy among the severely physically disabled.	4.07	1.03
Counseling should be required for teenagers who ask for abortions.	2.28	1.19
The FBI (government) should keep files on individuals with radical political affiliation.	3.40	1.17
Government is inefficient and wasteful.	2.91	1.10
Elected politicians lost touch with the public pretty quickly.	2.05	.87
Government controls too much of daily life.	2.96	.94
Regulation of business does more harm than good.	3.29	.95
Government should be run for the benefit of all people.	4.43	.77

The 38 POS items were combined to determine a total POS score. Total possible scores on the POS ranged from 38 – 190. With a mean of 145.17 ($SD = 12.93$) results indicated moderately liberal views among participants. When scores for subscales were examined, results on three of the four subscales also revealed moderately liberal attitudes. Specifically, with a range of possible scores of 10 – 50 on both the Support for Self-Determination and the Sense of Social Responsibility subscales, results revealed a mean score of 41.70 ($SD = 4.71$) on Support for Self-Determination and 38.39 ($SD = 5.12$) on Sense of Social Responsibility. Both of these mean scores indicated fairly liberal views. Similarly, with the range of possible scores being 9 – 45 on the Respect for Basic Rights subscale, a mean score of 36.45 ($SD = 4.72$) indicated that participants held liberal views. The fourth subscale, Commitment to Individual Freedom, also had a range of possible scores of 9 – 45. A mean score of 28.18 ($SD = 4.59$) on this subscale, however, indicated participants' views were neutral (neither liberal nor conservative), meaning participants were more conservative in their views about individual freedoms than in other areas. When all 50 political ideology items included on the survey were combined to determine an Overall Political Ideology Score, results revealed that participants scored slightly liberal. With a possible range of 50 – 250, and a neutral score equaling 150, participants in the current study had a mean score of 182.91 ($SD = 15.48$). To further aid in understanding where participants fell on the liberal–conservative continuum of political attitudes, Overall Political Ideology Scores were categorized into “liberal,” “moderate,” and “conservative” score levels by dividing possible scores into thirds. Using this approach a score of 50 – 117 was considered conservative, 118 – 183 was considered moderate, and 184 – 250 was considered liberal. Viewed in this context, approximately two-thirds of the participants (67.9%) scored in the liberal range and one-third (32.1%) in the moderate range of the continuum. None of the participants scored in the conservative range.

4.2 Ideological Differences Among Groups

Bivariate analysis was conducted to determine whether there were differences in political views based on demographic characteristics. All total scale scores and subscale scores were analyzed in relation to each demographic characteristic. No statistically significant differences were found on any of the measures of political views based on gender or age. Scores on a single subscale were found to differ based on students' level in the program and scores on two subscales differed based on ethnicity. In addition, statistically significant differences among groups based on political party affiliation and religious affiliation were found.

Statistically significant differences in participants' scores on the Sense of Social Responsibility and the Respect for Basic Rights subscales were found based on ethnicity. Results of a One-Way ANOVA ($F = 3.83, p = .033$) revealed that with a mean score of 32, Native Americans reported neutral views regarding Sense of Social Responsibility while all other groups reported varying degrees of liberal views. With a mean score of 43.22, the most liberal views were reported by African Americans. Scores of other groups were very close in range. Specifically, group scores on Sense of Social Responsibility based on ethnicity were as follows: Asian ($M = 39.38$); Hispanic ($M = 39.14$); Caucasian ($M = 36.80$); and Other ($M = 37.50$). Similarly, with an $F = 2.85$ and a $p = .019$, One-Way ANOVA results revealed differences among groups on the Respect for Basic Rights subscale. The most liberal views were reported by African Americans ($M = 38.20$) and Caucasians ($M = 38.17$). These were followed by Other ($M = 36.88$), Asians ($M = 36.00$), and Hispanics ($M = 35.13$), then by Native Americans ($M = 31.50$) with the lowest score.

In terms of level in the program, a single difference between beginning and advanced graduate students was found regarding their views on the Commitment to Individual Freedom subscale. With a mean score of 28.98 ($SD = 4.66$) advanced students were slightly more liberal than foundation students ($M = 27.33, SD = 4.39$). With a $t = -2.00$

and a corresponding p value of .048, Independent Samples T-test results revealed this difference to be statistically significant.

Although scores for all participant groups tended to be moderately liberal on the Sense of Social Responsibility subscale, scores did differ among groups based on political party affiliation. With an $F = 3.72$ and a corresponding p value of .007, One-way ANOVA results revealed that Democrats ($M = 39.42$) had the most liberal views, followed closely by Other political party ($M = 39.33$) and No political party ($M = 38.03$) participants. In contrast, Republicans ($M = 33.73$) and Independents ($M = 36.30$) had the least liberal views on Sense of Social Responsibility. There were no significant differences on any of the other scale or subscale scores based on political affiliation.

The final area of difference among groups was based on religious affiliation. While no statistically significant differences were found for scores on the POS, the POS subscales, or the Overall Political Ideology Scores based on particular religious affiliations, differences in participants' views on Respect for Basic Rights were found based on whether participants reported having a religious affiliation or not. Religious affiliation data were recoded to include all participants who reported being affiliated with a religious denomination into a religiously affiliated group and those who reported being atheist or agnostic into a non-religiously affiliated group. An Independent Samples T-test ($t = 2.23$, $p = .027$) revealed that with a mean score of 38.63 ($SD = 4.28$) non-religiously affiliated individuals were more liberal than religiously affiliated individuals ($M = 36.04$, $SD = 4.71$). Importantly, even though these differences did rise to a statistically significant level, both religiously affiliated and non-religiously affiliated scores were solidly in the liberal area of the liberal–moderate–conservative continuum of scores. There were no other differences in scores based either on being religiously affiliated or based on particular religious faiths.

5. Discussion

Overall, the results of this study lend support to the idea that social work is a liberal

profession although results would indicate moderately liberal rather than very liberal views among participants. Similarly, while most scores were in the liberal range, a full third of participants could be more accurately described as moderate, calling into question the assumption that the social work profession is a liberal monolith and supporting the idea that a range of views are tolerated by the profession. Similarly, as all participants in this study were students enrolled in a graduate level social work education program, results appear to indicate social work students have fairly liberal views overall. Little evidence exists, however, that these liberal views are the result of the educational program. Rather, results may more accurately reflect who chooses to come to social work education rather than what social work education does to students. Two-thirds of the student participants in this study scored in the liberal range, one-third in the moderate range, and none in the conservative range on overall political ideology, and beginning and advanced students reported few differences in their political views.

No conclusive explanation for the higher percentage of liberal views found in the current study as compared to prior research is possible from the available data. The sample in the current study did differ in that social work students rather than social work practicing professionals made up the sample. Additionally, differences in social, economic, and political environments may exist between the time frame of the current and previous studies. Political ideology is influenced by social political environments and worldview (Buila, 2010; Koeske & Crouse, 1981), and American's values and beliefs currently are more polarized along partisan lines than at any point in the past 25 years (Pew Research Center, 2012). In any case, participants in the current study reported more liberal views than found in prior research, and did so at the time of entering the profession (at the beginning of their educational program). These results do not support the idea that the social work professional standards or social work educational programs coerce individuals into liberal views.

The overwhelming majority (78.9%) of

participants in this study reported they had a religious affiliation of some kind. Only 16.4% of participants reported no religious affiliation. These results are consistent with religious affiliation among the adult United States (U.S.) population as a whole. According to the Pew Research Center (2008) 83.4% of adults in the U.S. report some sort of religious affiliation compared to 16.1% who report no religious affiliation. Interestingly, in spite of concerns identified by NAS and others about social work ethical guidelines and accreditation standards not respecting political and religious views of individual social work students, no differences were found in political opinions based on participants' religious faith, and only a single difference in the area of Respect for Basic Rights was found between religiously affiliated and non-religiously affiliated students. Even with this difference, however, both religiously affiliated and non-religiously affiliated participants held liberal views. While it is certainly possible that opinions may differ between religiously affiliated and non-religiously affiliated social workers on specific social issues or specific social policies, the social work value-based policy areas examined in this study provided little evidence of this. In contrast, opinions and attitudes among students regardless of religious affiliation were remarkably consistent.

Very public complaints and concerns have been expressed about the profession of social work in terms of the professional focus on diversity and social justice, and alleging that students in social work programs have been mistreated based on their political or religious views (NAS, 2007; Will, 2007). Participants in this study were similar in their political views across demographic groups. Participants also tended to express moderately liberal political views so may be unlikely to provide much information about the experiences of those who might have conservative ideologies. Likewise, while most participants in this study indicated a religious affiliation, no information was collected about the degree or level of participants' religious beliefs or involvement. These factors could have an impact on individuals' opinions, and it is unknown whether individuals could feel that their personal religious

values are discrepant with social work professional values, ethics, or practice guidelines. In the current study, however, data were examined to determine whether there were differences in political views between beginning and advanced students as such differences might indicate a particular type of impact by their experience in the social work education program. Only a single difference in views (on the Commitment to Individual Freedom subscale) was found, with advanced students being slightly more liberal in this area. Data were also examined to determine whether religious affiliation differed between the beginning and advanced students in this study. Although not statistically significant, it was interesting that a higher percentage of advanced students (86.9%) reported being religiously affiliated than foundation students (78.7%). If, in fact, social work educational programs influence or coerce students to change or deny their own personal opinions or values in order to fit into the profession or to succeed in the educational program, one might expect religious affiliation to decrease during students' time in a social work program. This was not the case for participants in the current study.

6. Conclusion

This study provides evidence of significant agreement on political values issues by students entering the social work profession regardless of political party or religious affiliation. According to social work professional standards and ethical guidelines, respect for diversity and the pursuit of social justice include respecting political and religious differences (CSWE, 2008; NASW, 2012). The profession of social work is clearly committed to these ideals. Three decades ago Koeske and Crouse (1981) aptly stated that "social workers, as individuals and as a group, have been characterized as both 'liberal' and 'conservative,' depending upon who is rendering the characterization and when it is rendered" (p. 194). They went on to state that applying labels to an entire profession is, of course, dubious, but that people, nonetheless, tend to act on such beliefs (Koeske & Crouse, 1981).

Acting on assumptions about the entire profession of social work may be the explanation

for recent attacks on social work education and the social work profession. No evidence was found in the current study to support the idea that participating in a social work education program swayed political ideology among students. While it is obviously important to examine complaints, concerns, or particular experiences of any students alleging inappropriate pressure or exclusion based on their beliefs, fears of such occurrences may be overstated. It is generally unhelpful to make allegations or draw conclusions about an entire profession or academic discipline based on unsubstantiated assumptions or discontent related to perceived political agendas. Such may be the case in the current debate about the values and ethics of the social work profession.

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Ethics in Action: An Exploratory Survey of Social Worker's Ethical Decision Making and Value Conflicts

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Journal of Social Work Values and Ethics, Volume 11, Number 2 (2014)
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Abstract

A social work educator/practitioner and a philosopher collaborated to design, test, implement and analyze responses of a large survey of social workers about ethics and values. This exploratory study surveyed responses of social work students, social work educators, social work administrators and social work practitioners in a variety of circumstances and contexts.

Keywords: Relationships, ethical conflicts, codes of ethics/standards of practice, boundaries, collegial consultation

1. Introduction: Initial Collaborations

We began our collaboration informally as our offices were next to each other and we engaged in the sharing of stories and problems in each of our teaching in professional ethics courses (Gough, 2012b). We secured research grants¹ and with the intellectual and moral support from our colleagues² we undertook a literature review, focusing on current articles, online journals of social work and ethics, current and popular British and North American textbooks and social work ethics course outlines. Faculty departments in colleges

are generally smaller than universities so that collaborative research often effectively involves mentoring among colleagues³ from different departments, programs and academic disciplines out of necessity, crossing discipline borders based on shared problems with a need to share knowledge and grow in experience to enrich teaching courses.

Each of us had experience with ethics research from different perspectives, with the philosopher focused on researching and writing journal articles, developing and teaching professional ethics courses for different professional programs and the social worker developing inclusive and comprehensive workshops, such as the "Ethics Road Show"⁴ to identify the problems and issues at the practical level of implementation. This difference in research background proved to be complementary and not divisive, helping each of us to achieve a better understanding of issues than we might have on our own. The process of collegial mentoring is antithetical to the process of individuals working in isolation on research projects of their special interest with little or no transfer of knowledge and skills from one discipline to another, which has been the tradition for many years in academic institutions and which has been criticized as generally unproductive and elitist (Lloyd, 2010).

2. Method: The Survey

We designed a survey⁵ to be distributed to Registered Social Workers in Alberta. Over 1,800 Registered Social Workers opened the professional magazine *The Advocate* where the invitation to participate in the survey was placed. Preliminary and incomplete findings from this survey were presented at a national conference of social work diploma educators⁶ and at a local social work conference in Red Deer, Alberta.⁷ While over 800 social workers opened and began the survey, the over 300 full responses to the twenty questions we posed in our online use of Askitonline (www.askitonline.com) were helpful, with many respondents persevering through the entire narrative-based survey. We sorted through the responses with the intention of identifying themes, conflicts and contexts that contributed to difficulties for social workers in making good ethical decisions. Throughout this research project it has been our intention to let social workers tell us their stories of ethical conflicts and inconsistencies, as well as significant contextual

factors that contribute to ethical problems in the performance of their professional ethical responsibilities. Ethics in practice is not a spectator activity but one that involves engaged practitioners who are faced with either giving good ethical information or making good ethical decisions and actions. Either way, ethics is not a dispassionate distraction but an activity that has important outcomes, serious and significant practical consequences.⁸

In response to question 20, we received a profile of the demographics of our surveyed population (Table 1). While 87% of the respondents were female (figure 1), over 50% of respondents had 16 or more years of experience (figure 2). A third (33%) of respondents attained a BSW degree, 32% an MSW degree, and 18% had a Diploma of Social Work (figure 3). Over 50% were either employed by a non-profit agency or the Provincial health services. The number of respondents who had at least one diploma and/or degree was high, as well as the number who had graduate degrees, which testifies to the knowledge base of the group

Table 1

Age	Female	Male	Total	Percentage
16-20	3		3	
21-25	216	7	223	3
26-30	624	40	664	10
31-35	681	76	757	12
36-40	702	95	797	12
41-45	710	102	812	12
46-50	678	133	811	12.5
51-55	700	107	807	12.5
56-60	638	167	805	12.5
61-65	400	129	529	8
66-70	125	47	172	2.5
71-75	32	14	46	.5
76-80	15	8	23	
81-85	8	3	11	
86-90	3	1	4	
91-95	1		1	
	5,635	929	6,465	

This is based on the total membership of the Alberta College of Social Workers as at May 31, 2012.

of respondents (Table 2). This information helped us to understand some of the responses, since it provided us with information about the context of the surveyed responses. We will use this information to draw inferences about some of the subsequent responses to particular questions.

3. The Study Responses: Conflicts, Inconsistencies in Context

The 20 survey questions shed light on the issue of ethics in social work practice as described by respondents. A brief discussion of each question and the research responses follows.

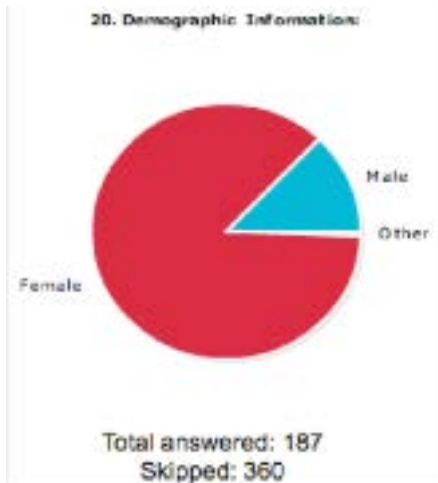


Figure 1

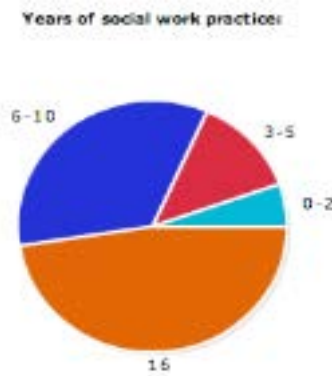


Figure 2

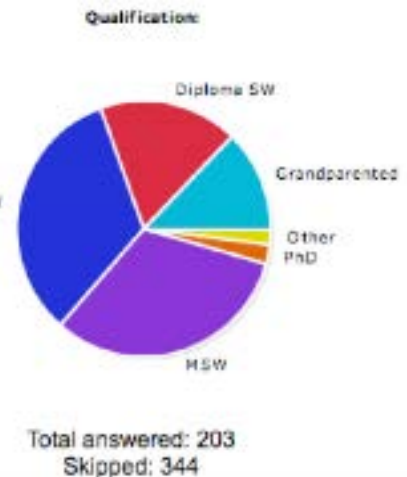


Figure 3

Table 2

Diploma/Degree	Highest Level of SW Education	Percentage of Total	Degree/Diploma attained
Ph.D./DSW	51	1	51
MSW	1,488	23	1,533
BSW	2,794	43	3,928
Diploma	1,201	18	2,006
Other*	957	15	

*Other – Social workers who qualified for registration without a degree or diploma from a recognized program of social work.

The first column of numbers shows the highest level of education attained. The last row of numbers shows the number of social workers who have received that credential (multiples apply).

Area of Practice (multiples apply)

- AB Government – 1,366
- Health Services (AHS & Private) – 1,778
- Municipal Government – 214
- Federal Government – 62
- Aboriginal (On Reserve) – 100
- Aboriginal (Off Reserve) – 98
- Non-Profit Agency – 1240
- Family Service – 190
- FCSS – 89
- For Profit/Private Agency – 175
- Private Practice/Contract – 395
- School/School District – 256
- Post-Secondary – 18

Question 1: Have you ever encountered an ethical situation that involved conflict between your personal values and:

- (a) those of the profession, 53%
- (b) the organization where you are employed, 82%
- (c) the program or school you attend, 66%
- (d) your client(s), 75%

To better understand the overwhelming response to a negative employment organization, it may be useful to diagram the differing relationships a social worker may be part of on a daily basis, in the process of simply doing their job (Gough, 2012a). Each relationship may have a different structure, impose different obligations or duties, promote different optimal outcomes and ascribe to the individual a distinctively different role. These differences may be the foundation for conflicts and inconsistency in expectations or the optimal performance of any individual social worker.⁹

1. Employer → Employee creates an obligation to perform tasks assigned to the job identified clearly by the employer, consistent with the conditions of employment.
2. Professional → Professional organization creates an obligation to perform tasks that are consistent with implicitly agreed standards of the profession in terms of ethics and competency.
3. Personal relationship → Employment Organization
4. Personal relationship → Professional Organization
5. Personal relationship → Employment situation
6. Personal relationship → Professional Colleague or Peer
7. Personal relationship → Client

There is one response to conflicts between obligations in 1 and 2, which indicates that 2 should take priority over 1, while another response indicates the employer, as “the piper that pays the bills should have the loyalty and the prior obligation of the employee.” The employer may perceive her/himself to look bad under public scrutiny of her/his poor performance, in handling ethical issues that could adversely affect any member of the public making use of a social worker’s services. The employer may institute an internal gag order on employees not to talk to the media or any other member of the public the organization was intended to serve.¹⁰ The image and values inherent in the workplace are not necessarily those of the professional practitioner. In potential conflict, the social work professional organization indicates that loyalty to the profession means “As individuals, social workers take care in their actions not to bring the reputation of the profession into disrepute” (CASW, 2005, 2). In her report, the complaints director of the ACSW identified 33 complaints involving an abuse of authority and identified recent trends in complaints such as: an increase in complaints related to people working beyond their skill level, an increase in complaints about bullying as well as an increase in complaints about abuse of authority, all of which seem to focus on the relationship between a social worker and his or her employment organization problems (MacDonald, 2010). The finding of a significant increase in complaints about bullying in the workplace is reflected not only in the responses to Questions 1 and 2 of this study but in other studies as well (Van Heugten, 2010).

Does any practicing social worker maximize the interests of the employer/employee relationship out of material necessity? Does one inconsistently maximize the interests of the professional organization, social work, which the CASW Code of Ethics suggests? There exists a conflict of commitments unless we impose a ranking priority on the interests (Gough, 1987). So, to resolve this conflict, relationship 2 needs to be ranked higher than 1, with a failure of 1 being the least desirable failure of the two possibilities (CASW, 2005).

Question 2: Have you ever been aware of, but not directly involved in, an ethical situation that involved conflict between your values and those of the organization where you were employed or educational institution you were attending?

- (a) those of the profession, 22%
- (b) the organization where you were employed, 34%
- (c) the program or school you attend, 11%
- (d) your client(s), 27%
- (e) have not been aware of an ethical situation, 6%

Responses to this question are consistent with responses to the first question. The 34% who noticed the conflict in the organization and the 27% who noted the conflict with clients indicates that the certainty of others' values is modified somewhat when we evaluate the situation in others. This is a positive outcome, since we need to be very cautious in ascribing motives for the behavior or actions of others.

The responses in (b) and (c), organization and client, corresponded to the responses in the first question to organization and client. This suggests that the context of the relationship between the organization and the practicing professional social worker with the client is the one identified to most likely produce an ethical conflict. The cause of this conflict may be inconsistency. The organization is not contributing to the best outcome for client and social worker but, inconsistent with social work values and standards of practice, a possible causal contributor to conflicts of values. The economically powerful situation of an organization that is an individual's employer relative to the weaker situation of the employee makes it difficult in cases of conflict for the employee to be able to take actions contrary to the wishes of the employer. Yet, implicitly professional organizations like social work expect that social workers will identify and react to negative aspects of organizations that do not allow optimal ethical decision making, especially when it affects clients. This expectation must be supported by suitable action and support

from the social work professional organization or else it leaves the individual social worker in an untenable situation at the mercy of the workplace organization and their values. This claim holds true for other helping professions whose job is to identify threats to the interests of the public because of their immediate relationship to problem situations and their expert knowledge of how to deal with these situations (CNA Code, 2012). Societies provide such professionals with exclusive rights to practice on the implicit condition they will benefit society by making us aware of dangers or threats to our well-being in the practices of others or organizations. This places a duty on professional social workers to the general public, as well as to their individual clients.

Question 3: Briefly describe the specific nature of the situation.

All the written responses identified a situation where the organization failed to protect client interests and confidentiality, and failed to provide access to needed services and information about options.

This failure to respect and protect client interests is in conflict with what a social worker is essentially required to do as a central feature of his or her profession. This is a serious conflict with the goals, ethos¹¹ and practice of social work professionals, the organizational goals espoused of the social work profession and any licensing agreements or contracts with social workers.

Following the responses to the first and second question, this third set of responses indicates that examples identify serious ethical issues to the social worker's functioning ethically and efficiently to protect client's interests. The power imbalance and control exerted by the organization, whether intentional or indirectly driven by funding considerations is ethically unacceptable. Both the organization and the social worker need to work within the same ethos, set of ethical principles and relationships or there will be a persistent ethical conflict. What seems to be happening is sometimes called situational control (Cooper, 2004), where an

individual's actions are determined beyond his or her will by the organization and its structure, seriously jeopardizing individual freedom of choice and individual responsibility (Foucault, 1995).

The costs to both the efficient functioning of the social worker in her job and the efficient operation of the organization to effectively deal with ethical conflicts has been shown to be significant (Nelson, 2008). Both the organization and the individual social worker should have an interest in fixing the failed relationships inside organizations. In the CASW Code of Ethics, social workers are directed "Where conflicts exist with respect to sources of ethical guidance, social workers are encouraged to seek advice, including consultation with their regulatory body" (2005). Some of these responses about failures to protect confidentiality, failure to protect the client's interests and provide needed services and information, may constitute an instance of possible boundary issues. That is, the organization may be crossing the line by determining whether and how information is distributed, whether client confidentiality is protected or whether client's interests predominate or not. These represent conflicts between some agency actions or relevant inactions, support for actions and even agency values that seem to conflict with social work values and possible actions. The professional social worker would seem to need a protected domain of decision-making, especially with reference to decisions involving vulnerable clients, decisions that are not made at the whim or under the control of the agency. This could involve the workplace acting in ways that inhibit good decision making or not acting in ways that positively support good decision making.

4. Critical Discussion of Survey Respondents' Answers to Questions 1-3

(a) The overall issue raised in these responses deals with relationships involving human beings, both formal and informal. So, it follows that what has to be fixed are

relationships and their ethical intersections in practice.

- (b) To fix a relationship, there needs to be a shared understanding of the integration of the goals, aims and ethos of employment relationships, professional social work relationships and caring relationships with clients and customers. That is, the employer needs to recognize that the social worker's education and contracting into the ethos and standards of the social work profession entails ethical obligations. These should not be overridden by employment obligations and clients need to realize that a social worker cannot override considerations of professional obligations and responsibility even for the antithetical personal interests of a client. This suggests an educational opportunity between employers, social workers, the professional organization, and clients to provide an open forum for the exchange of essential ethical information would be valuable.
- (c) There needs to be a clear focus and subsequent open public discussion (conference or workshop) of the nature of ethical relationship conflicts, the means of resolving such conflicts, the institution of professional representatives installed in organizations of employment whose express purpose it is to help identify professional ethical issues inside the organization and ways to successfully deal with these problems.
- (d) There needs to be a systemic re-evaluation of the CASW Code of Ethics to determine how adequately the expressions in the Code deal with the ethical conflicts generally and specifically in relationships identified in this set of survey responses. This should be conducted not only by members of the professional association of social workers but in collaboration with knowledgeable experts from other professionals, who interact with social workers in the field, as well as with

trained experts in ethics and with a select group of clients.

- (e) There needs to be an evaluation of the educational programs training social workers to identify best practices within these programs that deal with issues of relational ethics and conflicts between various sets of relationships.
- (f) Finally, there needs to be an ongoing critical discussion in the classrooms of social work programs, the meeting rooms of organizations that employ social workers and social work professional conferences and workshops on boundary conditions that social workers need to identify and ways that these boundary conditions spell out limitations in behavior within and across relationships. This is a project in community building, for which social workers should be prepared or at least aware of possible strategies to accomplish such projects. The buck often stops at the most personal of all relationships within the set, namely that between a social worker and client, so all the other relationships must somehow be oriented to support this one which is central to the activities of the professional social worker.

Question 4: Check all the factors that applied to the (conflict) situation (identified in 1-3).

Of the 11 possibilities answered, between 10-15% identified the following set: organizational ethics, policies or constraints (15%), staffing problems (10%), Code of Ethics (11%), Standards of Practice (11%), boundaries (crossings, violations) (10%), confidentiality (10%), client regard/lack of regard (10%). The written responses concerned relativist ethical issues: violations of the social workers' rights to practice his or her faith, cultural ignorance of other cultures, differences between power and authority of new staff compared to more experienced staff, all of which seem to be informal relationship and organizational ethical issues, especially when connected to the 25% who

identified organizational and staffing problems. It is important that 11% of respondents listed both the Code of Ethics and the Standards of Practice as a factor that applied to the conflict situation, but it is not clear whether these applied positively or negatively. That is, the Code could have provided positive support to the resolution of the conflict. However, the responses to the utility of the Code and Standards of Practice in other responses would put this positive spin to challenge. This negative interpretation seems consistent with the responses to question 5 below.

Question 5: What did you do, or what was done, and by whom, to address the situation described above?

The most prevalent set of responses was consultation with colleagues and supervisors to deal with the conflict problem(s). This is interesting because only one of these responses mentioned the CASW Code of Ethics, which was supported by management. None mentioned that the Code of Ethics was used to attempt a resolution to the conflict. However, one of the components of social work education highlights the need to consult with colleagues and supervisors before making significant ethical decisions. This consultation fits with the response that 83% of respondents chose an informal over a formal approach to making ethical decisions (in question 12) and a majority found the most influential feature in making a good ethical decision was experience (in the responses to question 18). The CASW Code was not ranked high in the influence in making an ethical decision in the responses to question 5 but it did indirectly support consultation with others as a means to using it as a guide to making a good decision. In response to Question 19, 29% of the respondents indicated that the greatest influence in forming their idea of professional ethics was education. Social work professional education stresses the need to consult with colleagues in dealing with conflicts, which as indicated does happen in the responses to this question.

Question 6: Were you satisfied with how the ethical situation was addressed (one choice)?

Only 25% of the respondents were satisfied with how the ethical situation was addressed, while 38% were not satisfied and 37% were partially satisfied. When the last two are combined, more than 75% were either not satisfied with how the situation was addressed or only partially satisfied. This suggests that there needs to be some substantial improvement in how ethical situations are addressed. We can break down the dissatisfaction with the way the ethical situation was addressed by considering the responses to Questions 13 and 14, where only 33% of respondents thought the process followed was effective (13) and 35% thought there was adequate and sufficient support for the decision-making process. This suggests that 65%-67% thought the process was somewhat ineffective or ineffective and the support for the decision making process inadequate and insufficient. We know that both the process operating effectively and the support for the process require an organization committed to making the process operate efficiently. This, again, points us back to the context, the organization, the workplace where ethical decision making takes place, a context which was initially criticized in the responses to Questions 1 and 2. If we use the responses to Questions 6 and 19 as an indication, we can infer that the problem with the unsatisfactory addressing of the situation must fall to the context of the workplace organization and not the inadequate educational ability of someone to address the situation satisfactorily.

Question 7: What aspects were satisfactory?

Significantly the satisfactory aspects focused on what was communicated, such as “staff were aware of the problem,” “I learned not to trust the system,” “a conflict between staff rights and management was identified,” “awareness of how others see the situation,” “all points of view were heard,” and “the care and concern of the client” were ranked high. Positive distribution of open communication can be gleaned from the comments that “staff were aware of the problem,” “awareness of

how others see the situation,” “all points of view were heard,” and “the care and concern of the client” were ranked high since this gives evidence of an openness and fair distribution of opinion across the set of individuals affected by the situation. It is identified as an important aspect of social intelligence known as listening.

Listening well has been found to distinguish the best managers, teachers, and leaders. Among those who are in the helping professions, deep listening is among the top three abilities of those whose work has been rated as outstanding by their organizations. Not only do they take the time to listen and so attune to the other person's feelings; they also ask questions to better understand the person's background situation—not just the immediate problem or diagnosis at hand (Goleman, 2006, 145).

This is a start to making a good ethical decision but it is a long way from achieving a resolution to a conflict or inconsistency. Many of us have been frustrated by a sympathetic nod or tongue clicking response like “I hear what you say” and “I know where you are coming from” that is not accompanied by any effective ethical decision-based action at all. More than being frustrated by such communications, people often find them condescending and dismissive of those making the claim or having the problem. One aspect that the code should consider introducing into the content of skills is the value of deep listening, as a unique aspect of the process of making a good ethical decision, as well as a valued and somewhat unique aspect of the ethos of the social work profession itself. This deep listening has to be done under the constraints of the protection for confidentiality, protection for the good of society, while maintaining professional boundaries.

Being aware of “the point of view of others,” “staff being aware of the problem,” “all points of view were heard” all suggest an initial openness to the situation, which is a positive feature of the circumstances. But these features would not impact a formal process, since how others see something or their relative position is not

a necessary factor in a formal, detached, impartial and objective evaluation of the situation and proposed solution. Instead, all these factors are important in forming caring, personal relationships, which suggests a positive approach to solving and ethical problem.

Question 8: What aspects were unsatisfactory, or you wish you or your organization could have done differently?

All the comments focused on the need to be open, honest and flexible when making decisions and moving the focus away from target numbers and budgets to protecting the interests of vulnerable clients, especially children. The needs of the budget should not be put before the needs of clients. This is certainly consistent with the conflict expressed in the responses to Questions 1 and 2. It is more likely the organization that would focus on target numbers and budgets and not individual social workers. Certainly the operations of some organizations are not open, honest or flexible. The response to this question is also consistent with the positive aspects of the positive distribution of open communication identified in the responses to what was satisfactory in previous Question 7. It seems, then, reasonable to conclude that these are some of the factors of organizations that led to the negative influence of organizations in making good ethical decisions expressed in the responses to Questions 1 and 2. The positive distribution of open communication is either an organization issue or a system-wide issue. That is, it is often the structure and function of an organization that makes this possible or impossible, not the actions of discrete individuals within the confines and structure of the organization. It is possible that the conditions necessary for the survival of the workplace organization are inconsistent with the conditions necessary for the efficient and successful making of ethical decisions on the part of social workers within it. It has been argued elsewhere as a result of health care practitioner studies that moral integrity, for example, cannot be based on the rigid application of inflexible principles since professionals must

engage themselves in a multi-valuing social matrix with differing moral positions held by others (Edgar, 2011).

Question 9: What do you believe the Code of Ethics (CASW 2005) directed you to do?

The comments all focused on honesty, respecting the rights and interests of clients, making (policy) compromises for their interests and remaining client friendly. It is significant that no references were made to specific articles, sentences or parts of the Code. There were no specific references using the formal legalistic language of ethical obligations, duties or rights in the Code. However, the values expressed are those found in the CASW Code-honesty, respecting rights and the interests of clients, and so on. While there are no specific references to the Code, there are references to the values the Code promotes. This may mean that the Code is used in spirit but not in letter. That is, the intent of supporting certain values expressed in the language of the Code is translated into respect for these values in making good ethical decisions, even though direct reference to the Code itself is missing. In this indirect way, the Code of Ethics is providing positive direction for those wishing to effectively use it to help them make important ethical decisions. The first paragraph of the Code identifying its purpose states explicitly "Both the spirit and letter of this Code of Ethics will guide social workers as they act in good faith and with a genuine desire to make sound judgements" (CASW, 2005, 2). Codes of ethics, of course, do not provide direct rule determination for behavior but rather act as a guide to help individuals make good decisions in specific contexts. The Code's ethical direction, then, may be well understood as implying certain values and approaches while social workers in workplace practice do not appeal directly to the specific, written letter of the Code.

The direct application of the letter of the Code may incur the following ethical problems, which are antithetical to making good ethical decisions: (a) blindly following the rules or laws when doing so could jeopardize a client or an effective

client/social worker relationship, (b) moralism, which can often be counterfeit to morality, where “humans insinuate malice, self-satisfaction, and complacent oppression even as they celebrate their enlightenment and rational progress” (Fullinwider, 2006, 18) by using rules as crude clubs to indiscriminately evaluate the behavior of others, (c) judgmentalism, “the habit of uncharitably and officiously passing judgement on other people” (2006, 9), which is a danger that anyone who holds the balance of power in a relationship must be constantly vigilant of applying indiscriminately.

Following the intention of the Code may involve treating people differently, with reference to the same prescription, avowing that the uniqueness of an individual and his or her situation count for more than they should when the public application of rules has to be seen to be consistent, unbiased, without prejudice and objective so that “social workers strive for impartiality in their professional practice” (CASW, 2005, 6).

Question 10: What do you believe the Standards of Practice (ACSW, Standards, 2007) directed you to do?

The written responses were quite varied with specific messages like: “report incident to supervisor” and “address (incident) with offending party,” to vague or general claims like: “provide appropriate care,” “respect the dignity of the client,” “cultural competency,” “act in accordance with the Code of Ethics.” There seemed to be an underlying confusion about how the Standards of Practice were to be employed with one person openly criticizing the recent push to revise the Code of Ethics once again, wondering “What will those less inclined to consider their Standards of Practice make of this?” This would seem to be an understanding of a standard of practice as static, fixed, eternal and not subject to changes due to new information illuminating the need to change. There would seem to be some confusion, which can itself generate conflict, between the uses of the Code of Ethics and the Standards of Practice. General and vague claims provide less direction and action guiding in context than more specific claims, like reporting the

incident to the supervisor. What is the difference between standards of practice and a code of ethics? This question is open to all professions that have both and remains open to critical evaluation.

Question 11: What did your own values direct you to do?

Interestingly the focus for comments in response to this question was contradictory with some centered on “speaking out” and “speaking for those who cannot,” “caring about the needs of the marginalized and others in need of support,” while others indicated that their values told them to “get out,” “not become involved in co-workers relationships,” “explore options or ask questions.” Distancing or detachment (Russon, 2009) occurs in an attempt to objectify a relationship as in legal relations, while engagement is a process where the parties to a relationship each have an interest in preserving and maintaining an effective personal relationship—not one guided necessarily by rules, formal procedures or laws. The difference is that the individual relationship is important not the general laws which govern it. The latter needs to be interpreted in terms of the former (Comartin & Gonzalez-Prendes, 2011).

Question 12: What decision making process or processes were followed?

Of the options provided, clearly 83% chose a non-formal approach, one that involved using an ethical theory, a decision-making model or the Code of Ethics/Standards of Practice. Almost one third of respondents (28%) said they employed an informal approach, caring attitude or relationship, 26% indicated they used personal values or an intuitive approach, and 28% indicated they employed consultation with supervisor, peer, instructor, family or other. The seminal work of the psychologist Carol Gilligan identifies this approach as indicative of feminist ethics (1982) and we note that 87% of the respondents were female. This later came to be known as caring ethics through the initial work of Nel Noddings (1984). However, we cannot be so single-mindedly gender focused on this finding

since in all the health care service professions, the emphasis is on caring relationships, in which the issue is not to focus on formal, distancing and objectifying processes but on inclusive and personal relationships within sustained professional boundaries (Hajdin, 1994).

The process is not judicial, yet Codes of Ethics and Standards of Practice are written like legal documents and established, in some uses, as the basis for formal legal responsibility. The critical issue here is between public expectations and informal approaches and actual practice which rely instead on informal consultations which are not codified. The process of deliberation using the formal code of ethics that the public might suppose happens clearly does not always happen when the decision is made. Any uniformity or universality in approach to dealing with ethical conflicts or issues cannot be guaranteed with clearly predictable outcomes, because of the shift in focus to the client's interests and the focus on personal relationships with colleagues, supervisors, and so on.

Question 13: Was the process followed effective in dealing with the ethical conflict?

One third of the respondents (33%) indicated that the process followed was effective and two thirds indicated that it was not effective (26%) or only somewhat effective (41%). There is clearly a level of dissatisfaction with the effectiveness of the informal approach, yet it is by far the most often employed process. This seems a bit inconsistent as the preferred or chosen approach was found wanting and the comments indicated that this was, in part, due to issues of consistency. Responses included statements such as "it will be difficult not to follow the concerning policy unless other workers do the same" and "there has to be a consequence for not following ethical standards and standards of practice which is missing" and "the policy was followed as best I could." Consistent with the responses to Questions 1 and 2, the problem may be centered in the organization or workplace context. Context support or lack of support plays a crucial role in good ethical decision making processes

being followed or not, followed consistently or only occasionally. There appears to be an on-going level of frustration expressed at the ethical inconsistencies in organizations or the workplace as indicated by the comments above. Additionally, the lack of consistent adherence to policies, lack of consistent consequences, and lack of any consequences caused individuals to do the best they could under the contextual circumstances.

Question 14: Was there adequate and sufficient support for you in your decision-making process?

Again, consistent with the responses to 12 and 13, 35% indicated the support provided was adequate and sufficient while 32% indicated it was not adequate and sufficient and a significant 33% indicated that the support was somewhat adequate and sufficient. This corresponds to the findings in the response to what process was followed (Question 12) since personal relationships and informal approaches often appear to be somewhat inadequate or insufficient. It also aligns with the negative responses to whether the informal process was effective or not in making an ethical decision. The relatively low numbers who believe the support for their ethical decision making was sufficient may be related to the on-going issue identified in Questions 1 and 2 about the conflict with the workplace organization, which has already been cited as a place where good ethical decisions are not supported.

Question 15: Are you familiar with the CASW (2005) Code of Ethics?

The responses to this question were interesting because 69% of respondents reported they were familiar with the CASW Code of Ethics and 29% were somewhat familiar with it. This indicates that a high percentage, (99%) are either familiar or somewhat familiar with the Code. Yet based on responses to Question 12, only 17% of respondents followed a formal approach using an ethical theory, decision making model, or the Code of Ethics when making ethical decisions.

While a large majority of respondents (99%) were familiar with the Code, they seem either not comfortable or not able to use this same Code in the process of making an ethical decision. This seriously questions the limited use of the Code or Standards of Practice in making ethical decisions by social workers with—on average—over 16 years of experience in the profession. However, this reading may not be accurate. Another interpretation is possible. On the basis of this alternative reading, we again need to distinguish between the spirit and letter of the Code, with ample evidence that the first may be a guide to making decisions but the latter is not. If the understanding of the spirit of the Code is sufficient to form the basis for “sound” ethical decision making, then the letter of the Code may be usefully employed as part of an individual’s documented reporting of what happened after the ethical decision is made. This relationship of familiarity is not a formal, objective application of a universal law or abstract rule but an informal relationship in which access to the Code is based on a reading of its intentions and subsequent consistent applications. This latter reading contextualizes ethical decision making within the framework of a busy work schedule and a mixed set of tasks, making accessing a legalistic document and following the slow and ponderous decision making of a judicial procedure not only impossible but implausible as an accurate description of what could happen in most cases.

Question 16: Are you familiar with the ACSW Standards of Practice (2007)?

The response to this question is similar to Question 15, with 57% familiar with the standards and 40% somewhat familiar with the standards, for a total of 97% having at least some familiarity with these standards. Again, only 17% of those responding reported that they actually employed it in making ethical decisions. So, familiarity does not have a significant effect on use, unless we consider the letter/spirit distinction we raised in our responses to questions 9 and 15. As we indicated in our analysis of Question 10, there was some confusion

as to what claims to make and what process to follow using these standards, specific directives or generalizations with no specific actions attached to them. The conflict is between a general set of claims and the individual required to translate these into specific decisions. This requires interpretation, training and experience to be able to do it well. There is a set of definitions, a set of clarifications and a general set of guidelines that are somewhat more specific than the CASW Code of Ethics because there is an expressed intent to formally define standards as one formally defines rules and infractions of them in codes of law. This is not just to identify some general guidelines. Setting minimal standards and meeting standards are two different activities which have to interact with each other. That is, the intentions of the standards need to be made clear and the possibilities of meeting them or not also needs to be made clear. The two activities cannot take place in isolation from each other in order to achieve an effective compliance through practice.

Question 17: Do you rely on, or believe you would rely on, the following to make ethical decisions? Please rank in descending order of importance.

The numbers and ranking again indicated that education provided a significant role in making ethical decisions but the law ranked as the first influential consideration. The respondents ranked the laws first with 51%, followed closely by 46% identifying personal ethics and values, 40% the CASW Code of Ethics, 30% the ACSW Standards of Practice, 18% agency policies or procedures, 9% supervisors, and 7% colleagues and peers. The close proximity between the percentages of those who identified legal statutes, personal ethics and values and CASW Code of Ethics, suggests some significant differences in the respondents’ replies to this question. The close proximity between the next three possibilities, colleagues/peers, supervisors, ACSW Standards of Practice and agency policies, also suggests a multi-faceted ranking. The clusters may represent confusion in the wording

of the question between two different possibilities: what do you rely on, and what would you rely on, but perhaps more importantly we missed the significance of relationships in the posing of this question. If the personal relationship is the essential focus of ethical decision making, then different components will play different parts in the best ethical relationship, with the law taking primary precedence in some specific cases and personal values taking priority in other situations.

The CASW Code of Ethics seems to discount the possibility of priority ranking of influences or values. As they say “the Code of Ethics does not specify which values and principles are most important and which outweigh others in instances of conflict” (CASW Code, 2005, 12). It is confused to say that ranking is a personal decision, since one would want to know a preference or a tendency in ranking that pre-dates the actual ethical decision, minimally as an indicator of what generally to expect. Implicitly, the code does rank starting with legalism, ranking adherence to the law as a value prior to any other ethical consideration. The Code states “when required by law to override a client’s wishes, social workers take care to use the minimum coercion required” (2005, 4). What to ethically count as a minor or a child are referenced to legal definitions so that “Social workers are encouraged to maintain current knowledge with respect to legislation on the age of a child, as well as capacity and consent in their jurisdiction” (2005, 10). For what constitutes a human right, there is a formal referencing of legal documents (2005, 10-11). After this legal authority is satisfied, the priority ranking is given to clients described as vulnerable individuals. The advice in the code seems to be to satisfy legal conditions first, then to proceed to satisfying the interests of vulnerable individuals next. This seems to be a priority ranking in fact, if not in explicit statement. The claim to no ranking coupled with the implicit ranking makes the prescription that “social workers need to be aware of any conflicts between personal and professional values and deal with them responsibly” (2005, 2) problematic,

especially when there is no process identified and no procedure hinted at to explain how to deal with them responsibly.

Question 18: As you gain years of experience, (as a student or professional), do you believe your ethical decision making process has changed, stayed the same or improved?

A significant 76% of respondents indicated that their ethical decision making process has improved, while only 1% indicated it had gotten worse, 12% thought it had stayed the same and 11% thought that it had changed but were not sure if this is for the better or worse. Clearly experience seems to be playing a major role in the perception of what factors into making good ethical decisions. Often, it is experience that develops clarity and precision in making decisions about those engaged in personal relationships, rather than textbook or law-like determinations. This speaks to the requirement that social workers go through a process of continually up-grading their education and knowledge of various aspects of their professional practice. While not all professions take such a distinct interest in continual knowledge and skill improvement, social work education may be a factor that contributes to the positive effect of increased experience. Since a large number of the respondents to the questionnaire had a significant set of experience and some formal education, there is some reason to believe that improvement would be sought by such an experienced and well-educated group.

Question 19: Who or what has been the most influential in forming your sense of professional ethics?

It was “education” that 29% of respondents indicated was the most influential in forming a sense of professional ethics, followed by “self” at 23%, “employment” at 18%, and “other” at 17%. This may indicate an important component in the category of “other” was missed. This could be the category of “experience” that may also be covered by the concept of “self”. When we contrast

education to other possible influences (peers, supervisors, organizations and codes or published standards), this is a significant finding providing support for the positive effects of social work education on forming a positive sense of professional ethics. Knowing that social work is taught in nine colleges and one university across the Province of Alberta, it is relevant that there is some significant uniformity perhaps in the education of social work students, with reference to the ethics educational experience ranked as the highest. It suggests some consistency across these various teaching institutions. This bodes well for the public's perception of the profession as providing some consistency in the education of social work professionals. This is not necessarily the case with other health care professions where education has not been identified as a positive influence on forming a sense of professional ethics. Rather, peers and friends are cited in this primary role, according to a study published in a nursing journal (Gough & Joudrey, 1999).

5. Tentative Observations and Conclusions to Responses to Questions 1-19

- (a) The clear message is that ethical decision making dealing with conflict situations is focused on non-formal, personal relationships with colleagues, peers, supervisors. This identifies a relational-individual approach, placing the individual and his or her interests inside a supportive, caring relationship and not at the discretion of a detached and objective formal process. This runs counter to some professionals' claims about professional ethics, namely that legalistically following the formal rules of a code or standard of practice is "enough for responsible conduct" (Davis, 2003, 62).
- (b) The use of a Code of Ethics/Standards of Practice is often identified as crucial by those who try to protect the public's interest in knowing the formal accountability relationship between a professional and his or her professional association's standards, in order to be able to predict what can be expected from a professional in practice. However, if the code and standards are not well understood and used effectively by professionals, then the public's use of them should be reconsidered.
- (c) The education process for social workers seems to be working well, when it comes to information and familiarity with the professional Code of Ethics/Standards of Practice. However, it may not be working as well in practice at the level of overtly implementing these formal approaches into actual decision making. Internalization of formal Codes and Standards may be "second nature" and under-reported as a source of decision-making, especially for seasoned professionals.
- (d) If professional social workers get better at the process of making ethical decisions, based on experience in the profession, then there is a need to ask what it is they are learning in practice settings that they did not get in their formal education into the professional of social work.
- (e) The workplace or organization that structures, and to some extent determines through situational control, a social worker's behavior and decisions needs to be integrated into the community of practice of social work better than is currently the case. Since over 50% of social workers responding to this survey reported that they operate inside the non-profit or the government health organization, this is not uniquely an issue with private service providers. This is an issue of communication, consistency in following and promoting or supporting the same processes to achieve the same outcomes for both social worker and organization. Otherwise, organizations that provide services are doing so inefficiently.
- (f) Inconsistency contributes to conflicts and at the very least does not seem to contribute to resolutions to ethical conflicts or issues. Consistency needs to be maintained, supported and promoted in ethical relationships for

social workers to be capable of performing the tasks of their profession effectively.

- (g) It is not surprising that personal values can provide an obstacle to the resolution of conflicts inside and outside organizations, between professional and client, but it is surprising that having a personal value system seems essential to forming personal relationships that are deemed essential to making effective ethical decisions. The issue becomes how to manage personal values, the professional role of a social worker, and the necessary professional boundaries that protect the client and the profession's ethos and reputation.
- (h) There may be a need and an opportunity to continue the education of social workers beyond the parameters of formal education so that the experience that is so valuable to improving ethical decision making processes is shared along the spectrum of a social worker's career.
- (i) Multicultural societies present a context that puts significant pressure on social workers to avoid bias (MacDonald, 2010), while maintaining personal values consistent with acting on professional values. This establishes the issue of boundaries which will continue to be the possible source of conflicts and inconsistency, making ethical decision more difficult. Boundary crossings and violations are not just an ethical issue of importance to those immediately involved in the situation. These issues are also of ethical importance for the profession of social work generally. Every social worker is affected in the workplace by the general perception of the social work profession.
- (j) As the educational level of the general public increases, service providers decrease services, and the access to social services increases, the focus on ethical conflicts involving social work professionals may increase. This makes it more imperative to address inconsistencies, disparities and the confusion in the understanding and use of codes of ethics and standards of practice.

6. Recommendations

- (a) There should be yearly workshops or conferences to inform and engage workplace organizations who employ social workers in the decision making processes of professional social workers, who ascribe to their own professional Codes of Ethics and Standards of Practice. Communication and understanding can follow from an integrated collaborative continuous educational experience. Limits and sacrifices need to be identified by workplace organizations, consistent with the professional standards of their social work employees. The social work profession should not be compromised by the expediciencies of different workplaces but rather the workplace needs to do all it can to ensure clients' interests are protected by social workers' ethical priorities. Society needs the assurance that professionals will not have their ethical and practical standards compromised by the workplace. This assurance is the foundation for society granting professions the exclusive privilege to practice, a privilege which society could revoke if the profession fails to provide professional standards of practice and conduct on the part of its members.
- (b) There should be a suggestion of how to prioritize values in ethical decision making so social workers are not left to their own interpretation or personal values. If the latter happens, then this defeats the idea of a consistently applied set of standards or practices for professionals making ethical decisions. To set priorities is not to press them into stone. Priority rankings are flexible and can change due to changes in circumstances. However, the public has a good ethical reason to expect that professional social workers will be able to provide a basis for the ranking of their ethical choices, even if the outcome of the ranking is not necessarily the same in all situations due to circumstantial differences affecting priorities.
- (c) Experienced social work professionals should try to identify some of the specifics of how

they actually make informed ethical decisions in the workplace and bring this information to other professionals or new students of the profession. That is, there needs to be a clear on-going intergenerational and collegial understanding of how to make informed ethical decisions in the workplace among social work professionals. Social workers face similar ethical conflicts in practice, that need to be resolved based on reasonable priorities, set on the basis of experiential understanding shared among colleagues. Any conformity in practice cannot be enforced but it can be determined on the basis of informed, critical reflection of similar cases and shared principles in the process of making an ethical decision. As we suggested earlier, social workers are expected to be active, attentive listeners, so the intelligent counsel of others is not a stretch (Goleman, 1995, 145-146).

- (d) There needs to be some re-thinking, on the part of professional social workers, of the role and function of the Code of Ethics and Standards of Practice in actual ethical decision making. The value of making ethical decisions on the basis of the spirit of the Code or Standards of Practice should be emphasized, as well as the value of following the letter of the rule or principle, as we indicated earlier in this paper. In teaching ethical decision making, social work programs should emphasize the character of the decision in relation to the Code of Ethics rather than just the matching of the decision in one universal way to the ethical action which follows it (Gough, 1987, 224-230).
- (e) The ethos¹⁴ of the profession of social work should be identified and made clear at the beginning of the Code of Ethics and incorporated into the education of professional social workers to provide the acknowledgement of a consistent set of characteristics that identify the professional social worker as an attentive listener, an advocate for the vulnerable, an informal caring relationship advocate of the interests and rights of others, especially the

least fortunate in society, and a passionate proponent of social justice for all. An ethos recognizes the shared ethical identity of the community of social workers, and, as such, it should be made manifest to social workers who must make ethical decisions.

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Footnotes

¹ Special Projects Funding Grant from Red Deer College Board/Faculty Professional Development Fund and an Innovative Research grant supported by Alberta Colleges and Technical Institutions, AACTI, Innovation Secretariat and support in kind from the Alberta College of Social Workers Interdisciplinary Advisory Group and Delphic groups.

² James Wilson, Red Deer College, helped us organize the survey and format it, introducing us to AskitOnline (www.askitonline.com). Social work teaching colleagues Elizabeth Radian offered helpful suggestions on possible questions and Tera Dahl-Lang made helpful suggestions on ethical issues, while social work student and research assistant Jordanna Huggins themed some of the responses to the questions.

³ While born of necessity in the context of some education organizations, independently collabora-

tive research has its benefits to programs, faculty and students. It has the effect of breaking down artificial, institutionally or organizationally created, barriers to effective research communication, highlighting difficulties with obscurantist technical language designations determined by discipline traditions, discovering important commonalities concurrent within the approaches of different approaches from different sources, and so on.

⁴ Elaine Spencer was a co-developer and team member (with Alison MacDonald, PhD, RSW, and Duane Massing, PhD, RSW) of a successful team project that led social worker educators and practitioners on a voyage of discovery as they travelled across the province of Alberta leading discussion seminars and workshops about important ethical issues and case studies that impacted the practice of social work in various geographical locations in the province. The "Ethics Road Show" [Original,

Part I and Part Deux] was based on a workshop that included Elaine, Alison, Duane, and Suzanne Rosebrugh, MSW, RSW.

⁵ *Is Ethical and Effective Distribution Possible?* Presentation to the 7th Annual ACCESS, Association of College Educators in Social Services Conference, June 8, 2011, Montreal, PQ.

⁶ *Recent Research in Ethical Decision Making in Social Work*, Presentation to the Central Alberta Social Work Conference, June 21, 2010, Red Deer College, Red Deer, Alberta

⁷ The survey proposal and methodology was submitted to the Red Deer College Research Ethics Board, and was approved, prior to being disseminated.

⁸ There has been a long-standing and traditional split in the study of ethics by philosophers in which the practice of ethics and questions about it are thought to be independent of the questions prompted by the theories of ethics or meta-ethical considerations. Although it is sometimes thought that there are separate domains for the critical practices of each, it is also the case that the distinction breaks down as ethical decision makers are prompted to become internally self-reflective on what they are doing and how they are applying a theoretical principle or consideration. See, for example, Andrew Fisher and Simon Kirchin (Eds.), 2006. *Arguing about Metaethics*. NY: Routledge, which is predicated on the continuation of the meta-ethics/ethics distinction.

⁹ An initial important qualification needs to be considered. Since the survey was given to social work individuals and not delivered to organizations, some organizations or their representatives may have a different self-image or self-characterization from that identified by their social worker employees.

¹⁰ The public transparency and anonymity provided by social media internet outlets now makes this option less effective than in the past.

¹¹ The “ethos” of a profession has a variety of possible interpretations but for our purposes it represents a dominant characteristic(s) that separates, individuates, defines, actions and

decisions as consistent with the character of a professional group or inconsistent with it. So, for example, the ethos of most helping social service professions involves characteristics of care, concern for the other, altruistic motives, empathetic reactions and personal engagements, which are not the characteristics of other professions, like that of a professional engineer or architect.

¹² We developed this idea of the difference between the letter and the spirit of the code in our response to Questions 9 and 15, above. As well, all our combined teaching experiences in the area of professional ethics taught us that this distinction was often an issue with students understanding what to do in practical situations.

¹³ This is a common problem with many codes of ethics and their use by many professions and is not restricted to the application of a code by social workers. Codes need to be interpreted on site, as it were, and there should be some guidelines as to how the individual can manage potential and actual conflicts between different aspects, duties or rights contained in the same code. If such guidance is not provided in classroom instruction or in initiation into a profession, then there is a real problem of conflict and confusion that could render the code unusable and unworkable by the very people who it was intended to help. The existence of a code in a profession is not enough to guarantee that it will be used at all, be used effectively, or taken seriously, as the basis for making good ethical decisions.

¹⁴ As indicated earlier, this is a communal, shared, sometimes tacit, sometimes implied, not always expressed but often recognized in attitudes, behavior, approaches and equally often common to the ethics of a group or community. A caring attitude, for example, is an important part of the social work community's shared ethos but also, we argued, attentive listening should be incorporated as an integral part of this caring profession's communitarian character.

The Silent Dimension: Speaking of Spirituality in Addictions Treatment

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Journal of Social Work Values and Ethics, Volume 11, Number 2 (2014)
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Abstract

Professionally trained addictions clinicians are often required to discuss uncomfortable subjects such as abuse, trauma, sexuality and finances during their course of treatment. However, ambivalence about discussing spirituality in the therapeutic relationship (Canda et al., 2004; Frame, 2003; Humphreys & Gifford, 2006; Kriegelstein, 2006; Rice & McAuliffe, 2009; Sheridan, 2009) confirms Miller's (1999) original labeling of spirituality as "the silent dimension" of the social science of addictions. Despite the ambivalence, since the 1990s interest in the clinical impact of spiritual interventions has increased (Sherr et al., 2009). Research on attitudes and behaviors of clinicians has appeared in the literature, along with debate about the benefits, harms and appropriateness of a variety of spiritual interventions (Canda & Fuhrman, 1999; Gilligan & Furness, 2006; Hodge, 2011; Rice & McAuliffe, 2009). Consensus has emerged, however, on the need for an ethical model that will provide context-sensitive but systematic guidelines for ethical practice when incorporating spirituality into treatment (Canda, 2004; Rice & McAuliffe, 2009; Sheridan, 2009). In this paper, using client narratives, we outline why it is important and ethi-

cally appropriate to address clients, notwithstanding the inherent challenges. We identify several ethical dangers in discussing spirituality in the context of addictions treatment and evaluate competing ethical models for managing these dangers and integrating spirituality ethically into professional practice.

Keywords: spirituality, ethics, addictions, treatment, empowerment

1. Why the Ambivalence?

There are several reasons why discussing spirituality with clients is uncomfortable for clinicians. First, in many countries, addiction treatment has been historically divided into two, often disconnected, camps. One camp is comprised of both 12-step groups (populated by those who have experienced addictions) and faith-based substance abuse treatment programs. In the 12-step tradition, addiction is seen as, in part, a spiritual disease (McGrady et al., 2002) and discussion of spirituality is integrated into the recovery process, within the confines of the program. Faith-based treatment programs are, by definition, focused on the spiritual dimension of recovery (Lyons et al., 2011).

The other camp is secular in nature. It comprises professionally trained clinicians offering evidence-based treatments such as Cognitive-Behavioral Therapy (Emmelkamp & Vedel, 2006) and Motivational Interviewing (Lewis et al., 2011; Miller & Rollnick, 2002). These approaches emphasize theoretical testability and do not routinely include a spiritual component (Galanter, 2008; Hodge, 2011; Krieglstein, 2006). One of the consequences of this bifurcation is that secular clinicians may simply refer clients who have spiritual needs to the 12-step community, faith-based treatment or other designated pastoral care providers. As we will show, this is an insufficient response.

The second reason clinicians are ambivalent about discussing spirituality is lack of training (Canda et al., 2004; Frame 2003; Gilligan & Furness, 2006; Hodge, 2011; Morgan et al, 2008; Sheridan, 2009). Humphreys and Gifford (2006) have noted that addiction training programs either do not discuss spirituality or give it only a cursory overview. Social work training is also impoverished despite the leadership demonstrated by the Council on Social Work Education (2008) in its call to include religion in social work education (Furman et al., 2004; Rothman, 2009; Sheridan, 2009). Lack of training leaves clinicians at a disadvantage in understanding their clients' spiritual beliefs or helping them cope with their spiritual struggles without harming or proselytizing them (Canda et al., 2004; Frame, 2003; Hodge, 2011; Krieglstein, 2006; Kuczewski, 2007; Sheridan, 2009).

The third reason why spirituality remains in the shadows is because secular addiction treatment services are often a public service, subject to secular norms and accountability. By contrast, spiritual matters have been considered a private affair, best left to the realm of pastoral care (Guss Jr., 2011; Morgan et al., 2008; Muldoon & King, 1995). Additionally, as social work sought the recognition of its professional status in the 20th century, it distanced itself from its moralistic religious roots (Krieglstein, 2006). Therefore the inclusion of a spiritual focus in treatment now may feel uncomfortable for some. Unless spiritual interventions are clearly

therapeutically indicated and consented to by clients in the United States, they could be interpreted as violating the separation of church and state (Frame, 2003). The assumptions inherent in the public-private distinction are contestable; however without an explicit ethical model articulating the therapeutic imperative and offering guidelines that would correct for inappropriate boundary crossing, clinicians are constrained.

In sum, we identify three reasons why spirituality is a silent dimension in addiction treatment: it is overlooked in evidence-based approaches to treatment, it requires knowledge and training secular-based clinicians lack, and it appears to risk violating the religious neutrality embraced both by secular theoretical and liberal political orientations.

2. What Is Spirituality and Why Is It Relevant to Addiction Treatment?

"Spirituality" as a concept is broader than "religion." For the purpose of this paper, we understand religion to be "an organized, concrete form and expression of a *particular* spirituality experienced and practiced in a particular community of faith with specific scriptures, rituals and traditions" (Guss Jr., 2011). It is important to recognize "spirituality" encompasses phenomena that are not captured in the definition of religion. For clinical purposes, therefore, focusing on spirituality is more inclusive.

In the academic literature, there are varying definitions of "spirituality," with convergence on some fundamentals. Most definitions emphasize the meaning of life, the integration of ultimate values, and connectedness with the transcendent. The transcendent is viewed variously as the natural world, God, the divine, or the community; Notwithstanding the variation in the "sources" or "objects" of transcendent value, seeking meaning through connectedness to ultimate values is part of the human condition.

A novel account of spirituality offered by Rolheiser (1999) helpfully expands on the cognitive/relational account offered above by introducing the further element of eroticism into our

understanding. According to Rolheiser, as humans, we all have divinely-given powerful energies flowing through us, and spirituality (healthy or not) is about how these energies are directed. The addition of the erotic dimension is illuminating because it highlights how clients themselves often experience their addictions. Clients with substance use or gambling problems frequently refer to their urges as “uncontrollable impulses”, or even a “kind of madness.” This is erotic energy gone awry; a thrust in a direction that puts them at odds with their ultimate values or compromises their attempts at integration and meaning-making (Gedge & Querney, 2012).

The erotic energies of others may be implicated in addictions too. Clients struggling with childhood sexual abuse, violence, or parental substance abuse are coping with the effects of the misdirected erotic energies of others. Our working understanding of spirituality, therefore, presupposes that the appropriate direction of erotic energies is a key component of spiritual health, and is importantly linked to the spiritual goals of finding meaning, integration and connectedness to the transcendent. When the erotic is misdirected, as in the case of addictions, there is a risk of spiritual crisis.

Based on the above, we take spirituality to encompass cognitive/relational and affective/erotic dimensions. The cognitive/relational orients the person towards that which they value. The affective/erotic is the driving force facilitating spiritual connection. However, that drive may be misdirected, as in the case of addictions.

3. Why Breaking the Silence Matters

Despite the discomfort around spirituality, conversations about spiritual issues are important for client recovery. Consider the following anonymized client narratives:

3.1. Disconnection From the Transcendent (Abandonment)

Alice, former treasurer at her church, attended treatment because she had stolen money from the treasury to fund her gambling addiction.

Though Alice had confessed to her community, paid the money back and received their forgiveness, she was still troubled. Alice is devout and had taken great comfort in hearing God’s voice when she prayed. However, despite being forgiven by the church, she could no longer hear God. As a self-ascribed penance, Alice worked tirelessly at the church. But nothing changed, and she became suicidal and at-risk for relapse.

3.2. The Meaning of Life and Healing the Outcome of Misdirected Erotic Energy

Claire came to treatment for her alcohol and gambling addictions. As a child, she was sexually abused by strangers, and emotionally neglected by her parents, who also had substance use problems. Through treatment, Claire had been able to reach her goal of abstinence, but could not reconcile a loving God with her suffering.

3.3. Disconnection From the Transcendent (Allah and the Community)

Hakim’s gambling was considered sinful by his Muslim community. He told his clinician that he is “not religious”. Hakim believed that his gambling was so engrained that it was literally in his blood – an inescapable biological reality. He dared not speak to his community about his problem for fear of ostracism. His wife wished for him to atone for his sins by quitting gambling, but this felt impossible to him. His clinician wondered whether Hakim’s declaration of atheism and his alienation from the community was a defense against unbearable shame.

Clients do need to, and often want to, articulate their spiritual struggles (Frame, 2003; Hodge, 2005); this being the first reason for integrating spirituality into addictions treatment. Although referral to a spiritual advisor may be warranted or preferable, this can be problematic if the client has no religious affiliation, has been alienated or has withdrawn from his or her spiritual community, or had a traumatic or dysfunctional religious past. When dealing with addictions, such circumstances are often the case. Nevertheless, a spiritual crisis may be at the heart

of the client's condition, and a skilled and ethical response is required.

The second reason is a *holistic* approach to addiction treatment is effective (Hepworth et al., 2010). Holistic treatment is not only about the addiction itself or one's activities of daily living, but also addresses the psychological, emotional, physical and social aspects of the individual. A completely holistic approach should also include the spiritual. Clients must create and sustain an integrated life if they hope to maintain their goals. Successful relapse prevention is associated with learning how to resist the 'quick fix' of substance use or gambling when confronted with difficult situations or emotions. Following Rolheiser (1999), we argue clinicians must help clients to stay in their angst (their urges, cravings, intense emotions) long enough to allow the painful tensions to be resolved, and for transformative integration to take place. The recent emergence of mindfulness-based therapy (McMain et al., 2007) which helps clients "stay in the moment" reflects a growing awareness of the breadth of holistic care, and an implicit acknowledgment of the role of spirituality in that care.

The third reason for integrating spirituality into addictions treatment is that there is already an implicit mandate to do so. If holistic treatment is most effective and if spirituality is an important dimension of the whole human being, then integrating it into addictions treatment is mandated by the commitment to offer the "total care that could be possible" (Morgan et al., 2008). The holistic approach best expresses the values and practices of many addiction clinicians, and the same rationale that supports holistic treatment will support an expansion to include spirituality (Smith, 1998). In addition, several national bodies implicitly legitimize the need to incorporate the spiritual dimension into addictions treatment, including: the Canadian Association of Social Workers (CASW), the National Association of Social Workers (NASW), the Australian Association of Social Workers (AASW) and the Canadian Centre on Substance Abuse (CCSA). The CASW, with its emphasis on anti-oppressive practices and client self-determination, requires social workers

to serve clients without discrimination – including religious discrimination (Morgan et al, 2008). It recognizes spirituality as an important part of an individual's identity, and, by implication, falls within the domain of care. In the same vein, the NASW requires its members to achieve cultural competence through education and seeking to understand diversity, including spiritual diversity (NASW, 2001). The AASW highlights the need to recognize and honor the religious and spiritual worldviews of clients. The CCSA, which developed a set of Canadian behavioral and technical competencies for all addiction clinicians, states at the intermediate level clinicians should possess "considerable knowledge and understanding" of spiritual issues that affect diverse populations. An increasing awareness of the relevance of spirituality to treatment is therefore emerging in the official statements of many regulatory bodies.

4. Breaking the Silence Ethically

How can spirituality be incorporated into addictions treatment ethically? As noted earlier, clinicians worry that due to inexperience and lack of training they could harm clients in the attempt to offer spiritual guidance. The obvious response to this concern is to integrate appropriate training into clinicians' professional development (Morgan et al., 2008). Our first recommendation, then, is that social work education and professional development must incorporate comparative religion and spirituality into professional training. Hodge (2011) notes courses, professional conferences, and scholarly journals provide opportunities for this purpose, though on an elective basis. A more systematic and routinized approach is required.

A more complex worry is over proselytizing, as previously stated. This worry is both political and clinical. Politically, the right to develop and hold one's own spiritual beliefs is a key pillar of liberal politics and gives rise to the objection that public representatives should exert no pressure on individuals regarding spiritual matters. Clinically, because of the power asymmetry within the therapeutic relationship, there is a risk that clinicians may exert an inappropriate influence on

clients articulating or questioning their spiritual beliefs. It is important on both grounds to ensure a best practice is developed around integrating spirituality into addiction treatment so as to protect the independence of the clients' beliefs.

Ethicists and clinicians are divided about how to address this issue. Both share a concern about harm to clients and undue influence over clients' belief systems. As cited in Sheridan (2011), some would advocate for a rigid separation of the 'private' area of spirituality as a response. The problem with that response though, as we have seen, is it violates the mandate to provide the best possible care. Furthermore, studies show spiritual interventions are indeed taking place and are viewed as important for client health, notwithstanding the absence of clear and consistent ethical direction (Canda et al., 2004; Frame, 2003; Rice & McAuliffe, 2009; Sheridan, 2009). Therefore, professional bodies must develop and integrate guidelines for discussing spirituality and incorporate them into an ethical model.

Following the work of Canda (1990), a number of authors have proposed ethical guidelines for spiritual interventions. Proposed guidelines emphasize prioritizing the care of clients, starting where the client is, aligning interventions with client interests and goals, and protecting clients' dignity and self-determination. Some authors (Frame, 2003; Sherr et al., 2009) explicitly note the importance of being aware of the operation of power within the therapeutic relationship, clarifying roles and setting boundaries, and all emphasize the importance of professional competence. However, as Canda & Furman (1999) state, an ethical model that is context-sensitive yet systematic is still lacking.

A central issue in developing such a model is how power circulates in the therapeutic relationship to promote or to inhibit client wellbeing and self-determination, and to assign responsibility. Here three possible ethical models offer different insights. According to the client-centered model (Cohen et al., 2007), discussion of spirituality can be appropriate and safe as long as only the client's beliefs are engaged. In the client-centered model

the role of the clinician is that of active listener and intelligent respondent. The clinician should engage the client on spiritual issues, if welcomed, and may even request a "spiritual history" (Hodge, 2005). Client-centered clinicians should see their role as that of helping the client to identify her/his ultimate values. If further discussion is therapeutically indicated, the clinician could translate spiritual values into religiously neutral language. Thus, for instance, the religious doctrines of creation can be understood as existing in relation to other humans; sin can be understood as the breakdown of relations and salvation as reconciliation (Guss Jr., 2011). Using such neutral language, clinicians may then proceed to suggest strategies of adaptation or healing, without explicit discussion of religious or spiritual beliefs, and importantly, without disclosing anything about their own spirituality.

Determining to what degree clinicians should disclose their own spiritual beliefs is central to finding an adequate ethical model. Studies show clinicians are often motivated to engage in spiritual discussion or intervention because of their own spiritual beliefs (Sheridan, 2011). An important question will be whether the client-centered model is right to prohibit clinician self-disclosure, and whether client wellbeing and self-determination are compatible with a mutual sharing of personal beliefs and perspectives. In a more liberal spirit, a second model, the transparency model, has been suggested. According to the transparency model, it may sometimes be appropriate for clinicians to engage in a mutual interchange of spiritual beliefs with their clients in contrast to the client-centered model. (Kuczewski, 2007). Although the client-centered model would see this as a boundary violation, the transparency model argues holding oneself apart when discussing momentous issues creates an unhelpful distance from a client and forfeits a therapeutic opportunity as well as a chance to affirm our shared humanity. For instance, a Catholic clinician might talk to Alice about how the clinician himself had experienced God's forgiveness of sin through the sacrament of penance. In such an interaction the priority is still the dilemma of the client; but the clinician

is neither pretending to be spiritually neutral, nor is he disclosing for the sake of being heard. The therapeutic imperative is guiding the discussion, and importantly, the substance of the discussion is the client's spiritual crisis as she understands it.

There is much to commend both models, but each has its own particular shortcomings and naivetés. With the client-centered model, the risk of explicit proselytizing is low; however, it still exists and perhaps is all the more threatening to client self-determination for its overt prohibition. All therapeutic interactions are value-laden (Hodge, 2011), whether this is acknowledged or not, so it is naive to think that prohibiting counselor self-disclosure removes the danger of undue influence over clients' spiritual beliefs. In addition, the distance and spiritual neutrality between client and clinician that is advocated by the client-centered model is therapeutically limiting. The distance and neutrality do not necessarily protect the client from clinician incompetence, since sensitivity and judgment are required in the translation of spiritual or religious beliefs into neutral language, and the neutral language itself may be unsatisfactory as a pathway into the heart of the client's problem.

The transparency model is appealing because it acknowledges the shared humanity of the client and clinician, and because it can allow for richer therapeutic discussion. However, even if a clinician discloses her/his spiritual beliefs and values, as might be permitted under this model, a power asymmetry still exists and may influence client self-determination negatively. Critics point out that a clinician, as a professional, may be inappropriately viewed as a spiritual authority, or that the client may confuse the roles of clinician and companion-traveler (Cohen, 2007; Hodge, 2011). In disclosing her personal stories or beliefs, the clinician thereby risks compromising the client's autonomous moral or spiritual development, especially if, for lack of self-scrutiny or spiritual health, the clinician's disclosure is self-indulgent (Kuczewski, 2007; Skinner & Paterson, 2004).

Recognizing there is no such thing as a value-free intervention, some authors (Frame,

2003; Hodge, 2011) consider the desirability of prescribing a pre-emptive self-disclosure of clinician values, assumptions and beliefs as part of the informed consent process prior to the start of the treatment process. At this point clients could decline further engagement about spirituality, or client or clinician could recommend a change in who provides treatment. However, such pre-emptive self-disclosure seems forced – it may be therapeutically premature, and/or may preclude or disrupt the development of the trusting relationship in which spiritual issues most helpfully emerge. Rather than prescribing the timing and nature of a process to ensure clients' beliefs are protected, a context-sensitive ethical model will rely heavily on clinical judgment about the helpfulness, the timing, and the scope of self-disclosure. Thus, having a prescriptive informed consent procedure is no substitute for clinical judgment about spiritual self-disclosure. Nonetheless, the operation of power within the therapeutic relationship must be acknowledged and addressed.

How might the advantages of transparency be incorporated into an ethical model that provides context-sensitive yet systematic direction? We advocate an empowerment model. The empowerment model integrates the benefits of transparency, but highlights the operation of power in the therapeutic relationship. First, cultivating a robust awareness of the naiveté of the "myth of equals" in this context, a clinician must neither "deny nor avoid the power of his or her position, but see how it affects the helping process" (Skinner & Paterson, 2004, pg. 81). The appropriateness of spiritual disclosure by a clinician must always be judged in light of both its relevance to the helping process and the degree to which the power asymmetries advance rather than limit client recovery. This is where the context sensitivity called for by Canda (1990) and others is vital.

The link between context and empowerment is frequently made in the literature on the ethics of care, whose norms are helpful in the treatment context (Held, 1993 and 2006; Noddings, 2010). A central focus of care ethics is to

identify ethical norms arising in relationships of unequal power, such as relations between parents and children, teachers and students, clinicians and clients. Because each relationship is in some way unique, care ethics accepts ethical conduct must be a response to particulars about the relationship and its stakeholders, must, in fact, be context-sensitive. However, care ethics is not simply relativistic; it proposes norms that are applicable to all relationships and analyzes the fruits and risks of asymmetries of power. Caring relationships requires of the caregiver to give receptive attention to the circumstance and expressed needs of the cared-for, as well as have a motivational displacement such that responding to the needs of the cared-for takes precedence. In a caring relationship cultivating these dispositions is normative, and the norms provide a standard by which to judge the quality of care. Unlike the ethical principles of non-maleficence, beneficence, autonomy, and justice arising out of traditional ethical theory, the norms offered in care ethics build in context sensitivity since it would be impossible to succeed as a good caregiver without being sensitive to and motivated by the particular needs of the person cared-for.

Along with providing norms for caregiving, care ethics revises the concept of power as it applies to relationships of care, such as that between clinician and client. Meeting the needs of a vulnerable other, particularly if that vulnerable other is an autonomous person, is not a matter of wielding power or neutralizing asymmetries so as to become equals. Equal moral worth is assumed. Rather, the caregiver seeks to empower the cared-for in order to achieve the goals of the caregiving relationship. As has been shown, achieving the goal of empowerment may call for a spiritual intervention, and in the context-sensitive judgment of a clinician it may call for the clinician to disclose his or her spiritual beliefs, history or practices. Employing the norms of care ethics should give clinicians confidence such a practice can be ethical.

In the empowerment model, ethical responsibility for the appropriateness of spiritual self-disclosure is not carried by clinicians alone.

The client-clinician interaction is nested within a context of overlapping power relationships. According to Skinner and Paterson (2004), the ethical space in which treatment takes place is co-constructed by a diverse group of parties including clients, clinicians, agencies and professional bodies - each having rights and responsibilities. In that complex space, it is vital to recognize the many ways in which power circulates as support or hindrance to the ethical judgment of clinicians as they aim to empower clients. Clients are supplicants to clinicians, who have the power of knowledge and authority; but as employees, clinicians themselves are subject to the authority of agencies. Agencies are accountable to the communities they serve and both agencies and clinicians must conform to the professional and ethical requirements of professional bodies. There are multiple relationships of power and dependence, of responsibility and entitlement impacting the one-on-one interaction between clinician and client. Although, as we argue, clinical judgment is irreplaceable in determining whether and when a spiritual intervention is appropriate and likely to be helpful, the empowerment model maintains that the clinician shares with others the burden of responsibility for sound judgment. In its recognition of ethical complexity and shared responsibility for empowerment, the empowerment model is an advance on both the client-centered and the transparency models.

According to the empowerment model, what are the specific ethical responsibilities of agencies and professional bodies in supporting sound ethical judgment on matters of counselor spiritual intervention? First, because it recognizes the complex ethical space inhabited by clinicians and clients, the empowerment model demands agencies and professional bodies use their power to provide ongoing education to support ethical conduct. For instance, clinicians may encounter clients whose addiction stems partly from abuse in religious institutions (e.g., Canadian aboriginals in residential schools) and need to know how these scandals are being viewed and dealt with outside their own practice. Such knowledge may help

them understand how their clients' suffering has been shaped, and may limit or enhance treatment options. Regular education sessions with expert speakers or consultants, and comprehensive, accessible, and current resources on spirituality should be provided.

Second, treatment agencies must provide routinized peer/supervisor debriefing and incentives for clinicians to discuss cases touching on spiritual issues. A few authors, including Canda et al. (2004) and Frame (2003) recognize the importance of dialogue with colleagues, seeking consultation and supervision. Clinicians should be invited in a non-punitive atmosphere to share their fears and failures. As Skinner and Paterson (2004) note, cultivating sound ethical behavior in an organization requires "clear policies, guidelines and shifts in practice to encourage and support disclosure?" (p. 78).

Third, and perhaps most importantly, clinicians must be supported in learning and maintaining habits of spiritual self-scrutiny and self-care. Clinicians must strive for spiritual health themselves so as to avoid narcissistic or needy disclosures with clients to reduce the risk to themselves of witnessing client spiritual crisis, and to remain faithful to the primary mandate of client empowerment (Canda and Furman, 1999; Frame, 2003; Krieglstein, 2006; Rice & McAuliffe, 2009; Skinner and Paterson, 2004). Agencies share responsibility for encouraging clinicians to monitor themselves regularly for residual biases and to accept there are limits to their own expertise (Hodge, 2011; Kuczewski, 2007; Morgan et al., 2008). Agencies must offer resources for clinicians' professional and spiritual self-care, and provide incentives for accessing them. Agencies' expectation that clinicians will practice spiritual self-care can be implemented, for instance, in scheduling time with a support group or a spiritual director. Agencies or professional bodies can offer manuals with suggestions for regular self-care, such as those offered by Skinner and Paterson in the context of encouraging ethical practice. The authors suggest that clinicians assess their own ethical 'health' by asking themselves such questions as: Am I

reluctant to pursue consultation? What are my reasons for urging the client to confront or address this issue? Am I just trying to exercise control, or can my power/authority be used to good effect for the client? Would I include details of this conversation in the client record? In a peer group? To my supervisor? If not, why not? This self-assessment template recognizes the operation of power, and can inform a best practice of discussing spirituality. It acknowledges the possibility that spiritual disclosure could empower clients, yet recognizes that disclosure could be wrongly motivated or unhelpful. It emphasizes the importance of transparency to peers, the dangers of secrecy, and the possibility of clinician self-deception. Thus, it highlights the fact that sustainable ethical behavior on the part of clinicians is a function of the structure and ethical ethos of organizations, as well as the individuals themselves (Skinner & Paterson, 2004). To the extent that organizations incorporate resources and supports for enhanced spiritual knowledge and clinician self-care, their openness to fully holistic care will translate into superior clinical interventions.

5. Applying the Empowerment Model to the Cases

5.1. Alice

Alice attended treatment for two years. During this time, she spoke of wanting to die because she felt so abandoned by God. The clinician, who was also a Christian, tried many evidence-based strategies to help Alice stay alive while in this angst, hoping for transformation and healing. He also engaged Alice several times in spiritual discussions in which he shared his own religious experience and conviction that God was willing to forgive her. However, these attempts did not appear to help. Privately, feeling at a loss and wounded by the rejection of his assertions, the clinician prayed for God to make His presence known to Alice. As the months went on and she remained in despair, the clinician began to question his own faith and felt angry with God for not intervening in a situation that was clearly desperate.

In this case, the empowerment model could assist the clinician in several ways. First, he would engage in spiritual self-care to mitigate the effect of Alice's angst on his own spirituality. Second, the clinician would have the routinized support of his employer and peers for problem-solving, stress relief and clinical brainstorming. Third, through training, the clinician would know there is therapeutic value in Alice remaining in her spiritual angst (namely, so that transformation could take place), that her despair was not pointless, and by exercising the norms of attentive listening and motivational displacement he would be confident his clinical judgment about self-disclosure was well-founded. This may decrease his anxiety and help him stay hopeful. The empowerment model, however, would recommend that he seek Alice's consent before praying for her (Frame, 2003).

5.2. Claire

Claire attended treatment for four years. During the first three years, her treatment consisted of evidence-based strategies for relapse prevention and trauma – spirituality was not a focus. In her fourth year of treatment, however, Claire decided that she wanted to examine the impact on her spirituality of the trauma and the addictions. She started attending a church and began to consider how her faith as a child was something that helped her to survive the abuse. This meant Claire's treatment sessions became distinctly more spiritual in focus. The clinician, however, felt limited in her ability to assist Claire in her spiritual healing.

With her clinician's encouragement, Claire began a three-month course of spiritual healing at her Church. The Church asked for the clinician's approval of the content (that is, the clinician endorsed Claire's readiness for the depth of work that was involved) and the clinician was given a copy of the materials discussed.

In this case, under the empowerment model, the clinician exercised spiritual self-scrutiny, acknowledged the importance of the client's spiritual seeking, but recognized her own limitations honestly. She welcomed the engagement of peers – this time experts outside

the agency. In the sharing of materials there was an opportunity for expanded education in cultural and religious practices, as well as a sharing of responsibility for Claire's recovery. Rather than accepting the dichotomy between faith-based and secular recovery approaches, the agency saw the value of diverse perspectives and supported the clinician's judgment.

5.3. Hakim

Hakim's clinician, an atheist, knew that the Islamic faith sees gambling as a sin from which Muslims are expected to abstain. However, lacking any further insight into Islam, she felt hesitant to explore with Hakim why he says he is not religious and what happens in the Muslim community when a member cannot adhere to their rules for living. The clinician attempted to help Hakim by recommending that he seek urge management medication from his family doctor to solve his "biological problem." This, however, was unsuccessful. Hakim still faced two issues: alienation from his community and potential alienation from the faith in which he grew up.

Under the empowerment model, the clinician would be encouraged to do three things: ask her employer for expert resources on Islam and Islamic communities so as to offer Hakim informed support; use supervision/peer support to consider how to ethically probe around the spiritual issues with Hakim and engage in spiritual self-scrutiny to ensure that her atheism was not compromising Hakim's treatment.

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The Politics of Research Ethics in Social Work: Reflections From a First-time Researcher

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Journal of Social Work Values and Ethics, Volume 11, Number 2 (2014)
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Abstract

This paper reflects upon the experiences of a novice researcher negotiating ethical concerns that arose while interviewing women survivors of intimate partner violence. I begin with a brief history of research ethics and feminist contributions to social science research. Drawing from my Honours project I reflect on interviewing friends, boundaries, managing distressing disclosures and the personal politics of research.

Keywords: research ethics, feminist research, interviewing friends, research politics, boundaries

1. Introduction

...research in the social sciences is first and foremost a moral activity (Hallowell, Lawton & Gregory, 2005, p. 142)

According to Shamoo and Dunigan (2000, p. 205) “ethics as a discipline deals with the broader value system of our society that encompasses the consensual agreement on what is right and wrong”. In Australia, social workers are bound by the Australian Social Workers (AASW) Code of Ethics which promotes respect for persons, social justice and professional integrity as core values (AASW, 2010). For social work researchers, abiding by this Code of Ethics means that research proposals should have merit and integrity, promote community participation, be respectful of participants’ privacy and honour Indigenous cultures.

Researchers must also ensure that research participants have informed consent and that their information is treated confidentially, while aiming to publish research that promotes social change (AASW, 2010, pp. 36-38).

2. A Brief History of Ethics in the Social Sciences

By configuring research ‘subjects’ in particular and limited ways, ethical review procedures are not only often problematic for social justice researchers but fail to consider ethical questions that are vitally important to them such as voice, representation and collaboration (Brown & Strega, 2005, p. 4).

More thorough ethical review boards were established after some well documented medical experiments challenged the ethical boundaries of research. One of the most well-known unethical studies took place in Alabama, USA. Known as the *Tuskegee Study*, the purpose of the research was to observe the “natural course of untreated syphilis” (Brandt, 1978, p. 22). Beginning in 1932, nearly four hundred poor, rural, black men were recruited to the study without the knowledge of the true purpose of the research. Years after a cure for syphilis was found, they still did not receive treatment for the disease. Instead the men were subjected to numerous invasive tests and experiments that were initially proposed as a six month study, but went on for decades.

Findings from the *Tuskegee Study* were published in over a dozen peer reviewed journals, including the *Journal of Chronic Diseases* in 1955. The article, *Untreated syphilis in the male Negro* described in its methods section what would be considered unethical practices today. The men were recruited directly by a health worker and were promised the incentive of “free medicine (for diseases other than syphilis)” (Schuman, Olanksky, Rivers, Smith & Rambo, 1955, p. 545). The paper goes on to report that nine of the men did not ‘cooperate’ in the second step of the research but as “news of their illness or disability is readily available” they [the researchers] were still able to observe them (1955, p. 546). These ‘experiments’ continued until 1964 until Peter Buxton (a social worker) and his allies, brought the unethical research practice to an end. Meetings with the authorities who governed medical research had proved futile. It was only when they approached the media that sufficient pressure was applied to end the research (Rubin & Babbie, 2001; Blaskett, 1998; Brandt, 1978). Brandt (1978) asserts that white privilege and racism were instrumental in the development of the project and in allowing it to continue as long as it did. If proposed today, it is unlikely that the study would gain ethical clearance due to the with-holding of treatment for a deadly and communicable disease, direct coercion of participants by someone in a position of power over them and non-consensual observation of men who had chosen to withdraw from participating.

During the 20th century unethical medical research practices also took place in Australia. From the end of World War 2 until the early 1970s, research was being undertaken on babies and children living in institutions and orphanages in Victoria (Blaskett, 1998, p.20). Tests were done to trial possible vaccines to prevent communicable diseases like herpes simplex. By current standards issues such as informed consent were treated with little ethical consideration. Similar to the Tuskegee Study, it was a media attention after an investigation by journalists at the *Age* newspaper that drew the research to the public’s notice, albeit 20

years after the experiments had been discontinued (Hughes, 2004). Commenting on this in an editorial in the *Medical Journal of Australia*, Larkins (1997) wrote that the doctors conducting the trials were well meaning due to “the huge burden of the infectious disease”, that “they made no attempt to cover up the procedure” and that “the details were published in the most widely read Australian medical journals” (Larkins, 1997, p. 60). However it is unlikely that these medical journals were either accessible or widely read by anyone other than the medical profession, therefore close scrutiny by outsiders was hardly possible. Unethical medical research like the examples discussed above has led to far closer examination of current ethical procedures in the research process.

Today, in-house university-based ethics committees (or boards) are commonplace. In Australia, research undertaken within the social and behavioural sciences is required to comply with the National Health and Medical Research Council’s *National Statement on Ethical Conduct in Human Research* (2007). The role of an ethics committee is to consider the ethical validity of proposed projects involving human subjects, with particular attention paid to the merit and integrity of a project, plus a focus on justice, beneficence and respect for participants. Sometimes the committees play a range of conflicting roles. A basic task is to vet projects for potential poor treatment of those involved in the research. While protecting the interests of research participants, they also seek to protect universities from allegations of unethical conduct, which can have serious financial, legal and reputational consequences if pursued and proven (National Statement on Ethical Conduct in Human Research, 2007, p. 29)

More recently, questions are asked about choice of research methodology, involvement of participants (rather than subjects) and dissemination of findings to include those from whom the research data was gained (Truman, 2003). Compared to even ten years ago, the level of detail required of applicants has increased, with attention given to perceptions of risks and proposed contingencies

(Truman, 2003). Blaskett (1998) suggests that the profession of social work with its core value of social justice for all members of the community has a lot to offer the ethics review process.

Even though ethics committees' endorsement of approved projects can lend credibility to both researchers and their findings, some researchers still see ethical review processes as a nuisance or irritation (Blaskett, 1998, p. 21). Others see ethics applications as a form of censorship, a "bureaucratic exercise in form-filling" (Hallowell et al, 2005, p. 144) or a hurdle to beginning the research process (Guillemin & Gillam, 2004, p. 263). Once a project has gained ethical clearance, there is currently no guarantee of whether the research undertaken, analysed and reported adhered to the ethical processes promised (Pich, Carne, Arnaiz, Gomez, Trilla & Rodes, 2003; Dickson-Swift, James, Kippen & Liamputtong, 2006).

Annual reports are sometimes required but even they can be carefully constructed to sidestep having to explain any deviations or complications from proposed processes. From a feminist or anti-oppressive practice perspective (Dominelli, 2002) however, I knew that such a dismissive stance was simply unethical and as a first time researcher, learning how to negotiate the ethics procedure proved to be a valuable learning experience which helped define the parameters of my project.

3. Feminist Contributions to Ethical, Social Science Research

Traditionally, research has also been an expression of power where the researchers are viewed as being in a position of authority or power over research participants. More recently there have been significant challenges to the notion of researching down towards a more egalitarian framework based in researching with rather than on communities. This has been especially reflected by feminist researchers and the paradigm of feminist research (Smith & Pitts, 2007, pp. 9-10)

Second wave feminist researchers brought to the attention of academia the gendered bias

occurring in research and how that bias was obscuring true data representation (Gilligan, 1982; Cotterill, 1992). The principals of feminist research are to produce relationships between the researcher and the researched that are "non-hierarchical and non-manipulative" (Cotterill, 1992, p. 253). Known as participatory research (Reinharz, 1983), this can be achieved by making interviews an "interactive experience"—where the researcher builds rapport or friendships and shares her own knowledge and common experiences with the participant (Cotterill, 1992, p. 594).

Over the last few decades feminist contributions to university ethics processes has been mixed. Many feminist researchers have had a positive influence on the ethical considerations of research in the social sciences. Issues of power relations and empowerment of participants are now routinely considered, while feminist research methods have influenced ethics review board's policies (Gottlieb & Bombyk, 1987), even if this is not made explicit. Yet this influence has not necessarily extended to ethics committees respect for the many non-positivist research methods many feminists prefer. Ethics committee members may even show antagonism "towards research informed by feminist or other critical theory approaches to social enquiry" (Blaskett, 1998, p. 21), making ethics applications potentially more complicated for social work researchers operating from an anti-oppressive practice perspective.

Like some forms of frontline social work, some forms of social work research projects are shaped by anti-oppressive practice perspectives, where empowering participants in the research process is emphasised (Dominelli, 2002; Blaskett, 1998, p. 20). Feminist scholars operating from an anti-oppressive practice perspective have questioned the power imbalances often operating between researchers and the researched (Reinharz, 1992), urging researchers to think through the many ethical issues likely to beset them, including but not limited to 'researching down' or with people with lower social status, who might feel compelled to participate or make particular

utterances, unless care is taken to ensure consent is properly informed (see Brown & Strega, 2005). From an anti-oppressive perspective, the values of social justice, self-determination and empathy are not just important to frontline social work but also in research design, resourcing and implementation. Studies involving equals or peers are included in the broad repertoire of possibilities (for more on interviewing peers, see Tang, 2002).

As will be described later in this paper, the women I interviewed for my research could be considered as equals, peers and friends. This simplified some aspects of my research, for example in recruiting participants (especially as they were not being paid), being of similar age, class background and having ‘shared experiences’. It also meant that our interviews were open and relaxed, rather than being guarded, as interactions with strangers can sometimes be. Yet other issues complicated my research, such as those discussed in Dickson-Swift et al’s (2006) study of qualitative researchers of sensitive topics—such as intimate partner violence—where they found a range of ethical conflicts between building rapport with participants and the disclosure of distressing accounts which can create ongoing physical and mental health problems for researchers. Cotterill (1992) also raises some possible ethical problems that could occur in relation to ‘interviewing friends’, such as that women may not identify with each other based on gender alone and the moral and ethical matter of possible or perceived exploitation (p. 595).

4. My Research Project

...most researchers will first encounter fieldwork while engaged on a dissertation that is mostly a solo enterprise with relatively unstructured observation, deep involvement in the setting and a strong identification with the researched. This can mean that the researcher is unavoidably vulnerable and that there is a considerably larger element of risk and uncertainty than with more formal methods (Punch, 1994, p. 84).

Below are my personal reflections about conducting a research project for my Honours thesis in Social Work. I interviewed five women over forty years of age who had experienced intimate partner violence in their early years. The aim of the project was to discover how the women fared years after their relationship had ended, to recognise their strengths and to better understand the coping methods they had used post separation. There were many ethical issues that I encountered throughout my research project, but for the purpose of this paper I have chosen to discuss the issues that follow on the basis of them being more common to feminist research projects. All names used in this paper are pseudonyms chosen by the participants.

4.1 Interviewing ‘Jane’

Over lunch one day at university early in my Honours year, a woman who I had occasionally studied with asked about my Honours research project. When I explained, she said that she fit the criteria and that she had some friends who may be willing to be interviewed as well. We exchanged contact details and after the final ethics approval came through, I sent her the relevant information and consent forms. We arranged a day where I would travel to her home in the country to conduct the interviews. I spent a full day there, interviewing her (she later became known as ‘Marie’) and two of her friends (‘Jane’ and ‘Sandra’).

In recognition of Marie offering to open her home to me for the day, I arranged that I would make a pot of soup for lunch while Marie offered to provide coffee and biscuits. The sharing of food can often “lighten the atmosphere” and be a distraction to the enormity of the topic at hand (Irizarry, 2011, pp. 165-168). On this day it really helped me ‘break the ice’. As we ate, I talked about my research and we shared some of our experiences of intimate partner violence. The mood was up; we were a group of working class women of a similar age who were survivors rather than victims. Despite our difficult histories we all recounted funny stories from our younger days.

Proving that Adelaide is indeed a small place, it turned out that Jane and I had worked in the same industry for many years and at different times we had both worked for the same employer.

After lunch, Jane and I began our interview. I explained to Jane about how I would respect her anonymity. Her reply was “I am happy to tell you anything—I have nothing to hide, anyway we are friends now”. Jane went on to tell me a confronting and tragic account of years of physical and emotional abuse suffered at the hands of her intimate partner from the age of fifteen. As a result of the violence, their four year old daughter died after being hit by a car while running to protect Jane from her father’s abuse (see Jarldorn, 2011; Fraser & Jarldorn, forthcoming). I found it difficult to hide my emotion at this disclosure and even more so when she went on to reveal that she went back to him after their daughter’s funeral and even years after they broke up for the last time she kept in contact with him via social media.

As I drove home that afternoon, I could not get Jane’s story out of my head. A heavy smoker for over forty years, Jane has a distinctive voice that I can still hear as easily as I can picture her sitting across from me at Marie’s kitchen table. That night I was reminded that conducting research can be lonely work (Punch, 1994). While I spent that night with my family, ethical considerations of confidentiality meant that I could not talk about Jane and could only say I had a rough day. I needed time to process the revelations I heard from the three interviews I did that day. That night, for the first time ever, I took a sleeping tablet and felt relieved as my recollections of the day began to leave my mind and I drifted into a dreamless sleep. Unfortunately, sleeping tablets don’t stop the thoughts from coming back—Jane’s story troubled me for a long time later.

Around four weeks into the writing up process of my thesis, I realised that I had been avoiding writing a chapter in the women’s stories about how they felt intimate partner violence had affected their children. All five women I spoke to had raised this issue, even though it was not a topic I

had planned to cover when designing my research project. But I knew that for my project to be ethical and valid, I had to include what the participants deemed important (Massat & Lundy, 1997). I was having great difficulty coming to terms with Jane’s story and this was causing my ‘writers block’. I felt cross with her, not for returning to her partner all those times they had broken up previously, but for remaining in a relationship with this man after the death of her daughter which she unmistakably described as his fault.

I tossed this experience around in my mind every day from that first interview with Jane, leaving working on the chapter till last, always finding ways to tweak the other chapters rather than write the chapter on how children can be affected when their mother experiences abuse and violence from a father figure. Eventually, I began to come to terms with Jane’s experience and felt disappointed in myself. I now understand that I had placed some of the blame on Jane for her daughter’s death—I realised that was blaming the victim of abuse rather than the perpetrator. This revelation came after reading research critiques about the policy construct of ‘failure to protect’ that helped me to see what should have been so clear from the start (see Magen, 1999; Strega, 2012). This led me write up the ‘children’s chapter’ and to also provide some practical considerations for social workers in my conclusion.

4.2 Interviewing ‘Barbara’

Two weeks after interviewing Jane, I conducted my final interview for the project with a woman I had known for around five years. We met at our children’s school and saw each other fleetingly at the school gate, at children’s birthday parties and other school events. ‘Barbara’ asked about my research when we went on a school excursion together and offered to participate. In contrast to Jane, Barbara did not recount horrifically physically violent experiences but instead spoke at length about control and emotional abuse. Over the last ten years, Barbara had accessed feminist based counselling—the only participant that had—and as

a result she had a nuanced understanding of gender inequality, power, coercion and control, so was able to articulate her insights with some powerful stories. As I wrote up my findings I found I was giving a lot of space to Barbara, believing some of her quotes to be feminist inspired ‘gems’.

Whether it was Barbara or any other woman, it can be a nerve racking experience portraying individuals in an official document, such as a thesis. When Barbara asked if I had finished writing my thesis I printed her out a copy and carried it around for a couple of days before finally giving it to her. I was worried about what she would think about how I had represented her. I had used many quotes from Barbara throughout my thesis and I believe I represented her—and the four other women—fairly and accurately. However I still feared that she may disagree with my analysis of her experiences. When I did see her some weeks later I was still feeling nervous about what her reaction may have been. To my delight, she thanked me for how I represented her in my thesis. She said no one had ever listened to her like I had and validated her stories the way I did. She said she appreciated how it was written in a way that was easy to read and that she had put it away for the future, hoping her children would read it one day. Finally she told me that she felt the experience had given her closure from the events of the past. I am pleased that she got so much out of participating in this project and felt energised about the prospect of undertaking further research.

It was tempting to put my completed thesis up on the shelf in my study and to move on to other projects. However, Dickson-Swift et al (2006) reminds qualitative researchers that it is important to confront issues such as the blurring of boundaries, the concept of friendships in research and to consider the effect that distressing disclosures can have upon researchers. I have decided to reflect upon these issues that have the potential to impact heavily upon researchers, especially as one of the ethical responsibilities of social work research is to “observe the conventions of ethical scholarly enquiry” (AASW, 2010, p. 36), one of

those conventions being that social workers will “accurately and fully disseminate research findings” (AASW, 2010, p. 37). Having been involved in producing articles for publication in the past, I know that this can be an emotional roller coaster ride for the writer/researcher, but I also understand that pursuing publication is a way of recognising the gift of knowledge and trust these five women gave me. Ultimately, the knowledge they have gifted me is more about me as a researcher than it was about them, a gift for which I am eternally grateful. Writing this paper is part of my ongoing reflections and dissemination of findings.

5. Ethical Considerations and Reflections on Interviewing ‘Friends’

...relationships between researchers and participants rest at the heart of feminist ethical concerns in research (Gringeri, Wahab & Anderson-Nathe, 2010, p. 393).

The two interviews described above were both made possible because of friendships. Barbara was already a friend due in part to our children’s shared place of learning. Jane however, felt that our past shared experiences made us friends. While Jane had stated that she was happy to have her identity made public, my promises to our ethics committee meant that could not happen and as a result I could not meet that request. My pre-existing relationship with Marie had made possible the interviews with the other women. Without Marie vouching for my character as an equal rather than a university researcher, they were not likely to have occurred. Our shared lunch provided a friendly ‘warm up’ to break down barriers and provide a comfortable interview space that would follow. Our ‘friendships’ helped strengthen my research by allowing for a deeper account of private lives that may not occur in interviews with unknown women (see Cotterill, 1992 and Harris, 2002). We had a “social and collective identity” (Lamont & Molnar, 2002, pp.169-177) that cemented our trust in each other, allowing rich and thick accounts of personal

histories that are rarely shared with strangers.

I think I was able to bridge the power imbalances that are possible in the researcher/researched relationship, mostly by interviewing women who I considered equals. McRobbie (1982) argues that as a feminist researcher I should acknowledge my own history to maintain a balance of power. In disclosing my experiences or my “use of self” I was able to build rapport with the women, but later had to subject myself to “critical scrutiny” of my own politics and ethics (Zubrzycki, 2002, p. 352). Nevertheless, I was at times challenged by the way the women had handled their experiences and the choices they made. On closer reflection, I would guess that parts of my story would challenge them too. I learned from this process that not everyone’s experience will be the same as mine and the decisions others make will probably be different than mine (for more see Fraser & Jarldorn, forthcoming).

6. Personal and Feminist Politics in Research

The ‘cookbooks’ of research methods largely ignore the political context of research, although some make asides about its ‘ethical dilemmas’ (Oakley, 1981, p. 55).

According to historical, scientific research values of objectivity and neutrality (Longino, 1990), I should not allow my own political values influence my scientific research. Yet without my political values, I would not have approached the research design, literature review, interviews and data analysis in the ways that I did. Under this cloud, figuring out the extent to which my values and beliefs could influence the ideas and processes I used was not easy. Early into the research process I realised I was being led by my heightened emotions. My personal and feminist politics had taken over in the quest to understand more about why men can perpetrate violence against the women who love them and why the women persevered with their relationships as long as they did. Before I undertook the interviews I had become so

immersed in the literature, trying to answer my own questions that I was becoming re-traumatised. I was not sleeping well and was probably not the best parent or partner throughout this research project. By the time I went out into the field, I was not treating this as an emotionless experience as textbooks instruct us to do (Oakley, 1981) but felt angry with perpetrators all over again. Upon further reflection, I believe that a lot of this anger came from the realisation at just how much research has been undertaken on the dynamics of intimate partner violence, yet it felt that within Australian society, little has changed.

I agree with Rubin and Babbie (2001) who suggest that no research in the social sciences is ever conducted without the researcher having pre-conceived opinions, personal morals and history. This is especially true, given that academics recommend novice researchers choose a topic that will ‘sustain their interest’ (Fraser, 2009, p. 88). While there are many similarities between the research interview and a therapeutic interview, I found the biggest difference was the time I spent reflecting on the content of the interview and its process, particularly as I used a narrative analysis as my research method. The time spent listening, transcribing, reading and reviewing the interviews embedded the women’s stories (and my reactions) into the forefront of my daily thoughts well past the submission date of my thesis. Dickson-Swift et al (2006) suggest that given the complex issues in qualitative research like those I experienced, further attention from researchers, their supervisors and ethics committees needs to be paid developing protocols to better manage the effects of the blurring of boundaries (p. 867).

7. Conclusion

No research is carried out in a vacuum (McRobbie, 1982, p. 48)

Along with Morley (2009), I have come away from this feminist, social work research wondering what good I have done for the women I worked with on this project. Will it produce any

structural or institutional change for women? I understand that up to this point, I am the only person who has directly benefitted from this research; I got some great data for my Honours thesis and along the way have begun to train my mind, eye and soul in researching women's lives (Hill, 2007). I cannot really tell if I have "done no harm" (Fraser, 2009) in interviewing the five women and can only endeavour to continually reflect upon this experience and use it to maintain working towards social justice role in social work, whether it be on the frontline or in the loneliness of research.

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Ethics Issues and Training Needs of Mental Health Practitioners in a Rural Setting

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Journal of Social Work Values and Ethics, Volume 11, Number 2 (2014)
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Abstract

Through an exploratory survey of a representative sample (n = 316) of licensed and certified counseling and social work mental health professionals (N = 1,324) in one rural state, ethical issues and training needs were identified by the providers. The intended goal was to obtain direct feedback about ethical issues and ethical training needs from practitioners themselves who work in rural settings. Results identified three primary ethical issues: dual relationships, confidentiality, and competence; and three primary ethical training needs: boundaries, state rules and regulations, and supervision. The discussion examines in

more detail the ethical issues and trainings needs and provides some recommendations for further research and investigation.

Keywords: social work practice, ethical dilemmas, ethics, continued education, rural practice

1. Introduction

Individuals enter the mental health counseling profession with a desire to help others (Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005; Rønnestad & Skovholt, 2003); however, ethical issues continually arise in this work. Research has addressed a diversity of ethical challenges in

mental health work such as boundaries, supervision, gift giving and receiving, termination of services, confidentiality, multicultural awareness, and practitioner wellness (Borders, 2005; Brown & Trangersrud, 2008; Carney & McCarren, 2012; Cummins, Massey, & Jones, 2007; Frame & Williams, 2005; Glosoff & Pate, 2002; Lawson, 2007; Moleski & Kiselica, 2005; Pope & Keith-Spiegel, 2008; Trimmerger, 2012; Vasquez, Bingham, & Barnett, 2008). Even though there are numerous ethical quandaries faced by mental health professionals, this research endeavor was designed to hear from rural practitioners themselves about their ethical challenges and training needs.

1.1 Ethical Decision Making Errors

Practitioners are human and can make poor ethical decisions. Strom-Gottfried (2003) examined types of ethical complaints made against the ethical codes of the National Association of Social Workers (NASW). Of 267 adjudicated cases, 107 involved sexual activity, 77 involved dual relationships, 70 involved other boundary violations, 55 involved failure to seek supervision, 41 involved failure to use accepted practice skills, 34 involved fraudulent behavior, and 33 involved premature termination. Other types of errors identified were failure to maintain records, discuss informed consent, and make referrals. In a survey conducted to assess ethical misconduct in a national sample of graduates from counseling training programs, Trigg and Robinson (2013) found the most frequent ethical violations were “practicing outside of the scope of one’s training and experience and practicing while impaired due to substance use or mental health matters” (p. 28), violations of professional boundaries (both nonsexual and sexual), and breaches of confidentiality. Rural settings provide unique opportunities and challenges in ethical dilemmas and decision making.

1.2 Ethical Dilemmas in Rural Settings

Ethical dilemmas are intensified in rural settings with issues such as dual relationships, multiple roles, unique community standards, isolation, and lack of access to training and supervision

(Casemore, 2009; Erickson, 2001; Nickel, 2004; Phillips & Baker, 1983; Schank & Skovholt, 1997). Providers in rural settings are often given cases for which they are not prepared, lack adequate supervision, and are expected to carry full caseloads (Lawson & Venart, 2005). These challenges, coupled with feeling isolated in rural settings, can lead to increases in ethical dilemmas. Cellucci and Vik (2001) identified a greater percentage of substance abuse clients in rural as compared to urban areas and their study suggested additional training was needed for psychologists working with substance abuse in rural settings. In a qualitative study of 43 school counselors, Lehr, Lehr, and Sumarah (2007) identified problems in rural settings including role conflicts, inconsistencies, and idiosyncratic choices in such ethical practices as confidentiality and informed consent.

1.3 Resources for Practitioners

Even with ethical challenges, there are resources for practitioners to utilize to help reduce ethical violations. Three of these resources include ethical codes, licensing boards, and continued education.

Codes of ethics. Ethical codes can assist with ethical quandaries, protect consumers, and clarify the standards of professional organizations (American Counseling Association [ACA], 2005; Corey, Corey, & Callanan, 2007; NASW, 2008; Ponton & Duba, 2009; Trimmerger, 2012). Codes of ethics are available as guides for navigating the diverse world of ethics and are continually updated to reflect changes in societal norms and knowledge (Kaplan, Wade, Conteh, & Martz, 2011; Kocet, 2006; Walden, Herlihy, & Ashton, 2003).

In 2008, NASW updated their ethical codes for social workers. The NASW’s codes support the mission of the social work profession to enhance the well-being of all humans; particularly empowering those who are vulnerable, oppressed, and living in poverty. The 2008 NASW *Code of Ethics* recognizes the importance of responding to diverse clients and to a variety of therapeutic settings, as well as providing a set of values, principles, and guidelines to ethical decision making (NASW,

2008). For example, the *NASW Code of Ethics* (2008) section 1.05c states that:

Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability. (p. 9)

Licensing boards. In addition to using the codes when encountering an ethical issue, practitioners can also access their state licensing boards and professional associations' ethics committees (Chauvin & Remley, 1996; Neukrug, Milliken, & Walden, 2001). Professional boards hold ethical violation hearings to address conflicts, hear complaints, and enforce infractions to protect the public (Corey et al., 2007; Strom-Gottfried, 2003; Welfel, 2005). Boards can provide ethical decision making consultation for practitioners. Resources such as codes, state boards, and professional organizations are important components in the ethical risk management toolbox for all practitioners (Wheeler & Bertram, 2012). In addition to consultation, practitioners need to use an informed consent, documentation, and supervision (Borders, 2005; Wheeler & Bertram, 2012). Ultimately, it is each provider's responsibility to stay informed and current on the ethical standards of care, best practices, and codes; in part, this responsibility can be addressed through continued education.

Continuing education. Continued education is designed to assist practitioners in learning about the changes in codes, as well as to address ethical struggles throughout the counseling process (DePauw, 1986). Educating practitioners about the many complexities in ethical practices helps them be better prepared to respond effectively to ethical dilemmas (Carney & McCarren, 2012; Corey, Corey, & Callanan, 2005). Education can enhance both cognitive functioning and moral reasoning in mental health professionals (Sias, Lambie, & Foster, 2006) and social-

cognitive maturity has been found to be related to higher measures of legal and ethical knowledge (Lambie, Hagedorn, & Ieva, 2010). Even though ethical training does appear to enhance competencies in mental health practitioners, ethical training programs and methods are not consistent across or within disciplines (Hill, 2004; Urofsky & Sowa, 2004)

1.4 Ethical Errors and Real-World Practice

In spite of access to resources, practitioners can become habituated, unaware, and even burned out in the day-to-day practices of clinical work (Lawson & Venart, 2005). Wheeler and Bertram (2012) described two types of habituation: 1. being *bounded ethicality*, when decisions are made in a setting with limited data, and 2. having *ethical fading*, when everyday operational events such as assigning a diagnosis can blind a practitioner from awareness of ethical implications. Everyday practice may have a lack of safety for practitioners to honestly discuss personal needs and wants, thus they may feel afraid to openly talk (Flynn & Black, 2011; Nelson, Barnes, Evans, & Triggiano, 2008; Warren & Douglas, 2012). In daily practice, factors such as the providers' personal traits, the job duties, and the agency's culture can influence ethical decision-making (Trimberger, 2012). Providers can compromise their ethical rigor when faced with multi-faceted ethical dilemmas. Of 188 substance abuse practitioners, Sias (2009) found that moral reasoning level scores were significantly lower in personal, authentic, and/or real-life decisions, when compared to hypothetical ethical dilemmas.

Questionable ethical decisions may reflect unique rules of diverse settings, such as a rural community, and may not be well understood or communicated in the professional literature (Flynn & Black, 2011). However, committing an ethical error does not mean a practitioner is on an inevitable slippery slope to where he/she is doomed to make more errors. Instead, a practitioner may be making a decision seemingly appropriate for the situation (Gottlieb & Younggren, 2009). All work settings and

specializations present unique ethical challenges (Calley, 2009; Linton, 2012; Shallcross, 2012). When ethical dilemmas do occur, there are social norms, competing values, and contextual conditions to consider such as the client's well-being, unique legal mandates, moral values, community standards, economic considerations, and business survival (Calley, 2009; Flynn & Black, 2011; Foster & Black, 2007; Guterman & Rudes, 2008). These competing priorities are exacerbated in rural settings by demands such as large caseloads, managed care, and on-call expectations (Lawson & Venart, 2005). Thus, the current researchers seek to better understand ethical issues and ethics ethical training needs within a rural setting.

2. Purpose of the Study

The purpose of this exploratory study was to identify self-reported ethical challenges and ethical training needs of a sample of clinical practitioners who were licensed or certified under the same board in one rural state. The licensing board was a composite board combining both counseling and social work mental health professionals and substance abuse providers.

3. Methodology

The two research authors who created the surveys and categories, have practiced in rural mental health settings for 23 years and 10 years, respectively. They relied on their experience in counseling in rural areas to create a simple survey seeking information about the challenges practitioners face. The survey was mailed to every fully licensed or certified mental health and social work practitioner in the state at the time of the study, which included a total of 1,324 professionals.

The entire state was considered "rural/frontier" except for two counties. More specifically, 74% of the counties had fewer than six residents per square mile and therefore, by definition, were considered "frontier" at the time of this study. An additional factor important for

understanding the unique aspects of this setting was that the entire state was designated as a shortage area for mental health care; consequently, both counselors and social workers provided similar mental health services and were both overseen by the same licensing board (Wyoming Department of Health-Office of Rural and Frontier Health Division, *n.d.*).

Although there are differing rules and regulations across states regarding ethics training requirements for counseling professionals (Wheeler & Bertram, 2012), the state in which this study occurred aligned its licensing and certification requirements with national standards through its work with the American Association of State Counseling Boards (AASCB) (2012). Participants who were licensed were required to meet the minimum of a master's degree level of education, supervised experience, and examination requirements, which allowed them to provide independent practice. The licensed professionals included: Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Addictions Therapist (LAT). Participants who were certified were required to obtain a bachelor's degree or bachelor's degree equivalent and were allowed to provide services only under clinical supervision of a qualified licensed professional. The certified professionals included: Certified Addictions Practitioner (CAP), Certified Social Worker (CSW), Certified Mental Health Worker (CMHW), and Certified Addictions Practitioner Assistant (CAPA). At the time of this study, all licensed and certified professionals were regulated by the same board, must have renewed their credentials every two years, and were required to complete at least three contact hours of continuing education in professional ethics every two years.

The procedures for the study were approved by the university's Institutional Review Board. One mailing of the survey was sent to every counselor and social worker licensed or certified by the state (N = 1,324); this included an introductory letter with an explanation of the

study, an informed consent statement, the survey, and a stamped and addressed return envelope. There were no incentives offered to participate in the study. The participants were asked to complete a brief demographic questionnaire and respond to two questions:

1. The most difficult professional ethical dilemma or situation I have encountered in the last two years has been: _____
2. Two primary ethical trainings I would find to be most helpful in my practice are: *self-care, boundaries, rules and regulations, malpractice, supervision, professional competency, risk management, end of life, suicide, duty to warn, confidentiality, diagnosis, spirituality, multicultural topics, and other.*

Although this was an exploratory study, the survey responses were analyzed with IBM SPSS version 19 to determine the descriptive statistics, frequencies, and relationships.

4. Results

There were 1,324 surveys mailed with approximately 155 returned non-deliverable. Of the remaining 1,169 mental health providers presumed to be contacted by mail, 316 (27%) responded to the survey. Because the response rate was significant, a non-response bias was not considered to be a significant limitation of the survey results (Alreck & Settle, 2004). Mail was used in lieu of e-mail to personalize the survey and because access to email is not consistently available in some rural areas. According to the original data provided by the board, distribution results of the survey sample (see Table 1) closely approximated the current distribution of licensing and certification in the state; thus, this was considered a representative sample.

Table 1: Demographic Information

Demographic	Number reporting	Percent of total
Gender		
Male	87	27.5%
Female	229	72.5%
Race/ethnicity		
Caucasian	294	93%
African American	0	0%
Hispanic	3	1%
Native American	4	1%
Biracial	3	1%
Other/no response	12	4%
Years of Practice	M = 12.49	SD 8.8
Licensing Breakdown		
MSW	93	29%
LPC	148	47%
LAT	10	3%
LMFT	14	4%
CMHW	10	3%
CAP	8	3%
Multiple Licenses/other	33	10%

Table 1: Demographic Information, continued

Demographic	Number reporting	Percent of total
<i>Place of Service</i>		
Community agency	98	31%
School	44	14%
Private	60	19%
Hospital	23	7%
Residential	19	6%
Other	35	11%
Multiple Settings	37	12%

Note. Based on a sample of n = 316. MSW-Masters in Social Work, LPC-Licensed Professional Counselor, LAT-Licensed Addictions Counselor, LMFT-Licensed Marriage and Family Counselor, CMHW-Certified Mental Health Worker, CAP-Certified Addictions Professional

5. Ethical Issues

The survey began with open-ended questions intended to identify two ethical issues experienced by the participants in the previous two years. Most participants responded with two or three words; a few responded with lengthier responses describing the ethical issues they had faced. Two of the research authors analyzed each of the 316 surveys and developed categories and coding rules for the responses (Popping, 2010). The researchers followed the procedure described by List (2003), in which the raters spent sufficient time together to sort out problems and come to an agreement on the meaning of the open-ended responses. Fourteen categories were identified: isolation, caseload, burnout, impairment, supervision, confidentiality, dual relationships, competence, diagnosis, peer impairment, professional silence, duty to warn, suicide, and mandatory reporting. Thus, every response was coded into one of the categories and there were no other possibilities mentioned in the first question response. A third rater, who was trained in the meanings of the categories, independently rated half of the surveys in order to substantiate inter-rater reliability (Johnson & Christensen, 2012). The correlation between raters was .78 and the ratings were deemed reliable. There were a limited number of stories and comments provided by the respondents.

The top three issues identified by the first question (see Table 2) were *dual relationships* (19%), *competence* (19%), and *confidentiality* (17%). Concerning dual relationships, one respondent said, “Seeing clients in a small town [is a difficult ethical challenge because it is] where I also have to do business with the same people. No other choices.” Two additional findings regarding ethical dilemmas encountered were *professional silence* and *supervision* representing 10% and 9%, respectively. Professional silence refers to the fear of discussion of ethical issues in oneself or others. Binomial tests for categorical variables were run to compare the number of mentions of ethical dilemmas to the expected number, given all possibilities were equal. In a one-sample binomial test, *dual relationships* ($z = 11.46, p < 0.0001$), *competence* ($z = 10.92, p < 0.0001$), *confidentiality* ($z = 9.84, p < 0.0001$), *professional silence* ($z = 3.37, p = 0.0004$), and *supervision* ($z = 2.47, p = 0.0068$) were significantly higher than the expected value. The supervision variable included one notable comment identifying a difficulty with “a counseling supervisee with a substance problem and a mood disorder that was severe.”

Table 2: Self-Identified Ethical Issues

Issue	Number reporting	Percent of total
Dual relationships	99	19%
Professional competency	96	19%
Confidentiality issues	90	17%
Professional silence	54	10%
Supervision	49	9%
Duty to warn issues	30	6%
Peer impairment	29	5%
Mandatory reporting	27	5%
Isolation	22	4%
Suicide issues	19	4%
Impairment	16	3%
Diagnosis issues	14	3%
Caseload	10	2%
Burn out	6	1%

Note. Based on a sample of n = 316 who identified one or more most difficult professional ethical dilemmas or situation issues. There were 531 identifications in the responses.

6. Ethical Training Needs

The second item asked the participants to select two ethical trainings from a pre-determined list of 15 options, which they considered might be most helpful for their practice. These were ranked by frequencies of responses. Although the respondents were asked to choose two trainings, 40 of the respondents chose more than two, with one respondent checking all of the training topics that were listed. The top three ethics trainings selected were *boundaries* (12%), *rules and regulations* (12%), and *supervision* (10%). One respondent stated, “I think in our state it is more difficult to maintain professional boundaries because of the closeness of our communities. For instance, in my neighborhood I am surrounded by former clients as neighbors.” In a one-sample binomial

test, *boundaries* ($z = 5.85, p < 0.0001$), *rules and regulations* ($z = 5.06, p < 0.0001$), and *supervision* ($z = 3.17, p = 0.0008$) were found to be highly significant; the percentages of these options were much higher than would be expected if all trainings were equally valued. In addition, there were four issues that were second-place in percentages, including *professional competency* ($z = 1.91, p = 0.0281$), *self-care* ($z = 1.75, p = 0.0401$), *duty to warn* (not significant), and *risk management* (not significant), and each issue representing about 8% (see Table 3). Self-care was particularly concerning to one respondent who indicated, “Burn out and quality treatment” need to be addressed.

Table 3: Self-Identified Ethical Training Needs

Issue	Number reporting	Percent of total
Boundaries	85	12%
Rules/Regulations	80	12%
Supervision issues	68	10%
Professional competency	60	8%
Self-care	59	8%
Duty to warn issues	57	8%

Table 3: Self-Identified Ethical Training Needs, continued

Issue	Number reporting	Percent of total
Risk management	57	8%
Confidentiality issues	50	7%
Diagnosis	43	6%
Spirituality	35	5%
Malpractice	34	5%
Suicide issues	33	5%
End of life	26	4%
Multicultural topics	19	3%

Note. Based on a sample of n = 316 who identified their top two needs for training. There were 710 training needs identified in the responses.

Statistical analysis was used to look for relationships between demographics, issues, and training needs in order to identify if there might be any tentative connections. Because these were categorical responses, chi square analysis was used to look for significance. When ethical issues and training needs were analyzed together with Pearson chi-squared analysis, a few significant relationships were found. These findings were not the primary focus of the study; however, they are included to add additional perspectives. Fifty-two percent of those who indicated that *dual relationships* were an ethical issue chose *boundaries* training ($\chi^2(1) = 22.57, p < .0005$). For example, one respondent reported problems with “reporting unethical conduct by my spouse” as an example of the difficulty with boundaries. Forty five per cent of those who reported professional *competency* as an ethical issue requested *competency* training ($\chi^2(1) = 7.49, p = .006$). Additionally, there was a significant correlation between the issue of boundaries and the issue of self-care ($\phi = .15, p = .008$), indicating a small relationship.

Based on the demographics, using frequency and chi-square analysis, some statistical relationships were found in the desired trainings and demographics, including years of licensing and practice and type of credential. Regarding years licensed, 22% of those licensed less than 10 years requested training in *self-care* and 16%

of those licensed more than 10 years chose *self-care*. Those who had been licensed longer were more likely to request *duty to warn* (19%) and *risk management* (22%) training than those licensed less than 10 years (17% and 19%, respectively). The difference in *risk management* among different years of licensing was found to be statistically significant ($\chi^2(1) = 6.00, p = .049$) with the Pearson chi-square test of independence. Those who have been licensed longer listed *risk management* training more frequently than those who were more newly licensed. Likewise, *malpractice training* was strongly indicated by those who have been serving for more years ($\chi^2(1) = 8.76, p = .003, \text{odds ratio} = .069$); for every additional year of practice, the odds of a counselor requesting *malpractice training* goes up by 7%. On the other hand, for every year of service, the odds of a request for *confidentiality training* decreased by 5% ($\chi^2(1) = 6.51, p = .011, \text{odds ratio} = -.046$). Licensing area also showed that addictions specialists were more likely to indicate a preference for *self-care* training; indeed, the results of Pearson chi-square ($\chi^2(6) = 20.76, p = .002$) indicated that the choice of *self-care* training was dependent on the licensing area. Training responses were tallied in demographic groups and analyzed with Pearson chi-square analysis. Gender was found to be independent of the top five training preferences, meaning there was no relationship between genders and training requests. Ethnicity was not tested due to

the limited numbers of practitioners who were not Caucasian. Finally, the results showed no significant relationships between the setting of services and choices of training.

7. Discussion

This study provides a descriptive picture of self-reported ethical situations and the desired ethical trainings from a representative sample of mental health and substance abuse practitioners, licensed or certified, under one board in one rural state. There were three notable self-reported ethical issues: *dual relationships*, *competence*, and *confidentiality* (see Table 2). Overall, the findings closely reflect the findings of both Strom-Gottfried (2003) and Trigg and Robinson (2013), where practitioners and/or boards reported ethical violations in competence (including impairment and using accepted practice skills), boundaries (dual relationships), and confidentiality. The results from our study also reflect research findings on ethical issues faced by counseling practitioners in both specialty practices and rural settings where dual relationships, confidentiality, and competence are identified (Cellucci & Vik, 2001; Erickson, 2001; Lehr et al., 2007; Nickel, 2004).

Dual relationships and boundary issues are complex, and permeate the social work and counseling professions (Nickel, 2004; Pope & Keith-Spiegel, 2008; Strom-Gottfried, 2003; Trimberger, 2012). There are many issues around boundaries in rural practices such as responding to crisis referral and discovering the client is an acquaintance, being a community soccer coach with some players being clients, or being a member of an agency board and some of the clients use the service. Rural professionals need to carefully include boundary delineations in their informed consents, identify strategies to avoid boundary crossings when possible, and include boundary issues in supervision and consultation work (Pope & Keith-Spiegel, 2008).

In general, research demonstrates that competency and confidentiality are fairly common ethical challenges (Lehr et al., 2007; Wheeler &

Bertram, 2012); our study is consistent with these findings. Particularly in rural settings, practitioners are required to work in areas in which they have not been trained due to a shortage of both workforce and relevant training opportunities. The first author remembers practice in a rural setting during one day in which the client load included a truant teenager, a schizophrenic adult, an emergency suicide attempt, a sex offender, and a young adult who had been sexually abused. The issue of competence to respond effectively to these diverse client issues was an ethical wonderment; yet, the requirement to work with diverse issues is a reality in rural settings.

In addition, issues of confidentiality in rural settings can be difficult due to the challenges of boundaries and low workforce. For example, an individual may work as a counselor on Friday; however, on Saturday this same person may be coaching a football team with a child who is a client. Confidentiality must be maintained but can be difficult in such situations. Another example can occur, when the teacher of a small rural school informally asks the counselor how a particular student is doing, yet the counselor cannot respond. Sometimes a low workforce means providers serve in several roles, such as a practitioner teaching part-time, thus confidentiality is a constant ethical standard that is tested.

Although *professional silence* and *supervision* represented a smaller number of ethical problems identified, they were ranked in the top five issues (see Table 2). Professional silence could be similar to “professional mistrust” (p. 466) as reported by Flynn and Black (2001) in their qualitative survey of 25 counseling professionals. Professional silence can result from fear and shame and lead to an absence of dialogue; thus, silence can unwittingly contribute to unintended ethical infractions that may be avoided if discussed (Warren & Douglas, 2012; Welfel, 2005). It would be helpful to explore and define what professional silence means for the participants. In a similar manner, it would be interesting to identify if professional silence is addressed in supervision. Do counselors

openly dialogue with their supervisors about their ethical dilemmas? How might the supervisory relationship address professional silence? Supervision can be a challenge for ethical practice in rural settings due to a lack of available resources (Erickson, 2001); however, supervision is critical for ethical practice at any stage of practitioner development (Borders, 2005; Lawson & Venart, 2005; Nelson et al., 2008; Rønnestad & Skovholt, 2003; Wheeler & Bertram, 2012).

The results of this study suggest that rural mental health and substance abuse providers identify *dual relationships, competence, confidentiality, professional silence, and supervision* as primary ethical issues they faced in the previous two years. Based on these results, *all five areas* may need to be infused into rural based ethical training and supervision. In addition, through validating these challenges, rural providers may be more open to recognize these ethical issues as problems and proactively enhance dialogue, compassion, supervision, and relevant ethical training (Warren & Douglas, 2012; Welfel, 2005).

The most notable ethics trainings selected by rural mental health and substance abuse providers were *boundaries, state rules and regulations, and supervision* (see Table 3). Boundaries are often identified as ethical challenges (Moleski & Kiselica, 2005; Nickel, 2004; Strom-Gottfried, 2003; Trimberger, 2012). The fact that boundaries were identified as a training need is supported in the research on boundary problems in counseling situations (Carney & McCarren, 2012; Moleski & Kiselica, 2005; Nickel, 2004; Pope & Keith-Spiegel, 2008; Trigg & Robinson, 2013; Trimberger, 2012). Shank and Skovholt (1997) reported that psychotherapists knew applicable ethics codes; however, they were unsure of how to apply these codes within the rural environment. Specifically, several participants described attending worship services with clients, which can result in dual relationships. Because there were some apparent relationships between ethical issues and training needs, these results may suggest that providers do proactively recognize ethical challenges and

prevention is possible (Welfel, 2005). Ethical challenges do not have to be a predestined slippery slope (Gottlieb & Younggren, 2009); instead, they can inform training needs.

There were additional and speculative observations from our survey results. Respondents who had been in practice for less than 10 years more often requested training in *self-care, boundaries, and confidentiality*. Perhaps this reflects a type of self-interest (Flynn & Black, 2011) which may be more evident in newer practitioners. The complexities of confidentiality (Glossoff & Pate, 2002; Lehr et al., 2007) may be more confounding for newer practitioners. In this study, practitioners who had been licensed for a longer time period (more than 10 years), listed *risk management and malpractice* training more frequently. Perhaps years of practice bring forward complexities in counseling such as changes in state rules, duty to warn, and risk management. Prolific experience as a practitioner undoubtedly brings forth challenging cases where training in *risk management and malpractice* could be useful at addressing precarious or dangerous situations. Longer term practitioners can become lax and thus be more vulnerable to making ethical errors (Jennings et al., 2005).

To interpret the meaning of the finding that as length of service increased, the desire for *malpractice* training increased, and *confidentiality* decreased is speculative. Researchers will want to conduct more detailed interviews in order to identify the meanings of practitioners of all levels of experience. Although research suggests that longer-term practitioners may be more vulnerable to ethical infractions than those newer to the field (Jennings et al., 2005), perhaps those who have extensive field experience may recognize how practice-related issues are constantly changing and updates in rules and risk management procedures are needed.

Another speculative finding is that training programs need to consider specializations and years in practice when designing training. Although this study found no significant results regarding the employment setting and gender of

respondents being related to their training needs; findings did indicate that there was preference for *self-care* training among addictions professionals. Perhaps this finding reflects some of the difficult issues faced by professionals working in addictions (Cellucci & Vik, 2001). Training needs to reflect specialized needs.

Although survey results can inform researchers of where research is needed, the absence of information can also be informative. The request for training in *multicultural topics* was the lowest requested priority. This area of awareness could be a missing part of ethics training and/or awareness in this rural state; and could be related to the lack of ethnic diversity that may be represented in some rural/frontier states. Though the representation of ethnic diversity may be lacking in many rural states, the lived experiences of people of diversity reflects marginalization. That is, persons of different color, race, ethnicity, religion, sexual orientation, disability status, etc., may remain unrecognized, thus disempowered to address issues that are paramount to their well-being and personhood. Diversity in ethics is infused throughout providers' codes (Kocet, 2006; NASW, 2008) and is an important part of ethical competencies (Frame & Williams, 2005); however, multiculturalism was not identified in this study as a training priority. Possibly, multicultural awareness and competency is lacking in some rural settings.

8. Limitations

There are limitations in this study. The endeavor was exploratory and intended to set the stage for further research. The survey included only two questions: one was open-ended and the other incorporated a selection bank, which creates more room for interpretation error. Results may only be applicable to rural settings; they may be biased due to self-reporting, social desirability and possible researcher bias; and there were limited numbers of minorities in the state. Without further feedback, to understand the wording used, such as professional silence and multicultural, the findings can only be speculative. This, of course, is true for the other self-identified ethical issues that are discussed.

9. Implications and Future Research

The significant positive relationship found between training in *boundaries* and *self-care* could reflect the importance of counselor wellness (Lawson, 2007; Lawson & Venart, 2005), and may suggest that wellness is related to boundary problems. A future study could explore how ethical practices, such as maintaining healthy wellness could influence boundary decision making in rural communities. Further, identification of ethical practices that positively influence the experience of wellness could lead to the creation of helpful continuing education training for those practicing within rural environments.

The fact that some longer-serving respondents in our study requested less training in *boundaries* and *self-care* and more in *state rules*, *duty to warn*, and *risk management*, could reflect the importance of offering training fitting that corresponds to the stages and needs of any professional (Jennings et al., 2005; Rønnestad & Skovholt, 2003). The *supervision* training request may suggest that additional supervision and supervision competency are important ethical needs for counselors in rural settings. Competence in supervision is critical for the wellness of counseling professionals (Borders, 2005). Future qualitative analyses could help clarify what specific supervision training is desired of participants.

Another observation from the findings is that providers identified *competence* as an ethical issue and *supervision* as a desired ethical training. A potential area of research could investigate more in detail to identify the areas of practice in which counseling practitioners need additional training. For example, these results reflect those of Cellucci and Vik (2001) who reported that rural psychologists believed their graduate training was inadequate for substance abuse work.

Future researchers would do well to examine issues of diversity training within the rural setting. The areas of multicultural competencies need to be further investigated in rural settings given that many clients, such as clients of color, the gay and lesbian population, and other minority groups, will seek services in rural settings. These clients

may encounter discrimination if additional training and awareness are not provided. Perhaps, qualitative interviews that explore practitioners' level of comfort and confidence in knowledge when working with minority clients would allow researchers to better understand the specific diversity training needs.

Additional research is needed to more clearly identify issues and needs in rural settings for counselors. It is important to replicate this study in other states. Perhaps a more standardized survey like the Ethical and Legal Issues in Counseling Questionnaire (ELICQ) developed by Lambie et al. (2010) could add a more rigorous quantitative measure. The ELICQ is a 50-item multiple choice instrument designed to measure ethical and legal knowledge (Lambie et al., 2010). As mentioned earlier, narrative feedback from practitioners can add depth to the findings. Given that "Thank you!" was written at the end of many of the survey pages may suggest that providers appreciated the opportunity to share concerns about ethical issues and training needs.

One last thought is that this study may lead to discussions about how to best provide ethics education in social work and counseling related training programs, especially, with practitioners who intend to work within the rural setting after graduation. It might be helpful to consider infusing ethics education throughout the curriculum, rather than having a stand-alone ethics course. The NASW *Code of Ethics* does not directly mention how to teach ethics education within a social work program, but the *Code of Ethics* does set guidelines for how a social work educator should interact with students (NASW, 2008). Because there is not consistency in ethics education there is an ongoing debate in the counseling literature as to *how* to provide the most effective ethics education (infused/separate class, etc.) (Hill, 2004; Urofsky & Sowa, 2004). Further research in ethics education may enhance how to create consistency and best-practice ethics education to both students and practitioners. Possibly an exploratory survey of how ethics education is currently provided across

social work and counseling related training programs could be a starting point.

10. Conclusion

This inquiry into what rural practitioners face ethically and need professionally might serve as a guide to select meaningful counseling ethics education for licensing boards and mental health professionals, as well as inspire future ethics studies. It is important to obtain direct feedback about what happens in practice within small-town settings. Research shows that rural providers are challenged with ethical dilemmas which may be distinct from issues more prevalent in urban areas (Casemore, 2009; Schank & Skovholt, 1997; Phillips & Baker, 1983). The results of this study may contribute to the enhancement of ethics training, provide insight into rural issues, and give voice to mental health and substance abuse providers in one state. This study may lead to discussions about how best to provide continuing education to rural practitioners. A preventative training approach may contribute to reductions in ethical errors and increase professionals' trust and dialogue (Warren & Douglas, 2012). Studies which encourage providers to share ethical issues need to be ongoing, and results need to create training and offer support for those who work in rural settings.

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Book Review

Zurbriggen, E. L. & Roberts, T.A. (2013). *The Sexualization of Girls and Girlhood: Causes, Consequences and Resistance*. NY: Oxford University Press.

Reviewed by Amanda R. Nixon, BS (Consultant), & Stephen M. Marson, Ph.D., Senior Editor

Journal of Social Work Values and Ethics, Volume 11, Number 2 (2014)

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Because of my long relationship with Oxford University Press, they sent me The Sexualization of Girls and Girlhood: Causes, Consequences and Resistance for review. Though I have completed course work in women's studies, I feel that I was a bit out of my element. As a result, I asked my respected colleague, Amanda R. Nixon, to assist. Of all the people I know who are deeply involved in women's studies, I find Ms. Nixon to have the most profound insights. I have made several attempts to synthesize our diverse perspectives; I failed. Thus, this first part of the review is written by Ms. Nixon, while the last is written by me.

Amanda R. Nixon, BS (Consultant)

I want to start by saying that I was thrilled to see a scholarly work addressing an issue that I (as a former high-school teacher and aunt of three girls) feel is enormously important and one that in general I think is mostly ignored by society at large. It's too easy to say "sex sells" or "it's what girls want these days," thereby ignoring that at this period of their development, it is difficult enough for young girls to cultivate a healthy self-concept and an abundance of self-esteem with the pressures that already exist, not to mention pre-maturely introducing a "sexual-self" component to the mix. We must question as our daughters, nieces and young sisters are finding their way in this world do we really need to impose a complex sexual development upon them precipitately in their growth process?

And regardless of their anatomical development, social media, and influence of media and peers, what can we do as parents and mentors to ensure a measured and sound progress into maturity where the development of self and confidence precedes heavier questions and considerations of sexuality? These are the topics I hoped to find addressed, and in most cases the main questions and concerns were covered, some more thoroughly than others. Where the collection of essays fell short for me was more in the lack of depth, as well as the failure to focus comprehensively on the varied aspects that can contribute to the sound, healthy development of a young girl, aiding in arming her with the tools she needs in a society where sexuality is pervasive at younger and younger ages.

First, structurally, the introduction was thorough and informative. The authors are quite effective in defining the issue and delineating the schools of thought as to how girls absorb or acquire the messages around them. However, the subsequent chapters, while loosely organized in a methodical and clear manner, wasted pages being repetitive by re-stating the issue of sexualization in an unnecessary manner since the "problem" or issue had been so well introduced and defined in the first chapter. While these were individual essays or positions, they could have been more effectively edited to make the overall message more cogent and less exhausting of the reader's patience by the time he/she reaches the 3rd or 4th chapter. They also did little to deepen the understanding of the

problem, per se. At the end, I was left feeling that the treatment of the subject was a bit too surface and unfocused, regardless of the consequences and notes on fighting sexualization offered. I almost feel that one singular book written by one author instead of a collection of edited essays would have been more beneficial to such a serious and growing issue.

Perhaps one of the most useful aspects of this introductory is the defining of self-objectification and how this plays in to the development, in this case sexual self-awareness and self-esteem, of the young girl throughout her journey into womanhood. This I find to be the most significant issue at hand, as it has far reaching consequences, even beyond the sexual. A deeper exploration of this concept and the factors that play into it would have probably been more valuable, not only for the understanding of how sexualization affects the young girl, but also of how the factors that play into self objectification can be utilized to combat sexualization's effects on her.

What I found to be the biggest issue throughout the book was the lack of factoring in the individual girl's psychology, outlook or self-awareness in whether sexualization will/would have an effect on her and cause self-objectification to occur. For example, the multitude of studies quoted relaying the amount of exposure to media, whether it be via TV or music videos, seem to only draw a correlation between the amount of TV/videos observed and a girl's self-esteem and/or outlook on her own sexuality, how she sees and portrays herself in reference to her sexuality, and how she sees herself as a sexual object for the pleasure of others or not. None of this takes into account her own self-awareness, confidence, education or self agency and ability to think for herself at all. The same can be said of the authors' references to the media by way of advertising affecting how girls dress. Some of the studies quoted seem to suggest the more exposure a girl has to magazines and advertising portraying young women in sexual ways, the more likely she is to see herself as a sexual object

and dress that way (i.e., the more she is exposed the less conservative she will dress or the fewer clothes she will wear.), or the more likely she is to have an increased concern about her attractiveness to the opposite sex, thereby instigating an over concern with weight, makeup, etc., all to be more attractive to men. It is even suggested that this in turn can lead to a lower self-esteem since the images portrayed are no doubt unrealistic. While all of this could have an effect, the major factor left out of this is the ability to think for herself and the self-concept she had developed to that point.

The author negligibly addresses the role of the girl's mental outlook already and even less so of the role parents play in this. Though intrapersonal relationships and their influence on a young girl are addressed, very little time or mention is given to parental influence. How a girl is raised and the messages from her home life and close friends are all but ignored. These would seem to have a mitigating factor as to how these images and messages out in society are interpreted and absorbed. However, the authors fail to explore this to the extent that I feel is warranted in the scheme of influence over a girl, as well as in how they factor into combating sexualization. If a girl is raised with a positive self-image, she will take the images she sees or messages she hears out in society and interpret them appropriately. To suggest otherwise is to say girls are mindless sponges. So whether more intricate studies should have been included and utilized for demonstration or more credence and focus given to the influence of parenting in whether girls end up self-objectifying, this subject should have been canvassed more extensively.

There is no doubt that women, more than men, are evaluated on their attractiveness and that the higher the perceived attractiveness, the more worth some segments of society are likely to assign. And the advertising and media sources that show young girls in "adult" situations, poses, clothes and makeup are not helping and are inappropriate. However, this alone does not make a girl self-objectify or focus on what the author calls a

'body project.' And it is probably accurate to say that the more other attributes and talents/skills are highlighted in women (creating a task-involved climate, for example) the less likely they are to self-objectify. However this can not solely be laid at the feet of TV, advertising and other media. This most likely has more to do with interpersonal relationships building the intrapersonal relationship a girl has with herself as a strong or weak filter for the messages to which she is exposed throughout her girlhood.

For example, Deborah Tolman's essay is supposed to address how the sexualization of girls affects young boys, men and adult women. While she has very valid concerns over what she calls the "pornification" of the media, what she seems to concentrate on is how sexual objectification is becoming normalized for young boys. She focuses a good portion of her essay on how video games display women solely as sexual objects or unintelligent, vulnerable beings and that objectifying these women often is equated to power. Additionally she asserts that ideals about femininity and masculinity are concreted in such games with the men being the powerful heroes (often inflicting violence upon the women) and the women being objects of desire in inferior positions, often enjoying being aggressed. This, among other pornified images, she feels constitutes the sexual education of young men. While I do not disagree with her that this is a huge issue, I do feel that, for one, it is nothing new, and two it doesn't actually connect solely as an effect of an emerging sexualization of young girls, except that the alleged pornification is simply happening at an earlier age of female. Hence, I found her argument to be extremely sound insofar as it discusses the formation of attitudes towards women being developed during this sexual "education" of boys.

Especially poignant are her assertions that boys and men are at worst, vicariously educated about sex through porn itself, which because it is made for the most part by and for men based on what is perceived to be arousing for a man, often leads to

unrealistic expectations of women's sexual behavior and appearance, learned scripts for "breaking down" women's resistance, possible dehumanizing of women, equating of violence and sex and overall dissatisfaction with partners. Although I wholeheartedly agree with this train of thought, I do not believe it necessarily relates to the topic at hand. I feel it says more about a problem that has existed for a very long time in relation to attitudes towards women but less about the sexualization of girls. The assertion that these videos and porn use characters that are supposed to be young (as this is what I see only to be a trend) may actually be more applicable in the argument. However, Tolman only explores how this affects women and their obsession with remaining youthful, as this is perceived to be more appealing to men now.

I don't know how much this can significantly be tied to sexualization of girls, since men preferring younger women (as a generality) and women being obsessed with youth are actually ancient phenomena, as old as history itself. She cites the increase in plastic surgeries such as labiaplasty and vaginal rejuvenation as evidence of this. She claims they are solely for the aesthetic pleasure of men. For one, the increase of these probably has more to do with their recent technological improvements and increased availability and affordability than to some new desire to look young simply because young girls are being sexualized in the media. More importantly, these surgeries, especially vaginal rejuvenation, are not solely aesthetic. They are in many cases required for additional support of vaginal walls and organs after childbirth and trauma. When not for medically necessary causes, they are performed also in order to give women a tightening of the walls to increase their own sexual pleasure. Tolman's point that when women are unable to live up to perceived body standards they develop a lower self-image, and that can lead to less enjoyable sex (through inability to become aroused, participate in certain acts of sex or orgasm) are valid. However, this falls more under self-objectification, which has previously been discussed.

Each essay does some version of what Tolman did. While they all elaborate (some more convincingly than others) on the idea there is a growing issue of sexualization of young girls and the various contributors to this sexualization, most fail to submit a comprehensive understanding of how these factors are absorbed by girls and what internal factors, such as self-awareness and self-esteem, and external factors, such as family and environment, can combat its influence.

Stephen M. Marson, Ph.D., Senior Editor

As both a father and a sociologist, after I completed this book, I found myself depressed. As a father, I became distressed because of the world in which my daughter lives. At that point, I began to think like a sociologist. As Ms. Nixon pointed out, the central theme among all the authors is treating “media” as the single most important independent variable, while sexual objectification is the dependent variable.

The authors do not address family influence or socioeconomic status (SES). On page 264, SES is noted, but not as an independent variable. A question: Do families make a difference when their daughters face the real world of sexual objectification? Is there an outcome difference between a female child who is sold into prostitution by her father and a female child whose father reads to her every night before she goes the bed? I realize the reductio ad absurdum dimension of my question. However, the main problem with this book is that it focuses on bivariate causal relationships. For example, the authors present this causal feature:

Media → Objectification

This bivariate relationship is misleading, intellectually dissatisfying and most importantly, has little applied value. The hypothetical model should include Media as an intervening variable, as illustrated:

Family Relationships → Media → Objectification

Frankly, I am troubled. Essentially, *The Sexualization of Girls and Girlhood: Causes, Consequences and Resistance* is a comprehensive synthesis and review of literature on sexual objectification of females. It is incomprehensible that no multivariate analysis (multiple regression, path analysis, etc.) has been employed to control and identify the strengths of key independent variables. Failure to include multivariate analysis will inhibit social advocates to pursue policies and strategies that could combat the sexual objectification of females.

With all its shortcomings, this is a critically important volume to be adopted in every academic library. For universities that have women’s studies programs with a research arm, the book will be extremely valuable as a catalyst for contributing to the knowledge base.

Book Review

Furman, R., Bender, K., & Rowan, D. (2014). *An Experiential Approach to Group Work, 2nd ed.* Chicago: Lyceum Books, Inc.

Reviewed by Charles Garvin, Ph.D., MSWCML, University of Michigan

Journal of Social Work Values and Ethics, Volume 11, Number 2 (2014)
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This book offers a series of individual and group exercises that can be used to teach group work skills. The chapters each consist of a brief theoretical introduction to the topic and one or more individual and group exercises, followed by appropriate checklists through which to examine the reader's understanding of the topic after completing these experiences. Brief, well-chosen examples are also included. An introductory chapter discusses group work history, types of groups, group theories, and group development. Emphasis is given to a "social justice model," which is an important reflection of the authors' own set of values. The value of experiential learning of group work skill is discussed, and this is the rationale for writing this text.

The scope of the twenty short chapters in this book is wide. Opening chapters deal with each stage of the evolution of the group such as planning for the group, group beginnings, group dynamics, evaluation and endings. The next set of chapters focuses on types of groups such as skills groups, support groups, treatment groups, psycho-educational groups, task groups, macro-practice groups, and anti-oppressive practice groups. A set of chapters presents groups for such problems of people as eating disorders, persistent mental illness, school children experiencing conflict, pregnancy in adolescents, the situation of immigrants, and coping with HIV/AIDS. Another chapter presents group work with Latinos and Latinas.

A chapter that has a strong value base is that dealing with anti-oppressive practice. Topics included here are exercises to help group members deal with

inequality in their own lives and their "internalized oppression" and disempowerment. The members and workers are also able to use the exercise that helps one examine one's own power and privilege. The authors recognize that in these instances the separation between micro and macro practice dissolves. As one who shares this interest in overcoming oppression, I think that in all types of groups there are many occasions to challenge oppression and erase the differentiations between macro and micro practice.

The other chapters do not raise as many issues regarding the relationship of values and ethics to practice, as I would have liked. For example, it would have been helpful to explore what value issues enter into choosing members for groups, determining purposes of groups, examining power issues at each group phase, evaluating the group, and so on.

The authors are all experienced group work educators at such institutions as the University of Washington, Tacoma; the University of Denver, and the University of North Carolina, Charlotte. They show in their choice of content a good knowledge of group work practice and theory and the ways of teaching these topics.

This book, however, is short and mainly composed of exercises, although there are brief theoretical introductions to each chapter. I could use this book as a summary of what the students learn from more extensive treatments and as a guide to the use of exercises in class – a practice I enthusiastically support.

Book Review

Payne, R. K., Dreussi-Smith, T., Shaw, L., & Young, J. (2014). *Bridges to Health and Healthcare: New Solutions for Improving Access and Services*. Highlands, TX: Aha! Process, Inc.

Reviewed by Rasby Marlene Powell, Ph.D.
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The purpose of this book is to provide a lens through which the reader will be able to accurately view the impact of class on healthcare delivery. The authors demonstrate that each class brings with it different resources, which affect interactions between healthcare providers and patients. Just a few of the resource differences they cover are relationship models, support systems, emotional health and coping strategies. They also discuss the tacit norms and expectations within each class that can cause multiple communication problems between providers and patients. In addition, the authors move beyond analyzing the problem at the individual level and consider how class differences impact healthcare outcomes on the institutional and community levels, as well.

The authors bring a valuable combination of experience and professional perspectives in this easy-to-read, yet profound book. Ruby Payne, Ph.D., is a well-respected author and award-winning educator. Her theories of working with impoverished students spawned the ideas in this book. Terie Dreussi-Smith, MAEd., is a consultant, trainer, educator, and author who uses Dr. Payne's theories in her own work. Lucy Y. Shaw, MBA, was president and CEO of The Regional Medical Center of Memphis during the 1990s. She has special expertise in financing medical care for the underserved. In addition, she is an author and a well-respected trailblazer in health and healthcare issues. Dr. Jan Young, DNSc, is the executive director of the Assisi Foundation of Memphis, before which she was senior vice president of operations with leadership

accountability for clinical and support services at St. Joseph Hospital in Memphis. These are but a few of the many accomplishments of the authors.

The book is organized into two parts and a conclusion. The first part includes four chapters that help the reader gain an appreciation of the Bridges Lens. Chapter One outlines the lens, and Chapter Two presents relevant health care research findings. Chapter Three discusses the resources and norms of economic class and how those impact healthcare delivery. Chapter Four discusses how class differences in language affect communication between health care providers and patients. The second part includes three chapters which focus on community resources, social cohesion, social capital, and building effective relationships. This section includes an excellent discussion on the conflicts between individual and institutional needs. The final chapter in Part II presents four case studies. The conclusion contains several appendices with information and tools to help readers use the tools and strategies presented in the book.

This book has multiple strengths. The writing style is clear, concise, and accessible to the general reader, as well as academics and professional health care workers. The authors use research data to illustrate their points and case studies to show the efficacy of the lens. Several appendices in the conclusion section provide additional information and tools to help readers use the lens in their health care delivery. Their multilevel analysis of individuals, institutions, and communities demon-

strates the complexity of the issue and illustrates how problems in one area may lead to problems in the other areas. While I did not find any particular weaknesses in the book, I did come away with a desire to know more about an issue they touch on in Appendix A. They discuss the difficulty of trying to find much needed creative solutions within an institutional framework of rules and regulations that typically restrains creativity. I hope they continue to address this question in their future work.

Overall, I highly recommend this book and believe it can serve multiple purposes. I believe that any healthcare provider who is interested in improving services to impoverished populations would benefit from this quick read. In addition, social science and nursing students would benefit from improving their understanding of how class affects healthcare delivery and contributes to health disparities among different populations. In fact, I was so impressed with the book that I passed it on to my personal physician, who devotes about half of his practice to underserved patients.

Book Review

Bell, J. M. (2014). *The Black Power Movement and American Social Work*. New York: Columbia University Press.

Reviewed by Bishnu Mohan Dash, MSW, M.Phil., Ph.D.
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In this book, Joyce Bell has added considerable depth and detailed analysis on the development of Black professional associations by filling a research gap in the existing literature concerning the institutionalization of the Black liberation movement during the age of Black Power. It has also offered a critique of state-centered studies of social movement outcomes. The book reveals in-depth scholarship on both the Civil Rights and Black Power movements revolving around social movement theory and new knowledge about race and power. The book has examined the leadership models and the importance of intra-organizational dynamics in shaping the national association of Black social workers.

The project of Bell is based primarily on extensive archival research, participant observation and Theory Guided Process Tracuity (TGPT) to examine the ways in which the movement became institutionalized within formal organizations.

Divided into eight chapters, the book has particularly highlighted in depth the institutionalization of Black Power politics into the professions, particularly social work, and the far reaching impact of the Black Power movement on U.S. society. In the first chapter, the author has discussed that Black Power was the central motivation and political lens for the creation of new racial practice within organizations in the late 1960s and early 1970s in the U.S. The author has looked specifically at the rise of Black professional associations and the use of the specific case of American social work to

illustrate the role of the movement in shaping the profession. Placing the activism of Black social workers during the late 1960s and early 1970s in the context of institutionalization of the rights revolution and the expansion of Black Power politics, the author has argued the rise of Black professional associations in general - and within social work in particular - is a primary example of the institutionalization of the Black Power movement.

Chapter 2 provides the historical perspectives of the Black liberation movement in the United States and critically describes that it was not a sort of political formation but morphed into a political form and simultaneously ushered in new radicalized norms within institutions to carve out institutional space for African Americans and reinforced class cleavages within the Black community. The unprecedented Black access to higher education and white collar employment, combined with their movement ideology, led to the growth and development of an independent Black organization, which has been discussed in Chapter 3. This chapter has also explicated the relationship between action and organization of Black social workers and the framing of the Black Power movement.

Chapter 4, which is very important for social workers, helps readers to understand the relationship between the Black liberation movement and social welfare. The social workers, who straddle the fence between activism and service delivery, are forced to rethink their roles in movements. The atmosphere of uncertainty, caused by the shifting

movement of ideas and practices, created openings for dissenting social workers to seek change within the profession. Chapter 5 traces the process of the mobilization of Black social workers and the emergence and transition from a Black caucus of settlement workers to a multi-cultural campaign. More significantly, it describes emotional dynamics at work in the conflict within the organization.

Chapter 6 describes the emergence of the Black Social Workers Association for pursuing their goals independently amid the perceived constraints of the larger professional organization in the context of shifting radical ideologies and the expansion of Black Power politics. Chapter 7 presents the comparative outcome of Black social workers' activism in two relatively prominent, similar social work organizations and discusses the role of emotional labour in these struggles. The author has developed a conceptual model for understanding the role of intra-organizational social movements in civil institutionalization. The concluding chapter highlights the popular conceptions of the Black Power movement in the development of Black

professional associational life and explores the idea of treating the Black Power era as a transition period in race relations.

The book will be useful to understand the divergent paths of these movements and the relationship to the larger structure of the Black Power movement. It will also help readers develop deeper insights to understand the process of how movement gains became institutionalized within formal organizations. The social workers will be highly benefitted by reading the work of Bell to understand the impact of the Black Power movement and its, not only into their professional lives, but also into education and culture.

I believe that social work academicians and researchers should seriously consider use of this book while teaching papers on social movements, which will be definitely very much useful to understand new dimensions of the movement, social dynamics and the relationship between social movement and social welfare.

Book Review

Van Soest, D. (2014). *Just Mercy*. Baltimore: Apprentice House.

Reviewed by Peggy Proudfoot Harman, Ph.D.
Marshall University

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The death penalty is and has been one of the most controversial issues of all time. The concept of “just” punishment for brutality being brutally administered by the “State” continues to illicit images of barbarians. Those opposed to the death penalty often present themselves as pacifists, soft on crime, and/or zealously religious. Pro-death penalty advocates maintain an opinion that the death penalty is a deterrent to homicide and a just punishment for barbarous acts. Interestingly enough the pro-death penalty opinion is also rooted in religious doctrine.

These extreme opinions have been cleverly couched in Dorothy Van Soest’s, *Just Mercy*. Van Soest takes us into the lives of Bernadette and Marty, a couple who moved to Texas as a result of Marty’s appointment as a university professor. Bernadette is a professor’s wife who has raised the couple’s two biological children and one adopted child. As the story opens, we find Bernadette attending the execution of Rae Lynn Blackwell, a young woman sentenced to death for the murder of Bernadette and Marty’s youngest daughter Veronica, (who was prior to Veronica’s death, an anti-death penalty activist), watching Rae Lynn being prepped to die in the death chamber. “Bernie” watches the process and is simultaneously horrified and relieved that “justice is served.” Bernie and Marty’s children Annamarie and Fin are indelibly tangled in this story and bring their views of society, their sister’s murder, and their own strong opinions on crime and punishment to bear on the reader’s impressions.

The story highlights the emotional rollercoaster experienced by the family in response to external circumstances. We initially see Bernadette as an emotional wreck who has literally changed her deeply held views of the death penalty since the murder of her daughter. This change in ideology has morphed the once positive personality into a bitter woman set on justice for Veronica. We see Bernadette’s former opinion deeply ingrained in her son, Fin, who is a social worker and adamantly opposed to the death penalty. Fin’s thoughts and actions are juxtaposed to his sister Annamarie, a lawyer who is portrayed as angry and eager to see Rae Lynn Blackwell suffer for murdering her sister.

My reaction to this read was initially tentative. As a former federal mitigator for death row inmates, I have been exposed to the intricacies of heinous crimes and the often tortured lives of the perpetrators. My experience tended to color my initial opinion of the characters as less than realistic. However, as I continued the story I found myself having emotional responses to the characters as the ebb and flow of their experiences and opinions filled the pages. The story alludes to the facts of Veronica’s murder without exposing the reader to excessive detail. What we are exposed to are the reactions of individual family members and the family unit to the horrific loss of a child. Bernie, Marty, Finn, Annamarie and Annamarie’s daughter Patty have grieved the loss of Veronica for over 10 years. Van Soest uses her social work acumen to introduce the reader to the variety of actions and the process associated with grieving. Van Soest

moves the reader through the transformation of Bernadette from a hostile grief-stricken mother to working through her grief productively. Through Bernadette, we begin to see the circumstances surrounding Rae Lynn Blackwell's life, which influenced her ultimate demise to murderess. Through Marty we encounter the voice of reason as he maintains a stance of acceptance of Rae Lynn's sentence and of his own possibly life-threatening health issues.

Various caveats throughout the story line are useful in exposing the many issues and emotions surrounding the institution of the death penalty. The crescendo of the storyline is somewhat predictable but still adds an interesting and motivating twist.

I believe this book should be included as an ethics assignment for both graduate and undergraduate social work students. It provides an unusual look at many sides of the death penalty as punishment, deterrent, and as a tool for taking out aggressions by those adversely affected by the perpetrator's actions. It is also an excellent tool to examine societal, environmental, and developmental risk factors for violence.

Van Soest's novel provides fodder for considering the complexities associated with crime and punishment and will provide students with a provocative groundwork from which to discuss and debate ethical issues associated with society's use of the death penalty.

Book Review

Schmiesing, K. (2014). *Catholicism and Historical Narrative: A Catholic Engagement With Historical Scholarship*. Lanham, MD: Rowman & Littlefield.

Reviewed by Steve Drewry, Ph.D., LISW-S
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First, in the interest of full disclosure, let me confess that I am a cradle Catholic. Twelve years of Catholic education under my belt, and with a few perhaps less than devout excursions in a past not nearly as sordid as I might wish, I seem to have developed what my old friend, Father Mike Mahoney, once called an adult relationship with the Church. My path back has been a circuitous one, characterized by caution and curiosity.

And so it is that I took up the reading of *Catholicism and Historical Narrative*, edited by Kevin Schmiesing, a scholar and author out of Penn, late of the Acton Institute in Michigan. Schmiesing has assembled an all-star roster of scholars to augment and often contest the traditional narratives of noteworthy incidents in American history. In some cases, the authors attempt to challenge the usual discourse of conventional American wisdom, such as Scott McDermott's piece on Protestant scholasticism during the early years of Harvard University. In others, for instance Ernest Greco's substantive reimagining of the role of the Catholic Church in the Holocaust, the traditional narrative (that Catholic popes were at least passively anti-Semitic during the years leading up to Hitler's attempt to eradicate the Jews from Europe) is frankly confronted and amended. And while each essay in this book has merit, a close reading and consideration of *Catholicism and Historical Narrative* yields something else: an underlying commentary on the moral state of the nation.

Let's look at some examples. The aforementioned conventional wisdom understood by most reasonably educated Americans is that the Puritans left England, involuntarily, stopped in the Netherlands to plan their next move, and crossed the Atlantic in the *Mayflower* bound for the New World to establish Plymouth and the Massachusetts Bay Colony. Seeking religious freedom and new opportunity, the Puritans created an essentially Protestant state, and are responsible, certainly as much as anybody else, for creating the Protestant culture upon which the United States was later built. McDermott suggests, however, that while Catholicism did not perhaps purchase a first-class voyage on the *Mayflower*; it did indeed travel as a stowaway in the hold. He uses the development of scholasticism at Harvard University as his microcosm, arguing that from its earliest days, Harvard was not a purely Puritanical temple of learning but was rather influenced by foundational teachings of the Holy Roman Church, among which were the two great New Testament commandments: Love God, and love thy neighbor as thyself.

From its earliest days, American society and the mythology of American culture have been driven by four pragmatic concepts: the pressing outward of white expansion, most vividly illustrated in the search for the limits of the *frontier*; the use of *freedom* and initiative to seek broader *opportunity* for the individual; and the pursuit of personal *choice* as the vehicle to explore and attain the other three. Thus the formula, if you will, for the practical pur-

suit of success in the New World has historically been freedom + opportunity + choice + frontier = success (or transcendence).

To this reader, the formula has no greater depiction in American letters than Nathaniel Hawthorne's *The Scarlet Letter*, wherein Hester Prynne and Arthur Dimmesdale escape from the confines of Puritan society to the wilderness so they may pursue choice and opportunity (in the quest for romantic love, or transcendence). A lovely story, to be sure, but let us not forget their quest was cheapened by the larger society and ultimately condemned as sin.

Thomas Jodziewicz, in his treatise on Dorothy Day and Peter Maurin, reinforces the power of personal choice in the American narrative by stating that America has always been a "pro-choice" nation. Not, he quickly adds, in the rather shallow, or at least focused and politicized, current narrative on abortion, but as a general core belief in the American consciousness. Jodziewicz, via his description of the American mantra, *a la* Day and Maurin, of individual rights and collective responsibility, leavens the mantra with its correlate, collective rights and individual responsibility. And it is here that a larger critique of the moral state of our nation begins to fully emerge. Implicit in Day's and Maurin's thinking, according to Jodziewicz, is the notion that these two conceptual pairings must be balanced with one another for a genuinely moral and just society to flourish. In modern America, Day and Maurin might well argue, the balance has been offended, with inordinate weight placed upon the rights of the individual and insufficient attention granted to the need for collective rights in a democratic society.

A third essay in Schmiesing's book, one assured to offend more than a few readers given the current climate of ideological battle in our United States, is by Clement Anthony Mulloy, and addresses the path of progressivism in American thought as exemplified by Margaret Sanger. As many readers no doubt already know, Sanger is often considered the patron saint of women's rights and reproductive

freedom in America, and elsewhere. And Mulloy takes more than a little time and space in validating some of Sanger's contributions to these issues. Yet Mulloy also points out the wages of extremism that, some would argue, pervaded 20th century progressivism in its later days. As an example, he discusses Sanger's abiding debate with the Catholic priest, Monsignor John Ryan.

Ryan's focus was on the need of a living wage for the working class in America. Thus, his principles arose from a core belief in economic justice. His form of progressivism, were one to call it that, was to oppose the excesses of capitalism which, in Ryan's view, were antithetical to the pursuit of a living wage for the working class and the attainment of something approaching economic justice in the early decades of the American 20th century.

The debate between Ryan and Sanger was essentially a debate over the meaning of natural (or moral) law. Ryan argued that moral law was abiding, and established through the course of human history, per St. Augustine. Sanger's position was that moral law was more fluid, changing with societal changes and advances in the human condition. Where the argument boiled over was on the relationship of moral/natural law and what was known then as the eugenics movement.

Eugenics was an outgrowth of the generally progressive ideal of improving society via social engineering. While many aspects of progressivism were embodied in the improvement of the immigrant experience, the redistribution of wealth, and the empowerment of the working class, eugenics sought nothing short of the elevation of the human condition by means of limiting the reproductive powers of citizens deemed inadequate or undesirable. Examples were immigrants, whose rates of childbearing were rapidly outpacing those of nativist Americans, the "enfeebled," and others whose sterilization was considered to be beneficial to the overall well-being of American society. To Margaret Sanger, the possibilities of such engineering were an extension of her definition of reproductive

rights; to Ryan, eugenics was a grievous offense against moral and natural law.

Woven throughout the essays in this book are the issues of generally accepted moral authority, the path to salvation and transcendence that is part of what constitutes the so-called American Dream, and the gradual cheapening of our pragmatic American formula for achieving this dream. In one way or another, using one historical episode or another, the authors combine to suggest that in America, the grand pursuit of new experience, freedom, opportunity and choice have become

debased into the idolatry of narcissism, the chimeric search for meaning through consumerism, and the drugging of our individual and cultural dreams. Pretty heavy stuff.

Unfortunately, though, these themes must be teased out from the accumulation of each individual story. What is missing from *Catholicism and Historical Narrative* is a summative chapter or epilogue that makes overt and possibly enriches what attentive readers must presently consider solely on their own. Whether this is a strength or a weakness of this book, each reader must individually decide.

Book Review

Haskett, M. E., Perlman, S., Cowan, B. A. (Eds.) (2014). *Supporting Families Experiencing Homelessness*. New York: Springer.

Reviewed by Wayne C. Evens, Ph.D.
Bradley University

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Mary E. Haskett, Ph.D. is a professor of psychology at North Carolina State University. She has done research in the areas of parenting and children's social adjustment. She has published in the area of children who have experienced harsh parenting. Staci M. Perlman, Ph.D. is an assistant professor at the University of Delaware. She has done research and published in the area of parenting while homeless. Beryl Ann Cowan, Ph.D., J.D. is a therapist in Needham, MA. She works with children and families.

Chapter One, "The why and the who of family homelessness," by John C. Buckner, uses "musical chairs" as a metaphor to explain why there is homelessness and why people become homeless. The author points out that homelessness is created by a lack of affordable housing in a geographic area. He argues that being a single mother, race and ethnicity factors, lack of financial resources, lack of education and marketable skills, weak social networks and supports, partner violence, mental health issues and substance abuse involvement are all factors that increase the likelihood of a family becoming homeless. He indicates that subsidies can help individual families, as can other interventions, but only the creation of more housing stock can reduce the incidence of homelessness.

Chapter Two, "The developmental trajectories of infants and young children experiencing homelessness," by Katherine T. Volk, reviews the cognitive, social-emotional, and physical development

impacts that homelessness can have on children at several developmental stages. It reviews the evidence that exists that supports the harm homelessness does to children. It acknowledges that some homeless children, given the right support, show resilience. The chapter closes with a list of proposals to improve outcomes for children. These are developed in later chapters.

Chapter Three, "Trauma exposures and mental health outcomes among sheltered children and youth ages 6-18," by Beryl Ann Cowan, reviews the literature on mental health issues related children and youth who have experienced homelessness. It establishes that homelessness is an important risk factor for mental health issues in this population. It closes with a list of nine brief suggestions for policy and practice.

Chapter Four, "Parenting in the face of homelessness," by Staci Perlman, Sandy Sheller, Karen M. Hudson, & C. Leigh Wilson, reviews several issues that families confront in dealing with homelessness. These include separations because shelters do not accept some family members; shelters are often not sensitive to children's issues and cultural issues. Families face many stressors, which may lead to mental health issues. The chapter proposes that shelters adopt a trauma-informed approach. This would address helping families deal with the traumas of homelessness and supporting positive parenting. As policy proposals, it recommends rapid re-housing, ensuring basic needs are

met, helping families maintain relationships, using the shelter as an opportunity to help families grow, and ensuring that families have access to health and mental health services.

Chapter Five, “Needs of special populations of families without homes,” by Carmela J. DeCandia, Christina M. Murphy & Natalie Coupe, argues that although providing permanent shelter is crucial, additional services are needed for families, and they need to be tailored to particular family situations. It explores the needs of military families, LGBT families and immigrant and refugee families. The challenges faced by each type of family are reviewed, along with the opportunities to strengthen each type of family. The authors encourage policies and research focused on these unique family situations.

Chapter Six, “Collaborations across and within systems that provide services to families without homes,” by James H. Bray and Andrea Link, argues that families facing homelessness are frequently in need of multiple services. Ten evidence-based principles to guide collaboration are discussed: 1) develop a common mission, 2) have all stakeholders represented, 3) use evidence-based and solution-driven approaches, 4) use agreed-upon outcomes and have ways to measure outcomes, 5) develop common language and definitions, 6) establish clear policies and procedures, 7) keep lines of communication open, 8) ensure strong consistent leadership, 9) understand and respect different agencies’ cultures and systems, and 10) create relationships across agencies. The strategies are explained using case examples.

Chapter Seven, “Trauma-informed care for families experiencing homelessness,” is written by Kathleen M. Guarino. The chapter discusses the traumas associated with becoming and experiencing homelessness. It argues that the services homeless families need should understand and respond to the traumas associated with homelessness. It is very important to understand trauma and to establish services that create a safe environment in

which families can work through trauma.

Chapter Eight, “Cultural competence and individualized care in service provision,” by Bra Vada Garrett-Akinsanya, demonstrates that historically marginalized families are overrepresented in the homeless population. It addresses the personal and systemic barriers faced by these families. It reviews some programs that may show the way to more successful services for the homeless. The author argues that services should be “...*family-directed, family-centered, culturally affirming and trauma-informed* (p.145 italics in original).

Chapter Nine, “Research on programs designed to support positive parenting,” by Abigail Gerwartz, Kimberly Burkhart, Jessica Loehman, and Beth Haukebo, acknowledges that parenting is particularly difficult for homeless families. This chapter reviews the research evidence that indicates the importance of providing supportive services. It stresses the importance of cooperation between agencies and services to provide a continuum of services.

Chapter Ten, “Programs for homeless children and youth: A critical review of evidence,” by Janette E. Herbers and J. J. Cutuli, reviews the evaluation studies of interventions and programs to assist homeless youth and children. Very few rigorous studies have been published that meet standards for rigorous evaluation studies. Although there have been several published articles that attempt to evaluate services, there is a need for more rigorous studies.

Chapter Eleven, “Primary stakeholders’ perspectives on services for families without homes,” by Ralph da Costa Nunez and Matthew Adams, summarizes interviews with two policy makers, three advocates, three shelter providers and one formerly homeless person. The challenges that parents face are addressed, along with the positive and negative effects of some policies and service strategies.

This book should be an excellent resource for

Book review: *Supporting Families Experiencing Homelessness*

programs providing services to homeless families, to policy makers and to those advocating for improved services to homeless families. It provides solid, factual information about the nature and extent of homelessness. It makes clear the struggles of families facing homelessness, and the special

problems of minorities, veterans and special needs families. The services it promotes and the policies it proposes are well documented. The book makes clear what evidence we have and what research is needed. It dramatizes the many issues involved in homelessness in our society.

Book Review

Herwig-Lempp, J. (2013). *Resource-oriented Teamwork: A Systemic Approach to Collegial Consultation*. Bristol, CT: Vandenhoeck & Ruprecht.

Reviewed by Peter A. Kindle, Ph.D, CPA, LMSW
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Herwig-Lempp is a professor at the University of Applied Sciences in Merseburg, Germany. This book is based on his personal experiences of working to improve the teamwork at a specific Family Support Center, accordingly, the first person is used throughout. Even though the author provides a ten-page chapter in which he attempts to build a case for differentiating between three levels of teamwork, he keeps his theorizing to a minimum. This is a practical book about how to develop better communication among virtually any kind of team that is task-oriented. The “resource-oriented” phrase in the title refers to the different skills and perspectives each member of a team brings to the team processes, but within the text itself, this is a relatively minor issue.

How might a clinical team improve if the team members treated one another with the same viewpoint with which clients are approached? This is what Herwig-Lempp means by the term *collegial consultation*. The second longest chapter in the book defines the clinical framework used at the Family Support Center, a particularly non-directive approach to systems theory in which the author assumes many perspectives that may have broad acceptance, but without any real discussion of evidence to support it. These are the essential components of the author’s clinical framework, and all of the techniques and advice presented in the rest of the book assume this orientation:

- Mandate – Collegial consultation is founded on the presentation of a colleague’s specific concerns or presenting problem and are constrained by this mandate.

- Resources, strengths and competencies – Collegial consultation relies upon the presumption that synergies will develop as different perspectives and ideas are shared.
- Increasing options – All collegial consultation aims to expand understanding and increase options.
- Client responsibility – The colleague with the mandate is the responsible party for determining what final decision or action to take following the consultation.
- Respect and appreciation – Collegial consultation requires mutual respect and appreciation.

There are a number of inconsistencies in Herwig-Lempp’s presentation. He denies that systems exist except as we choose to construct them, then goes on to list the elements of professional intervention that enhance the chances of effecting change without appearing to realize that he cannot have it both ways. He spends almost five pages defining *team*, then concludes that none of these definitions are important because any group is a team if they choose to self-identify as such. He clearly affirms non-directive approaches to assisting clients, but then asserts many absolutes throughout the book, especially the focus on mandate and expanding options.

This is a 216-page book with fewer than 70 references, no footnotes, and a three-page index. It does not rise to the level of a research-based mono-

graph, and the team communication techniques appear to be relatively prosaic. For example, the author spends 11 pages listing a variety of sentence prompts for team use in brainstorming activities. If someone is looking for a “how-to” guide to improve team communication, this could be a place

to start, but I recommend instead the delightful *Facilitative Leadership in Social Work Practice* by Elizabeth M. Breshears and Roger Dean Volker. (Springer, 2013) which covers leadership theory, group dynamics, and social work ethics in more depth without sacrificing any of the practicality.

Book Review

Parrot, L. (2014). *Social Work and Poverty: A Critical Approach*. Bristol, United Kingdom: Policy Press.

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Journal of Social Work Values and Ethics, Volume 11, Number 2 (2014)
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Lester Parrot, who is Senior Lecturer at Keele University, has over 18 years of experience in both residential and field social work. He continues to teach, write and to explore the implications of social policy on social work practice, ethics and values.

In eight very readable, often passionate chapters, the author presents a compelling case for social workers to reconnect to the underlying bedrock of the profession and practice. “Why do you wish to be a social worker?” The inevitable reply, “I want to help people.” And Mr. Parrot seeks to generate a campaign to unite community and the profession in order to actively and realistically address poverty by focusing attention to the individual, the organization, as well as the social aspects of poverty. Advocacy is a powerful tool if it is honed to respond to crises rather than turn into a “social worker practice that has become increasingly tied to fulfilling managerial procedures that limit their professional judgment.” (p.140)

Although the focus is on social work and poverty in the United Kingdom, the history and events clearly will resonate with many who live in the United States. Beginning with poverty and social work in the historical context within the UK, the author re-counts how approaches to poverty were initially “communal,” but with the advent of industrial capitalism, approaches became more individualistic with a primary focus on self-help. A key to this focus of self-help was the establishment of the Society for Organizing Charitable Relief and Repressing Mendacity (COS, Charity Organization Society). COS sought to introduce scientific

principles to examine and evaluate the poor and then establish methods for helping them develop principles of independence and self-help.

As an example of policy leading to practice, through the establishment of COS the casework model was adopted as a promising practice. It was to be “scientific,” and thereby use established principles to examine and evaluate the poor. The caseworker was to be detached from personal or familiar entanglements with the poor in order to maintain objectivity. The caseworker would be a ‘role model’ and help the poor develop principles of independence and self-help. The underlying philosophy of this approach was “any help that was given should be temporary and reformatory to restore the applicant to independence.” (p.14) These ideas and principles had significant influence and spread throughout the UK, Australia and the United States where they retain some credibility and power even today.

The author provides an excellent overview of the concept of poverty, its definition and the major theoretical perspectives used to examine the cause(s) of poverty. He builds upon this consideration by then observing the service user perspective and the utility for social workers in better understanding the circumstance and events. For example, the role of language in communicating with people living in poverty can establish either useful dialogues or alienation between the service user and provider. One must recognize the power dimensions associated with language and the stigma that is attached to being poor.

As social work organizations respond to poverty in the United Kingdom, the author is critical of the influence of neo-liberalism on professional social work and suggests values and discretion are being undermined in a drive toward rational management. Consequently, the author suggests social workers must assess their organizations in terms of achieving social justice and seek to return to the original mission of the profession.

In each chapter, a case study is provided to illustrate the concepts and encourage further thought and debate. These are helpful for the student of social work as well as a useful refresher for prac-

tioners. The reader should understand this book provides a strong case for advocacy reform and action for the poor and as such, does not seek or promote parity. And while the focus may be on poverty and social work in the United Kingdom, the events, changing policies and implications for social work practice are equally insightful for social workers in the United States. Anyone with an interest in social welfare policies and programs should find this book worth their time and attention, especially given the current political environment in the UK and United States, which has aggressively sought to reduce resources to address the significance and growth of poverty.

Book Review

Nelson, T., & Winawer, H. (Eds.) (2014). *Critical Topics in Family Therapy: AFTA Monograph Series Highlights*. New York: Springer.

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Critical Topics in Family Therapy consists of chapters that evolved from essays in American Family Therapy Academy Monographs (AFTA) published between 2005 and 2011. It is the first in a planned series of volumes entitled *AFTA SpringerBriefs in Family Therapy*.

The volume is divided into six parts, addressing issues family issues in diverse contexts, including 1) families in war zones, 2) community practice, 3) natural disasters, 4) neuroscience and family therapy; 5) social justice, and 6) gender and sexuality issues. Contributors are primarily practitioners, including clinical psychologists, psychiatrists, counselors, social workers, and academics.

Strengths of this work are the variety of issues covered and coverage of unique topics not often addressed in the literature – for instance therapy involving erotic fantasy and “kinky sexuality.” Another strength is the book’s devotion to chapters concerning expanding the definition of “family” to include, same-sex couples and the inclusion of four chapters devoted to the linkage of clinical work to community practice, two fields of practice often considered virtually mutually exclusive.

The work is of particular interest to social workers engaged in clinical practice and social work educators teaching clinical practice. It would therefore be most appropriate for use in MSW-level advanced practice courses or electives focusing on preparing social work students for a career in clinical practice.

The editors of this work are Dr. Thorana S. Nelson and Ms. Hinda Winawer. Dr. Nelson is a faculty member in the Department of Family, Consumer, and Human Development at Utah State University, and is the author of numerous papers in the field of Family and Marriage Therapy.

Ms. Winawer holds the MSW degree and is a Licensed Clinical Social Worker and past president of AFTA (2011-2013). She is also co-founder and Executive Director of the Center for Family, Community, & Social Justice, Inc.