Journal of Social Work Values and Ethics, Spring 2009, Vol. 6, No. 1

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Editorial: Your Top 10 List

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

I have always found Internet technology a fascinating experience. Each time I become accustomed to the technology; new innovations emerge. The advantage of an online journal is the ability to count readers. I suspect that in the relatively new future, promotion and tenure committees will require this piece of information as part of faculty self-evaluations. For example, on resumés that I have been reviewing, I see a citation section. This is a listing of references where the author has been cited.

The following is a list of major articles published in the *Journal of Social Work Values and Ethics* (with the date of publication) and the number of times a reader has selected the article. Hot links are offered to enable the reader to review the piece of work.

Shown are the title, date published, and number of page impressions for the top ten articles.

Page Impression Statistics

Rank	Title	Hits
1	Professional Boundaries in Dual Relationships (2005-09-13 16:33:15)	32,695
2	Dual Relationship Legitimization and Client Self-Determination (2006-03-16 14:08:59)	25,185
3	I'm Still Standing: Impacts & Consequences of Ethical Dilemmas for Social Workers in Direct Practice (2005-03-15 15:20:59)	25,067
4	Ethical Decision-Making Among Hospital Social Workers (2006-03-16 13:55:33)	23,704
5	Ethical Dilemmas in Social Work with Right- Wing Youth Groups (2005-03-15 15:11:54)	22,119
6	Boundaries in Social Work: The Ethical Dilemma of Social Worker-Client Sexual Relationships (2004-09-08 16:19:20)	18,114
7	A Model for Ethical Decision-Making: The Context of Ethics (2006-03-16 13:51:43)	17,104
8	Social Workers and the Witness Role: Ethics, Laws, and Roles (2004-09-08 16:16:21)	15,997
9	Is Self-Determination Still Important? What Experienced Mental Health Social Workers Are Saying (2006-03-16 14:06:37)	13,921
10	A Comparative Study of Practitioners and Students in the Understanding of Sexual Ethics (2004-09-08 15:45:40)	13,921

Letters to the Editor

Letters to Steve Marson and Patricia Welch Saleeby

Hi, Steve and Trish:

Congratulations on the special issue of JSWVE. Julie Watkins and Ira Colby were excited to read the announcement [of the special issue on disabilities, for which CSWE's Council on Disability and Persons with Disabilities was the catalyst]. Thank you for all of your hard work!

Lisa Weidekamp, MSW
Research Associate
Council on Social Work Education

Dear Editors:

Ditto from me!! Great job!!!

Marcie Lazzari, PhD, ACSW, LSW
Professor & Founding Director, Social Work Program University of Washington Tacoma

A response to Spano and Koenig: Code of Duties or Ideological Club?

Paul Adams, Ph.D.
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Journal of Social Work Values and Ethics, Volume 6, Number 1 (2009)

Abstract
In rebuttal to Spano and Koenig (2008), the argument for an ideologically broad and inclusive interpretation of the NASW *Code of Ethics* is restated. The *Code of Ethics* defines duties in light of values, principles, and standards, but it is not a device for enforcing uniformity of belief.
Key words: *Code of Ethics*, orthodoxy, ideology, secularism, religion

Introduction

I am grateful to Professors Spano and Koenig (2008) for their recent clarifications in response to my critique of their contribution (2007) to this journal, "What is sacred when personal and professional values collide?" Here I will restrict my focus to the central question of how broadly or narrowly the NASW (1999) *Code of Ethics* should be interpreted and enforced. Should we view the *Code* as a list of duties and responsibilities with general statements of defining values and principles? To what extent does the *Code* go further and define an ideological club—whether in the sense of an ideologically exclusive association or of something with which to clobber those with unorthodox views within or aspiring to membership in the profession?

But I do want to assure Spano and Koenig (2008) that I have neither authority nor inclination to decide who is or is not a Christian. I preferred George's distinction between the two orthodoxies he defines as secularist and religious to Keith-Lucas's (1983) typology of Christians for three reasons. First, Keith-Lucas's typology differentiates among types of Christians, not between the Judeo-Christian tradition and the secularist orthodoxy that prevails in universities and social work.

Secondly the Keith-Lucas typology seemed *more* invidious than the decision to include the non-orthodox or theologically liberal in the same camp as secularists. Trying to apply the Keith-Lucas typology to myself, I wanted to answer "all of the above" rather than pick a type. The George

(2001) framework passes no judgments on Christians as Christians. (His whole point is that the orthodox position is superior on rational and non-religious grounds, leaving aside how religion may or may not inform the different orthodoxies.) It rests on the empirical observation that in the matters under dispute—those relating to life, death, and sex in the forms of abortion, euthanasia, embryonic stem cell research, same sex marriage, and so on—the theologically liberal routinely take the secularist side and make common cause with secular liberals against their orthodox co-religionists.

Finally, George (2001) makes the key point that the clash in question is not one between reason and faith, enlightenment and medieval darkness, but between two orthodoxies, one of which conceals even from itself its own status as an orthodoxy and presents itself simply as reason or common sense.

What is allowed?

Spano and Koenig (2008) conclude their case for a more restrictive understanding of the NASW *Code of Ethics* with this assertion: "If professionals are allowed to reinterpret the *Code* based on personal worldviews, there is no protection afforded clients, nor are there standards for care that can be expected when seeking services from members of the profession." Despite that menacing word "allowed," I concur with their emphasis on the power differentials implicit in the practice of this or any profession and their implications for an ethical code. Among other things, such codes hold professionals accountable for not abusing the rights and privileges of their professional status vis a vis clients (or supervisees, or students).

This is not an all-or-nothing matter. Spano and Koenig (2008) correctly note that "With privileges and the exercise of special rights inherent in professional status come certain responsibilities that govern and restrict behavior" and they give the example of having sex with clients. Of course, different professions allow or mandate behavior that would be forbidden to others, such as cutting open a client's body; but the prohibition of sex with clients applies generally and, as the authors say, is never acceptable.

Limits of authority

The authority of a profession is always limited by the scope of its professional knowledge and expertise, and different ethical codes reflect these differences. That authority does not extend to pronouncing on all political and social matters at issue in the society at large. This is a special

problem for social work in view of the difficulty we have in defining the scope and limits of our expertise and authority. The temptation, in policy and practice, is always to extend our mandate and claim special knowledge of (and authority to speak as professionals about) what is good for individuals and society. If social work has little to define it but an ideological consensus (aka values) about contested social issues, i.e., to the extent it is a political and social movement, its claims to professional status are correspondingly weak and hard to defend from attack. At the same time, to the extent social work is more movement than profession, to that extent it will tend to extend its authority and control with regard both to its members and its clients beyond any point justified by its specific knowledge, expertise, or legal mandate. The *Code of Ethics* then becomes a political platform rather than a code of duties.

It is precisely the power differential between instructors and students in social work education that has drawn attention to the Code's potential for misuse as a tool of ideological coercion. According to the National Association of Scholars (2007) study of ten major public universities, preemption of inquiry and coercion of conscience are endemic in social work education, not simply a matter of the excesses of a handful of over-enthusiastic secular- liberal professors. However, that may be, there is certainly a marked difference between the NASW *Code* and the codes of other professions in the extent to which ideologically fraught terms are used to emphasize the profession's commitment to advocacy for social change of particular kinds.

Marriage, abortion, and social justice

As I argued in my critique, those terms, like social justice, only become objectionably coercive in a professional code when they are interpreted narrowly. The positions that Spano and Koenig (2007) take to be implicit in a reasonable reading of the *Code,* on abortion or marriage, for example, are not required by the *Code* as published, nor compelling on other grounds. The authors rightly stress the profession's commitment to the weak, oppressed, and vulnerable. But a strong case can be made, on social-scientific as well as orthodox religious grounds, that it is precisely the destruction of the traditional and universal (until yesterday) understanding of marriage that has resulted in increases in child poverty, that leaves millions of poor individuals and families, minorities, women and children at increased risk of deteriorating income, assets, health, mental health, and safety (Amato, 2005; Amato & Keith, 1991; Center for Marriage and Families, 2005; Child Trends, 2006, 2007; Glenn, 2001; Lerman, 1996; National Fatherhood Initiative, 2004;

Sawhill, 2003; Waite & Gallagher, 2000). That near-universal understanding defines marriage, as Blankenhorn (2007) puts it, as "socially approved sexual intercourse between a woman and a man, conceived both as a personal relationship and as an institution, primarily such that any children resulting from the union are—and are understood by the society to be— emotionally, morally, practically, and legally affiliated with both of the parents" (p. 91).

The growing marriage gap between rich and poor, along with the extraordinary increases in out-of-wedlock births, cohabitation, and divorce in the last forty years among those of lower income, is a *class* divide that hurts those it is social work's self-proclaimed duty to advocate for and protect (Hymowitz, 2006). Indeed, all these developments, including same-sex marriage, that tend toward the destruction or deinstitutionalization of marriage may be seen as representing the subordination of the needs of children to the freedoms of adults (Marquardt, 2006).

To recognize this social reality is not to create exclusions from the benefits of marriage, as Spano and Koenig (2008) suggest. It is to acknowledge marriage as our most pro-child institution, and to see its undermining or hijacking in theory and practice as putting women and children at greater risk of almost all the social problems that social work aims to address. As Blankenhorn (2007) says, "Marriage does not exist in order to address the problem of sexual orientation or to reduce homophobia. Marriage does not exist in order to embody the principle of family diversity or to maximize adult choice in the area of procreation and childrearing" (p. 199). Once we lose the central focus and purpose of marriage in terms of giving children the right to be raised and supported by the two parents who made them, marriage itself is not extended to more people (same-sex couples, polyamorous groups, etc.) but deinstitutionalized. It is dissolved as a key social institution, as opposed to a private and personal arrangement among two or more adults, to the detriment above all of women and children, and those who are already disadvantaged and oppressed.

Similarly, treating abortion as a legal right deprives the most weak and defenseless of legal protection against being killed at the most vulnerable stage of their lives. None of us exists or can be the subject of any other rights except by surviving this life-stage. If social work is committed to the most vulnerable among us, it must surely advocate for solidarity with and legal protection for children prior to birth, as well as of babies who survive attempts to abort or who are in the process of birth. At least—and this is all I claimed—such a view is perfectly arguable within the

values and ethics of social work. The *Code* neither does nor should attempt to pre-empt the question by imposing secular-liberal orthodoxy on its members.

Conclusion

Like those we serve, social workers reflect the deep ideological divide in society captured in the phrase "culture war." We live in a pluralistic society where there is no consensus on the issues we have discussed in these exchanges. It may be true, as Pellegrino (2008) claims, that a profession by its very nature has the capacity to reach a higher level of agreement about the goods of the profession itself, of the good life, and the good society. But given the lack of consensus within the profession as in society at large, it is reasonable to err on the side of inclusion of minority opinions rather than use the prevailing construal of a professional code of ethics to discipline or exclude those who disagree with that interpretation.

No profession licensed and supported by the state may coerce the consciences of its members, expelling them, or keeping out those potential colleagues who disagree with the majority on the matters discussed here. We may outline, in a deontological code, duties both general (no sex with clients) and specific (matters of competence). What we may not do, in the language of the U.S. Supreme Court (1943), is "prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein."

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Response to Adams: Free speech and special responsibilities of the profession

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Abstract
The authors comment on Adams' latest response to their original article entitled, *What is sacred when personal and professional values collide?* (2007/2008). In their remarks, the authors reiterate principles outlined in the original manuscript and provide a critique of Adams' response entitled, *Code of ethics or ideological club?* Specifically, a guiding principle distinguishing personal and professional values is highlighted: all personal worldviews held by social workers must be mediated through the *Code of Ethics.* The authors express concern about Adams' inability (or unwillingness) to distinguish between free speech in the public square and the special responsibilities and benefits placed on the social work profession.
Key Words: Code of Ethics, free speech, professional responsibility, personal worldview

All personal worldviews must be mediated through the Code of Ethics

We wish to thank Professor Adams for his willingness to continue a dialogue around a broad range of issues that are embedded in our original article entitled, *What is sacred when personal and professional values collide?* (Spano & Koenig, 2007/2008) as well as in subsequent responses (Adams, 2008; Spano & Koenig, 2008). In the following remarks, we clarify our position on the salient points of the original article and respond to points of the critique provided by Adams (2009) in his latest response entitled, *Code of ethics or ideological club?*

Adams' responses continue to miss the point and principle that we believe is essential – all personal worldviews that social workers bring to the table must be mediated through an understanding of the NASW *Code of Ethics* (1999). He reacts to the exemplar of Christianity that we provide, but not to our stated principle. Thus, Adams argues for radical social work to be held to the same standard as orthodox (Evangelical) Christians. We agree and previously stated this position clearly in the abstract of the original paper. However, Adams sees our examples, which are currently being debated, as an attack on one side, rather than an illustration of the principle to

be applied across the ideological spectrum. For our purposes, a person's worldview may be drawn from many sources (e.g., religion, political science, sociology, psychology, parents, friends and Aunt Esther). No matter what the source, the translation of these ideas and values into action in one's professional life is open to examination and is the legitimate purview of the profession.

Adams accepts in his latest response that it is correct to place some limits on professionals' behavior (e.g., no sex with clients). If you accept the premise that clients are vulnerable and limits need to be placed on professional behavior, the question becomes "Who imposes those limits?" We purport that it is the larger profession that sets limits through an agreed upon code of ethics.

Ideology, professions, and orthodox Christianity

Adams argues that any restrictions placed on professionals' behaviors contribute to the development of an ideological club in which some are excluded from membership. We understand that every profession espouses a particular ideology or philosophy that combines knowledge with values and ethical principles. In essence, an ideology or philosophy undergirds all professions. For example, the medical profession does not allow physicians to engage in assisted suicide, as it runs counter to the ideology of its profession (e.g., values such as protection of life and use of knowledge regarding the means to end life). Attorneys must provide a vigorous defense for their client, whether or not the person committed a heinous act. No judgment based on the attorney's personal perspective is allowed to intrude on this professional responsibility. The profession of social work is no exception. Social workers cannot refuse to work with those who are Republican, pro-life, or considering an abortion, or who are members of the GLBT population. These refusals run counter to our profession's ideology (e.g., values such as self-determination and respect for diversity combined with knowledge of relational and problem-solving skills to assist clients in their decision making).

It is ironic that Adams refers to himself as "unorthodox" when describing his position within the social work profession. Indeed, Christian, Jewish, and other social work scholars (e.g., Keith-Lucas, 1972; Loewenberg, Dolgoff, & Harrington, 2009; and others) have described the professional importance of keeping "in check" strongly held personal and religious values so as not to pass judgment on clients that subsequently affect professional behavior. Professionals who refuse to serve clients based on personal values alone are viewed as unorthodox and based on our *Code,* are engaging in unethical behavior. As noted by social work ethics writers, these judgments,

combined with behaviors, violate clients' self-determination or undermine the respect due to them based on their status as human beings. Indeed, this type of behavior rooted in strong personal, religious beliefs is viewed as unethical within the profession of social work. What is even more ironic is that Adams states, "that I have neither the authority or inclination to decide who is or who is not a Christian." However, Adams substitutes George's assertion that only orthodox positions are Christian. All other expressions of Christianity are "thrown out" or put in the category of "secular."

Free speech and professional responsibilities

What does concern us deeply is Adams' inability (or unwillingness) to distinguish between free speech in the public square and the special responsibilities, benefits, and restrictions placed on any profession – including, but not limited to, social work. Adams referred to the National Association of Scholars' (NAS) study (2007) of ten major schools of social work. NAS expressed outrage at the fact that social work schools emphasize social justice as part of the profession's purpose. Their fundamental stance, which seems worthy of acknowledgement, is that there are different conceptions of social justice that need to be articulated in social work education. Otherwise, students are being brainwashed rather than educated. NAS takes a stance that any limit placed on the concept of social justice is an abridgement of free speech and free flow of ideas. We have no argument with this position when applied to liberal arts education.

However, schools of social work are preparing students to translate ideas into behavior directed toward some professional purpose, not to debate ideas in the abstract. Professional social work education can and should provide students with opposing frameworks for understanding social justice, but those ideas need to be evaluated based on professional purpose and our *Code of Ethics.* Therefore, if one conception of social justice (e.g., based on equity or equality) better promotes the well-being of populations that are the focus of professional concern, e.g., marginalized group of people based on race, gender, age, or sexual orientation, then, social workers must choose the one that is more useful than another to achieve the profession's stated purpose. To accept NAS' argument for free speech strips the context from the ideas. Hence, all ideas are somehow equal no matter what their consequences are for people in obtaining services from a profession.

Conceptualizing marriage, abortion, and poverty

Adams anchors his analysis of marriage, abortion, and poverty within the current patriarchal conceptual framework (which he fails to acknowledge). He discusses marriage as a protection for women and presumes women cannot make it on their own but must rely on the protection of men. Adams views abortion and poverty as outcomes of the erosion of marriage. We differ with his conceptualization and view this as a form of "context stripping." Larger social issues such as racism, sexism, homophobia, and ageism are causal factors that contribute to the problems identified by Adams. For example, the earnings of women and people of color continue to lag behind those of white men and contribute greatly to the poverty faced by women and children. Further, the lack of adequate and affordable child and health care for all human beings also contributes greatly to the poverty faced by women, children, and also men. The examples are not driven or linked to marital status. These are larger social issues whose roots run deeper than the personal, religious positions held by orthodox Christians about abortion and marriage. We agree with Adams that this is a "class" issue, but do not view it as attributable to the marriage gap between the rich and poor. Instead, broader social structural issues, within which families exist, are causal factors that shape their economic circumstances. Adams argues for preserving traditional marriage as a solution for abortion and poverty. How does this strategy address social and economic injustice driven by forces beyond the family?

Conclusion

Adams' concluding quote from the U. S. Supreme Court has no connection to our discussion about codes of ethics for professions. We have never taken the position that professionals cannot hold *personal views* on "politics, nationalism, religion or other matters of opinion or force citizens to confess by word or act their faith therein" (U. S. Supreme Court, 1943). This legal decision is about First Amendment rights for citizens. What we have argued is that in their *professional lives,* social workers must adhere to standards set by the profession and that if they fail to do so; they should be held accountable by their colleagues. Perhaps a more relevant citation, 1.06b Conflict of Interest (NASW *Code of Ethics,* 1999), better applies to this discussion: "Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political or business interests." When we recognize that all professional relationships are based on power imbalances between professionals and clients, then any intrusion of personal, religious, or political views on the part of the worker is a violation of

the *Code of Ethics.* Professional codes of ethics create frameworks that direct our professional actions. To suggest that we be allowed to do as we please with regard to imposing personal values on clients deconstructs the very notion of profession and creates real potential for harm to those for whom we have responsibility.

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Ethical Decision-Making in Social Work: Exploring Personal and Professional Values

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Journal of Social Work Values and Ethics, Volume 6, Number 1 (2009)

Abstract
Little systematic research appears to exist that explores the complex and essential process of ethical decision-making among social workers. This paper presents results of a study of NASW members that explored factors that relate to ethical decision-making, discrepancies in ethical decision-making, and rationales for courses of action chosen. Findings suggest that both personal and professional factors are related to ethical decision-making and predict the degree to which ethical decisions are discrepant.
Key words: Social Work Values, Ethics, Ethical Decision-Making, Diversity, Code of Ethics

Introduction

Questions of ethics and its relationship to human consciousness have been the focus of philosophical consideration for thousands of years and can be understood as encapsulating "traditions of belief that have evolved...in societies concerning right and wrong behavior" (Hopkins, 1997, p. 5). Modern professions incorporate the idea of ethics into practice by developing specialized codes of ethics to apply order and guide professional decision-making (Dolgoff, Loewenberg, & Harrington, 2005). In the United States, the National Association of

[1] The authors would like to acknowledge support from the University of Maryland, Baltimore, School of Social Work. The authors wish to thank Elizabeth Greeno, Ph.D., Donna Harrington, Ph.D., Anna Hayward, Anne K. Hughes, Kelli Larsen, Ph.D., JuYoung Park, & Karen L. Parker. Correspondence may be addressed to Otima Doyle, Ph.D., Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Box 3527, 718 Rutherford St., Durham, NC 27710 or otima.doyle@duke.edu.

Social Workers' (NASW) *Code of Ethics* (1999) is accepted as the primary ethical standard for the profession. The *Code of Ethics*' set of core values and the principles and standards developed on the basis of those values are designed to inform ethical decision-making. However, the *Code of Ethics* does not provide universal prescriptions for behavior, nor does it specify a hierarchy of values, ethical principles, or standards. This is likely due to the complex, context-bound nature of the process of ethical decision-making (NASW, 1999).

In America in particular, social work's ethical considerations have evolved to include ethical standards (Dolgoff et al., 2005), questions of risk management and quality of service delivery, and the need to satisfy funding agencies and regulatory bodies with demonstrated competence in practice (Strom-Gottfried, 2000). As social workers increasingly navigate community-based treatment modalities and participate in interdisciplinary teams in which each member might operate from a different service or treatment paradigm or from a different set of professional values, the frequency and intricacy of ethical dilemmas will likely increase (Hoy & Feigenbaum, 2005). Given the complexity of this topic, the current article focuses on values and ethical decision-making among social workers in the United States, although it is important to note that some social work values may transcend international boundaries (Abbott, 1999).

The social work profession's value base and its attendant ethical structure in the United States are built on a foundation characterized by mainstream cultural values (Abbott, 1988). These generally accepted "mainstream" values and moral traditions might serve to exclude culturally determined ethical standards of people from other backgrounds, whether they are social workers themselves or clients served by the profession. Respect for diversity, one of the profession's explicit values, applies to both social work professionals and clients (CSWE, 2002). Social workers, regardless of their own background, must incorporate a comprehensive understanding of each client's culture and values into their work (CSWE, 2002). They also need to be aware of the possible influence of their own beliefs and values on practice in ethically challenging situations (Csikai, 1999). Therefore, in addition to managing competing professional values social workers must also manage the influence of their own personal value systems while simultaneously considering their clients' values when making ethical decisions.

Despite the importance of the topic, there appears to be a paucity of research that explores the relationships between the multiplicity of factors that influence social workers' values and

ethical decision-making. Many articles that document factors related to how and why practitioners make ethical decisions are based on theoretical aspects of ethical decision- making (Mattison, 2000; Walz & Ritchie, 2000), descriptions of the types of ethical violations reported to NASW (Strom-Gottfried, 2000), or recommendations for future practices (Dolgoff et al., 2005; Hoy & Feigenbaum, 2005; Mattison, 2000). Given the limited empirical base in this area, as well as the complexity and importance of ethical decision- making for social work practice, it is critical to develop a greater understanding of the patterns of ethical decision-making as they relate to the diverse personal and professional characteristics of social workers themselves. Further, it is important to understand the rationales that social workers use to make such decisions. Do social workers base their decisions on the standards within the *Code of Ethics,* or are their decisions influenced by other factors?

Almost all of the issues faced by social workers are based in ethical principals (Dolgoff et al, 2005). Becoming aware of and being willing to acknowledge ethical dilemmas and their complexity, in practice, are important steps toward acquiring the skills to manage those ethical dilemmas (Dolgoff et al., 2005). However, it is suggested that some social workers may not acknowledge the ethical dilemmas that arise in practice for a variety of reasons. For example, they may be uncomfortable making ethical decisions, they may think they know the "right" answer to the ethical dilemma, or they may be uneasy dealing with such issues because they do not feel they have the skills to manage ethical problems (Dolgoff et al., 2005). Given these possibilities, it is also critical to develop an understanding of the personal and professional factors that influence discrepancies in the ethical decision-making process.

This paper presents findings from an empirical study that explored patterns of ethical decision-making and rationales for making those decisions among a national sample of NASW members. Findings are also presented regarding personal and professional factors that predict discrepancies between what practicing social workers reported they would do versus what they felt they should do when confronted with ethical dilemmas. This exploratory study focused on three research questions: 1) What personal and professional factors are related to social workers' courses of action when making ethical decisions? 2) What rationales do social workers use to make ethical decisions? and 3) What personal and professional factors are related to discrepancies in ethical decision-making among social workers? After an extensive review of the literature, it

appears that no social work specific theoretical model describing what factors impact upon ethical decision-making exists. As such, a theoretical model from the business literature (Hopkins, 1997) was adapted, incorporating relevant factors supported by the social work literature and used as a guiding framework for this study.

Literature Review

Ethics are distinct from values, although the terms are often used interchangeably, and the concepts are inextricably linked. For the purposes of this paper, that distinction is a key consideration, and the relationship between the two, particularly the direct influence values have on the development of ethical standards (Boland, 2006; Csikai, 1999), is essential. The notion that personal and professional values are integral to the ethical decision-making process is strongly supported by the conceptual and theoretical literature on the topic (Abramson, 1996; Dolgoff et al., 2005; Freud & Krug, 2002; Hopkins, 1997; Mattison, 2000; Pike, 1996; Reamer, 1998). However, there is a limited body of research that explores the relationship between values and ethical decision-making in social work. Some suggest that personal rather than professional codes for behavior are more likely to influence the resolution of ethical decisions (Canda & Furman, 1999; Haynes, 1999; Smith, McGuire, Abbott & Blau, 1991). Study findings suggest that the *Code of Ethics* does not serve as the primary basis for ethical decision-making but that practice wisdom, personal values (Dolgoff & Skolnik, 1996), and supervision (Landau, 1999b) are key resources that inform decision- making. In a study of ethical decision-making in a related field, researchers concluded that psychologists utilized formal rules and codes of ethics when considering what one should do when presented with an ethical dilemma. However, they relied on personal values and practical considerations in order to determine what they would actually do given the same situation (Smith et al., 1991).

From this perspective, questions regarding the source(s) of personal values become relevant considerations. It is commonly believed that people from different backgrounds will have different perspectives about how to behave in different situations. The influence of one's culture on one's personal values and ethics (Hopkins, 1997) has been supported by others in the social work field who note that values influence ethical decision-making (Boland, 2006; Csikai, 1999).

Because "there are as many different ethical...standards as there are different cultures" (Hopkins, 1997, p. 16), it is important to identify personal factors that may relate to differences in

values, and in turn, discrepancies in ethical decision-making. Hopkins identifies several major demographic factors related to human diversity. These categories go beyond racial, cultural, and religious contexts to include age, gender, spirituality, language, disability, sexuality, and geography. There are a number of ways that each category can be explored to identify differences in people's value systems. For example, culture might be explored through the examination of race, ethnicity, nationality, or color. Several factors identified by Hopkins are also noted in the social work literature as having an influence on one's values and ethics. They are: culture/ethnicity, gender, and religion/spirituality. The empirical literature in these areas is discussed below.

Personal Factors and Ethical Decision-Making

Culture/Ethnicity

The majority of articles included in this review largely focused on Caucasian respondents, and articles that addressed culture approached the topic from different perspectives (e.g., race, ethnicity). Empirical evidence exists within the social work literature suggesting that race has a bearing on the degree to which social work values can be considered universally accepted (Abbott, 1999). Examining issues specific to hospital social work, Csikai (1999) found that cultural beliefs tended to be negatively correlated with attitudes toward the legalization of euthanasia and assisted suicide. However, Perkins, Hudson, Gray, and Stewart's (1998) study involving community mental health providers did not find significant relationships between ethnicity and the tendency towards making conservative decisions in ethically challenging situations.

Religion/Spirituality

Though some argue that religion is incompatible with the mission of social work (Miller, 2001) there has been increased interest in, and emphasis on, religion and spirituality in the social work field over approximately the last decade (Canda & Furman, 1999). Religion and/or spirituality are likely to present themselves in practice when dealing with a multitude of issues such as terminal illness, bereavement, aging, difficult family relations, foster parenting, domestic violence, natural disaster, mental illness, and poverty (Canda & Furman, 1999; Dudley & Helfgott, 1990; Hodge, 2005; Miller, 2001). Findings from empirical research demonstrate that many social workers value religion and spirituality in their own lives and are incorporating both in their practice (Canda & Furman, 1999; Miller, 2001; Sheridan, Bullis, Adcock, Berlin, & Miller, 1992). Further research has demonstrated that graduate students in an NASW sample were highly motivated by

their own religious belief systems (Hodge, 2005). Csikai (1999) found that both personal (religious and cultural) and professional values impacted upon social workers' attitudes toward morally and ethically charged issues. Specifically, religious beliefs among social workers have been found to be negatively associated with attitudes related to euthanasia and assisted suicide (Csikai, 1999). With regard to ethical judgment, Landau (1999a) found that those who perceived themselves as religious appeared to assign greater importance to moral considerations than those who perceived themselves to be non-religious.

Gender

A number of the articles included in this review did not explicitly explore differences related to gender in their studies. Haas et al. (1988) reported moderate gender effects on patterns found between courses of action respondents selected and the rationale used to support those decisions. However, in their study of community mental health providers Perkins et al. (1998) did not find gender to be significantly related to conservative ethical decision- making.

Professional Factors and Ethical Decision-Making

Social workers are expected to critically examine ethical issues in order to come to a resolution that is consistent with social work values and ethical principles and to thereby minimize unethical behavior. In order to assist students and practitioners, various process models have been suggested to guide ethical decision-making (e.g., Abramson, 1996; Dolgoff et al., 2005; Linzer, 1999; Linzer, 2004; Manning, 1997; Mattison, 2000; Reisch, & Lowe, 2000; Spano & Koenig, 2003). These models are thought to assist in the application of social work values in the decision-making process. In addition, the social work literature focuses on several factors that are thought to minimize unethical decisions. These include the years of experience one has in the field, exposure to formal and informal ethics training, the degree to which one identifies with social work values, and one's level of social work education.

Social work education

There is an implicit assumption that incorporating ethics content in the curriculum will affect the attitudes and behaviors of future social workers. However, few empirical studies have challenged this assumption (Dolgoff et al., 2005). Some posit that "students understand the professional in terms of the personal" (Haynes, 1999, p. 41), and others suggest that learning about

values and ethics may not result in the incorporation of those ethics into decision-making (Dolgoff et al., 2005; Haynes, 1999).

Landau (1999a) explored the impact of professional socialization and a variety of demographic variables on both ethical judgment and ethical decision-making. Her findings suggest that although social work education plays a key role in the acquisition of social work values, professional socialization does not affect ethical judgment and does not appear to directly support the use of a process of ethical decision-making. Another study indicates that although BSW students and faculty can recognize ethical dilemmas and identify conflicting values, they are not proficient with regard to proposing resolutions to ethical dilemmas (Wesley, 2002). There is some support for the notion that one's level of education relates to ethical attitudes. More specifically, master's level social work students were reported as more likely to agree with the legalization of assisted suicide and euthanasia than bachelor's level students (Csikai, 1999).

Formal and informal ethics training

Studies exploring ethical decision-making among psychology students have not found significant relationships between formal and informal ethics training and ethical decision- making (Haas et al., 1988; Perkins et al., 1998). However, findings from social work research suggest that whether or not one has had ethics training influences one's ethical attitudes (Csikai, 1999) and ethical decision-making (Boland, 2006) in particular for hospital social workers. Specifically, Csikai found that attitudes toward the legalization of assisted suicide differed significantly in relationship to whether or not hospital social workers had received formal ethics training. Boland found that prior ethics training was identified as the only significant predictor of the use of a decision-making process when hospital social workers confronted ethical dilemmas.

Years of experience

Haas and colleagues (1988) found that respondents with fewer years of experience seemed to be more inclined to choose to report or confront an offending party in an ethical dilemma than were those with more years of experience. In addition, Perkins and colleagues (1998) found that those who had longer tenure at an agency tended to make fewer conservative decisions regarding boundary related ethical dilemmas. However, they did not find the same association between experience and conservative decision-making. Another study found that as social work experience increased, so too did the likelihood that social workers agreed to participate in either euthanasia or

assisted suicide (Csikai, 1999). However, Boland (2006) did not find a significant relationship between years of experience, in either social work or hospital social work, and the use of a process for making ethical decisions.

Social work values

The social work literature is characterized by mixed findings with regard to social work students' adherence to the professional values base. Some findings support the idea that students' adherence to social work values increases over time (Abbott, 1988; Frans & Moran, 1993), whereas others either indicate no change over time, or change that was not in a desirable direction (Enoch, 1989; Manzo & Ross-Gordon, 1990; Wodarski, Pippin, & Daniels, 1988). However few studies were located that examine the relationship between social work values and ethical decision-making. Boland (2006) explored the degree to which health care social workers can identify an ethical dilemma, provide a rationale for a decision made, and follow a process to resolve the identified dilemma. No significant relationship was found between social work values and the ability to identify an ethical dilemma. Findings do suggest however that internalized social work values are related to the use of a higher order rationale process for identifying ethical dilemmas. Csikai (1999), in a study designed to examine the impact of personal and professional values on the ethical attitudes of hospital social workers found that professional values (self-determination and social justice) were positively correlated with willingness to participate in euthanasia or assisted suicide.

Summarizing the Literature: A Model for Exploration

Taken together, the literature provides support for the exploration of patterns in ethical decision-making among social workers, as well as identifies both personal and professional factors that may either minimize or increase discrepancies in ethical decision-making. The combination of personal and professional factors represents an adaptation of Hopkins' model in two ways. First the model is modified to include only those personal factors available in our dataset that are both identified by Hopkins' model and supported by the social work literature and are thought to relate to differences in values and in turn, discrepancies in ethical decision-making. Second, the model is expanded to incorporate social work factors that are thought to minimize discrepancies in ethical decision-making. Specifically, the literature provides support based upon theory and prior research

that the following variables are potentially related to ethical decision-making among social workers: ethnicity, religion, gender, social work education, ethics training, and social work values.

Method

Participants

Participant demographics are consistent with the general population of licensed social workers (NASW, 2006). The sample is comprised of primarily white (88.3%) women (80.5%) with a mean age of 49.5 years (SD = 14.39, range = 20 to 85 years) who have been practicing on average for 18.82 years (SD = 12.32 years, range from 0 to 53 years) and work primarily in direct practice (68.7%) in the areas of mental health (43%) and child welfare/family (10.3%). In addition, the majority of respondents hold a master's degree (84.2%), are licensed social workers (85.8%), and have had formal ethics training (82.1%).

Procedure

As a part of a larger collaborative project, the research team developed a survey that included demographic questions, an adapted version of the Professional Opinion Scale (Abbott, 1988), and an adapted version of the vignette-based Ethical Choice Score Rating System (Smith et al., 1991). The survey was pilot tested with 30 social work practitioners and students. Modifications were made and the survey was distributed following procedures approved by the University Institutional Review Board. Five hundred and one individuals were randomly selected using a random number generator from a sample of 2005-2006 NASW members. This national sampling frame was selected because of its potential to capture a broad range of practitioners, both clinical and non-clinical in orientation.

Participants received four mailings between January and March 2006 following a modified Dillman (2000) approach to increase response rate. Materials sent to eight individuals were returned by the postal service marked "return to sender" with no forwarding address, leaving a final sample of 493. Two hundred thirty-four respondents returned a completed survey by June 30, 2006, and six declined to participate in the study, yielding a response rate of 47.5%.

Measures

The survey contained a series of demographic questions about personal and professional characteristics and two standardized measures. Questions regarding personal characteristics included demographic questions such as, age, gender, race/ethnicity, religious affiliation, and

household income. Some of these demographic variables were converted to dummy variables based upon patterns in the overall sample, as well as the requirements of particular analyses. For example, the following variables were created for religion: Catholic, Jewish, and Protestant. Additionally, due to the limited racial/ethnic variability in the sample, the variable "minority" was created to incorporate all participants who identified themselves as racial or ethnic minorities (e.g., African American, Spanish, and so forth). Though this delineation does not capture the differences between the cultures in each category, it provides a starting point from which to explore the relationship between ethnicity and ethical decision-making. Questions related to professional characteristics included years of professional experience, educational degrees obtained, and whether or not participants had engaged in formal ethics training.

Social work values

The Professional Opinion Scale (POS) (Abbott, 1988) was utilized for this study because it assesses social workers' commitment to social work values (Abbott, 1999). An adapted version of the 40-item POS (Abbott, 1988) was used (Alpha = .86) (for more information, see Greeno et. al, 2007). Questions are designed on a five-point Likert scale ("1" = strongly agree to "5" = strongly disagree) with higher scores corresponding to greater commitment to social work values and lower scores corresponding to lesser commitment to social work values (Abbott, 1988). The scoring procedures for this study followed Abbott (2003), Boland (2006), and Greeno et al. (2007).

Ethical decision-making

The Ethical Choice Score Rating System (ECSRS) is a modified form of the 10-question vignette measure first developed by Haas et al. (1988) and then modified by Smith et al. (1991). Further modifications were made to Smith and colleagues' (1991) measure for the purposes of this research in an attempt to better capture the broad range of social work practice. This resulted in an adapted measure consisting of six vignettes addressing both macro and clinical issues. The measure asked respondents to read each vignette containing an ethical dilemma and then to answer four questions using the response choices provided: (a) what the respondent would do in the situation described, (b) the associated rationale choice, (c) what the respondent thinks he/she should do in that situation, and d) the associated rationale choice. Rationale choices included: (a) upholding the law, (b) upholding the *Code of Ethics*, (c) unable to identify a specific reason/it feels right (intuition), (d) upholding personal moral values/standards, (e) financial need, (f) fear of

reprisal (e.g. malpractice suit), (g) fear of verbal/social reprisal from supervisor, colleague, or client, and (h) protection of personal/professional reputation (adapted from Smith et al., 1991).

Each research question captured specific aspects of this measure for its corresponding analysis. The first research question focused on the courses of action that respondents indicated they "would" and "should" take given the scenarios in the vignettes. For the second research question, the relationship between these answers and rationale choices was explored. The original eight rationale choices were condensed into two categories representing "codified" or rule-based options (e.g., upholding the law or *Code of Ethics*) and "non-codified" options (e.g., "it just feels right") following the model used by Haas and colleagues (1988) (see Appendix 1). For the third question, a difference score was calculated according to the number of times that the respondent selected a different answer for their "would" and "should" response across the six vignettes, thus representing a discrepancy between what the respondents reported they would do in the given situation versus what they felt they should do in the same situation.

Data Analysis

All survey responses were entered into a database in SPSS® version 11.0.1 (SPSS Inc., 2001). Descriptive statistics were used to gather sample demographics and to determine frequencies, means, and standard deviations where relevant for each of the study variables. To answer the first question, "What personal and professional factors are related to social workers' courses of action when making ethical decisions?" chi square analyses and a MANOVA were conducted to examine the relationships between social workers' demographic characteristics and their selected courses of action for both would and should responses. In order to answer the second question, "What rationales do social workers use to make ethical decisions?" chi-square analyses and a MANOVA were conducted to examine the relationships between the respondents' courses of action and their rationale choices. In order to answer the third question, "What personal and professional factors are related to discrepancies in ethical decision-making among social workers?" multiple regression was utilized to examine which factors were related to higher or lower discrepancy scores on the ECSRS. Predictors included formal training, years of experience, highest degree, minority status (0 = non- minority, 1 = minority), Catholic (0 = other religions, 1 = Catholic), Protestant (0 = other religions, 1 = Protestant), Jewish (0 = other religions, 1 = Jewish), spirituality, and POS score. Following Stevens (2002), the sample size: predictor ratio was within

reasonable limits (n = 201 with 10 predictors) for the regression analysis. Because of the exploratory nature of this research question, an alpha level of 0.10 was used (Cohen, Cohen, West & Aiken, 2003). Assumptions were checked and adequately met.

Results

The vignettes were examined in order to identify patterns in decision-making and whether those patterns were related to codified or non-codified responses. Due to the complexity of the data, and the relatedness of research questions one and two, results for both of these questions are integrated in this section of the manuscript. The vignettes are presented sequentially and organized in the following manner: (a) a brief summary of the vignette, (b) a discussion of significant relationships between the demographics and the corresponding courses of action for both "would" and "should" responses, (c) a table depicting the significant findings reported in "b" above (where applicable), (d) a discussion of any significant relationships between the courses of action and the rationale choices for both "would" and "should" responses, and (e) a table depicting the significant findings reported in "d" above (where applicable). In some instances, near significant findings of interest are also presented.

Vignette 1 (Referral/Do Not Respect Coworker)

Vignette 1 presented (table 1) the following scenario: as a therapist you are asked by the Clinical Director to refer a client to a therapist whose ability you do not respect. The three courses of action offered to the respondent were: a) refer the patient, b) refer the patient and indicate your reservations, and c) refuse to refer the patient.

Demographics and course of action

Only commitment to social work values was related to how individuals felt they would respond (F = 3.274, p = 0.04). Though the relationship only approached significance (p = 0.054), it appeared that those with greater commitment to social work values selected option "C" (refuse to refer the patient) (M = 4.065) versus "B" (refer the patient and indicate your reservations) (M = 3.942).

Table 1. Significant relationships between demographic variables and course of action for Vignette 1 *(Referral/Do Not Respect Coworker)*.

	A Refer the Patient	B Refer the Patient and Indicate Reservations	C Refuse to Refer the Patient to that therapist
Would response choices			
Commitment to SW Values*		Lesser Commitment	Greater Commitment
Should response choice			
Ethnicity		Minority	Non-Minority
Commitment to SW Values*		Lesser Commitment	Greater Commitment

Note. * The overall F test for the ANOVA was significant. However, post-hoc analyses did not yield any significant relationships between the individual items and the respondents' POS scores.

Both ethnicity (χ^2 = 10.744, p = 0.005) and commitment to social work values (F = 3.244, p = 0.041) were related to what individuals felt they should do. Minority respondents selected option "B" (refer the patient and indicate your reservations), whereas non-minority respondents selected option "C" (refuse to refer the patient). As before, commitment to social work values showed a relationship that only approached significance (p = 0.071): those with lesser commitment to social work values (M = 3.942) selected option "B" (refer the patient and indicate your reservations) and those with greater commitment to social work values (M = 4.069) selected option "C" (refuse to refer the patient).

Course of action and rationales

No significant relationships were found between response choices and codified or non-codified rationale choices for either "would" or "should" questions.

Vignette 2 (Sexual Misconduct)

Vignette 2 presented the following scenario: a client tells you that a previous therapist made sexual advances toward her. This is the third client from whom you have heard such allegations. The four courses of action offered to the respondent were: a) call ethics committee/state licensing board, b) tell patient she has right to contact ethics committee or state licensing board, c) call the previous therapist about the violation, and d) discuss the patient's anger but not the issue of professional standards.

Table 2. Significant relationships between demographic variables and course of action for Vignette 2 *(Sexual Misconduct)*.

	A Call ethics committee/state licensing board	B Tell patient she has right to contact ethics committee or state licensing board	C Call previous therapist about violation	D Discuss patient's anger but not the issue of professional standards
Would response choices				
	--	--	--	--
Should response choice				
Jewish	Jewish	Non-Jewish	--	--

Demographics and course of action

Table 3. Significant relationships between course of action and rationale choices in Vignette 2 *(Sexual Misconduct)*.

	A Call ethics committee/state licensing board	B Tell patient she has right to contact ethics committee or state licensing board	C Call previous therapist about violation	D Discuss patient's anger but not the issue of professional standards
Would response choices				
Rationale Choice	Codified	Non-Codified	--	Non-Codified
Should response choice				
Rationale Choice	Codified	--	--	Non-Codified

None of the demographics were significantly related to how individuals felt they would respond to the scenario. Being Jewish (χ^2= 11.670, p = 0.009) was related to what individuals felt they should do. Jewish individuals tended to select option "A" (call ethics committee/state licensing board) whereas non-Jewish individuals selected option "B" (tell patient she has right to contact ethics committee or state licensing board).

Course of action and rationales

For the "would" response patterns in this vignette, those respondents who chose option "A" (call ethics committee/state licensing board) tended to do so based upon codified rationale choices, and those who chose options "B" (tell patient she has right to contact ethics committee or state licensing board) and "D" (discuss the patient's anger but not the issue of professional standards) tended to do so based on non-codified rationale choices (χ^2 = 14.186, p = 0.003).

In terms of "should" response patterns, those who chose option "A" (call ethics committee/state licensing board) tended to do so based upon codified rationale choices, and those who chose "D" (discuss the patient's anger but not the issue of professional standards) tended to do so based upon non-codified rationale choices (χ^2= 9.296, p = 0.026).

Vignette 3 (Referral/Funding Cut)

Vignette 3 presented the following scenario: funding has been cut for a drug treatment center and, as executive director, you have been asked to decide which clients will be served. The four courses of action offered were: a) discharge/refer based on own judgment, b) advocate for additional funding, c) take no action, and d) hold staff meeting to discuss discharges and/or referrals.

Table 4. Significant relationships between demographic variables and course of action for Vignette 3 (Referral/Funding Cut).

	A Discharge/refer based on own judgment	B Advocate for additional funding	C Take no action	D Hold staff meeting to discuss discharges and/or referrals
Would response choices				
Education	--	Bachelor's	--	Master's
Commitment to SW Values	--	Greater Commitment	--	Lesser Commitment
Jewish	Non-Jewish	Non-Jewish	--	Jewish
Should response choice				
Education	--	Bachelor's	--	Master's / PhD's
Formal Training	--	Yes	--	No

Demographics and course of action

Education level (χ^2= 18.757, p = 0.027), commitment to social work values (F = 8.826, p < 0.0005), and being Jewish (χ^2 = 8.263, p = 0.041) were related to how individuals felt they would respond to the scenario. Having a bachelor's degree, a greater commitment to social work values (M = 4.122) and being non-Jewish were related to choosing option "B" (advocate for additional funding). Having a master's degree, a lesser commitment to social work values (M = 3.933) and being Jewish were related to choosing option "D" (hold staff meeting to discuss discharges and/or referrals). Being non-Jewish was also related to choosing option "A" (discharge/refer based on own judgment).

Both education level (χ^2 = 18.973, p = 0.025) and having had formal ethics training (χ^2 = 8.068, p = 0.045) were related to what individuals felt they should do. Those with bachelor's degrees tended to select "B" (advocate for additional funding) whereas those with master's and Ph.D. degrees tended to select "D" (hold staff meeting to discuss discharges and/or referrals). Those with formal training tended to select "B" (advocate for additional funding) and those without tended to select "D" (hold staff meeting to discuss discharges and/or referrals).

Table 5. Significant relationships between course of action and rationale choices in Vignette 3 (Referral/Funding Cut).

	A Discharge/refer based on own judgment	B Advocate for additional funding	C Take no action	D Hold staff meeting to discuss discharges and/or referrals
Would response choices				
Rationale Choice	Codified	Codified	Non-Codified	Non-Codified
Should response choice				
Rationale Choice	Codified	Codified	--	Non-Codified

Course of action and rationales

For the "would" response patterns, those who chose options "A" (discharge/refer based on own judgment) and "B" (advocate for additional funding) tended to do so based on codified rationales, and those who chose "C" (take no action) and "D" (hold staff meeting to discuss discharges and/or referrals) tended to do so based upon non-codified rationales. (χ^2 = 17.785, p < 0.0005).

In terms of the "should" response patterns, those who chose "A" (discharge/refer based on own judgment) and "B" (advocate for additional funding) also made those selections on the basis of codified rationales and those who chose "D" (hold staff meeting to discuss discharges and/or referrals) based their decisions upon non-codified rationales (χ^2 = 11.482, p = 0.009).

Vignette 4 (Immigration Status and Petty Crime)

In sum Vignette 4 presented the following scenario: a refugee resettlement center providing emergency services has been turning a blind eye to the immigration status of clients. The case worker comes to you (Program Manager) regarding an illegal immigrant who may have committed a petty crime. The four courses of action offered were: a) take no action, b) inform the Executive

Director of the situation, c) contact appropriate officials, and d) direct the case worker to address the issue.

Table 6. Significant relationships between demographic variables and course of action in Vignette 4(*Immigration Status and Petty Crime*).

	A	B	C	D
	Take no action	Inform Executive Director of issue	Contact appropriate officials	Direct case worker to address issue
Would response choices				
	--	--	--	--
Should response choice				
Education	--	Bachelor's	Master's	PhD

Demographics and course of action

None of the demographics were significantly related to how individuals felt they would respond to the scenario. Education level (χ^2 = 17.521, p = 0.041) was related to what individuals felt they should do. Those with bachelor's degrees tended to select "B" (inform the executive director of the situation), those with master's degrees tended to select "C" (contact appropriate officials), and those with Ph.D.'s tended to select "D" (direct the case worker to address the issue).

Course of action and rationale

Table 7. Significant relationships between course of action and rationale choices in Vignette 4 (*Immigration Status and Petty Crime*).

	A	B	C	D
	Take no action	Inform Executive Director of issue	Contact appropriate officials	Direct case worker to address issue
Would response choices				
Rationale Choice	Non-Codified	Codified	Codified	Non-Codified
Should response choice				
Rationale Choice	Non-Codified	Non-Codified	Codified	Non-Codified

For the "would" response patterns, those who chose option "B" and "C" tended to do so based upon codified rationales, and those who chose options "A" (take no action) and "D" (direct the case worker to address the issue) tended to do so based upon non-codified rationales (χ^2 = 21.142, p < 0.0005). In terms of "should" response patterns, those who chose option "C" (contact appropriate officials) tended to do so based upon codified rationales and those who chose "A," (take no action) "B" (inform the executive director of the situation), and "D" (direct the case worker to address the issue) tended to do so based upon non-codified rationales (χ^2 = 16.694, p = 0.001).

Vignette 5 (Duty to Warn)

Table 8. Significant relationships between demographic variables and course of action in Vignette 5 *(Duty to Warn)*.

	A Plan to discuss further at next session	B Contact girlfriend and/or police without informing him	C Inform him that you must warn girlfriend and/or police
Would response choices			
Gender		Males	Females
Should response choice			
Gender		Males	Females
Ethnicity		Minority	Non-Minority
Jewish		No	Yes

Vignette 5 presented the following scenario: you are a therapist for a Vietnam veteran with a history of impulsive antisocial actions who discloses that he is planning to kill his current girlfriend because she is dating another man. No significant relationships were found between demographics and course of action for option "A" (discuss this further at the next session). The other two response options for this vignette are described in the findings below.

Demographics and course of action

Gender (χ^2 = 6.919, p =0.031) was significantly related to how respondents felt they would respond to the scenario. Males were more likely to select "B" (contact his girlfriend and/or the police without informing him) and females were more likely to select "C" (inform him that you must warn his girlfriend and/or the police). Gender (χ^2= 7.517, p = 0.023), ethnicity (χ^2 = 10.580, p = 0.005), and being Jewish (χ^2 = 10.409, p = 0.005) were related to how individuals felt they should respond to the scenario. Males, minorities, and non-Jewish respondents were more likely to select choice "B" (contact his girlfriend and/or the police without informing him). Females, non-minority respondents and Jewish respondents were more likely to select "C" (inform him that you must warn his girlfriend and/or the police).

Course of action and rationales

No relationship was found between response choice and codified or non-codified rationale choices for either "would" or "should" responses.

Table 9. Significant relationships between demographic variables and course of action in Vignette 6 *(Diagnosis)*.

	A	B	C
	Do not inform him of risks; give him a much "milder" diagnosis	Do not inform him of risks; diagnose as indicated	Inform him of risks; diagnose as indicated
Would response choices			
Formal Training	--	No	Yes
Should response choice			
Formal Training	--	No	Yes
Jewish	--	Jewish	Non-Jewish

Table 10. Significant relationships between course of action and associated rationale choices in Vignette 6*(Diagnosis)*.

	A	B	C
	Do not inform him of risks; give him a much "milder" diagnosis	Do not inform him of risks; diagnose as indicated	Inform him of risks; diagnose as indicated
Would response choices			
Rationale Choice	Non-Codified	Non-Codified	Codified
Should response choice			
Rationale Choice	Non-Codified	Non-Codified	Codified

Vignette 6 (Diagnosis)

Vignette 6 presented the following scenario: you are a worker in an emergency room of a community mental health center about to admit a man best diagnosed as paranoid schizophrenic – you are weighing risks of diagnosing him as schizophrenic, including his potential resistance to hospitalization. The three courses of action offered were: a) do not inform him of risks; give a "milder" diagnosis, b) do not inform him of risks; diagnose as indicated, and c) inform him of risks; diagnose as indicated.

Demographics and course of action

Formal training (χ^2 = 13.664, p = 0.001) was significantly related to how individuals felt they would respond to the scenario. Those with formal training tended to select "C" (inform him of risks; diagnose as indicated) and those without tended to select "B" (do not inform him of risks; diagnose as indicated). Formal training (χ^2 = 18.397, p < 0.005) and being Jewish (χ^2 = 5.996, p = 0.05) was related to what individuals felt they should do. Those with formal training and those who were non-Jewish tended to select "C" (inform him of risks; diagnose as indicated). Those without formal training and those who were Jewish tended to select "B" (do not inform him of risks; diagnose as indicated).

Course of action and rationales

For "would" response patterns, those who chose option "C" tended to do so based upon codified rationales and those who chose "A" (do not inform him of risks; give a "milder" diagnosis)

and "B" (do not inform him of risks; diagnose as indicated) tended to do so based upon non-codified rationales ($\chi^2 = 6.949$, $p = 0.031$). For "should" response patterns, those who chose option "C" (inform him of risks; diagnose as indicated) tended to do so based upon codified rationales and those who chose "A" (do not inform him of risks; give a "milder" diagnosis) and "B" (do not inform him of risks; diagnose as indicated) tended to do so based upon non-codified rationales ($\chi^2 = 45.191$, $p < 0.0005$).

Predictors of Discrepancy Between Would and Should Courses of Action

The overall multiple regression model was significant ($F = 1.726$, $p = .077$) and accounted for 8.3% of the variance of "would/should" discrepancy scores. Years of experience, highest degree, Catholic, Protestant, Jewish, gender, and spirituality were not significant predictors of discrepancies in ethical decision-making. However formal training ($B = -0.224$, $p = 0.094$), ethnicity ($B = 0.225$, $p = 0.1$), and commitment to social work values ($B = -0.286$, $p = 0.045$) were significant predictors (see Table 11). The mean score on the POS was 4.03 on a five-point scale, with higher scores representing greater commitment to social work values. Minority status was not related to whether or not one had received formal training ($p = 0.827$), nor was it related to the respondents' scores on the POS ($p = 0.186$). These results indicate that having formal ethics training and a greater commitment to social work values are associated with fewer discrepancies between respondents would and should choices, whereas minority status is associated with a greater number of differences.

Table 11. Summary of Regression for Variables Predicting Differences Between Would and Should Choices (N = 201).

Variable	*B*	*SE B*	*β*	*t*	*p*
Formal Training	-0.224	0.133	-0.124	-1.685	0.094
Years of Experience	-0.006	0.004	-0.108	-1.367	0.173
Highest Degree	0.166	0.115	0.109	1.434	0.153
Gender	-0.040	0.124	-0.023	-0.321	0.748
Minority	0.255	0.154	0.119	1.655	0.100
Catholic	-0.038	0.136	-0.021	-0.281	0.779
Protestant	0.008	0.116	0.006	0.072	0.942
Jewish	-0.167	0.173	-0.073	-0.966	0.335
Spirituality	-0.023	0.043	-0.039	0.529	0.597
POS Score	-0.286	0.142	-0.146	-2.014	0.045

Discussion

The first question this exploratory study sought to answer was, "What personal and professional factors are related to social workers' courses of action when making ethical decisions?" The analyses of the data suggest that both personal and professional factors are related

to ethical decision-making among social workers. Personal demographic factors were related to course of action for would and/or should responses in most vignettes, including vignettes 1) referral/do not respect co-worker dilemma), 2) sexual misconduct dilemma, 3) referral/funding cut dilemma, 5) duty to warn dilemma, and 6) diagnosis dilemma. Personal factors that were related to these vignettes included ethnicity, religion (being Jewish or non- Jewish), and gender. Vignette 5 (duty to warn dilemma) was the only vignette that showed significant relationships between all three of the above-mentioned demographic factors and the courses of action selected. Differences in courses of action seemed to relate to whether or not the responding social workers would inform the patient of their duty to warn the girlfriend/police prior to the notification.

Professional factors were also related to course of action for would and/or should responses in most vignettes including, 1) referral/do not respect co-worker dilemma, 3) referral/funding cut dilemma, 4) immigration status and petty crime dilemma, and 6) diagnosis dilemma. Professional factors that were related to these vignettes included commitment to social work values, education, and whether or not respondents had received formal ethics training. Vignette 3 (referral/funding cut dilemma) was the only vignette that showed significant relationships between all three of the above-mentioned demographic factors and the courses of action selected. No one personal or professional demographic factor was related to course of action across all vignettes for either would or should responses. In addition, an interesting finding in Vignette 3 (Referral/Funding cut) points to the possibility of an inverse relationship between level of social work education and having had formal education and its relationship to how social workers' feel they should manage caseloads in the face of budget cuts.

The second research question was, "What rationales do social workers use to make ethical decisions?" Data analyses indicated that regardless of demographic influences. social workers tend to make ethical decisions that are sometimes based upon rules and/or codes (codified), and at other times they tend to make decisions based upon other factors rather than rules and/or codes (e.g., intuition). Unlike in the findings of Smith and colleagues (1991), no clear pattern emerged across all vignettes between the respondents' course of action and their rationale for taking that particular course of action. Interestingly, in a number of instances, respondents chose more than one course of action in the same vignette and justified each action based upon the use of a codified rationale. For example, in Vignette 3 (referral/funding cut dilemma), those who selected options "A"

(discharge/refer based on own judgment) and "B" (advocate for additional funding) did so based upon codified rationales. Conversely in Vignette 1 (referral/do not respect co-worker dilemma) and Vignette 5 (duty to warn dilemma), no relationships were found between social workers' courses of action and their rationale for choosing that course of action.

The third research question was, "What personal and professional factors are related to discrepancies in ethical decision-making among social workers?" The findings suggest that fewer discrepancies in would/should choices are related to having had formal training, and to greater commitment to social work values, whereas more discrepancies are associated with being a minority rather than a non-minority.

Taken together, these findings indicate that, although there is no clear pattern of ethical decision-making among NASW members in either what they report they would do or in what they think they should do if faced with an ethical dilemma, differences in social workers' courses of action do exist and appear to relate to both personal and professional demographic factors. The findings support previous literature suggesting that both personal and professional factors should be considered in regard to ethical decision-making (e.g., Csikai, 1999; Smith et al., 1991).

Social workers use both codified and non-codified rationales for dealing with ethical dilemmas. Significant relationships between demographics and courses of action indicate that multiple courses of action are utilized by social workers, and course of action bears some relationship to demographic factors (ethnicity, being Jewish, and gender). However only minorities report a discrepancy between what they would do versus what they think they should do in the face of some ethical dilemmas.

The fact that a greater commitment to social work values and having had formal ethics training are related to fewer discrepancies in ethical decision-making may be indicative of the idea that the more one is adherent to the set of social work values, the more solid a frame of reference one has to draw from in making ethical decisions in practice. However, there may be alternate considerations. Given the relatively inchoate state of research in this area, the reader is cautioned about reaching such a conclusion. As Dolgoff and colleagues (2005) note, some social workers may not acknowledge the ethical dilemmas that arise in practice because they are uncomfortable making ethical decisions, think they already know the answer to the ethical dilemma, or are uneasy dealing with such issues because they do not feel they have the skills to manage ethical problems

(Dolgoff et al., 2005). Given Dolgoff and colleagues' conception, the reasons social workers' report minimal discrepancies in ethical decision-making remain unclear. Although ideally one would like to think that the social worker has learned to effectively resolve ethical dilemmas, this may not actually be the case. These findings reflect the complexity of ethical decisions given the difficulty in establishing universal prescriptions for behavior. Considering that there is no one right or wrong answer to address any particular dilemma much more information is needed to understand the process and outcomes of ethical decision-making among social workers.

Strengths

Findings from this exploratory study begin to build a foundation for future inquiry into the multi-faceted process of ethical decision-making. This study's conceptual base is an important strength particularly given the absence of guiding social work models. Further, the study yielded an adequate response rate from a random, national sample of licensed social workers and as such may be generalizable. In addition, the measure used to assess commitment to social work values (POS) appears to be the most frequently used measure of this construct (Abbott, 2003). Utilization of this measure contributes to the knowledge base in this area.

Limitations

The limitations of the current inquiry relate to the lack of variability within the sample itself, the simplicity of measures, and the inability to compare vignette rationale choices to right or wrong answers. Although the study population matches that of NASW members (Whitaker, Weismiller, & Clark, 2006), it is not necessarily reflective of all social workers. For example, social workers with religious affiliations other than those identified in the dataset are not represented in this study. In fact, members of NASW represented only approximately 38% of all self-identified social workers in the United States in 2004 (Whitaker et al., 2006). The available database limited the ability to examine particular constructs in their full complexity. The following constructs were explored using simple measures: culture/ethnicity (minority status), religion (Catholic, Protestant, Jewish), and training (received training or not). In addition, reliability and validity of the adapted version of the ECSRS remain unknown. And it is also important to note "would/should" responses on the ECSRS were not compared to any version of right and wrong answers for this study.

Implications

Education

It is possible that cultural, ethnic, and/or gender differences might impact upon ethical decision-making among social workers. It is critical to consider the impacts of socio-cultural context on educating students regarding ethical decision-making. Given the potential impacts of ethnic/racial background on ethical decision-making, it is essential to create classroom environments that are inclusive, promote ethical self-awareness (Abramson, 1996), promote cultural awareness, and provide space for a diverse body of students to engage with this complex content.

Research

The development of adequate means of measuring the dimensions of ethical decision-making for social workers will be key to increasing our understanding of how social workers' decisions are impacted upon by their continuing education, practice experiences, cultural backgrounds, and values, both personal and professional. Because ethical decision-making is a complex process rather than a rigidly defined construct (Dolgoff et al., 2005; Mattison, 2000; NASW, 1999), measurement of ethical decision-making is extremely challenging. Developing measures that capture all dimensions of the ethical decision-making process runs the risk of oversimplifying and/or misrepresenting ethical complexity (Walden, Wolock, & Demone, 1990). Attempting to establish "right" answers for the purposes of measurement does not account for ethical theory that suggests that there is usually no "one" right answer to an ethical dilemma.

Social work needs to begin to establish means of measuring ethical decision-making that take into account the complexity of ethical issues and are directly relevant to the circumstances practitioners might face. Vignette measures that focus on scenarios that are particularly relevant to social work practice at all levels might provide a useful starting point. In addition, more sophisticated measures that capture in greater detail the type, amount, quality, and the timing of ethical training will be essential to gaining greater understanding of how training relates to ethical decision-making.

Future research can also build upon this study by utilizing sampling frames that are more diverse in their racial, cultural, religious/spiritual, and gender make-up (e.g., state licensing boards), and that may be more representative of social workers in the United States. Such studies should include samples with larger numbers of cultural and religious minorities, and men in order

to make comparisons both within and across groups. Further, the religion variable can be expanded to explore types and degrees (conservative, liberal, orthodox, etc.) of religious or spiritual affiliation. Finally, further research is needed to better understand the reasons why social workers may or may not report discrepancies when responding to ethical dilemmas. The complexity of the content and the scarcity of research suggest a strong need for qualitative research in this area.

Theory

Significant findings related to ethnicity in terms of both course of action and discrepancy scores provide support for Hopkins' (1997) model. In adapting Hopkins' model for the purposes of this research, elements that are particularly relevant to the culture of social work, are supported by the existing literature, and are available in the pre-existing dataset, were added. Findings from this study lend support to the need to include ethical training and social work values in the model. A further proposed adaptation would be the inclusion of geography and the nature of one's practice setting. Continued refinement of the model can provide a foundation for the development of culturally sensitive, social work-specific ways of understanding ethical decision-making.

Practice

Particularly relevant is the fact that a large number of social workers are aging and nearing retirement (NASW, 2006; Whitaker et al., 2006). Accordingly, it will be necessary to recruit new social workers, and it has been argued that recruitment procedures should result in the inclusion of social workers that represent the demographic composition of the United Sates (Whitaker et al., 2006). Considering that minorities tended to reflect more discrepancies in "would/should" responses in this sample, it is imperative that more research in this area is conducted to understand what these differences mean and the impact they might have on the profession. In this vein, it will be important to be opened to understanding diversity from the perspectives of minorities. This type of openness to diversity, with a particular focus on values and ethical decision-making, may serve as an asset to social work's growth and development locally and globally as clients tend to be more ethnically diverse than social workers themselves (Whitaker et al., 2006).

This study adds to the body of social work literature by utilizing an adapted theoretical framework to ground the exploration of patterns in ethical decision-making among social workers. Findings from this exploratory study point to the possibility of new and essential areas of inquiry when considering ethics and its practical application for social work and social work education.

The more we as a profession can shed light on the factors that play a role in the complex process of ethical decision-making, the better able we will be to educate our practitioners, and in turn, to serve our clients.

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Appendix 1. Codified and Non-Codified Rationale Choices

Codified Rationales	Upholding the Law
	Upholding the Code of Ethics
Non-Codified Rationales	Unable to identify a specific reason/it just feels right (intuition)
	Upholding personal moral values/standards
	Financial need
	Fear of reprisal (e.g., malpractice suit)
	Fear of verbal/social reprisal from supervisor, colleague, or client
	Protection of personal/professional reputation

Highlighting the Role of Cross-Cultural Competence in Ethically Sound Practice

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Abstract
The value of cultural competence, as displayed by social work practitioners, is widely recognized. Yet little is known about the effectiveness of various methods for developing this capacity in human service workers. This case study illustrates the impact of cultural consultation, a strategy aimed at enhancing the culturally specific knowledge of providers. The authors argue that such strategies promote practice that reflects the values, ideals, and ethical standards of the social work profession.
Key Words: Cultural Competence, Consultation, Hmong-American Families

Introduction

The National Association of Social Workers' *Code of Ethics* (NASW, 2006) is replete with references to the importance of cultural competence on the part of practitioners serving diverse client populations. Social workers are admonished to "treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity" (p. 4). They are further advised to "understand culture and its function in human behavior" and to "demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups" (p. 9). Moreover, the expectation is made clear that they obtain education in order to acquire a knowledge base relative to the particular culture of the individuals, families, and communities that they serve (Ethical Standard 1.05).

The social work literature also highlights the importance of cultural competency in the delivery of human services to diverse populations. More specifically, it draws attention to inadequacies in service provision to ethnic-minority populations. For instance, a disproportionately high rate of unmet mental health needs for racial and ethnic minorities relative to non-Hispanic white Americans is clearly documented (U.S. Department of Health and Human Services, 2001). Recommendations offered toward the elimination of such disparities include the provision of mental health services that are tailored to culturally diverse populations and delivered by practitioners who respect the beliefs, norms, and values of the minority clients that they serve (President's New Freedom Commission on Mental Health, 2003)

Another emphasis in the literature is on providing a conceptual understanding of cultural competency and general guidelines for its development. Stanley Sue suggests that in order to attain a high level of cultural competence, providers should avoid drawing premature conclusions about the status of their culturally different clients and instead develop creative ways to test their clinical hypotheses. Practitioners are encouraged to avoid stereotypes, appreciate the importance of culture, and acquire culture-specific expertise (Sue, 1998). Authors Lynch & Hanson (1993) define cross-cultural competence as "the ability to think, feel, and act in ways that acknowledge, respect, and build upon ethnic, socio-cultural, and linguistic diversity" (p. 50). Like Sue, they assert that the development of this capacity includes learning culture-specific information about clients from varying cultural groups (Lynch & Hanson, 2004).

One strategy designed to enhance the cross-cultural competence of social work practitioners, *cultural consultation*, has received recent attention by authors. It involves the use of an ethnospecific cultural expert who offers services that supplement those provided by the primary worker. The consultant (typically a psychiatrist, psychologist, or social worker) performs an assessment of the client system and follow-up consultation to the primary provider in an effort to assist the latter in understanding the cultural meaning of the client's symptoms and the social context of their distress. Such services have been found to be successful in unearthing cultural misunderstandings, incomplete assessments, incorrect diagnoses, and the use of treatments inappropriate to the client's belief system (Kirmayer, Groleau, Guzder, Blake & Jarvis, 2003).

What follows is a case study that demonstrates the value in using cultural consultation as an adjunct to social work services provided to ethnically diverse clients and their families. More

specifically, it portrays the process through which workers providing behaviorally oriented social work services to a Hmong-American youth recognized the need for assistance in order to serve their client in a manner that was culturally competent and, thus, ethically sound. This case also reveals how practitioners changed course following the use of cultural consultation – a shift in strategy that resulted in dramatic improvement in the youth's behavior and her family's responsiveness to services. Based on this case review, recommendations are offered to social workers who aspire to meet the highest ethical standards of their profession by understanding and appreciating the cultural values of clients served.

The Case of Mai

Mai Khang[1] was a 15-year-old Hmong-American girl who presented with frequent and serious suicidal gestures and episodes of aggression. Upon referral to a social work team that provides intensive, in-home, behaviorally oriented services, it was reported that she drank small amounts of toxic chemicals (e.g., bleach, nail polish remover, laundry detergent) 2-3 times per day and assaulted her mother or father roughly 1-2 times per day. Mai frequently ran away from home and "hooked up with undesirable strangers." It was also noted that she had, on occasion, threatened to kill her parents with an axe. The mental health therapist who referred her for behavioral intervention had given her a diagnosis of major depressive disorder with psychotic features, in large part as a result of her reported visual and auditory hallucinations and suicidal ideations.

The behavioral specialists began, with the assistance of a Hmong-speaking interpreter, to attempt engagement with Mai's monolingual Hmong-speaking mother and father. The initial focus of services was on specifying the girl's high-risk behaviors and on developing a preliminary safety plan. The workers subsequently conducted a functional behavior assessment that defined the frequency and nature of the child's target behaviors, as well as their antecedents and consequences. Through this process, it was observed that Mai's aggressive and self-injurious behaviors were usually triggered by: rejection by a "boyfriend," limit setting by her parents (particularly with regard to phone use), or boredom (her access to age-appropriate activities was limited because of her parents' unwillingness to transport). The typical consequence of her acting-out behaviors was determined to be increased access to the people, places, and attention she desired. Thus, these

[1] The client's name was changed to protect her privacy.

dangerous behaviors were thought to express an underlying need for connection and belonging with others.

Consistent with this assessment, the behavior specialists-initiated strategies aimed at increasing Mai's access to recreational and peer-based activities in the community (e.g., Boys' and Girls' Club programs, youth group at Hmong Community Center). A safety plan was also developed to decrease her access to toxic solutions and "undesirable" strangers. With the assistance of the Hmong interpreter, her parents were encouraged to closely monitor her whereabouts at times when she was likely to sneak out of the home (late at night), limit her access to the phone, and utilize a behavior chart for tracking non- aggressive behavior. In addition, a system of positive reinforcement was set up in which Mai's parents were asked to reward her with stickers and other tokens when she behaved in a safe and responsible manner.

None of the above-named interventions proved successful. Mai refused to attend peer-related activities in the community. Her parents did not follow through with the behavior management systems recommended, despite their reported willingness to do so. They continued to assert that Mai was of age to be married and cared for by a husband who would deal with her need for structure. Eventually, the service providers concluded that they were stuck. Not having a full understanding of the values and practices of the Hmong culture, they were operating in the dark and making little headway toward managing the risk involved with Mai's behavior.

These workers sought out the assistance of a cultural consultant who contracted with the County Department of Mental Health to provide input to mental health providers regarding culturally specific issues that can impact a Hmong client or family's progress in treatment. Upon referral by the county department, the Hmong psychiatric consultant contacted the service providers on this case to gain basic information regarding the need for his services. Next, this consultant conducted several meetings at the provider's office, the first of which was held with the child recipient of services. He subsequently met with Mai's mother and sister-in-law and elicited information regarding their perspectives of her behavioral challenges. Finally, he debriefed with the primary providers, at which time he shared his findings and offered recommendations.

As a result of this experience with consultation, the primary social workers learned a great deal about faulty assumptions they had made that contributed to poor progress on the part of the child and family. Those were as follows:

1. Mai's language of choice was English. It was apparent to the consultant that, while Mai is bilingual (Hmong and English), she much preferred speaking in Hmong. When communicating in English, she often had had difficulty grasping certain concepts that were being relayed by the English-speaker.
2. Mai's parents understood her target behaviors to be dysfunctional and wanted them to stop. One of the most striking insights that emerged out of the cultural consultation process concerned the parents' interpretation of Mai's symptoms and behaviors. It was revealed that they understood her high-risk behavior to be an indication of her call into shamanism, a form of healing that originated over 10,000 years ago. The primary providers learned that, according to Hmong tradition, the call to shamanism occurs through the visitation of spirits. Typically, a young person is summoned to this vocation during a psychic or spiritual crisis that accompanies a physical illness. By overcoming the disease, the youth reportedly acquires the ability to heal others with compassion. In the Hmong community, the shaman is revered and thought to serve as a bridge between the material and spiritual worlds (The Split Horn, n.d.).

Mai's parents reported that an elder shaman had once confirmed that she had, in fact, been called into this profession. Because they respected her emerging role as a shaman, Mr. and Mrs. Khang did not wish to curtail her risky behaviors entirely; they merely wanted to keep her alive and free from serious harm. Mai, on the other hand, was not convinced that she was a shaman and appeared anxious when the topic was raised. Once the primary providers demonstrated their ability to discuss shamanism with her in a non- judgmental manner, her discomfort with this subject began to dissipate.

3. It is always appropriate to enter Mai's house for a home visit if a family member answers the front door. The cultural consultant clarified for the workers that when a cluster of green leaves is found hanging on the front door, it is a signal that spiritual cleansing is taking place within the home. This ritual, referred to as "caiv," is performed to protect the family from evil spirits. It was advised that when the team encountered this type of leafy display that they avoid entering the house; otherwise, they would disrupt the ritual, resulting in a need for the family to reinitiate the cleansing process.

Based on these new insights, the behavioral specialists re-conceptualized the therapeutic needs of Mai and her family. They redefined the function of her aggressive and self-harmful behavior as expression of her need to resolve identity confusion and attain validation within her family and cultural community. Consequently, their interventions focused on the following:

1. The use of written narratives and scrapbooking. These activities were done to assist Mai in ethnic identity formation and goal setting. Through this process, she identified an

interest in pursuing a career as a translator, teacher, or mortician (interestingly, all aspects of the role of shaman).

2. Joining with the family by recognizing their cultural beliefs and customs. The workers made an increased effort to recognize the family's beliefs and traditions. They began noticing and asking about pictures in the home that depicted extended family celebrations. In addition, they expressed an interest in learning more about shamanism from Mai and her parents. Consequently, family members welcomed visits by the providers and appeared more open to input and suggestions aimed at managing Mai's behavior.

3. Building skills in emotions regulation. Mai was taught how to formulate and utilize coping statements (e.g., "I can find something positive to do when I am bored," "I can control myself when mad," and "I don't need a boyfriend to be happy"). Social skills were also taught and practiced preparing her for connection to age-appropriate social activities.

Following this shift in strategy on the part of the behavior specialists, Mai made substantial progress. She learned how to access reading material at the public library and discovered a particularly strong interest in Hmong literature. Most importantly, she evidenced marked improvements in her behavior. While Mai continued to leave the home at times without permission, incidents of self-harm diminished, and she displayed a newfound ability to control her aggression.

When the providers neared completion of services, a Hmong-speaking staff member from their agency interviewed Mai and her parents with the intent to explore the extent to which they observed a change in the nature of service delivery subsequent to the implementation of cultural consultation. The family reported that the cultural consultant encouraged them to use the therapeutic services available – thereby granting implicit permission for them to accept help from members outside their cultural community. Mai and her parents all noted that following the meetings with the cultural consultant, the primary workers appeared more open to their culture and respectful of their customs. Mr. and Mrs. Khang also stated that, over time, the providers began encouraging them to use their cultural practices to help Mai decrease her dangerous behaviors. They recognized these workers for not giving up on them or their daughter and expressed their gratitude and appreciation for services rendered.

Discussion

The case study described above sheds light on the benefits that can result from the use of cultural consultation as an adjunct to social work services provided to individuals and families. In order to attain such benefits, providers must, first, be willing to recognize their limitations with regard to understanding the role of culture as it impacts individual or family functioning. Sadly, practitioners are often reluctant to admit when they are making minimal progress with a client or client system and, thus, in need of assistance from a consultant. Moreover, when provider-client cultural and linguistic differences are at play, the provider may inaccurately assume that the use of an interpreter is adequate in terms of meeting the individual or family needs. The worker may fail to detect his or her their own assessment of problematic behaviors or clinical issues misses the mark when it comes to reflecting clients' perspective of their own strengths and concerns.

As can be seen in the case example provided above, cultural consultation involves much more than linguistic translation. It offers an explanation of the client's cultural beliefs, customs, and traditions that may have eluded the provider's understanding or awareness. In addition, it places individual and family challenges into a rich context that leads the practitioner to previously undiscovered strengths and resources. As was illustrated above, cultural consultation holds potential for illuminating the function that a particular target behavior serves within a family or extended family system.

Another positive impact of this intervention is seen when the consultant is able to legitimize the role of the primary provider in the eyes of the client. By validating services and verifying the provider's trustworthiness, the consultant can pave the way to an increased level of client involvement in the therapeutic process. In the case of Mai, this benefit is reflected in the comments made by her parents indicating that the consultant encouraged them to utilize the assistance of the behaviorally oriented social workers. An intervention of this kind on the part of the consultant is invaluable – it serves to advance the client's willingness to engage with workers of differing cultural backgrounds, particularly if these providers begin to recognize and appreciate the client's values and customs.

In conclusion, the authors encourage social workers to consider the potential benefits of cultural consultation when conducting cross-cultural practice. Furthermore, they recommend that systems of care serving culturally, and linguistically diverse individuals and families assemble a

wide array of cultural experts and make their cultural consultation services readily available to human service providers. Such an investment in the provision of cross- culturally competent services is a requisite of service delivery that upholds the core values and ideals of the social work profession.

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Workplace Abuse: Roles of the Supervisor and the Supervisee

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Abstract
The management of workplace abuse in supervision and the subsequent remedial roles of the supervisor and the supervisee are complicated by the limited published literature in this field. This paper draws together health, education, psychology, and employment literature with the author's experience to present key issues relevant to this area. These viewpoints address ethical dilemmas concerning confidentiality, accountability, and emotional trauma, and are formulated into a process of care for clinical supervisors. This model encourages the supervisee to work towards resolving workplace issues while maintaining competency to practice. The efficacy of this model is demonstrated by means of a case example. Further research is recommended to understand and categorize workplace trauma, the result of workplace abuse, and appropriate responses for associated professionals.
Key Words: Clinical supervision, workplace abuse, ethical dilemmas, stress, care.

Introduction

Workplace Bullying (WPB) when identified within clinical supervision raises questions concerning the responsibilities of a supervisor and supervisee to each other, to the employer, and to the community. Supervision should ideally provide a safe, confidential, and useful transparent process (McMahon, 2002; Scaife, 2001a). Ethical dilemmas within the supervision process of holding or withholding ethical information needs critical reflection. A problem-solving process that meets the needs, values, and beliefs of both parties, while maintaining competency to practice, will be discussed.

For the purpose of this paper, Inskipp and Proctors' (1993) conceptualization of supervision is used: supervision is a confidential working alliance between two professionals where supervisees offer an account of their work and reflect on it, receive feedback and guidance

where appropriate, and is based on their 'formative,' 'normative,' and 'restorative' model of supervision.

This paper will concentrate on the ethical dilemmas within the context of supervision, in particular appropriate boundary setting and supporting agency procedures. A model designated Supervision Process of Care (SPC) addressing the dilemmas will be presented. It will draw on and bring together health, education, psychology, and employment literature, and the author's experience. Clinical supervision is one of the processes in place to assist ongoing development, standards of practice, and professional support. Although New Zealand legal policies and context are used to present key issues relevant to this area, it is noted that this information may or may not be transferable entirely to other cultural contexts.

Literature Review

WPB is a worldwide phenomenon brought to professionals' attention as victims of WPB (targets) retaliate (fight back) in an attempt to gain control of their lives. Researching the literature for information concerning the role of the supervisor when WPB is disclosed resulted in little information. However, there was a considerable amount of literature on the subject of harassment, WPB, discrimination, or violence.

Bullying is considered, by some, the single most important social issue of today (Field, 2006). The study of literature on bullying provides a chance to understand the behaviours that underlie conflict and violence in the workplace, schools, and community organisations. It reveals to what extent people's lives are affected, the cost to society, and the lack of effective legislation to address this issue (Field, 2006; Mueller, 2005; Needham, 2005).

Health and education organisations are not exempt from this problem. Experts in WPB (Needham, 2005; 2006; 2008), campaigning for safer, healthier workplaces, believe that the answer lies in improved leadership. Senior management must be accountable and take tough action, demonstrating purpose, values, and ethical principles. Supportive cultures of teams and legislation for the targets (supervisees) and employers must be in place (Bell, 2006; Burborough, 2006; Chartered Institute, 2004; Cotton & Hart, 2003; Gilbertson, 2006).

New Zealand Government policies on health and safety in the workplace refer to stress, harassment, bullying, temporary impairment, discrimination, and violence (Department of Labour NZ, 2004; Occupational Safety, 2005; Occupational Health, 2003; Public Service Association,

2003). Departmental strategies aim to lift workplace health and safety performance, and reduce staff turnover. These set out to achieve healthy, safe workplaces through innate quality leadership practices and training (Needham, 2008; Human Rights Commission NZ, 1997).

Employers are legally bound to provide safe working environments. New Zealand laws address major forms of abuse and harassment with little specifically covering workplace bullying. Options for legal redress are available on the basis of unsafe work environment, constructive dismissal, or a personal grievance. The process involves Labour Department mediation prior to undertaking court proceedings (Employment Relations Authority NZ, 2003). Mediation is considered an appropriate mechanism for many disputes. However, it is strongly advocated that it not be used as the first response or at all for WPB issues. Targets perceive the Employment Relations Service and the Human Rights Commission as bully-friendly (Needham, 2005; 2006; Olsen, 2006), hence many may not receive appropriate treatment. The Protected Disclosures Act 2000 (Ombudsman Office, 2002) protects employees who report serious wrongdoing (whistleblowing) in or by an organisation; however, WPB is not mentioned. When targets rely upon legislation, they appear to gain limited protection, validation, or recompense from the law. They are required to sign a confidentiality agreement while the bully appears unaffected. This is in contrast to such countries as Australia, Sweden, and Ireland where legislation is in place to protect targets (Larsen, 2007).

Organisational policies concerning the role of the supervisor in WPB issues remain unidentified. Although organisations have policies regarding the practice of supervision, it is unlikely the role of the supervisor in WPB will be linked to the complaints policies. Health and education services typically have organisational policies which deal with WPB, for example, complaints processes. However, this is not always the case, nor is there typically any reference to a clinical supervisor's role in relation to such a disclosure. Many private organisations do not appear to address this issue at all.

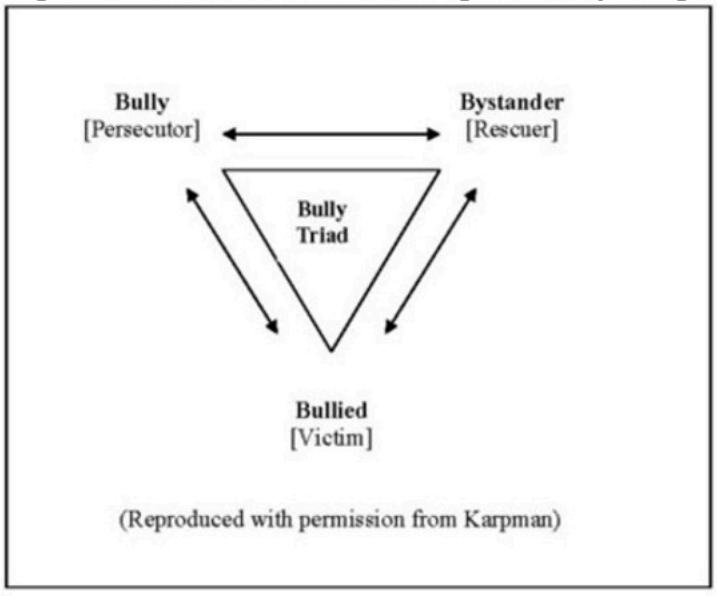
Workplace Bullying

WPB and harassment are defined as two different types of abuse (Field, 2006; Needham, 2005). Bullying is defined as conscious, persistent, offensive, abusive (verbal or non-verbal), intimidating, or insulting behaviours intended to harm. It is seen as the misuse of social power and control or unfair punitive sanctions for the purpose of hiding inadequacies such as lack of

leadership, people skills, or management skills. Bullies tend to project their inadequacies onto others, making the recipient feel upset, threatened, humiliated, and vulnerable. Whether it is premeditated or spontaneous, obvious or subtle, overt or covert, easy to identify or cleverly concealed, it can undermine self-confidence, emotional competence, and the ability to perform effectively. WPB and harassment are often used interchangeably. Although harassment is less severe, it is regarded as just as harmful (Field, 2006). It can cause temporary impairment, or over time serious stress related illnesses. More than three months of abuse is believed to cause lasting effects (Kinchin, 2005) such as panic attacks, flashbacks, loss of confidence and self-esteem, depression, and symptoms of Post-Traumatic Stress Disorder (PTSD).

Coloroso (2005) conceptualizes the differing roles of the bully, the bullied, and the bystander involved in WPB as the "Three B Bicycle" or "Bully Triad" (Fig.1). It describes a triangular interaction similar to Karpman's Drama Triangle involving the use and misuse of power (Ball, 2006; Coloruso, 2005; Karpman, 1968). These interactions are said to involve the unconscious shifting of role exchanges between persecutor, victims, and rescuer. Karpman describes the emotional roles of the persecutor/bully ("It's your entire fault"), victim/bullied ("Poor me") and rescuer/bystander ("Let me help you") in terms of a psychological drama analysis.

Figure 1 Assimilation of the Drama Triangle with Bully Triangle



When brought to a conscious level, the dysfunctional interactions emphasize the power and control issues. These raise awareness that transforms the dynamics to move forward and deal with the situation. While the roles of the bully and the bullied are recognizable, the 'rescuer' becomes the bystander who usually maintains a silent witness role. All three-hold knowledge of an ethical issue, WPB.

Understanding the demoralizing effects, temporary or otherwise, that the bully (persecutor) has on the bullied (victim) is important. The emotional experience can range from stress and anxiety to PTSD (Kinchin, 2005), whereby feelings of frustrations, hopelessness, helplessness, and entrapment, disempower the target from making decisions, and taking positive action. The nature of the trauma is often misunderstood because it is insidious, invisible, emotional abuse. It may be misinterpreted as a "personality clash" and/or the potential for harm minimized. It is suggested that workplace trauma should become a specific diagnosis in order for attitudes to change towards the seriousness of this experience (Field, 2007b; Kinchin, 2005). Without validation of these emotions, these experiences may impact on the individual's occupational performance (Crabtree, 2003).

Literature describes several remedial themes (Ball, 2006; Field, 2006, Field, 2007a; Needham, 2005; 2008). These include changes in leadership practices, environments, and in attitudes about the health and safety of targets. In addition, bystanders (witnesses) need to collaborate against bullying through validation and group pressure (Bell, 2006; Mueller, 2005). It is not sufficient to rely on workplace policies. Systemic management (human resources, service managers, internal processes) cannot be impartial. Workplace contexts can be compromised due to the will to support both parties (Cotton & Hart, 2003; Larsen, 2007). Mediation in this instance fails to take into account the power dynamics underlying this issue. Literature and the author's experience report that this type of action is inappropriate and rarely succeeds (Needham, 2005; 2008; Field, 2007b).

Supervision Ethical Dilemmas and Responsibilities

WPB bullying appears to impact on six important areas of the supervision process as revealed through literature. They are:

Ethics

New Zealand appears to have no established universal Supervision Code of Ethics. It seems that many supervisors and supervisionary courses rely on the New Zealand Association of Counsellors Code of Ethics to inform supervision practice (New Zealand Association of Counsellors, 2006). Therefore, the question arises: could a Supervision Code of Ethics across generic professions make a difference in the resolution of moral dilemmas such as WPB?

Many organisations do have a Code of Ethics. Others have a universal Code and rely on employees' professional Codes to guide conduct and practice. Literature reveals that a health organization's ethics may address clinical malpractice and client concerns, rather than managerial issues (Kidder, 1995; 2008; Occupational Therapy Board of New Zealand, 2004). However, ethical considerations are often embedded within organisational policies and procedures such as supervision and complaints policies. Some organisations believe that these policies, with human resource management, are sufficient to address WPB. A Joint Commission (2008) report signifies that WPB behaviours undermine a culture of safety for clients and members of health care teams. Kidder's commentary (2008) on this report indicated that organisations do not consider these behaviours as unethical, misconduct, or a breach of ethical codes. A workable organisational or service level Code of Ethics that is linked to appropriate service and or government legal policies may be one way to resolve this problem.

Ethical dilemmas involve confidentiality, the supervision contract, the supervisee's health and well-being, and competence to practice. This shared knowledge comprises legal and social issues, which impact on the supervisor, employees, and the organizations (Field, 2006; Hewson, 2002; 2005). The dilemma in WPB is not a right-versus-wrong situation. The latter presents no reason for discussion. However, it could be seen as a right-versus-right situation (going public-versus-preserving confidentiality or short-term-versus long-term resolution), particularly by organisations. Therein lies the ethical dilemma (Kidder, 1995). To "tell or not to tell" is an ethical question for all three parties in the triad, as they are holding (and withholding) important ethical information that may consequently affect the workplace.

Withholding ethical information may impact on both supervisor's and supervisee's performance, health and well-being, values and beliefs, and has possible long-term effects for the clients (Geldard & Geldard, 2006; Gilbert & Evans, 2002; Scaife, 2001b). Management withholds information on organisational WPB incidents in order to investigate and clarify certain issues. However, human harm and loss of credibility in system supports will be caused meantime whilst management attempts to reach a solution. Withholding information is a real ethical problem that should be acknowledged openly and widely debated.

Ethical choices are usually guided by professional Codes of Ethics and by law. Terms such as *legal* and *ethical* are often treated as interchangeable. However, there is an important difference.

Laws provide expected boundaries while ethics address Codes of Practice or Conduct. Therefore, when the two diverge, ethics should take priority ("Legal Vs Ethics," 2007). Codes are moral, not legal, guidelines and have limitations. They typically do not provide decision-making processes for situations, such as WPB. However, they are valuable indicators of professional behaviour, values and beliefs, models to guide, and resolved ethical issues (OTBNZ, 2004). Axten (2002) believes that truly ethical choices come from a complete understanding and consideration of all the information and varying points of view, both immediate and environmental. This would be true of WPB situations. The practice of ethical problem-solving should prevent harmful judgmental solutions.

For example: New Zealand Online "Values Exchange for Everyone" promotes democratic debate about topics of social concern and is one place where professionals can access an ethical reasoning programme (Seedhouse, 2005; Values Exchange, 2005).

Confidentiality and contracts

Confidentiality is considered one of the major ethical concerns raised within the supervisory relationship, along with competence, overwhelmed supervisees, and dual relationships (DeTrude, 1992). Therefore, supervision contracts should clarify the role boundaries, dual relationships, and confidentiality. These are informed by ethical codes, guidelines, policy, and law (Gilbert & Evans, 2002; McMahon, 2002). Contracts usually include an occupational health and safety clause and may provide a disclosure statement. This indicates that when certain circumstances occur, the supervisor may break confidentiality. While keeping this process transparent, supervisors can report unsafe practice. If confidentiality is breached without consent, the result is lack of trust. If confidentiality is maintained, the supervisee is left unprotected and potentially so are other people.

Supervision contracts and confidentiality issues may be contentious when WPB is revealed (for example, if the supervisee is adamant that it remains confidential to supervision and therefore unaddressed). It would be naïve and idealistic of the supervisor to give complete assurance that issues discussed in supervision would never be revealed to others. The limits to the level of confidentiality include record keeping, the supervisor's own supervision, the need to protect others, working with other professionals, participating in training, conference programmes, and where the law (mediation) requires disclosure of information (Geldard & Geldard, 2006). A

supervisee cannot give informed consent without being informed of all the implications/expectations. Supervision is able to provide reflection on outcomes.

Documentation

Professional Codes of Ethics include standards covering documentation for client care and litigious reasons. However, this does not cover supervision documentation. This information should be in the supervision contract and supported by organisational policies to ensure that supervisors document the date, time, and content of supervision sessions that address legal and ethical issues (Dewane, 2007). Supervision notes, usually written in a generic manner, should be confidential and kept in a safe place. If the supervisee decides to take legal action, both the supervisee's and supervisor's notes may be used as evidence. Therefore, sensitive material (bullying issues) needs to be recorded. Furthermore, the supervisee should keep a separate record (a timeline) of bullying situations for validation purposes. This provides additional protection for both the supervisor and supervisee (Field, 2006; Ferguson, 2005; Gilbert & Evans, 2002; Scaife, 2001a).

The supervisee

Supervision should meet the needs of the supervisee in conjunction with professional and clinical competence. Health and well-being of the supervisee often cause deliberation for supervisors and raise boundary issues. Supervisors encourage supervisees to work through personal issues, which may impact on their competency to practice. This is important in WPB situations where communication and interpersonal relationships are a requirement (Field, 2007a; 2007b; Geldard & Geldard, 2006; Geldard & Geldard, 2003).

Therefore, the question arises: where are the boundaries between evaluating personal needs, the therapist role, and the professional supervisor process? A supervisor will need to perform an evaluative role when assessing a supervisee's well-being and, furthermore, distinguish between impairment, incompetence and unethical practice (Forrest, Elman, et al. 1999; Howard, 2007; Scaife & Walsh, 2001). Evaluating includes examining the supervisee's response to WPB, for example the presence of anxiety, distress and or depression. Policies may not provide sufficient guidance. Nonetheless, it seems incumbent on supervisors to have some skills and recognition in the area of work-related stress.

Supervisors' ethical responsibilities

Clinical supervision is mandatory for Health Practitioners in New Zealand as outlined in the Health Practitioners Competency Assurance Act (Ministry of Health, NZ, 2003). Consequently, supervisors are accountable when employed within an organisation, to the hierarchical authorities or systems under which they work, such as employers, managers, professional bodies, and society.

Within organisations, the supervisor's major ethical challenge in accepting the role of a supervisor is to balance the responsibility for representing an organisation's core values to its employees, their own personal values, and the well-being and needs of the supervisees. Being ethically effective in this role is critical to both organisational and individual success and emphasises the need to be trained and supervised themselves (Axten, 2002; Ethics Resource Centre, 1992; Hewson, 2005; Scaife, 2001b).

A supervisor should attend to both his or her own and the supervisee's ethics of practice. Supervision is often a place for discussing ethical and clinical issues; consequently, an understanding of ethics is essential. A supervisor may be held responsible for the supervisee's behaviour. Therefore, a supervisor should challenge and encourage critical reflection, which provides professional conduct through modelling to cultivate skills and a professional conscience in the supervisee.

As a result of the widespread phenomena of WPB, anecdotal evidence suggests it is possible practitioners will have knowledge of this situation. Clinical experience and anecdotes disclosed suggest that supervisors may be the first to hear of concerns of WPB, (due to the trusting nature of the relationship), providing they recognise this experience. The supervisor may recognise these concerns through observation of behaviours, effects on competence, or direct disclosure. Furthermore, past harmful supervision should be considered: lack of trust, transparent processes, dual relationships, and unmet expectations often cause feelings of disempowerment (Axten, 2002; DeTrude, 1992; Ferguson, 2005; Hewson, 2005; Scaife & Walsh, 2001).

The impact on the supervision process relates to legal issues and social justice policy. Government legislation includes due process, duty to warn and protect (duty of care), confidentiality, ethical conduct, and social justice issues (Axten, 2002; ERANZ, 2003: Hewson, 2005; Scaife, 2001a). Moreover, the social, political, and economic forces within organisations result in feelings of vulnerability in supervisees and supervisors (Gonzalez- Doupe, 2001; Herkt

& Hocking, 2007; Scaife &Walsh, 2001; Towler, 2005). If disclosure of WPB is the desired result of ethical reasoning, do the organisational processes support it? Gonzalez-Doupe (2001), Gilbert & Evans (2002) and Towler (2005) suggest that the professionals' associations and organisations should be more responsive to the challenges that face practitioners by constructing regularly reviewed, and revised guidelines and procedures to support the supervisor and supervisee. The supervision contract should be enacted in the best interests of the supervisee, other colleagues at risk, the wider contexts of organisations, and society. Furthermore, it is essential that the supervisors continue to be supervised themselves and be provided with regular professional development in this growing field of knowledge.

Supervisee's ethical dilemmas

Anecdotal and experiential information from supervisees reveals common dilemmas:

- The nature of the trauma experienced by the supervisee is rarely recognized or understood by either the supervisor or supervisee.
- A fear of not being believed (personality clash, non-assertion, "you are mistaken"), reprisal, and ineffectual resolution, such as precarious policies and procedures.
- There is no clear decision-making process for either party at the initial stage of WPB disclosure.
- There is a lack of faith in the systemic policies, procedures, and processes making a difference.
- There is a lack of faith in organisational remedial counselling procedures even if they are available or offered free of charge.
- There are no clear procedures or processes for addressing the problem of the persecutor's (WPB) behaviour.
- If supervisees retaliate, they rarely win their case; continue to feel traumatized and obliged to leave the employment situation. Staying is often considered untenable.
- Retaliating through external resources (outside health and education services) is considered fairer, more validating, though expensive, time consuming and without due processes.
- Moving on to another employment situation was considered the least stressful option.

These ethical dilemmas indicate that an existing system of managing WPB is untrustworthy and less than successful. Moving to external mediation may prove more validating with individuals feeling justified in their actions, even if changing employment becomes necessary. Professional indemnity cover for both parties is considered essential.

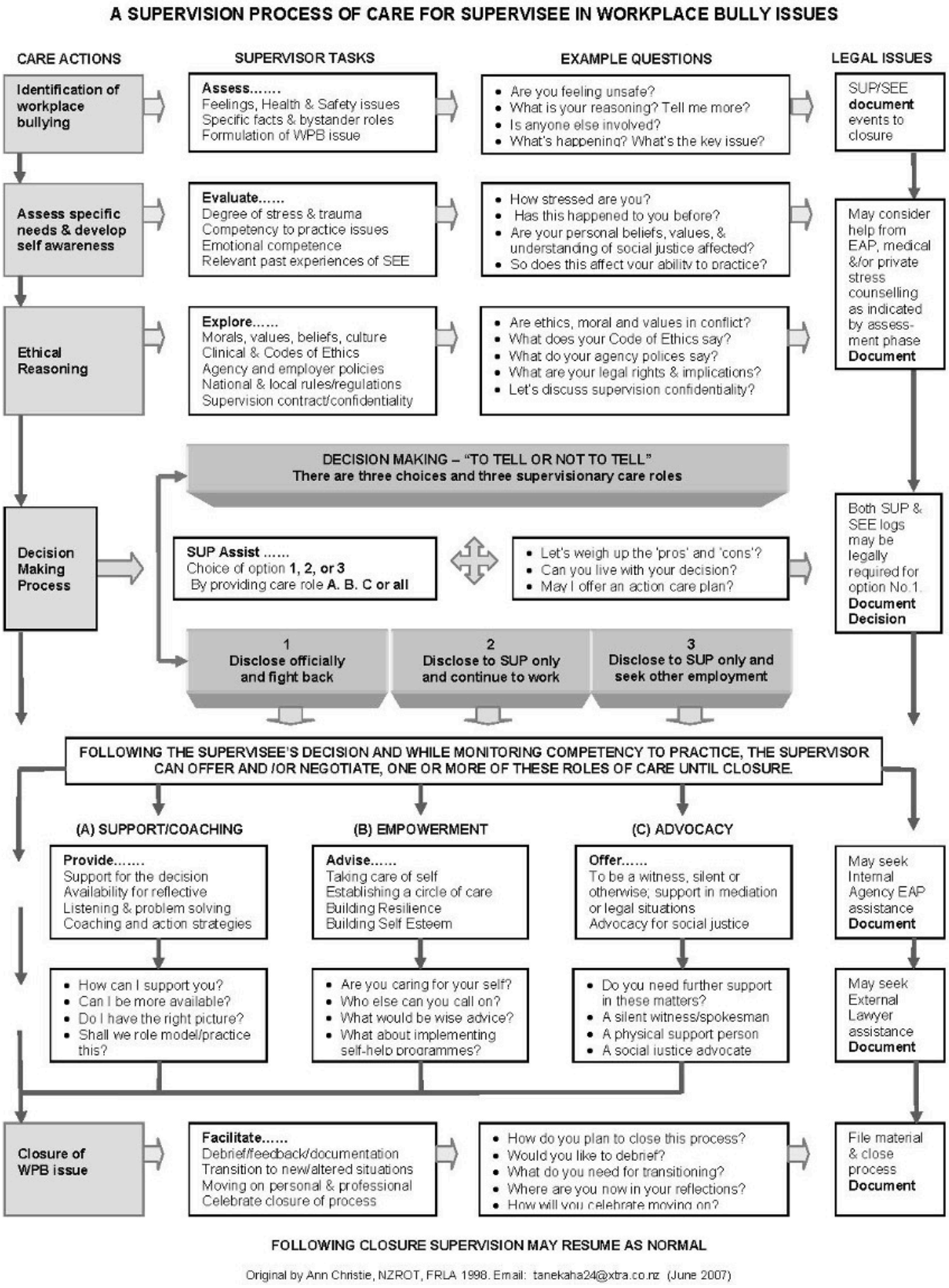
The author's experience and anecdotal evidence has accentuated a number of ethical dilemmas that intrude on the supervision process. A literature review revealed limited information

on how to address these issues. From this investigation, a model of Supervision Process of Care (SPC) is proposed as a method of dealing with the problem. The efficiency of this model in guidance and advocacy while maintaining competence to practice is demonstrated by means of a case example.

A Supervision Process of Care Model

For the purpose of this paper, a SPC is identified as a way of supporting a supervisee through a WPB situation (see Fig. 2). Irrespective of organisation supports, a target will require ongoing supervision to practice. Through the author's experience and anecdotal feedback, this practical process is intended to be flexible, transparent and collaborative. It intends to guide supervisor and supervisee through a course of reflective practice and ethical decision-making. Based on bands of supervision embedded in many models and justifiable approaches, it helps to define the role of the supervisor and supervisee.

Figure 2


A SUPERVISION PROCESS OF CARE FOR SUPERVISEE IN WORKPLACE BULLY ISSUES
CARE ACTIONS
SUPERVISOR TASKS
EXAMPLE QUESTIONS
LEGAL ISSUES
Identification of workplace bullying
Assess.....
Feelings, Health & Safety issues
Specific facts & bystander roles
Formulation of WPB issue
Are you feeling unsafe?
What is your reasoning? Tell me more?
Is anyone else involved?
What's happening? What's the key issue?
SUP/SEE document events to closure
Assess specific needs & develop self awareness
Evaluate.....
Degree of stress & trauma
Competency to practice issues
Emotional competence
Relevant past experiences of SEE
How stressed are you?
Has this happened to you before?
Are your personal beliefs, values, & understanding of social justice affected?
So does this affect your ability to practice?
May consider help from EAP, medical &/or private stress counselling as indicated by assess-ment phase Document
Ethical Reasoning
Explore.....
Morals, values, beliefs, culture
Clinical & Codes of Ethics
Agency and employer policies
National & local rules/regulations
Supervision contract/confidentiality
Are ethics, moral and values in conflict?
What does your Code of Ethics say?
What do your agency polices say?
What are your legal rights & implications?
Let's discuss supervision confidentiality?
DECISION MAKING – "TO TELL OR NOT TO TELL"
There are three choices and three supervisionary care roles
Decision Making Process
SUP Assist .....
Choice of option 1, 2, or 3
By providing care role A. B. C or all
Let's weigh up the 'pros' and 'cons'?
Can you live with your decision?
May I offer an action care plan?
Both SUP & SEE logs may be legally required for option No.1. Document Decision
1
Disclose officially and fight back
2
Disclose to SUP only and continue to work
3
Disclose to SUP only and seek other employment
FOLLOWING THE SUPERVISEE'S DECISION AND WHILE MONITORING COMPETENCY TO PRACTICE, THE SUPERVISOR CAN OFFER AND /OR NEGOTIATE, ONE OR MORE OF THESE ROLES OF CARE UNTIL CLOSURE.
(A) SUPPORT/COACHING
(B) EMPOWERMENT
(C) ADVOCACY
Provide.....
Support for the decision
Availability for reflective
Listening & problem solving
Coaching and action strategies
Advise.....
Taking care of self
Establishing a circle of care
Building Resilience
Building Self Esteem
Offer.....
To be a witness, silent or otherwise; support in mediation or legal situations
Advocacy for social justice
May seek Internal Agency EAP assistance Document
How can I support you?
Can I be more available?
Do I have the right picture?
Shall we role model/practice this?
Are you caring for your self?
Who else can you call on?
What would be wise advice?
What about implementing self-help programmes?
Do you need further support in these matters?
A silent witness/spokesman
A physical support person
A social justice advocate
May seek External Lawyer assistance Document
Closure of WPB issue
Facilitate.....
Debrief/feedback/documentation
Transition to new/altered situations
Moving on personal & professional
Celebrate closure of process
How do you plan to close this process?
Would you like to debrief?
What do you need for transitioning?
Where are you now in your reflections?
How will you celebrate moving on?
File material & close process Document
FOLLOWING CLOSURE SUPERVISION MAY RESUME AS NORMAL
Original by Ann Christie, NZROT, FRLA 1998. Email: tanekaha24@xtra.co.nz (June 2007)

Supervision Process of Care Model

The practicalities of SPC lie in the structure of five key areas: care actions, supervisor tasks, example questions, legal ramifications, and documentation. Care actions may begin at any level and irrespective of the supervision model. To date, the author has worked with eight supervisees experiencing WPB who reported SPC as exceedingly nurturing and supportive. The process wished to validate concerns, maintain self-esteem, and competence to practice in the supervisee.

Step 1: Identification of WPB

Abraham (2001) believes that uncomfortable or unsafe feelings are usually an indication that health and safety or ethical issues exist. It is essential that the supervisor provides validation of these feelings while listening empathetically. It is acknowledged that, unless the supervisor has an understanding of WPB, it is difficult to perceive the subtleness of what the supervisee may be experiencing. Therefore, knowledge and understanding of the trauma experienced, and the probable impact on ability to work is essential information for both supervisor and supervisee. Tim Field's (2006) Web site includes WPB identification, definitions, bully behaviours, and more.

Figure 3 The twelve bystander (BS) roles

"It's none of my business" or *"Pontius Pilate"*.	A person asks the BS for help in solving conflict, is met with refusal to mediate, and told to deal with it on their own.
"It's more complex than it seems" or *"Who Knows Anyway"*.	The BS is aware of the problem, claims it's too complex, implying things need to be simplified before getting involved.
"I don't have all the Information" or *"Ignorance is bliss"*.	The BS believes that, because they lack information they could make unsound judgments that might not be helpful, so do not get involved.
"I don't want to get burned again" or *"Let them fry"*.	The BS refuses to get involved because of similar uncomfortable or painful past experiences.
"I want to remain neutral" or *"I don't want to take sides"*.	The BS is a third-party mediator in a conflict who then exonerates themselves, claiming they wish to remain neutral – pretending to mediate without doing so.
"I'm only telling the truth (to others) as I see it" or *"Gossip is juicer than responsibility"*.	The BS is self-righteous, jumps to conclusions without checking the facts and spreads gossip.
"I am only following orders" or *"It's more than my jobs worth"*.	The BS is taking a moral stand claiming an inability to act because they are subject to higher authorities – lacks empathetic connection or engagement.
"The truth lies somewhere in the middle" or *"Six of one and half-dozen of the other"*.	The BS avoids making difficult judgments by applying the rule that the truth lies somewhere in the middle. A basic misunderstanding of what truth is
"My contribution won't make much difference" or *"Who, me?"*	The BS believes that the power and politics of an organization are so great that an individual cannot have any influence on outcomes.
"I'm just keeping my own counsel" or *"I'm alright, Jack!"*	The BS refuses to risk their sense of well-being by getting involved in problems that do not affect them.
"Victim assumption" or "*The just world assumption*".	The BS assumes or believes that the victims of a perceived injustice brought it upon themselves.
" I don't want to rock the boat" or "*I don't want to raise a difficult issue*".	The BS usually acknowledges the issue, is sensitive to injustice but they fear conflict and confrontation and avoid the situation.

(Reproduced with permission from Clarkson)

WPB is not an isolated incident experienced by one person alone. As described previously, there have been witnesses (bystanders) and unreported incidents by targets. If reported, this information is not shared with others, often held by managers, and as nothing observable changes, it is assumed that nothing has been done. Clarkson (1993) named these phenomena as bystander games. However, it is preferable to acknowledge these as "roles," as they are often

played out unconsciously by witnesses (Figure 3). The bystanders are holding or withholding ethical information, thus subtly colluding with the bully by not acting.

Documentation in supervision is essential and may become legal property. Establishing the facts, gathering anecdotal information, and developing a formulation that can substantiate WPB takes time. It is necessary that a supervisee keeps a specific log of "where," "what," and "who" experiences (Field, 2006; Field, 2007b; Needham, 2005). For example:

> *August 3rd: Bill came marching down the corridor, grabbed my arm, and pulled me into an unattended office and shouted, "Get that ***** project on my desk by lunchtime." He walked out not allowing me to reply. I felt humiliated, pressured, disrespected, and emotionally disabled.*

Initially, WPB logs read as isolated incidents. When compiled into a timeline along with witnesses, evidential phone calls, emails and letters, they become a powerful story. Although appearing emotive, documentation will be useful in any ensuing legal process.

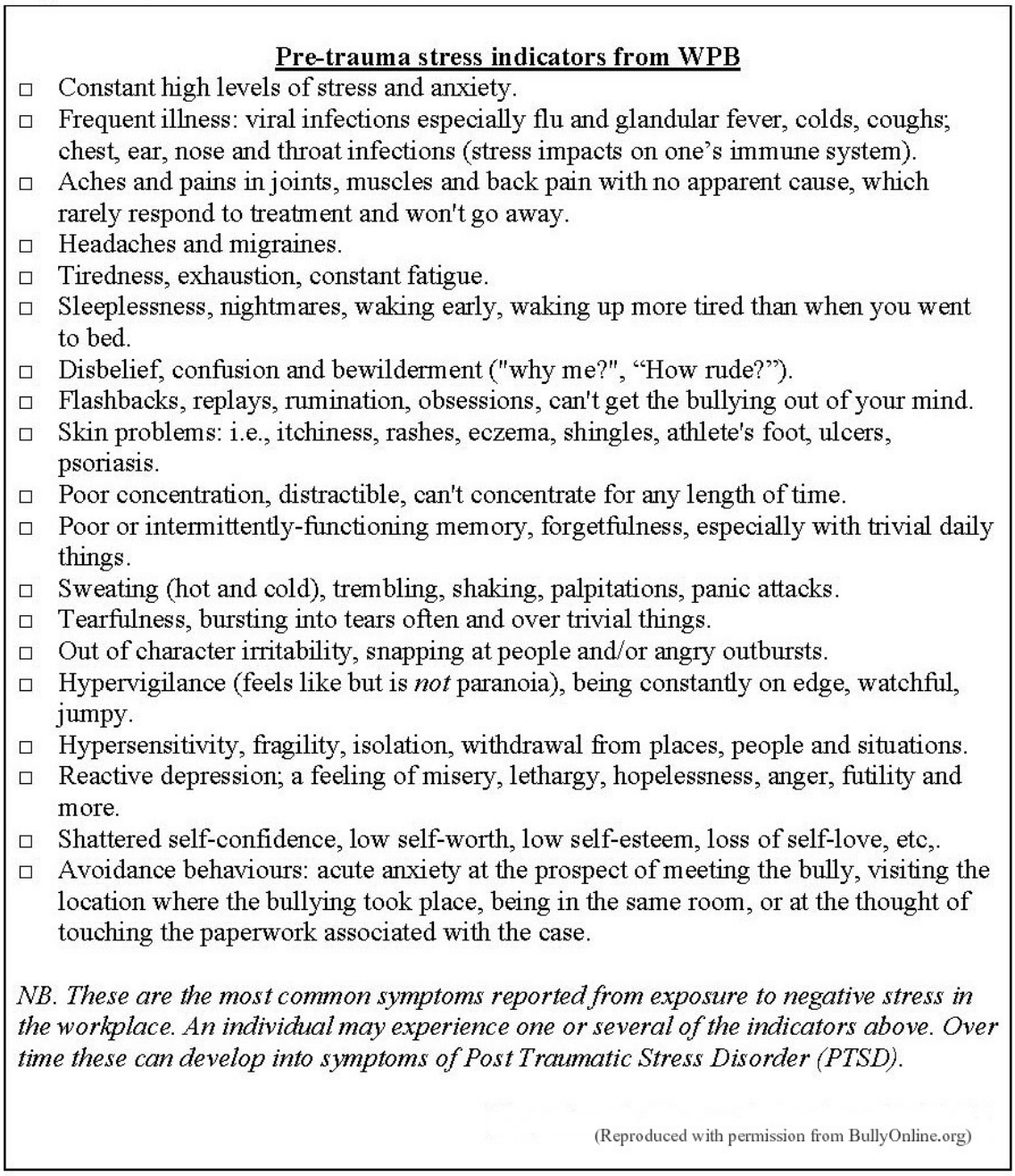
5.2. Step 2: Assessment

Emotional competence is an area often affected by WPB. Nurturing the supervisee's spiritual and emotional capability is part of the supervisor's role (Gilbertson, 2006; Goleman, 2004; Sheehan, 1999). Emotional competence includes self-awareness, self- regulation, motivation, social competence (how we manage relationships), empathy, and social skills (Goleman, 2004). It is a useful framework for guidance in supervision practice that enhances understanding of self and others, consequently providing opportunities for change (Carroll & Gilbert, 2005).

Performance issues may depend on personal resilience and emotional competence of the supervisee (Goleman, 2004; Reivich & Shatte, 2005). When competence to practice becomes a concern, the New Zealand Health Practitioners Competence Assurance Act (MOHNZ, 2003) directs that legitimate inquiry into practice by the professional organisations is essential to supervision and the welfare of the supervisee.

Recognizing and assessing the degree of trauma experienced by the supervisee is essential before it becomes a major health problem (Howard, 2007). Supervisors are an important mitigating force in preventing stress-induced poor judgments due to the insidious and emotional nature of WPB. A stress indicator (Figure 4) is helpful to verify these feelings.

Figure. 4. Pre-trauma stress indicators



Pre-trauma stress indicators from WPB

- Constant high levels of stress and anxiety.
- Frequent illness: viral infections especially flu and glandular fever, colds, coughs; chest, ear, nose and throat infections (stress impacts on one's immune system).
- Aches and pains in joints, muscles and back pain with no apparent cause, which rarely respond to treatment and won't go away.
- Headaches and migraines.
- Tiredness, exhaustion, constant fatigue.
- Sleeplessness, nightmares, waking early, waking up more tired than when you went to bed.
- Disbelief, confusion and bewilderment ("why me?", "How rude?").
- Flashbacks, replays, rumination, obsessions, can't get the bullying out of your mind.
- Skin problems: i.e., itchiness, rashes, eczema, shingles, athlete's foot, ulcers, psoriasis.
- Poor concentration, distractible, can't concentrate for any length of time.
- Poor or intermittently-functioning memory, forgetfulness, especially with trivial daily things.
- Sweating (hot and cold), trembling, shaking, palpitations, panic attacks.
- Tearfulness, bursting into tears often and over trivial things.
- Out of character irritability, snapping at people and/or angry outbursts.
- Hypervigilance (feels like but is *not* paranoia), being constantly on edge, watchful, jumpy.
- Hypersensitivity, fragility, isolation, withdrawal from places, people and situations.
- Reactive depression; a feeling of misery, lethargy, hopelessness, anger, futility and more.
- Shattered self-confidence, low self-worth, low self-esteem, loss of self-love, etc,.
- Avoidance behaviours: acute anxiety at the prospect of meeting the bully, visiting the location where the bullying took place, being in the same room, or at the thought of touching the paperwork associated with the case.

NB. These are the most common symptoms reported from exposure to negative stress in the workplace. An individual may experience one or several of the indicators above. Over time these can develop into symptoms of Post Traumatic Stress Disorder (PTSD).

(Reproduced with permission from BullyOnline.org)

Pre-trauma stress indicator

People respond with various degrees of stress to different stressors. Evaluation may lead to medical intervention or related assistance. According to Kinchin (2005), there are four factors that identify the degree of the individual's stress.

- *Control*: stress to the extent where they perceive they are not in control of the stressor.
- *Predictability*: stress to the extent where they are unable to predict the behaviour or occurrence of the stressor. Bully behaviour is usually unpredictable.
- *Expectation*: stress to the extent where they perceive their circumstances are not improving and will not improve. A bullying situation usually becomes worse as insight increases.
- *Support*: stress to the extent where they lack support systems, including work colleagues, management, family, friends, persons in authority, official bodies, professionals, and the law.

Following assessment and identification of stressors, an ethical reasoning process may take place.

Step 3: Ethical reasoning

Three models of ethical reasoning influenced the development of the SPC. No model can adequately capture the legal and ethical complexities faced by the supervisor and supervisee. However, these guidelines provide a systemic approach to the problem and an evidence-based safeguard (Dewane, 2007). They assist in transcending the emotive and judgmental issues that pervade this task.

Gilbert & Evans (2002) suggest five major areas to consider, emphasizing the influence of unconscious processes, counter transference and parallel processes. Carroll & Gilbert's (2005) model heightens ethical awareness for action and accentuates living with the ambiguities of having made a decision. Hansen & Goldberg's (1999) model, a multi- dimensional framework, incorporates moral principles and personal values, clinical and cultural factors, professional codes of ethics and conduct, agency and employer policies, national and local statutes, rules and regulations, and, where appropriate, case law.

Step 4: Decision-making process

It takes moral courage to report on abuse, retaliate, and become involved with the subsequent processes (Needham, 2005; 2008). The repetitiveness of bully behaviours causes a never-ending series of intense emotional experiences that disempower and subdue. Kidder (2005) explains that when the core values of moral courage, honesty, respect, responsibility, fairness, and compassion interconnect with danger and endurance, moral courage is elicited. To develop moral courage, he suggests assessing the situation, scanning for values, standing for conscience,

contemplating the dangers, enduring the hardship, and avoiding the pitfalls. It is part of the supervisor's role to nurture moral courage in ourselves and for supervisee support.

Following ethical reasoning, the supervisee may be ready to discuss a course of action. There are generally three choices.

- To disclose officially and retaliate/challenge the bullying.
- To disclose to the supervisor only and continue to work.
- To disclose to the supervisor only and seek other employment.

The supervisor builds on the supervisee's strengths, a restorative perspective, which is connected to competency and outcomes through understanding and exploring choices. Exploring alternatives is a helpful strategy, when reflecting on the consequences of each decision before making a final choice "to tell or not to tell."

While monitoring competency to practice, a supervisor may propose three roles of care until the WPB experience ends: Plan (A): Support and coaching; Plan (B): Empowerment Plan; (C): Advocacy. Some supervisees may choose all three (Figure 5). These roles assist the supervisee to implement and live with the ambiguities of his or her ethical decision. It may not be the perfect solution. The supervisee's choice is made in consideration of his or her best interests and

Figure 5

Case Example: A Supervision Process of Care over 18 Months

Identification:
Simon held a position of responsibility as an assistant manager for an organization. During supervision, Simon expressed his concerns that a challenging colleague (Bob) may be a workplace bully. The supervisor suggested relevant literature and resources that outlined bullying behaviours, the effects and cost to productivity. Both parties kept supervision logs and Simon recorded the "where, when, and what" incidents witnessed or experienced that demonstrated 'bully' behaviours towards himself and others.

Assessment:
Bob's behaviours were reported to Simon and his line manager by 'targets' and 'bystanders' in the organisation. These behaviours met the criteria of WPB. Simon accessed the organisations policies revealing a complaints procedure that went directly to the organization's head manager. There was no mention of harassment or bullying. Simon attended a seminar to increased his knowledge on WPB and the legal ramifications. Simon's symptoms as a target emerged with this increase understanding and reflection, i.e. low mood; self doubt, performance anxiety, rumination, and avoidance behaviours towards Bob were recognized. Simon was also being bullied, subtly and insidiously over time; by email, verbal innuendoes and finally covert and overt confrontations. He began to question his own work performance and shared this with his supervisor. Simon's initial reaction was disbelief gradually turning into feelings of disempowerment and despondency.

Ethical reasoning:
Ethical reasoning was required to resolve the issue before Simon's performance came into question within the organisation. The model used took into consideration Simon's current health status of stress, panic attacks and difficulties in making decisions. A plan of action was developed as it became apparent that others in the organization were also suffering from Bob's abusive behaviours. Both supervisor and supervisee perceived this as a major ethical, health and safety issue within organizations. Simon chose to retaliate (fight back) and requested support from his supervisor to act as an advocate in the process and throw light on the WPB within the organisation.

The plan:
- To approach the manager to discuss the issue of bullying within the organization
- To provide literature on WPB and anecdotal evidence gathered by SEE
- To recommend external remediation as advocated by literature
- To identify the organizations provision of support for both targets and the bully
- To make a further decision for legal support if and when it became necessary

Support/coaching, empowerment, advocacy:
Simon chose all three options in the care process. He was coached in role modeling of behavioural and verbal responses for use when challenges arose, i.e. safety in meetings with the Bully, knowing when to withdraw from conflict and protecting oneself. Self esteem and self help programmes on resilience were used to maintain emotional competence. Advocacy took the form of support person, silent witness and where indicated by Simon, a spokesperson.
Approaching management initially gained support for Simon. Management chose a systemic approach (internal) rather than call in experts (external). A 'form of a mediation' took place between Bob and Simon with an adjudicator who chose to make the issue a 'conflict of personality' thereby demeaning the real issue. Furthermore, management undertook to administer a 360 report on Simon's work practice that was completed by Bob and by colleagues he had previously targeted. Results of these two actions made no change in the situation and left Simon feeling demoralized, humiliated and misunderstood.
Without his manager's support Simon's distress increased. He took medical advice, located an external stress counsellor experienced in workplace trauma who recommended a lawyer to combat the ethical and legal issues of an unsafe work environment. Simon was advised to take medical leave while supervision continued to concentrate on a restorative process

Closure:
Supervision continued with moving on becoming important. The Supervision sessions supported Simon in his decision making and to transition to a new work position within another organization. Closure was in the form of documentation and reflection.

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information available. The withholding of ethical information and the possible impact on the supervisee's performance and welfare of client's needs to be conscientiously discussed (Geldard & Geldard, 2006; Gilbert & Evans, 2002; Scaife, 2001b).

Step 5: Potential roles of supervisor

Support and coaching

Managing anxiety arising from the decision (Carroll & Gilbert, 2005), facilitating critical reflection and ongoing problem solving, supports the supervisee. In this role, the supervisor can draw upon supervision skills. This may necessitate increasing supervision to include telephone calls or e-mails, particularly if retaliation has been chosen as an option. The supervisee will be encouraged to plan for the future regarding his or her reactions, actions and alternative employment. Coaching may be a useful technique for supporting the supervisee to move forward (Brockbank & McGill, 2006).

Organisational, health, or legal assistance will require further discussion. For example, this may include letting go of the ethical dilemma, accepting the limitations of the decision, seeking medical assistance, or taking stress leave. The supervisee may wish to access internal work-related systems (Employment Assistance Policies), external counselling, or legal assistance, particularly if he or she decides to retaliate.

Empowerment

Maintaining or building self-esteem and resilience is an integral part of supervision. The supervisor may recommend choices for the supervisee about taking care of him- or herself. Self-help programmes may prove useful for supervisees while the supervisor monitors progress and competency to practice. For example: A self-esteem building programme, developed by Self-Esteem Seekers Anonymous for the Internet (Messina & Messina, 1999), may prove beneficial for supervisees. It assists in identifying the negative impact of low self-esteem and provides a programme for recovery.

Alternatively, a resilience building programme, a cognitive behavioural approach based on 15 years of research, was considered in practice by supervisees as the most helpful resource (Reivich & Shatte, 2005). Capacity for resilience is not a genetically fixed trait, nor are there limits on how resilient a supervisee can become. Beliefs can be changed, and abilities can be boosted.

Resilience is comprised of seven abilities: emotion regulation, impulse control, empathy, optimism, causal analysis, self-efficiency, and reaching out.

Literature indicates developing a 'circle of care,' calling upon bystanders, colleagues, friends, and family to support the supervisee. It is believed that collaborative group pressure is one way to manage future interactions with the WPB, such as meetings to discuss offensive behaviours (Ball, 2006; Mueller, 2005; Larsen, 2007). This supports the supervisee's decision to stay and may help confront these ethical issues at an operational, systemic level.

Advocacy

Advocacy in supervision is about fairness and equity, key social justice components. Supervisors can advocate as and where indicated for social justice, individual rights (moral claim for freedom of action), and the health and welfare of the supervisee when organisational injustice occurs (Cooper, 2002). In this role, the supervisor can offer to be a witness, silent or otherwise, and support person. These actions sustain the supervisee through difficult and challenging circumstances. Example: a silent witness or spokesperson (when indicated by the supervisee in times of intense emotional stress), in formal or informal consultations, investigations, or mediation processes, systemic or legal.

Social justice issues are incorporated into supervision literature (Copper, 2002; Scaife, 2001a). It focuses on human rights, respecting the values of fairness and equity, acknowledging and understanding the positive and negative power and how this may impact on the supervisor and supervisee (Cooper, 2002; Hewson, 2005). It advocates power purposefully for the common good.

Step 6: Closure

To facilitate closure, the supervisor can encourage debriefing sessions, plans for transition, either to new employment, or to an altered way of working within the same organisation. Feedback is important in the care process in order to file documentation and relevant material. A celebration is frequently considered a satisfactory way to bring about closure. Following closure, regular supervision may resume.

Conclusion

This paper discusses complex ethical dilemmas that disclosure of WPB raises for a supervisor and supervisee in their contractual relationship. Viewpoints are based on anecdotal and clinical experience, supported by literature within the context of New Zealand legislation and

therefore limited by their lack of empirical evidence. Figures, including demonstration of early signs of workplace stress, WPB triad, and the bystander roles, are used to increase recognition of the ethical dilemma.

The supervisor's accountability has been discussed relative to supervision contracts, confidentiality, and legal implications, together with the ethical dilemma "to tell or not to tell" being raised. The questions concerning holding and withholding of ethical information and the consequences remain unanswered. A compilation of resources has been outlined to emphasise organisational and legal processes in an attempt to discover a solution. Findings suggest that this ethical decision remains significantly with supervisees and the systems that support them. Despite the good intentions of systems to address the issue, they are often considered unsafe or unsuitable by the supervisee for WPB.

A transparent and collaborative Supervision Process of Care model is proposed together with a case example that illustrates the efficiency of this process. The SPC is considered appropriate for all health, allied health, and educational professionals and non- governmental organisations to monitor the health, welfare, and competency to practice of the supervisee. The discussion emphasises the need for knowledge and understanding of supervision ethics, systemic pressures, and trauma of WPB.

The question remains: those with the power to create change appear to need further education and determination when it comes to resolving WPB. It is suggested that organisations need the cooperation of all employees, together with policies that reflect safe, healthy workplaces. These include an ethical Code of Conduct and informed, courageous, and effective leadership that will address the costly issue of workplace bullying. Could a Code of Ethics for supervision or a Code at the organisational/service level, linked to appropriate service and or legal policies, provide guidance for resolving WPB, given that literature suggests they are currently powerless to address complex issues?

Further research of the emotional trauma experienced by the targets that is not seen as noteworthy in the early stages, the impact on competency to work given due consideration, and investigation into the probability of classifying the trauma resulting from WPB as a serious health issue is recommended. Early identification at the operational level of organisations and by

employees, and by community general practitioners, would be exceedingly valuable and prevent the occurrence of serious illness such as PTSD as a direct result of WPB.

This paper has hopefully gone some way towards providing information for further thought and consideration of the role of the supervisor in WPB, the ethical issues which arise together with a model to support the supervisee while maintaining competency to practice.

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Book Reviews

Roberts, A. R. (Ed.). (2009). *Social Workers' Desk Reference, 2nd Edition.* New York, NY: Oxford University Press. Reviewed by Georgianna Mack, MSW, PLCSW, Assistant Professor of Social Work, University of North Carolina at Pembroke.

The late Albert R. Roberts, Ph.D. was a Professor in the Criminal Justice Program at Rutgers, The State University of New Jersey in Piscataway, New Jersey. He was a college professor for more than 35 years and taught criminal justice and social work courses for 19 years at Rutgers University. Professor Roberts published widely in the areas of Victimology, Domestic Violence, and Crisis Intervention. In addition to being the Editor-in-Chief of the *Social Workers' Desk Reference,* he has more than 250 publications, including 38 books. He was also the Editor-in-Chief of the journals *Brief Treatment and Crisis Intervention* and *Victims and Offenders.* He also edited the Springer Series on Social Work, the Springer Series on Family Violence, and the Greenwood Series on Social and Psychological Issues.

The 1st edition of the *Social Workers' Desk Reference* was edited by Albert R. Roberts and Gilbert J. Greene and published in 2001. It contained 146 chapters and 910 pages. The 2nd edition has grown to 171 chapters and 1,267 pages. Associate Editors were directly responsible for the content of the chapters they wrote and the revisions of chapters in their section that appeared in the first edition.

This enhanced edition continues to provide students, teachers, and practitioners an effective resource tool reflecting best practices in the social work field. It continues the tradition of the 1st edition by providing the reader the most up-to-date information in a straightforward manner written by experts in their areas of practice.

New to this edition is an Introduction and Overview, Part 1, Chapter 1, *The Synergy and Generativity of Social Work Practice*, written by Anita Lightburn. The author stresses changes in the profession in the seven years since the first edition and the attention to developing evidence-based practice in diverse settings. She addresses *The Strength of Multiple Perspectives* and the structure of service delivery changes. She states that "this well-honed prodigious work will be a critical support to social workers as we reaffirm what is relevant and define what needs to be known to practice in new contexts and transform how we work in traditional settings."

Part II: Roles, Functions, and Typical Daily Schedule of Social Workers in Different Practice Settings. In chapters 2 – 13, areas of practice are presented by professionals discussing activities that they engage in on a typical day.

Part III: Social Work Values, Ethics, and Licensing Standards is expanded from four chapters in the 1st edition to 11 chapters in the 2nd. Malpractice lawsuits, social work licensing examinations, social work regulation and licensing, the impaired social work professional, patient safety standards, procedures, measures, and quality standards and quality assurance in health settings. The section on online social work – ethical and practical considerations was expanded to the role and regulations for technology in social work practice and e-therapy social work.

Part IV: Theoretical Foundations and Treatment Approaches in Clinical Social Work. This area added four additional chapters. Significant is chapter 44 "How clients can effectively use assessment tools to evidence medical necessity and throughout the treatment process."

Part V: Assessment in Social Work Practice: Knowledge and Skills – This area reviews the DSM-IV-TR, its use and guidelines. Chapter 47, "Clinical Assessment of Bipolar Disorder: Balancing Strengths and Diagnosis," is new to this edition. The use of case examples clearly contributes to a better understanding of the disorders and symptoms associated with them.

Part VI: Working with Couples and Families – A number of chapters have been revised and added. Chapter 66, "Psychoeducation," discusses interventions that focus on educating clients in a topic area. It relies on learning theory, cognitive psychology, dynamic psychology, and developmental psychology.

Part VII: Developing and Implementing Treatment Plans with Specific Groups and Disorders – Chapters were updated and Chapter 71, "Using Evidence-Based Practice and Expert Consensus In Mental Health Settings: Step by step Guidelines for Schizophrenia," was added.

Part VIII: Guidelines for Specific Techniques was expanded from the 1st edition to include *Part IX, Guidelines for Specific Interventions.* The interventions are clearly outlined and case examples add to knowledge.

Part X: Case Management Guidelines – This area is significant in that it gives an overview of case management, followed by services involved in working with various populations.

Part XI: Social Work Fields of Practice – This area discusses the current and future status of social work in a number of practice areas, including adult mental health, alcohol and drug

dependence, proactive model of health care, and evidence-based practice in older adults with mental health disorders.

Part XII: Community Practice – Chapters in this area address "An Integrated Practice Model for Family Centers, International Perspective on Social Work Practice" and principles and practice guidelines in a number community support areas.

Part XIII: Working with Vulnerable Populations and Persons at Risk – The chapters in this area present a revision; initially it provides an "Overview of Working with Vulnerable Populations and Persons at Risk," and specifically discusses certain groups (LBGT, Older Adults, Refugees and Immigrants, Native Americans, Asian and Pacific Islanders, Latinos, and African Americans). Chapter 144 discusses and illustrates a culturagram that assesses the role of culture in a family and is a supportive tool to the eco-map and genogram.

Part XIV: School Social Work – This is a new section and addresses a number of issues specific to school social work. It begins with an "Overview of Current and Future Practices in School Social Work" and "Evidence-Based Violence Prevention Programs and Best Implementations."

Part XV: Forensic Social Work – An overview is presented, followed by chapters that support and define forensic social work, including "Expert Witness Testimony in Child Welfare," "An Interest-Based Approach to Child Protection Mediation," "Children Exposed to Domestic Violence," "Step by Step Guidelines for Assessing Sexual Predators," and "Elder Abuse".

Part XVI: Evidence-Based Practice – Chapters 161–171 support the overall science of Evidence-Based Practice. Experts in the field discuss "Developing Well-Structured Questions for Evidence-Informed Practice," "Locating Credible Studies for Evidence-Based Practice," as well as random trials, meta-analysis, systematic reviews, and practice guidelines.

The Social Workers' Desk Reference is a must have resource document for all social work practitioners. The text creates an environment for learning from the beginning to the end. The content is easy to read and understand. Students, educators, and practitioners will find it valuable as a reference guide in learning new knowledge and keeping updated with concepts, theories, and interventions that pertain to social work practice. The chapters contain Web sites and references, and most contain case examples that facilitate learning. The glossary is very well done and enables

a quick and easy explanation for terms and topics. Also included are an author index and subject index.

Sowers, Karen M. and Dulmus, Catherine, N. (eds.) (2008). *The Comprehensive Handbook of Social Work and Social Welfare* (4 volumes). Hoboken, NJ: John Wiley & Sons. Reviewed by: Stephen M. Marson, Ph.D., senior editor, and Ashley N. Bunnell, BSW candidate University of North Carolina at Pembroke

Upon first seeing *The Comprehensive Handbook of Social Work and Social Welfare* for the first time, one will be immediately struck with two reactions. First, one will be overwhelmed with its mass. *The Handbook* includes four hefty volumes. Second, since it was published the same year as *The Encyclopedia of Social Work,* a question will emerge: Was the *Handbook* published in order to compete with the *Encyclopedia*[1]The first part of this review includes a comparison between the works. The second part will examine the content.

Table 1 illustrates a quantitative comparison. Overall, the size, measured in page numbers, illustrates little difference. The *Handbook* has slightly more pages, but not significantly. The major quantitative differences exist in number of authors and chapters. Clearly, the *Encyclopedia* has significantly more authors and chapters. Our analysis shows that 31 authors are shared, but the content written by these 31 authors is not repeated. Thus, both the *Handbook* and *Encyclopedia* offer unique contributions.

Table 1

Characteristics	Handbook	Encyclopedia
Authors	119	569
Unique Authors	78	538
Shared Authors	31	
Pages	2,191	2,153
Chapters	114	296[2]

If one opens both works, two aspects are immediately apparent. First, the font size within the *Encyclopedia* is slightly smaller. Second, the pages within the *Encyclopedia* have a slight tan tint, whereas the pages of the *Handbook* are a purer white. Both reviewers independently concluded that the *Handbook* would be easier on the eyes over a long period of reading. These differences provide insight into the mission and nature of these two works. Clearly, the publishers did not intend to have competing works.

The *Encyclopedia* is available in an electronic version. The last edition of the *Encyclopedia* was not particularly user friendly; the current version has made the hard copy nearly obsolete and rarely used. During the writing of this book review, the *Handbook* was not offered in an electronic

[1] See Marson, S. M. & Dovyak, P. (2008). A book review of The Encyclopedia of Social Work, in The Journal of Social Work Values and Ethics, 5 (2): online at http://www.socialworker.com/jswve/content/view/89/65/

[2] This excludes biographies published in the Encyclopedia.

version. Just prior to publication of this review, an electronic version became available and information can be found at:

http://mrw.interscience.wiley.com/emrw/9780470373705/home/Order.html.

We have not had an opportunity to review the electronic version. The mentality of social work students and junior faculty has radically changed. They prefer electronic versions to hard copies.

Although difficult to uncover, the missions of the two works are quite different. The primary mission of the *Handbook* is:

> ...to focus on evidence supporting our theoretical underpinnings and our practice interventions across multiple systems. Content was designed to explore areas *critically* [italics added] and to present the best available knowledge impacting the well-being of social systems, organizations, individuals, families, groups, and communities. The content is contemporaneous and is reflective of demographic, social, political, and economic current and *emerging trends* [italics added] (page xi).

The emphasis placed on the words *critically* and *emerging trends* reflects the major difference between the *Handbook* and *Encyclopedia.* The style and content of these two volumes are quite different.

The Profession of Social Work Volume 1 is primarily an introduction to the profession. Entry level students are initially troubled by the expansiveness of client, target and action system.

Volume 1 offers an unambiguous conceptualization of social work that helps clarify the multi-dimensions of contemporary social work practice. Although the volume creates an accurate picture of the expansiveness of contemporary social work practice, simultaneously it demonstrates that this vastness of practice is manageable. This is a great volume for entry level BSW and MSW students.

The chapter written by Elizabeth DePoy and Stephen Gilson entitled, "Healing the Disjuncture: Social Work Disability Practice" offers a slightly different theme from the other chapters within volume 1. Although they begin their work with a traditional social work focus, they go off the beaten path and offer a different and refreshing alternative for the delivery of disability services. After reading their work, we are not sure that the term "disability" is proper or appropriate nomenclature.

Human Behavior in the Social Environment Volume 2 is reminiscent of Francis J. Turner's seminal work entitled *Social Work Treatment*. Although Turner is not the editor of this volume, he is one of the contributors. Like Turner's work, this volume offers a large variety of theories dealing with social, psychological, biological, and cultural factors linked with the individual and group development as it applies to the social work profession. Volume two also focuses on the study of behavior and life cycle development. It also addresses sub- systems within each theory within the context of the culture, organization, community, society family, and the individual. However, since the last edition of Turner's work was published in1996, the second volume of the *Handbook* is a necessary adoption for all social work libraries. Students, BSW, MSW and Ph.D., will find this volume an invaluable asset to their learning.

One particular chapter that is *not* reminiscent of Turner's work is Bruce Thyer's contribution entitled, "The Potential Harmful Effects of Theory in Social Work." Thyer's reputation as a maverick blossom forth in these pages. For a period of three days after reading it, we were totally preoccupied with his presentation. His views are a radical departure from the norm. We think that all professors need to read this work. Thyer's insights will guide professors to be better in the instruction of theory – particularly theory found in the HBSE courses. However, we have placed it on our blacklist for BSW students. The major problem with Thyer's contribution is not immediately obvious. Students, BSW and MSW, will conclude that they should not expend their energy on learning theory. Thyer is a real paradox. On one hand, for readers who are well versed in theory construction, his contribution is incredibly profound. For those readers who are untutored or lacking theoretical sophistication, comments like, "I want to be theory-free in my social work practice," are likely to emerge.

Social Work Practice Volume 3 consists of the professional application of social work values, principles, and techniques in a micro, mezzo, and macro scope. Factors of assessment, intervention, and specific populations are described. Individuals, families, groups, communities, and organizations are the overview of each chapter. Volume 3 would be useful to one who wants to know what exactly the social work practice requires; this volume offers a full knowledge of the human behavior and development, through social, cultural, and economic factors.

A contribution, typified within Volume 3, is the work Mart C. Ruffolo and Paula Allen-Meares entitled "Intervention with Children." Here the authors assist the reader to appreciate

various styles of practices for children at risk. On a micro level, the chapter offers details of the application for three types of empirically supported interventions, including cognitive behavior, multisystemic, and brief strategic therapy. As with the theme of the entire handbook, the authors go beyond micro. They include a refreshing and even-balanced examination of mezzo and macro intervention. The macro presentation is particularly inspiring, because the presentation is conceptually linked to the micro and mezzo sections. The authors demonstrate a rare creative ability to seamlessly link different levels of intervention (micro, mezzo and macro) into a unifying framework. This is an extremely difficult writing task that the authors execute flawlessly. As with the other chapters within this volume, the authors offer an analysis and plan that is rare in the social work literature.

Social Policy and Policy Practice Volume 4 provides two different views of policy. The first view is the traditional policy perspective that dominated social work education from the 60s to the first edition of Jansson's *Social Welfare Policy: From Theory to Practice* in 1990. Approximately a third of the chapters embrace a perspective that perceives social policy as an activity of great people making great decisions for the great masses. Although there is an important place for great ideas, this perception has greatly impeded the acceptance of BSW generalists and clinical social workers from accepting social policies as a relevant component of their social work education. MSWs who are or have focused on management, administration, and policy construction find this perspective energizing, while others quietly think the study of social policy is irrelevant.

Ira Colby, the editor of this volume, understands that the dynamics of social policy are critical components of service delivery. Thus, he made sure the presentation of social policy is comprehensive and palatable to those who do not specialize in policy, such as generalists and clinicians. Two particular chapters stand out: "Policy Practice" by Rodney Ellis and "Social Welfare Policy and Politics" by Richard Hoefer. These authors emphasize and introduce policy as *more* than an activity of "great thinkers" and "great ideas." Both of these chapters are intended to introduce their respective sections. However, the emphasis is clearly focused on readers who do not have a passion for policy. One weakness of instruction of social policy in higher education is the perceived lack of relevance to those who do not specialize in policy. If the publication of this

Handbook does nothing else except make social policy more palatable to the readers, it has made a significant contribution to the social work literature.

The Comprehensive Handbook of Social Work and Social Welfare is an outstanding contribution to social work literature. Although its initial appearance is that of an encyclopedia, it is nothing like *The Encyclopedia of Social Work*. *The Handbook* offers a unique and practical view of social work. We recommend that all academic libraries adopt this volume. Social work professors need to review it. These volumes will make significant contributions to student learning.