Editorial: "You'll not see nothing like the mighty Finn."

About 12 years ago, the BPD (Baccalaureate Program Directors) Board of Directors requested that the Committee on Information Technology and Social Work Education (CIFTSWE) disseminate technology information that could assist faculty members for the enhancement of the curriculum. To address this issue, the committee formed nine subcommittees, one for each of the curriculum areas. Each subcommittee became responsible for constructing a Web page as an avenue to disseminate cutting edge (or "bleeding edge") curriculum information. Jerry Finn developed the HTML format for all of the committees.

Jerry Finn and I were on the Social Work Values and Ethics Subcommittee. We had an epiphany. Values and ethics was the *only* curriculum area that lacked a journal. Thus, *The Journal of Social Work Values and Ethics* was born. We spent about three years studying the legal issues and searching for a publisher. Jerry and I attended numerous meetings in search of a publisher. While Jerry negotiated, I tried to restrain myself from speaking.

The development of *The Journal of Social Work Values and Ethics* was a Herculean task. Our journal would not exist without Jerry

Finn. Jerry and I have well-balanced personalities. Jerry is a true gentleman in the classical sense of the word. He is well organized and thinks before he speaks. He is strategic in his planning. As for me, I have none of these qualities. I know that I have too

much energy that must be tempered. Jerry, in his gentlemanly style, can control my over-abundant enthusiasm. As I was composing this tribute to Jerry, Dylan's song, "You'll not see nothing like the mighty Quinn," continued to pop into my head. Yes, Dylan's Quinn is like our Jerry Finn. The bottom line is this: Jerry's thoughtfulness enabled JSWVE to be born.

Jerry stated that he wanted to retire and get off our board. However, he graciously agreed to continue to work until I could find a suitable replacement. For the past two years, I have been in somewhat of a quandary. Frankly, I did not think I could find someone with Jerry's temperament. The search to replace Jerry was another Herculean task. I found someone who is willing to work with me! So – there must be a God.

I have known Donna DeAngelis since 1991. Currently, Donna is the Executive Director of the Association of Social Work Boards (ASWB). ASWB manages and controls the board exams for social work licensing and certification. When I first offered Donna the position of

co-editor, she was very reluctant. When I explained that her primary duty was to control me, she said, "Well, I've been doing that for over a decade."   She happily agreed and now I feel assured that JSWVE will continue to thrive.

Jerry, we will greatly miss you! Donna, welcome aboard!

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Steve Marson, Ph.D.
Senior Editor

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Editorial: A Dedication to Carol J. Williams

by Steve Marson, Ph.D.

Journal of Social Work Values and Ethics, Volume 8, Number 1 (2011)

I first met Carol in 1994 when she first joined the BPD's (Baccalaureate Program Director) Committee on Information Technology and Social Work Education (CIFTSWE). During that time frame, the committee members were frantically seeking to diversify its membership. Carol was the first woman to admit that she shared our nerd-like passion for computers and technology.

Unlike the rest of us, Carol was always quiet and unassuming.   I vividly recall the day when she told me that she had an MS in computer science. As it turned out, this quiet and unassuming woman had greater knowledge of computer technology than the entire membership of the committee. Her shyness was often *misinterpreted* as a lack of self-confidence.

This misinterpretation became apparent in 1998-1999. The entire computer-dependent world was on the threshold of panic while awaiting Y2K.* The BPD Board of Directors commissioned CIFTSWE to address the Y2K issue during the fall conference in St. Louis. Carol's quiet but self-confident posture reassured the BPD membership when she spoke to a standing room only presentation entitled "Y2K: Will my computer crash on January 1, 2000?" (at the 16th conference). Carol was able to translate her intimate knowledge of computer programming to reduce panic by explaining the specific problems *and solutions* that social work educators, students, and practitioner would face for Y2K. The attendees left the presentation reassured. The logo for the presentation was recycled on many BPD documents related to computers and technology.

Five years ago, Carol once again came to the rescue. As editor of JSWVE, I was having some technical difficulties. Although very busy, Carol went out of her way to assist me. It was at that point that I begged Carol to join the editorial board as a technical advisor. She did and was a great asset to our work. Her absence leaves a great void in the management of JSWVE.

After a long battle with cancer, Carol died Friday, November 12, 2010, at St. Peters University Hospital in New Brunswick. Later, Boylan Funeral Home handled a private cremation. On December 5, 2010, a memorial service was held where social work professors, students, and practitioners said their final good-byes to Carol. Following are memorial statements made by her friends and colleagues:

Carol was one of the BEST friends and colleagues that I have had the pleasure of having known. We met at the BPD Conference in San Diego more than 20 years ago, and we instantly became friends and colleagues. Carol and I published together and we would laugh that it took the two of us to publish, because both of our universities offered us limited resources. She had the resource of SPSS available, and I had limited funding available for the study. Her husband O'Neal was always by her side at our BPD conferences and in many ways became part of the BPD family.

Carol, I will miss you dearly. I am ever grateful that our paths crossed and that you shared your friendship and love.

Gloria Duran Aguilar, PhD, ACSW
Florida A&M University

I received the news that BPD member Carol Williams passed away over the weekend. Carol Williams of Kean University was a long-time member of BPD who made many significant contributions to the association. Many may know her as the publisher of the BPD Update, but she also served on a number of committees, including gerontology and technology. She was serving as a current member of our Nominations Committee.

She had been ill for some time and was receiving support from her husband, O'Neal. Carol will be missed by all who knew her, and BPD was significantly enriched by her presence. Please join me in expressing the deepest sympathies for the family.

Michael R. Daley, Ph.D., ACSW
President, Association of Baccalaureate Social Work Program Directors

I can't believe that I won't see Carole at the next conference. I always looked forward to catching up with Carole and O'Neal. She was always smiling and warm and helpful with anything you might need.

Deneece Ferrales, Ph.D., LCSW

Folks, I hardly "knew" Carole--we met face to face only once. But I relied on her technical knowledge, and we were long time e-mail buddies. I feel like I am out on a tightrope without a net now that she is gone. What a loss!

Susan Sarnoff

* During the 1960s to late 1980s there was a widespread practice in all computer software to use two digits for representing a year rather than using four digits. As the 1990's approached, experts began to realize that the use of two rather than four digits was a major shortcoming in computer software. In the year 2000, some computer systems would interpret 00 as 1900. This would cause massive shutdowns for millions of computer databases that used dates – including social work practice records. The panic was coined "Y2K." Large corporations were hiring computer programmers to debug their mainframes. Commonly, those who had Y2K skills were making $500 an hour for debugging. Everyone was in a panic!

Discursive Practices in Working with Pregnant Women "At Risk": Implications for Social Work Ethics

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Abstract

Perinatal social workers often find themselves participating in practice situations which involve pregnant women who are deemed "at risk" by health and social care networks. Through the theoretical lens of Michel Foucault, this paper will discuss the process and implications of designating some pregnant women as "at risk," identify challenges in ethical social work decision-making practices, and consider competing discourses and discursive practices that surround knowledge, power, and discipline.

Key Words: Foucault, Perinatal, Hospital Social Work, Ethical Decision-Making, Ethics

1. Introduction

Social work is among a number of different professions that pride themselves on values and ethics. However, the lens through which social workers view ethics constantly evolves over time (Reamer, 1999). Social workers are encouraged to view issues through multiple lenses and these lenses shift in response to cultural and societal developments (Reamer, 1999). Hospital social work is diverse and responds to psychosocial issues pertaining to vulnerable "at risk" populations including the perinatal and neonatal population. The emergence of complex psychosocial issues involving competing values suggests the importance of critically examining the implications of ethical dilemmas that surround the process of designating certain pregnant women as 'at risk'. Social work recognizes ethical dilemmas as situations with competing values, principles, and obligations (Reamer, 1999). Principles that are often embedded in policies or legislation are not necessarily in "harmony with one another" and they often conflict with professional codes and/or personal ethics (Beckett & Maynard, 2005, p. 12). Ethical dilemmas involved in deeming pregnant women 'at risk' have tremendous impact on the way that women are viewed by healthcare practitioners as well as on how they view themselves. In this paper I argue that Foucauldian analysis is well suited to help social workers understand the interdisciplinary discursive processes

involved in designating someone psychically and socially as 'at risk' and the ethical and personal implications of those processes. Informed by Michel Foucault's (Foucault, 1977; 1989) works on knowledge and power, I will explore the discursive practices that underpin how pregnant women 'at risk' are positioned within health and social care systems in ways that condition society's beliefs that affect the women's power and agency. I will explore the effects of power relations on pregnant women 'at risk,' because it is through the exploration of power that it becomes possible to uncover the invisible mechanisms that underpin ethical decision-making (or unethical decision-making) in perinatal social work practice.

2. Considering Foucault: Discourses, Discursive Practices and Discipline

Foucault's concepts, some would argue, form part of the postmodern turn in the social sciences. The main idea from Foucault that I want to explore is "that knowledge is inextricably bound to power" (Cheek, 2000, p. 22). Foucault focused on knowledge, power, and discipline and their inter-relations, which operate through the mechanisms of discourse or discursive practices. Discourses are merely ways of thinking, perceiving, and communicating reality - they give organization to a subject (Cheek, 2000). For example, in the hospital, discourses revolve around medical knowledge about the body. In order to understand bodily functions, therefore, certain truths about anatomy are realized and accepted by others and a hierarchy of medical professionals (doctors, nurses, etc.) are afforded a title as an 'expert' in their field of practice. This knowledge is embedded with authority, powers, responsibilities, and privileges that

are delegated to the professionals accordingly. However, healthcare has many other discourses such as political, legal, social, or religious knowledge that permeate understanding and drive thoughts and actions. When discourses converge they form discursive frameworks mediating the production of some truth-like statements and the exclusion of others (Cheek, 2000; Foucault, 1989; Pease & Fook, 1999). Cheek (2000) points out that "at any point in time there are a number of possible discursive frames…and not all discourses are afforded equal presence" (p. 23). Furthermore, whichever discursive frame is given precedence is a direct result of relations of power that do not always need to be repressive (Cheek, 2000; Henderson, 1994). Power can be repressive and potentially liberating at the same time, especially "[i]n situations where people are at risk due to their own lack of power, professionals with a duty of care may need to exercise control over others in order to protect them. This applies to children being abused, where social workers may apply for court orders to intervene in and overrule families in order to protect children" (Beckett & Maynard, 2005 p.120). Thus, Foucauldian analysis is helpful in exposing discursive practices around pregnant women 'at risk' by bringing awareness of those discourses that dominate understanding and those that become marginalized in the healthcare setting. Discursive practices are repressive when they desensitize those with authority to the seriousness of their use; when they are used without negotiation or consideration of the long term consequences; when they erode trust that is required to be able to work in supportive and non-threatening ways; when they are used to meet our own needs, to allay personal fears of losing control, or to punish a service user (Beckett & Maynard,

2005).

'Gaze' is a concept that Foucault introduces into his writings as a means of referring to the way people and populations are constituted and objectified. The 'observational gaze' explains the practice of scrutinizing individuals and groups based on particular dominant disciplinary discourses. Foucault's use of 'gaze' sheds light on the relationship between disciplinary practices and power (Cheek, 2000). The 'observational gaze' is derived from the example of the panopticon, a circular prison in which the guards were constantly observing the inmates from a concealed position (Cheek, 2000; Foucault, 1989; Henderson, 1994). Through the mechanism of the 'observational gaze,' a person or population becomes visible, objectified by the disciplinary gaze and as objects to themselves (Cheek, 2000). Foucault (1977, 1989) revealed that these observations are not mere passing looks but normalizing practices that assess their object according to some evaluative standard. Some of the characteristics of the object are then defined as deviant or are devalued in comparison to the implicit norms embedded in the disciplinary discourse. That is, the dominant discourse ultimately adjudicates what is normal and what is not. These Foucauldian concepts have implications for healthcare social work practice because vulnerable people, like pregnant women 'at risk,' innately believe themselves to be vulnerable, and therefore live up to and live out the expectations of those who hold the balance of disciplinary power.

In healthcare discourses, the body is an object of scrutiny and subjected to knowledge of science and anatomy as 'experts' examine evidence regarding disease and treatment (Cheek, 2000; Foucault, 1977, 1987; Lukes, 2005). However, the body is also subject to political and social scrutiny with corresponding regimes of truth allocated to them from other disciplinary discourses.

Even before hospital admission, pregnant women are subjected to different expectations than others in such matters as getting adequate prenatal care, abstaining from harmful substances, and displaying acceptable moral qualities (Lind & Bachman, 1997). As soon as a pregnant woman becomes known to an 'expert,' such as a social worker or healthcare practitioner, a web of disciplinary practices unfold "under the scrutiny of even more senior experts, such as funding bodies, health bureaucrats, and politicians" (Fitzgerald, 1996, p. 3). Discipline and surveillance of pregnant women 'at risk' does not rest entirely on an individual or individuals but rather relies on a web of relations that navigate the effects of power and which draw from one another (Foucault, 1989, p. 155). After the birth of the baby, the mother's behaviors are further scrutinized by means of sifting through existing discourses about what it is to be a 'good mother' versus a 'bad mother' (Swift, 1995). However, discourses can also reflect mythical assumptions that all parents are judged on "level playing fields" and that "all [parents] are subject to the same rules and scrutiny, and all who fail will be caught and punished by the same systems" (Swift, 1995, p. 10). Furthermore, a discourse is dominant not because it is logical or rational but because of the "power that both underpins and maintains the discourse" (Cheek, 2002, p. 30). Foucauldian analysis is invaluable in underscoring how pregnant women 'at risk' are positioned within dominant

discourses, thereby revealing the dynamics that potentially perpetuate oppressive practices.

3. Pregnant Women 'At Risk'

In order to understand what the concept of 'at risk' means, it is important to explain the surrounding social issues that prevail within this population. However, it is also a paradoxical task, because instituting a label, which is embedded in a disciplinary discourse, also reveals the power of Foucauldian thought. However, an explanation of 'at risk' is necessary in order to set the stage for understanding the concepts.

'Risk' in regard to the fetus or developing child is set out in statutes and powers that have developed over time based on cultural, moral, and societal beliefs in order to protect those individuals who can not protect themselves. Political bodies establish policies on child welfare that delegate powers, establish rules, and deliver consequences for contravention of those rules for parents and guardians of vulnerable children. This is evident in provincial child welfare acts that are administered by child welfare designated workers. The delegation of the term 'at risk' is interpreted differently based on which discourse is given dominance and which 'expert' is believed to hold the balance of power (which may fluctuate). Therefore, there is a struggle around the interpretation of the meaning of 'at risk' by those who define 'at risk' according to the various discourses (i.e., medical, political, moral, social) of those who want to protect the fetus or newborn infant. The following determinants of health suggest social issues that have potential to put a child 'at risk' when identified on a scale of minimum to extreme risk regarding what is

acceptable in a given society. Issues that suggest risk are persistent social (e.g., poverty and homelessness); emotional (e.g., coping and capacity); physical (e.g., HIV and drug use); and/or cognitive (e.g., mental illness or developmental) issues (Friedman & Alicea, 2001; Lind & Bachman, 1997).

4. On Becoming 'Docile Bodies'

Foucault (1977) points out,

> "…power cannot be understood except in relation to the establishing of a power exercised on the body itself… There is a network or circuit of bio-power, or somato-power, which acts as the formative matrix of sexuality itself as the historical and cultural phenomenon within which we seem at once to recognize and lose ourselves" (p. 186).

Foucault argues that as power is internalized, it becomes ingrained in thoughts and behaviors that become a part of the context in which we live, breathe and know ourselves. Thus, marginalized women learn what is acceptable and what is not through interactions with agents who impose disciplinary discursive practices. Disciplinary discursive practices can be used to oppress, and they can support the cycle of victimization that can permeate the thoughts and actions of marginalized women. On the other hand these discursive practices also assist the mother to be conscious of potential harms to herself and the baby and may also be beneficial. Discursive practices have a potentially dual character.

Friedman and Alicea (2001) discuss the consequences of women revealing personal

information that is painful or potentially self-incriminating because this knowledge can be undermined. For example, if drug-using women seek out help because they become pregnant they are aware that this information will put them at risk of losing custody of their child. Given this reality, they may not be motivated to seek help for their addiction. Additionally, addiction continues to be viewed as a moral failing rather than as a disease in need of treatment. The discourses that surround pregnant women 'at risk' place them at a morally disadvantaged position as compared with 'norms' of other more advantaged women. Thus, pregnant women 'at risk' are often deemed failures by the medical and social care professions. Their choices or rights to make decisions that affect their children or their own bodies are often not taken into consideration. Subsequently, by sharing their stories, women are rendered "voiceless" (Friedman & Alicea, 2001, p. 116). In this way, pregnant women 'at risk' become 'docile bodies'. Health and social care professionals become agents of disciplinary discursive practices rendering "control over women's bodies, recreating power hierarchies that place nonconformist women at the bottom of the social ladder while simultaneously perpetuating the dominant status of scientific knowledge" (Friedman & Alicea, 2001 p. 116). Scientific knowledge is not wrong in itself; it is the way in which power is attached to that knowledge that drives unethical discursive practices that are often employed by social workers. On the other hand this presents us with the opportunity to consider the influences on ethical decision-making practices. It is important to understand that by not acknowledging relations of power we encourage women to continue to look to the experts for guidance, which in turn reproduces

patriarchal oppression and reminds them of their failures as women and as mothers (Friedman & Alicea, 2001).

5. Practice Example

Jane was labeled a pregnant woman 'at risk' because she was suspected of using drugs during her pregnancy. The local child welfare agency had informed the hospital prior to delivery without Jane's consent or knowledge and a 'child-welfare alert' was flagged on the hospital computer system. There is a procedure between the child welfare agency and the hospital that when an 'at risk' pregnancy is admitted to the hospital, medical staff is expected to request drug screens for mother and baby. However, when the time came, Jane refused to consent to the drug screen for the baby based on a matter of principle. The child welfare social worker stated that if she had nothing to hide she would agree to the drug screen. However, Jane refused the drug screen because she did not want her baby to begin life with what she called a "black mark," or paying for her past mistakes. She stated that she no longer used drugs and she was being implicated in a vicious lie by her ex-boyfriend who wanted to discredit her. However, the comments from many nurses declared that if she had principles she would not have used drugs in the first place. The child welfare social worker had determined that if Jane had nothing to hide she would submit the infant to the drug tests. As a result, the child welfare social worker denied her right to breastfeed until she agreed to the drug screens.

The nurses were confronted with the task of not only caring for Jane's and the newborn's physical healthcare needs but also policing her motives and the relationship between her and her newborn.

Her bond and relationship with her infant was dependent on her following rules dictated by the child welfare social worker who had the power and authority to investigate under legislated acts. The child welfare social worker was, in turn, influenced by the decisions of her superiors who were assigned the task of interpreting the legislation and giving direction to the child welfare social worker. In the end, Jane chose to relinquish her position and agreed to the drug screen in order to reinstate her bond with her newborn. The perinatal social worker was afforded the task of negotiating and mediating the competing discourses and ensconced power relations in order to meet the needs and expectations of all the parties involved.

6. Theory Meets Practice

The fundamental need for the 'subject' to return to 'normal' is based on the initial finding of personal defects and establishing a diagnosis. The scenario focuses our attention on the nursing staff, who were observed to be overprotective of newborns under their care and used stigmatizing language and behaviors towards Jane. This is because the dominant medical discourse that drives nursing knowledge, communication, and understanding undervalues other ways of looking at the interaction between clinical and social (Foucault, 1987; Lind & Bachman, 1997). Disciplinary discourses are often taken for granted, but have a huge influence on both individuals with material means and those who are marginalized. However, it is those who are marginalized that usually become the "scapegoat" for social disciplinary action (Swift, 1995). The reality is that professionals fail to realize that stigmatizing comments and behaviors may

in fact negatively influence women from receiving perinatal or antenatal care, thereby placing both the woman and the unborn or newborn child at considerable risk (Carter, 2002; Lind & Bachman, 1997). This not only defeats the mandate of caregivers to care for both the woman and the fetus or infant but also encourages an "adversarial relationship between the mother and the fetus [and] works to no one's advantage" (Lind & Bachman, 1997, p. 77).

For example, in the scenario described above, knowledge of protection policies, child safety, and 'personal' interpretation of Jane's morality drove the child welfare social worker's use of her authority to restrict Jane from breastfeeding. The child welfare social worker was motivated by a mandate of 'child safety,' but her methods of uncovering the truth were based on competing personal norms, legislation, regulations, policies, and other organizational demands. It is easy to assume that the request for drug screens might not have been done on the basis of medical concern for the child but rather to reinforce power relations that permeate protective child services. The ethical conflict stems from the child welfare worker's authority to bypass medical knowledge. In fact none of the medical staff questioned the legitimacy of her authority to restrict breastfeeding. Yet she did not have the medical knowledge to determine that her decision was 'safe' for the child. This disciplinary action not only affected the newborn, which requires breastfeeding for optimum health, but also disrupted the bonding process for the mother (Lind & Bachman, 1997). Comments made by medical staff and the child welfare worker reflected a presumption of guilt in the mother. The driving force behind this presumption

seems to be previous knowledge of similar situations that informs and influences new situations, rather than medical or scientific knowledge (Cheek, 2000). Typically physicians have the legally mandated authority and knowledge as healthcare experts to question or deny the request for drug screens, but they often acquiesce to the power of child welfare. Lind and Bachman (1997) point out that this might be due to several reasons, such as lack of knowledge regarding child welfare legislation, or unwillingness on the part of the physician to become personally involved in the outcomes.

For example, consider the issue of disciplining pregnant women 'at risk' by means of litigation. This situation is not uncommon in some U.S. states which can prosecute women who use chemical substances while pregnant (Lind & Bachman, 1997). Though prosecution of drug-using pregnant women is not a practice in Canada, the information provided during interactions between healthcare professionals and child protection agencies is used as evidence gathering, pursuing knowledge to act as a means toward disciplinary action. This demonstrates how "authorities of various sorts have sought to shape, normalize and instrumentalize the conduct, thought, decisions and aspirations of others in order to achieve the objectives they consider desirable" (Cheek, 2000, p. 28).

Typically, the profession of social work has two roles in clinical practice. One role is individual change and the other is individual control (Lukes, 2005; Dolgoff, Loewenberg, & Harrington 2005). This is important to consider because it is easy for social workers to be caught in a maze of being used strictly as a means of individual control, by means of social controls (or

socially sanctioned means), i.e., policy, regulations, and 'best' practices. Such is the case in the scenario described above. The child welfare social worker was focused on correcting Jane's resistant behaviors and then imposed constraints for failure to meet expectations (Lukes, 2005). The peril of social workers acting predominantly as means of individual control is that the resulting coercion becomes the normal practice.

The 'observational gaze' presupposes someone is watching (evaluating, defining, and categorizing) without the conscious awareness of the one who is the subject and object of the gaze. An example of this is the alert system used to direct medical staff to a potential 'at risk' birth. Jane was unaware of this 'alert' throughout the pregnancy; yet the child welfare agency, physician, hospital social worker, and nursing staff were aware of her 'at risk' status in order to enact a disciplinary process. For example, when Jane entered the hospital and delivered her baby certain protocols were invoked that drove knowledge, power, and disciplinary practices. Was this ethical? Could she have been told about the 'alert' by child welfare beforehand in order to confront and deal with the accusations prior to the birth? Child welfare legislation would be an influencing factor inhibiting the child welfare social worker from direct contact with Jane prior to the baby's birth. In part this is due to the fact that in Canada the fetus does not have any rights as a child in need of protection until after birth. The Child, Family and Community Service Act (1996) defines a child as less than 19 years of age, but is silent on issues of the unborn. This mandate may conflict with child welfare social workers' protection priorities or ability to initiate preventive work with pregnant women 'at risk'. This

is important to consider because it may drive social workers to extraordinary measures in attempts to impose control on mothers, even violating ethical principles in order to obtain information to further a personal or legislative agenda. The more social workers impose control, the more marginalized women internalize oppression and continue the cycle of 'docile bodies'.

7. Implications for Ethical Social Work Practice

The concept that drives understanding of pregnant women 'at risk' being known to others and themselves as a 'docile body' is important because it reaches to the very core of ethical tension in perinatal social work practice. For pregnant women 'at risk,' experts are required to consider 'potential' risk for an unborn child, thereby attributing secondary concern for 'risk' to the woman. This duality can compromise equality of care for both mother and infant. In considering 'risk,' protective services may implement measures that restrict or inhibit appropriate bonding for the newborn due to lack of available staff to adequately assess the woman's situation in a timely manner. Additionally, the woman's mental health during this stressful time (including the psychological consequences and ethical implications of the imposition of disciplinary control) is seldom considered important based on the adversarial approach that is common practice (i.e., guilty until proven innocent). Furthermore, current competing discourses about 'risk' have an impact that often influences social workers' need to 'do good,' when in fact they may be responding to the mandated 'risk management' agenda without adequately considering the long term effects on the bond between the mother and child.

Lukes (2005) points out that because of

"… a desire to reduce appeals to the judiciary and reliance on the penal system,   social work would depend on a psychiatric, sociological and psychoanalytic   knowledge for support, hoping to forestall the drama of police action by replacing   the secular arm of the law with the extended hand of the educator" (p. 101).

What Lukes (2005) may have meant in this disparaging quote is that professions like social work may exchange one means of disciplinary power for another; in another sense it is *how* social workers implement that knowledge and power, and to what ends, that make the difference. Power relations work in concert with hegemonic discourses to produce and shape particular truths (Foucault, 1987). Ethical social work practice must understand the nature of competing discourses in order to influence change "at different sites of the capillary relations of power that pervade any context…." because this would offer workers the opportunity to analyze options for "resistance at the very edges of power networks - in the hospital ward or in the home" (Cheek, 2000, p.32).

Secondly, legal and political discourses determine the parameters surrounding acceptable 'risk' to newborn safety. This gives recognition to 'safety' as the highest priority within the professional ethical hierarchy. 'Safety' usually bypasses all other principles such as self-determination and confidentiality (Dolgoff et al., 2005). Therefore, when ethical principles converge with discourses that suggest that a woman 'at risk' is somehow not normal, the collision can result in justification of unethical actions. It is very important to

consider that 'safety' or any other ethical principle is viewed differently according to who possesses the knowledge that enacts disciplinary power in order to gain a desired outcome (Guttman, 2006; Reamer, 1999). One recent study (Boland, 2006) indicated that formal frameworks for considering ethical dilemmas are rarely used by social workers when determining ethical decision-making practices. Instead, the rationale used in ethical decision-making is "based more on skills and rules than on a systemic ethical process" (p. 18). Studies such as Canda and Furman (1999), Haynes (1999), and Dolgoff and Skolnik (1996) (all cited in Doyle, Miller & Mirza, 2009) point out that personal values and practice experience are more likely to influence the resolution of ethical decisions. It is imperative that perinatal social workers should instead constantly reflect on competing disciplinary discourses, the power inherent in these discourses, and relations of professional power, in order to guard against the pitfalls of unethical decision-making practices.

Finally, it is important for perinatal social workers not to cover up the problem or to be seen as 'doing something' or acting mainly as an agent of control, but rather to actively pursue the best interests of pregnant women 'at risk' in relation to changing the conditions that inform the cycle of marginalization that seems to overtake them. Social workers are often perceived as having considerable influence arising from their position in working with vulnerable people like pregnant women 'at risk' because they often control access to services and resources (Lind & Bachman, 1997; Beckett & Maynard, 2005). Social workers and healthcare professionals are perceived as having expert knowledge and skills. However, knowledge and skills often camouflage the reality of whether

they are indeed 'free agents' able and willing to apply them appropriately. Lukes (2005) postulates that there are degrees of freedom based on rival views of what freedom is, as well as degrees of what constitutes invasion or infringement upon that freedom. For example, in the scenario, was Jane 'free' to choose for or against her conscience in not wanting to test her baby for drugs? Are social workers 'free' to withhold 'confidential' information? As described in the scenario, the child welfare social worker was given direction from her superiors who interpreted the legislation; but it was the child welfare social worker who responded by what could be interpreted as coercion. However, did the child welfare social worker feel justified or strongly compelled to use coercion to meet this agenda? Or were lack of resources influencing her choices? Similarly, it is important to be aware that professional codes of ethics are guidelines, and are open to interpretation by individual social workers and according to organizational and political mandates. Furthermore, codes are by definition methods of professional ethical control subject to review by the professional associations' mandated ethical bodies (Dolgoff et al., 2005).

8. Conclusion

The strength of Foucauldian analysis lies in providing a powerful analytic framework for determining a reflective and informed response to ethical dilemmas that perpetuate disciplinary discourses and related discursive practices that influence how pregnant women 'at risk' are positioned within dominant systems of care. Perinatal social work is uniquely placed within the healthcare system to negotiate within the networks of power to bring awareness of ethical actions that

counter the current situation, in which hospital social workers are sanctioned to function merely as agents of control. Furthermore, by linking theory with practical experience, I have underscored the challenges that pregnant women 'at risk' face in situations that produce and reproduce feelings and behaviors of helplessness. As a value-based profession, social work has an ethical responsibility to continually look at professional practice and the effects on client outcomes. In keeping with client-centered social work philosophy, further research is needed to reflect personal narratives of pregnant women 'at risk' becoming known as and knowing themselves as 'docile bodies'.

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Jungian Theory of Psychological Type Augments the Translating of Social Work Values into Social Work Practice Behaviors

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Abstract

The purpose of this article is to link psychological type theory and constructs with a key value of the social work profession, respecting the dignity and worth of the individual. In addition it will demonstrate how an understanding and application of Jungian psychological type theory helps augment and translate this core social work value into practice principles. After discussing definitions and the core social work value of respecting the innate dignity and worth of the individual in historical context, the author will explore several principles that are derived from this core value and examine them through the theoretical lens of psychological type.

Key Words: dignity and worth, Carl Jung, Psychological Type theory, MBTI, social work practice

1. Introduction

People are unpredictable but in somewhat predictable ways. They often demonstrate thematic ways of behaving in both acting and reacting in their environmental contexts, such as in their families, schools, or work. People can all be of

> the same religion, the same race, the same generation, and have the same city of birth and even the same eye color. But they differ in striking and predictable ways with respect to the people they love, the way they love them, their emotional range, their sources of stress and typical coping

mechanisms, their way of resolving conflicts, their susceptibility to certain illnesses, their imagination, their self-esteem, their appetites, plus their career interests, work styles, and motivations, among other identifiable differences (Oldham & Morris, 1990, p. 12).

Understanding "typical," predictable, "thematic ways" of client behavior through an understanding of Jungian type/temperament theory can help social workers translate the core social work value of respecting the dignity and worth of individuals within a caring and just democratic society, and the attitudes and principles that stem from them, into competent practice behaviors with their

clients through the constructive use of predictable differences. It is beyond the scope of this discussion to explore other specific practice issues with clients such as specific problems, needs, and other diversity issues besides the diversity of psychological type, including age and developmental stage, gender, race and ethnicity, culture, spirituality, and geography.

Carl Jung (1923) is given the primary credit by psychological type and temperament theorists for developing the theory of psychological types. He espoused a particular theory of human behavior and emphasized that "besides the many individual differences in human psychology there are also typical differences" (p. 3). It is upon his theory of "common, uncommon needs" that a number of other scholars have built and made elaborations with implications and applications in various contexts.

Jungian psychological type theory with practical applications derived from his theory are embraced by many, but significantly by Isabel Myers (1987), Mary McCaulley (1981), and Judith Provost (1992) and others using the Myers Briggs Type Indicator (MBTI), a non-clinical personality test based upon his theory.

A number of social work scholars have referred to psychological type or temperament in their analysis of social work practice (Compton & Galloway, 1986; Keith-Lucas, 1994; McMahon, 1991; Scheafor & Horejsi, 2008). Others (Chess & Thomas, 1986; Jung, 1923; Keirsey & Bates, 1978; Kramer, 1993; McCaulley, 1981; Myers, 1987; Oldham & Morris, 1990; Provost, 1992) have written about psychological type and temperament in psychological and psycho-social interventions. However, no effort toward the integration of type and temperament theory with social work practice values has been attempted.

2. Definitions

According to Tieger and Barron-Tieger (1995) David Keirsey and Marlyn Bates became intrigued with the relationship between psychological type and temperament. Keirsey and Bates (1978) assert that personality type, temperament, psychological type and character are four different words meaning essentially the same thing. Others differ and differentiate the terms to some degree.

Peter Kramer (1993) indicates that one's neural chemistry [biology] is "inevitably modified by development, environment, life events, and now by discrete medicine" (p.149). Therefore, nature and nurture are always in interaction. To not take both into account is to be bifurcated and less than scientific or professional and less than artistic and creative. Kramer says that the "usage of the terms 'temperament' (nature), 'character' (nurture), and 'persona1ity' (both) was employed by David Reisman in The Lonely Crowd... [in 1950] and before that in psychiatry by Eric Fromm (p. 340)."

McMahon (1990) defines endowment as "the natural gifts, talents, and abilities that a person has at birth" and includes in this definition "genetic traits and characteristics along with the innate mental, physical, and cognitive abilities of a person" (p. 64). Also, in contemporary psychiatric research, Oldham & Morris (1990) discuss the biological and genetic influence in temperament and personality style.

This author agrees with Keirsey and Bates, Kramer, Fromm, Oldham and Morris, and McMahon and uses the terms psychological type, temperament, endowment, personality type, and personality style interchangeably and refer to "the biological underpinnings of personality even if the biology has been shaped or altered by [environmental]

circumstance" (Kramer, 1993, p. 149). The term "character" I will differentiate and assume to mean "the combined moral or ethical structure of a person or group." (The American Heritage Dictionary, 1991, p. 259) The term character would then have a significant environmental, cultural and moral determinant.

3. Psychological Type Theory Summary

The best synopses of Jung's theory of psychological type, as well as practical applications of the theory, came from Isabel Myers and Katherine Briggs as they developed the now popular non-clinical personality test called the Myers-Briggs Type Indicator (M.B.T.I.). The forced choice preference indicator evaluates first, the preferred way that people focus their attention and the ways they are energized, either extraversion or introversion; second, the preferred way people like to take in information when they are paying attention, either sensing, using their five senses to observe the actual, or intuition, using a sixth creative sense to notice patterns, relationships and possibilities; third, the preferred way people like to make decisions, either thinking by using a logical, cause-effect, and objective approach, or feeling by taking a person-centered and value oriented approach; and fourth, the preferred life styles of people as they are oriented to their environments, either judging by living in a planned, organized way, or perception by living in a flexible and spontaneous way.

The problem-solving model includes gathering facts, considering possibilities, weighing the pros and cons and reflecting upon values and commitments. Problem solving and decision making is summarized succinctly by Isabel Myers in Introduction to Type. She says, "To improve your ability to solve problems and make decisions, you need to make full use of

your perception (sensing and intuition) and judgment (thinking and feeling) (p. 30)." Then one will have considered "realities, possibilities, consequences, and human values (p.30)."
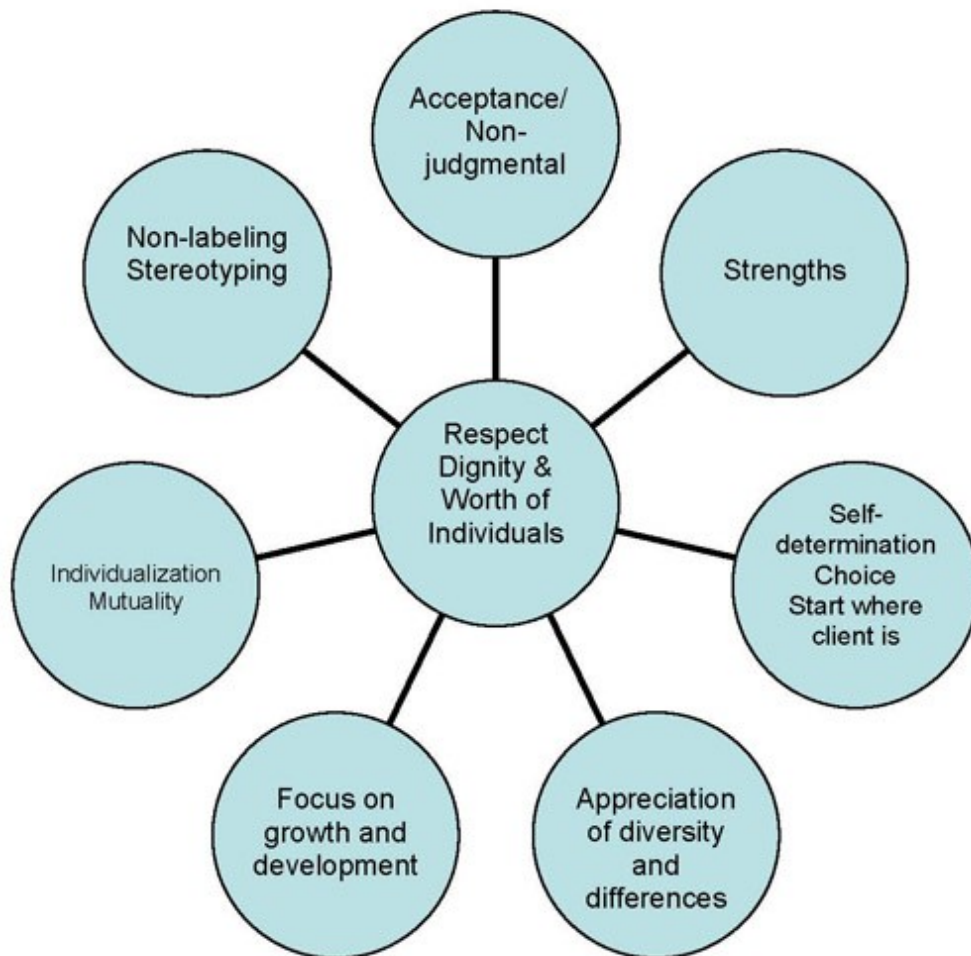Interventions are best planned after the competent exercise of sensing and intuition in the data collecting phase of social work practice and utilizing thinking and feeling in the assessment and planning stage of practice.

4. Psychological Type Theory and Key Social Work Values and Principles

Psychological type theory helps translate the core social work values in practice. Respect for the dignity and worth of people in a just and caring, democratic society are two interrelated value premises of the American social work profession and are the basis upon which other key social work practice attitudes, principles, and practice behaviors emanate. They include the following:

- respect for the right of client self-determination, the need to individualize and "start where the client is" in mutual worker/client decision making
- respect for diversity and the need to demonstrate acceptance and a non-judgmental attitude toward clients
- adopt a strengths perspective and assume a non-labeling and non-stereotyping attitude toward clients

The graphic below depicts the values, attitudes, and core social work principles that flow from the core social work value, namely, respecting the innate dignity and worth of the individual:

Respect Dignity & Worth of Individuals
- Acceptance/Non-judgmental
- Strengths
- Self-determination Choice Start where client is
- Appreciation of diversity and differences
- Focus on growth and development
- Individualization Mutuality
- Non-labeling Stereotyping

4.1 Respect for the Innate Dignity and Worth of the Individual

The respect for the innate dignity and worth of the individual, as noted earlier, has been emphasized historically in social work. Type theory emphasizes the value of all psychological types and need for diverse people with different gifts to pursue happiness in a caring and just, democratic society. Each individual that plays out well their unique parts will then manifest their unique purposes in and contributions to society. One of the main positive properties of the theory and practical applications of MBTI is that clients focus on their strengths and potential development that give them an appreciation of their own worth and dignity. Therefore, clients receive hope and gain motivation for the fulfillment of their rights to life (capacity growth and development), liberty (exercising self-determination), and the pursuit of happiness (creating or locating opportunities).

If the clients' personality types and their implications are not recognized by clients or

social workers during the initial engagement with clients there may be unintended negative consequences. What are initially seen in the presenting problems of clients may be concerns related to undeveloped potential. The concerns may be caused by a poorness of fit within the environment. The concerns may be caused by clients being overwhelmed by persistent and sustaining traumatic events to which any human being would succumb. Social workers at the initial point of contact with clients are often seeing clients in their weakest and most vulnerable states of being. Motivation and hope for both the client and social worker can come in part from knowledge of a client's psychological type potential or strengths as early as possible in the engagement, data collection and assessment phases with clients.

4.2 Respect for the Right of Client Self Determination, the Need to Individualize and "Start Where the Client Is" in Mutual Worker/Client Decision-Making

Social work has long espoused the primacy of the concept of the right of client self determination. Typing ultimately is an assessment that is determined by the client, not the social worker. Education, information, and feedback communication with and from the social worker is appropriate and needed, but in the final analysis, the client decides and acts upon any new insights and ideas derived from interaction with the social worker based upon type theory. In order for clients to communicate and tell their own stories in their on way, there must be an appreciation of individual psychological type and temperamental ways of expression. The social work maxim of "starting where the client is" becomes better actualized by allowing and encouraging the client to relate to the social worker concerning their situation uniquely according to their own individual psycho-

social communication style. Individualization is enhanced through a strengths perspective stance which combats the potential negative labeling of clients.

For example, if a client was primarily an extrovert, the social worker could possibly demonstrate respect for the client in the engagement phase and throughout the helping and problem-solving process by the following:

1. Attempt to generate and allow for active interaction with the client because extroverts would often need to talk problems out and get verbal feedback from the social worker.
2. Take a more introverted stance with the client by being an interested active listener.
3. Recognize and understand that extroverts tend to look outward (externalization) into their environments for problems and causes before reflection (internalization) and focusing upon the inward.

Conversely, if a client was primarily an introvert, the social worker could demonstrate respect for the client by the following:

1. Allow for long pauses, especially when asking the client questions, as introverts tend to process information and formulate what they may want to say and discuss.
2. Do not force introverts to share their thoughts and feelings before they are ready.
3. Allow introverts to ask questions to gain a better understanding of their concerns and situation before attempting a change in their behavior.

4.3 Respect for Diversity and the Need to Demonstrate Acceptance and a Non-Judgmental Attitude Toward Clients

The theory couches differentness and diversity as positives, focusing on strengths and uniqueness of individuals, and is very affirming of those gifts. The MBTI's nonjudgmental quality is a desirable feature of the instrument and facilitates the sharing of results with the client as client and worker together seek type development possibilities. As strengths become a focus, psychological type development can be emphasized. Psychological type development provides confidence and self direction. A greater appreciation for the aspects of one's life that come easily and those that are difficult also brings an appreciation and respect for individuals of different types whose strengths and struggles are different from one's own.

For example, if a social worker were working with a male sensing client and female intuitive client as a couple who were trying to learn to understand and better communicate with one another in their mutual problem-solving efforts around issues such as finances, child rearing, and use of leisure time, the social worker could demonstrate respect for each client's preference strengths by the following:

1. Asking the male sensing client to describe the current existing situation and relevant facts.
2. Use concrete examples with the sensing client to increase better understanding of communications.
3. Allow the sensing client to describe events with many circumstantial details without interruption.

Conversely, the social worker could demonstrate respect for the female intuitive client in the above example by the following:

1. Recognize that the female intuitive will grasp generalities somewhat readily.
2. Use analogies with the intuitive client to increase better understanding of communications.
3. Recognize that the intuitive client would tend to understand and appreciate relationships between things, people, and concepts and have a holistic conscientiousness.

In working with this couple the social worker could focus on the relative strengths of each person's preferences that were assets in their mutual problem-solving efforts with their various issues. The sensing and intuitive couple could learn from each other's strengths and further their own preference development in areas that were not their preference.

4.4 Adopt a Strengths Perspective and Assume a Non-labeling and Non-stereotyping Attitude Toward Clients

Social work practitioners can well integrate psychological type knowledge in work with their clients by assuming and emphasizing a strengths perspective. Dennis Saleebey (1997) in his book addressing the strengths perspective in social work practice, says that this emphasis on strengths "has been part of social work lore…for decades, but…has rarely been extended and articulated in terms of philosophy, principle, and practice" (p. 15). He stresses to the practitioner the importance of "moving away from a deficit approach to one emphasizing the resources and resourcefulness of clients (p.15)." Although he said the strengths perspective is not a "model…paradigm…or a theory" at the time of his writing, I suggest that Jungian social work interventions can be theoretically

oriented on just such a strengths perspective and give "guidance to the student or worker about what the obligations and methods of such an orientation might be" (Saleebey, 1997, p.14). Thus, type theory helps in the search for the health and well-being, strengths, and assets of a person (in their environment) that can be utilized in the problem-solving process, rather than staying focused on deficits and negative labeling with consequent possible pitfalls. Looking for health and well-being, "normalcy," strengths, assets, potentials, development, maturation, etc. within mental illness has been and is a hallmark of the social work profession.

Jungian psychological type theory is congruent with the strengths perspective of social work practice as both embrace a largely positive and hopeful view of human potential. This strengths perspective mitigates, or at least mediates, a more negative view of human nature that is seen as basically flawed and combats possible negative outcomes when people are negatively labeled. Myers & McCaulley (1985) observe that what counselors appreciate most about the theory is that "it gives clients a sense of worth and dignity about their own qualities" (p. 63). They assert that when clients find out about their own type, it becomes a "releasing experience, not a restricting one" (p. 63). For instance, when we discuss the right of client self-determination and the need to focus as much, if not more, on an individual's or a family's strengths, as well as weaknesses or problems, we actualize this basic value premise.

Psychological type "order", strengths, and assets assessments focus on "ease" rather than "disease" and "disorder" and on goodness of fit" with the client's environment. "When external influences cause falsification of type [meaning consistently relating and behaving in ways that are very untrue and unnatural to

one's true self or psychological type], emotional difficulties will follow" (Myers & McCaulley, p. 64). They continue by saying "this is particularly important in counseling, because a goal of treatment [or intervention] is to identify and strengthen the inherent preferences, not to continue to the falsification process" (p. 64).

For example, when planning and performing interventions with a client who has a judging preference, social workers could consider the following:

1. Recognize that judging clients may find it relatively easier to make modifications and adaptations in their own behavior rather than become innovative and creative.
2. Understand that judging clients may need assistance in "planning" to be flexible.
3. Appreciate that judging clients may need to start with decisions that have been made, or are likely to be made, before suggesting other alternative decisions that could be made.

Conversely, when interventions are planned and performed with clients with a perceptive preference, social workers could consider the following:

1. Recognize that perceptive clients would tend to prefer interventions that focus more on their being understood rather than being directed.
2. Understand that perceptive clients may need help in partializing and focusing on one task or a few tasks at a time rather than trying to start and complete too many tasks.

3. Appreciate that perceptive clients may need to make choices and do need deadlines for task completion.

A final example comes from the author's direct social work practice experience with families and children. After gathering initial data regarding the parents' or families' concerns, this author would help guide family members (usually the parents if the initial concerns were for small children) to focus on psychological type strengths. For a child that had a thinking preference strength, an approach to discipline with that child that was direct, objective, clear and communicated logical consequences of the child's behavior could be beneficial. For a child with a feeling preference strength, the discipline approach might be different. Pointing out the effect of choices on people, giving praise and encouragement and allowing the child to express his or her feelings openly could be beneficial. Naturally both of the suggested approaches could work with either child in a given situation, but the relative merits of individualized approaches with children with different preferences had positive outcomes in the author's practice.

5. Summary and Conclusions

Social workers need to reference a number of diversity variables in their assessments and interventions. This practice will maximize the individualization of a client's self-determination and actualize a core historical social work value – to respect the dignity and worth of individuals.

This article has focused on Jungian psychological type theory as a diversity variable. Jungian theory was briefly explained, and examples of how the theory can be implemented into social work practice were

provided.

The literature review revealed that a number of scholars from other fields and professions, as well as scholars from social work, have embraced psychological type theory as part of their analyses of social work practice. However, none have explained the theory as a way of actualizing the value of respecting the dignity and worth of individuals.

Psychological type information should be used in conjunction with other theoretical and assessment approaches. Type theory cannot tell someone certain things about themselves. It cannot indicate specific skills and level of competency in the skills in social role functioning at work, home and the community. Any theory, knowledge, information, technique, or skill can be misunderstood, mistimed, misused and misapplied. This phenomenon is no less likely with Jungian psychological type theory. Therefore, a degree of caution should be exercised by social workers when using and applying Jung's theory in their work with clients.

Jungian theory is not a panacea for all the problems of people or for difficulties that social workers encounter with people, but it is certainly a powerful and useful tool that can be applied appropriately in a myriad of individualized ways consistent with historic social work values and principles. An advantage to using the "labels" suggested here is that they are more benign, emphasize strengths, and suggest interventions that give hope regarding development, growth, and fulfillment. Even in the most hopeless of situations there will be suggested the possibility of making "active and willing" choices (Keith-Lucas, 1994) at the most fundamental level - the level of the spirit and in one's attitude toward health and growth - and taking the necessary steps to begin to maximize psychological type potential in spite

of truly difficult, even harsh realities.

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Social Eugenics Practices With Children in Hitler's Nazi Germany and the Role of Social Work: Lessons for Current Practice

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Abstract

This paper will explore the role of social work in Nazi Germany, as well as the ideas of social eugenics that underpinned government policies. This paper is written from the perspective of a Western Gentile, reviewing the implications for social work of the profession's involvement in the Nazi social policies of the day, and the lessons learned for contemporary practice.

Key Words: Social work, Nazi social policy, Human rights, Ethics.

1.   Introduction

The underpinning values of social work clearly align with human rights discourse, particularly in relation to upholding the importance of individual worth and dignity (Healy, 2008). In fact, today social work can be considered a human-rights-based profession, as indicated by our commitment to International Human Rights Declarations and Conventions. The Universal Declaration of Human Rights is one such example (Ife, 2001; International Federation of Social Workers, 2005). Our actions have stood in stark contrast to this at different times in history, however. The profession of social work has been and continues to be entwined within the context of caring/control roles. As described by Ife (1997), since its inception social work has been a contradictory and perplexing profession – operating within societies that want both to help and to control the disadvantaged. It is in such contexts that social workers have often operated at opposite ends of the caring/control spectrum, and even engaged in roles that have led to the oppression of the most disadvantaged. This is supported by Abramovitz (1998), who discusses the history of social work as including progressive activism, but also producing "handmaidens" who have served the interests of the status quo. As such, this history has created an ongoing struggle and contradiction in our profession. For the social worker operating in current practice, we are faced with this contradiction and have the

task of navigating through the caring/control dichotomy in our everyday interactions with clients. Therefore, in such a context, what is our mandate?

This perplexing reality can be clearly highlighted through consideration of the 19th- and 20th-century social eugenics movement that took hold on an international scale in Westernized countries, and was implemented through various social policies (Berenbaum & Peck, 1998). This movement was taken to extreme levels in Nazi Germany during World War II, as social policies based on ideas of "social hygiene" led to the genocide of millions. It is within this historical period that the contradiction and perplexing nature of social work can be clearly shown – as there were both those who actively operated within Nazi policy, and those who stood against it. This paper discusses the killing of children and adolescents in National Socialist (Nazi) Germany. Rogow (1998) argues that children with disabilities, orphans, juvenile delinquents and non-conformist young people were Adolf Hitler's "unwanted children," and subsequently Hitler ordered the killing of thousands of children who did not fit his "super race" ideal. This paper will explore the role of social work in carrying out Hitler's social eugenics policies. Consideration of this period and the social work role provides lessons for contemporary practice regarding our values and mandate to advocate for the most vulnerable, through upholding human rights.

2. Social Eugenics Movement: a Path to the Holocaust

The social eugenics movement was an international phenomenon that took hold in developed Western countries (Berenbaum & Peck, 1998). The movement was an extension of social Darwinism, and developed in the 19th Century (Kennedy, 2008). Its underlying belief was that human inequality was based on hereditary factors. As such, in order to improve mankind, it was held that "inferior" people must not procreate, while those considered "superior" must be actively encouraged to do so (Browning, 2004; Kennedy, 2008). Those determined inferior and superior were done so based on subjective value judgments around intelligence, diligence and sobriety, for example. This led to such judgments being grouped with racial and class groups that were accordingly stratified in society. For the most part, the poor and non-white groups were targeted as inferior (Browning, 2004).

The ideas of eugenics became incredibly popular and influential, shaping the work of many professions including politicians, social scientists, and even social workers (Kennedy, 2008). For example, among other countries, it became enshrined in policy in the United States, leading to the sterilization of individuals believed to carry genetic defects termed "mental retardation" (Giles, 1992; Kennedy, 2008). In an extensive exploration, Kennedy (2008) explores the ideas of eugenics and its influence on the beliefs and practices of social workers during the 19th Century in the United States. During this time and into the 20th Century, the belief in eugenics motivated various social work practices. These practices became embedded in the scientific, medical approach, emphasizing mental and social hygiene. As a result, this approach led to the social control of many populations, in particular the poor. Therefore, eugenics language and subsequent practice was adopted by many leading social work practitioners (Kennedy, 2008). Another international example of eugenics ideas in practice is the Stolen Generation of Australia. Between 1910 and the 1970s, under various policies Indigenous children were systematically removed from their families in order to be integrated and "civilized" into western society, and thus to annihilate the Aboriginal culture that was considered inferior and a burden on the settlers (Gigliotti, 2003; Krieken, 1999; Short, 2008). These practices came under the

banner of "protection and segregation" and as such were considered logical steps for improving society, as the Indigenous people would be civilized into mainstream Western values (Short, 2008). Other examples have included the First Nations peoples of Canada, and the Maoris of New Zealand, to name just a few (Armitage, 1995; Haigh-Brown, 1988). Again, the ideas underpinning these practices can be traced back to social Darwinism with an emphasis on the survival of the fittest (Short, 2008).

Social workers have actively assisted with the implementation of such policies, which is evident by our history of placing the demands of the state ahead of the rights of an individual requiring assistance (Williams, Soydan, & Johnson, 1998). This is supported by Lorenz (1994), who goes on to state that the most dramatic example of this is the situation of Nazi Germany, where many of the population, including social workers, have been implicated in assisting the government's "genocidal preoccupations." According to Browning (2004), the eugenics movement was international, but it took on a particularly horrifying form in Nazi Germany during World War II. This was due to three main factors. First, the belief in eugenics was widely accepted and taught in educational institutions, particularly universities. Second, eugenics strongly aligned and supported nationalistic values of promoting "Aryan" superiority and anti-Semitism. Finally, respectable individuals advocated for laws that went beyond sterilization and control to killing those judged to be "unworthy of life." Thus, the path to eliminating those considered "unfit" was incredibly straight (Browning, 2004). The main initiators of the policy were physicians (Browning, 2004; Giles, 1992), but ultimately they were supported through the actions and non-actions of Germans from all backgrounds, including social workers.

3. Social Eugenics Practices with Children in Hitler's Nazi Germany

The killing of men, women and children more than 60 years ago continues to haunt humanity. The Holocaust is still a thorn in our side, and never far away is our sense of questioning of how humans can commit such acts, and whether these events could be played out again.

The reign of the Nazi government has been described as one of propaganda and terror for those who came under its control. As shown by countless individual narratives from this era, no one was safe: children turned against parents, friends against friends, citizen against citizen (Rogow, 1998). Safety was ensured only for those who toed the Nazi party line. Mind control, secrecy, fear, and lies ruled the tyrannical system of the Nazi movement. The climate in Nazi Germany from 1939 onwards, if not earlier, was dangerous for those who did not fit the ideal of the Aryan race, and those who did not conform to Nazi beliefs were under threat of work camps or even death. By the end of 1941 no one was safe from Hitler. If one did not have correct social genetics, or did not conform to the Nazi ideals and values, one was at risk. Few were safe, least of all members of the Jewish race. Within this climate of mistrust, insecurity, and total dependence on the Nazi state was the policy of social eugenics, also known as social hygiene (Kunstreich, 2003). The ideas of social eugenics were wholly embraced by Hitler and the party to keep the "Aryan race" pure from defect and unwanted foreigners. As such, the government determined who was fit to live and fit to reproduce, and those who did not suit the criteria were forced into a sterilization procedure, as well as being killed off (Giles, 1992; Rogow, 1998).

It was a fable that only children with severe disabilities were killed under Hitler. In fact, no child was safe. Children of foreign/inferior breeding (Jewish, Gypsy and non-white children), and those with hearing or sight impairments, physical disabilities,

emotional or behavioural disorders, mental health problems, intellectual disabilities, and speech difficulties were all liable to be removed from caring institutions or from their families to brutal institutions which, in the most part, led to death (Rogow, 1998). Orphans, as well as teenage non-conformists and delinquents, were also subject to horrific measures under Hitler's social eugenic/social hygiene policies. For example, children with mental disabilities were sterilized without consent; boys were kept alive until they were ten, then becoming cheap slave labor for the Nazi Motherland. Those not selected for these jobs were killed in the gas chambers (Ziemer, 1941).

Children as young as twelve were working long hours for no pay. Furthermore, it was common practice to kill mental patients in order to free up hospital beds for wounded soldiers, or simply to keep the welfare costs down (Rogow, 1998). Under Hitler's regime parents were cajoled, coerced, or ultimately forced to give up their disabled children to institutions (Burleigh, 1994). Another tactic to place pressure on families to give up their children to the state was to refuse hospital care to any child with a disability. In the institutions, abuse, violence, hunger, and starvation were common, and the possibility of death always lingered (Burleigh, 1994). Moreover, atrocities were carried out by members of the SS, SA, Hitler Youth and League of German Maidens, who for fun took tours of children's institutions. These "visitors" saw the institutions as a "freak show," and participated in brutal behaviour against the children (Aly, Chroust, & Pross, 1993). Violence and degradation were the core values of Nazi Germany, where life was cheap if you did not conform to the "superior Aryan race" model.

The measurement instrument used to deem a child not fit for the Aryan race was based on pseudo-scientific measures, supported by faulty scientific rationales. At the time, however, the ideas of social eugenics were considered to be based on appropriate rational science, and were thus seen as logical and necessary for the improvement of the human race. Among these factors, coupled with the nationalist desires of the Nazi government, the path to genocide was smooth (Browning, 2004).

The removal of "defective" children from the community in Germany was developed for two reasons: firstly, as a result of the social eugenic policy of the day; and secondly, to send a message to the community that the Nazi government was in control of the public and private lives of German citizens (Peukert, 1987). Tactics of fear and control in maintaining power and authority were for the most part effective (Rogow, 1998).

Hitler and the Nazi party were experts in power and control. Opposition to their policies or criticism was not tolerated and a visit from the SS was commonplace. The belief that German parents approved of the killing of their children is challenged by hundreds of cases that were brought to the courts during that time, accusing the hospitals of negligence and causing the deaths of their children (Rogow, 1998). Pre-Nazi Germany had a progressive system of rehabilitative education and an integrated approach for children with disabilities. Children with learning and developmental needs had been integrated into community schools long before other Western countries implemented this approach (Rogow, 1998). All this was reversed when Hitler came into power. In Hitler's Germany, Nazi bioscience and racism were common in all aspects of social, health and educational policies. Social Darwinism and eugenics claimed that social problems could be solved by preventing people with mental health problems or intellectual disabilities from having children (Browning, 2004). Laws were implemented so that only people of genetic value (determined by the state) could marry and produce children (Peukert, 1987). Criteria such as suspected intellectual delay, poor

work habits, and delinquency were used as a system of social selection. This served as a powerful message to the citizens of Germany: conform or suffer the consequences.

4. Social Eugenics and Social Work: Campaign Against the Vulnerable

As early as 1943, genetic health courts were created for the sole purpose of enforcing Nazi health laws and decrees (Peukert, 1987). Documents from this era reveal that public health officials, doctors, teachers, and social workers were also required to report children who were deemed to have a disability or emotional problem (Rogow, 1998). According to Giles (1992), social workers and nurses had the responsibility to submit official documentation in regards to individuals they considered unfit. At times these submissions were based on the most slender of grounds. The hunt for Hitler's unwanted children was intense and exhaustive. Hitler was personally involved in the plan to kill children and adults with disabilities, as he went so far as to make propaganda films. *Victims of the Past* was a film made to persuade the public of the necessity of eliminating children and adults with genetic defects for the good of Germany; this film was shown across Germany.

It is well documented that doctors, nurses, and to a lesser extent social workers were involved in Germany's social eugenics policy (Kunstreich, 2003). Social workers worked in institutions where the children with disabilities resided. They were also given the task of seeking out children in the smaller communities and determining whether they were fit or unfit to live. Stories of mothers hiding their children from the authorities, including both nurses and social workers, were common.

In the 20th Century, there is a recurring theme of the state controlling particular minority groups' lives and determining whether, in effect, they should live or die. As stated, social work has a stormy past in carrying out the bidding of the government, for example the "Stolen Generation" of Australia. Up until 1973, it was Australian government policy to remove certain children from Indigenous families, and to relocate those children with white families or to brutal institutions; as in Nazi Germany, these practices were founded on the ideas of social eugenics (Short, 2008).

5. Exclusion Economics and the Children

Under Hitler, special schools, residential facilities and asylums were run down, and little capital was invested. Money was often siphoned off for "healthy children," for whom Hitler had free summer camps, allowances and public health care. From 1941, families with children with disabilities were denied family allowances. However, if the state a family healthy, they were then entitled to a family allowance (Rogow, 1998). This economic disadvantage served two purposes: firstly, to place pressure on the non-compliant family via withdrawing money, and secondly, to send a message that the government would not support unfit children.

Schools were taken over by Hitler's regime and in some locations if teachers wanted to keep their jobs they had to join the Nazi party. The state controlled how and what teachers taught students. The teaching profession, once highly regarded, received little status in Hitler's Germany (Rogow, 1998). Schools began to have a shortage of qualified teachers, so the number of untrained teachers increased.

6. The Euthanasia Programs in Hospitals and Institutions

Killing certain groups of children was an important priority on Hitler's agenda. In

1939, just a few days after the war began, Hitler passed a decree giving permission to doctors to eliminate children (Kogon, Langbein, & Rueckerl, 1993). It was referred to as the "Mercy deaths" or the "Program," where children were planned as the first to go, followed by adults with disabilities (Aly, 1993). Doctors were rewarded handsomely for their involvement in these "special programs." Despite some belief that the German public supported these killings, secrecy surrounded the euthanasia programs. The myth that children had a quick painless death is debunked by Burleigh (1994), as he argues that for many children death was long, drawn out, and painful. Experiments on children with cerebral palsy or other neurological conditions were common in Germany during this period. It was customary practice for children to be conscious and without any pain relief; and once research was completed the children were "disinfected" (killed). Many doctoral students gained their degrees via such experiments on children under Hitler's regime (Friedlander, 1995; Burleigh, 1994).

7. "Mercy Killings" and Secrecy

Killing disabled children extended to all of the Nazi-controlled countries, including Austria and Poland. The killing of children and adolescents did not stop until the Allied occupation, 21 days after Germany lost the war, May 29, 1945. Among the 250,000 to 350,000 people who were murdered in Nazi euthanasia programs, at least one fourth were children and adolescents (Rogow, 1998).

Silence surrounded this slaughter of unwanted children after the end of the war. There were very few published accounts of the child murders. In fact, doctors and nurses often continued in the same roles and hospitals where the killing had occurred (Rogow, 1998). Although, according to Rogow (1998), the Nazi victimization of vulnerable children was unique in its organization and in its perversion of science

for political gain, it remains a lasting reminder of the dangers of making value judgments on human life, and of separating science from humanity. The one thing that social work opposes now, it colluded with then. At the very hour when the vulnerable needed an advocate, many social workers were silent. In Hitler's Germany, the prevailing attitude was that children with disabilities were valueless and devalued by the general population. This attitude, along with the pseudoscience of social eugenics, sowed the seeds of discrimination, abuse, and death of the most vulnerable.

8. Social Workers Taking a Stand

Despite the reality that some social workers supported the Nazi regime and its various social policies (Kunstreich 2003), it is vital to highlight that there were practitioners who refused to live and act by the ideology of the day. These individuals took a stance that placed them on the opposite spectrum of caring/control roles, and actively did what they could to help the oppressed. First, Alice Salomon, who was considered a founder of German professional social work and social work education, continually advocated for peace and disarmament, and for women's rights. These actions put her in direct conflict with the Nazi party's goals of military expansion and clearly defined roles of women. As such, she was ultimately expelled from Germany (Kuhlmann, 2008). Another social worker, Irena Sendler, played a vital role during 1942-43, rescuing 2,500 Jewish babies and young children from a ghetto in Warsaw, Poland (Wieler, 2008). These women are but two exemplary examples of being a part of social work's history to advocate for the vulnerable and work towards social change embedded in a discourse of rights – most importantly, the right to life (Abramovitz, 1998).

9. Social Work and Social Eugenics

Nazi bio-genetic theory and pervading ideologies, supported by the pseudoscience of the eugenics movement, encouraged all Germans, including social workers and social welfare workers, to attribute everything that went wrong in their programs to the genetic faults of the children in their care (Browning, 2004; Peukert, 1987). In most cases, it was a "blame the victim" mentality. In reviewing the literature it is difficult to obtain a clear picture of the social work profession during this time. As identified by Kunstreich (2003), though, there is documented evidence that some social workers actively supported the Nazi regime, and as such assisted with implementing social policies that were based on "Social Hygiene." Moreover, their practice occurred in an environment of control and compliance. If one failed to follow instructions, then punishment, loss of career and possible persecution might follow – Alice Salomon being one such example.

Social eugenics was the current theory in Nazi Germany, a theory held to be scientific and therefore good for the whole of humanity. Professionals believed in this science and thus accepted some of the consequences of decisions made on the basis of social eugenics theories. Failures of the social welfare system were blamed on the un-treatability of the child clients, which further endorsed belief in social eugenics. One could possibly argue that these social workers were the product of their time, and caught up in a powerful ideology held as scientific and good for Germany. There is a good argument that the German social workers who implemented Nazi policy, however, were unethical and in breach of recognized universal social work ethics and values. Contemporary social work today grapples with the issue of ensuring global social work practices are ethical and value human worth, while faced with the demands of government policies that in many cases have the potential to control and oppress the disadvantaged (Ife, 1997).

10. Lessons from the Past: Values for the Future

Ultimately the Nazi government utilized social work in achieving its own goals, which including assisting the "worthy strong" at the expense of the "unworthy underclass" who were of no value under their ideology (Barney & Dalton, 2006). As such, too many social workers became parts in the Nazi machine that killed millions (Barney & Dalton, 2006). This is a difficult reality to face, as described by Kunstreich (2003), since few professions embrace criticism. This is supported by Williams, Soydan, and Johnson (1998), who state that this past has left a legacy that includes a reluctance to examine and learn from it. The lessons that can be learned from this historical situation, however, are vital and thus require magnification.

In our social work pursuit to improve human and individual well-being, we can become caught in a tangle of ideologies (as highlighted in the Nazi German situation) that can in fact do the opposite at times, and lead to the abuses of many vulnerable groups. Therefore, one can argue that social work operates on a fine ethical line that can be skewed, and thus requires an appropriate guiding framework that can prevent such atrocities being repeated. As identified by Barney and Dalton (2006) the Nazi experience highlights the need for a deeper understanding of contemporary moral dilemmas, and an evaluation of social work's response to these issues. Furthermore, our profession must be vigilant in examining possible socio-political oppression and discrimination, in order to avoid succumbing to the pressures of conforming out of fear or ambition. Furthermore, any denial of civil liberties in society should alert social workers to the possible misuse of power, and such realities should be motivators both for professional advocacy, and for individual and collective responses (Barney & Dalton, 2006). Such responses can be founded out of

a human rights framework, constructed by the discourses of relevant universal declarations and conventions. This is a timely discourse, considering its vast development that arose from the experience of World War II.

In his book *Human Rights and Social Work: Towards Rights-Based Practice*, Ife (2001) details such a framework. According to him, incorporating a human rights perspective in social work can strengthen our profession and provide a strong basis for practice that seeks to realize goals of social justice, in whatever setting. Furthermore, a human rights view can inform our everyday practice, across all levels of social work interventions (Ife, 2001). Where human rights discourse covers all sections of society, from individuals to communities, so, too, does social work practice (Healy, 2008; Ife, 2001). Therefore, our profession can align appropriately with a human rights framework founded on values of human worth and dignity, liberty, and the opportunity to live to your potential. As identified earlier, the social work legacy is based on a contradictory and perplexing identity, involving controlling positions, being instruments for carrying out unjust policies, and also standing against them. A human rights framework that is international in nature provides clarity to our profession, by clarifying our mandate to advocate for and with the most vulnerable.

In conclusion, the Nazi experience provides valuable lessons for contemporary social workers, by showing where we have come from and what can go horribly wrong. Therefore, in looking to the past, we can go forward and renew our dedication to the values and ethics of our profession that are based on a commitment to human rights.

11. Conclusion

The reality of Nazi Germany and the role that social workers played are an extreme example, but it highlights the potential for our profession to be caught in ideological frameworks and practices that can lead to devastating outcomes – namely the abuse of human rights. Consideration of these realities is vital for current social work practice, as we are able to learn from the past. This background highlights that to whatever context we practice, we bring ourselves – our history as a profession, as well as our values and beliefs. Our worldview is formed by this history and these values, and it influences our actions with clients. As such we must be clear about what those values are and the mandate of our practice – a mandate based on human rights discourse. When in a position of asking people to change or conform, what is it exactly that we want them to be? More importantly, is it consistent with our values and human rights ideals, and considered in the context of potential structural oppression? Such questions place us in a position to identify potential oppression, and act according to our social work mandate.

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A Social Justice Value Approach Regarding Physician-Assisted Suicide and Euthanasia Among the Elderly

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Abstract

Social justice, as the primary form of justice, incorporates other forms: commutative, contributive, distributive, and restorative justice. This article integrates the various forms of justice and the social work values in addressing the issues regarding physician-assisted suicide and euthanasia among the elderly.

KEY WORDS: Physician-Assisted Suicide, Euthanasia, Social Justice, Social Work Values

1. Introduction

Understanding social justice is a challenge for social workers, because they are sometimes unaware of the role social justice plays when implementing policies and practices related to issues such as physician-assisted suicide and euthanasia in older adult populations. Social justice, as the primary form of justice, incorporates four other forms of justice:

- *Commutative justice* defines the relationships of a member within the group culture and fosters equality for fair standards of reciprocity in society.

- *Contributive justice* advocates that individuals become productive participants in society and that

society has the obligation to empower them to participate.

- *Distributive justice* requires that the allocation of resources be evaluated from many perspectives so that many individuals in society have their basic needs met.

- *Restorative justice* seeks to reconcile conflicted parties in a way that enables them to find common ground for a new, more equal footing in broken relationships. (Himchak, 2005; Reisch, 2002).

All four forms of social justice encompass the human rights perspective as defined in the Universal Declaration of Human Rights as "inherent, equal and inalienable rights of all members of the human family and the

foundation of freedom, justice and peace in the world" (U.N. General Assembly Preamble, 1948, p. 1; Axin & Stern, 2006). Within the last decade, the social work profession has adopted the human rights perspective as the basic principle undergirding the formulation of social work policy in designing programs, the implementation for social work practice in services and the utilization of theory-based research methodology (NASW Code of Ethics, 2003). Since social justice is the overarching value, this article integrates social work values and end-of life decisions with various forms of justice. It also addresses these forms of justice in relation to several issues that are major concerns among the elderly. These issues are individual and cultural autonomy, family autonomy and decision-making, ethical dilemmas for health care professionals, and the legalization of euthanasia and physician-assisted suicide.

Physician-assisted suicide and euthanasia are rapidly becoming serious ethical dilemmas in all aspects of society, primarily because of advanced medical technology that rather easily allows the prolongation of life. Hence, complex ethical issues regarding physician-assisted suicide and euthanasia emerge not only among medical people, but also among the religious, legal, and social work professions, as well as the general population. There is a shift in attitudes regarding physician-assisted suicide and euthanasia. Public opinion polls, for instance, conducted from 1936 to 2002 found that Americans radically changed their attitudes regarding both physician-assisted suicide and euthanasia (Allen *et a*l., 2006; Emanuel *et al.*, 2000; Logue, 1993). The shift is largely due to the belief that individuals have the right to end their lives when they perceive their quality of life is significantly diminished and/or when invasive medical innovations that prolong life become too financially costly (Allen *et al.*,

2006; Emanuel, 2002; Logue, 1993; Loewy & Loewy, 2002).

Although policies concerning physician-assisted suicide and euthanasia affect all populations, this article focuses specifically on the geriatric population, because they are the fastest growing vulnerable group of Americans with the greatest numbers consisting of the frail elderly, 75-85 years of age. By 2030, the number of older persons (aged 65 years and older) in the United States is projected to increase to 66 million, making the issues of assisted suicide and euthanasia more prominent (U.S. Census, 2000). The majority of this population includes culturally diversified women who are widowed, living on limited incomes, and living with functional disabilities. Although Caucasian older adults continue to represent the majority of the aged population, minority elderly groups are growing rapidly. By the year 2050, there will be 22 million minority elderly (U.S. Census, 2000), most of whom will be African-American, Hispanic, and Asian (Angel & Hogan, 1992).

2. Distinctions and Terms

Before entering the heart of this article, it is essential to define the relevant terms, which are often muddy in popular literature. First among the concerns is understanding of death, especially as different people in different cultures perceive it. In general, individuals and societies envision *death* in three ways: as the antithesis of life, as a part of life, and/or as the end of life. *Thanatology* is the study of death and death related behavior, and *orthothanasia* is the science of dying a natural death. Religious and cultural beliefs; science and medical technology; and the ethics and values of the medical, legal, and social work professions (Pellegrino, 2001) have influenced both

concepts. Both concepts are at the core of the euthanasia and physician-assisted suicide debate.

The word "euthanasia" originates from the Greek language meaning "good death": eu, well; thanatos, death (Beauchamp & Childress, 2001). A good death requires that the individual has clarity in decision making and self-awareness in accepting death (Cameron, 2002). In today's society, the word *euthanasia* generally means the act of taking a terminally ill person's life for merciful reasons, generally known as "mercy killing" (Porter & Warren, 2005; Marker, 2006). However, physician-assisted suicide refers to a physician providing the means (such as medication or other interventions) of suicide to a competent patient who is capable of carrying out the chosen intervention (Allen *et al*., 2006; Gesundheit *et al*., 2006; Marker, 2006). In considering, euthanasia as a good death, the individual needs to understand and accept the fact that physician-assisted suicide and euthanasia terminate life, but it might not be a good death (Pellegrino, 2001).

The difficulty regarding the right to die is further confused by the failure to understand the differences between active and passive, and voluntary and involuntary, euthanasia and physician-assisted suicide (Rodgers, 1996; Shapiro, 1994). First, active or positive euthanasia involves a direct action to end a person's life for merciful reasons, for example, by administering a lethal injection. Passive or negative or indirect euthanasia is the failure to provide necessary care for survival, or the process of allowing people to die when they could be kept alive by medical or other interventions (Chaloner, 2007; Ersek, 2005; Gesundheit *et al*., 2006; Porter & Warren, 2005). Furthermore, both the active and passive forms of euthanasia can be:

- voluntary, i.e. with the consent of the person,
- involuntary, i.e. against the expressed will of the person,
- non-voluntary, i.e. when it is not possible to obtain consent because of the incapacity of the person (Chaloner, 2007; Ersek, 2005; Gesundheit *et al*., 2006; Porter & Warren, 2005).

3. Active and Passive Euthanasia

Whereas failing to be precise in the use of terminology often causes confusion about the moral justification of the practice of active and passive euthanasia, the differences between active and passive euthanasia are not a mere matter of "semantics." Rather, they are based on the objective reality of three factors: cause, motive, and means (Atkinson, 1983; Gesundheit *et al*., 2006). In the case of the terminally ill person, some argue that the ultimate cause of death is the disease or illness, and active euthanasia is just hastening the death process. Whereas the ultimate cause of death in active and passive euthanasia may be the disease or illness, there are major differences between them. In active euthanasia, an individual who does something directly to cause the death, whereas in passive euthanasia the cause of death is the natural course of the disease or illness, brings about death (Atkinson, 1983; Ersek, 2005; O'Rourke, 1991). The intention of the individual who hastens death is also a significant factor in the distinction between active and passive euthanasia. In active euthanasia, the intention is to directly terminate the person's life for merciful reasons; whereas, the intention of passive euthanasia is to allow life to end naturally by natural causes (Chaloner, 2007; Marker, 2006). The practice of passive euthanasia is generally accepted among the general population and among health care professionals, because it allows patients to make choices about life support, such as choosing not

to use life support or choosing to withdraw life support interventions.

The principle of double effect is often at play in terminal sedation when one intends to relieve pain through medication while realizing that the medication may also hasten the death. In other words, there are two effects from the same act. An action intended to achieve a "good" effect (such as relieving pain and suffering) is justifiable, despite the possibility of an unwanted secondary effect (such as hastening death) if the intent of the clinicians is the "good" effect. For example, if a patient is administered morphine with the intent to relieve pain, the action is morally acceptable regardless of any secondary outcome (Marker, 2006; Porter & Warren, 2005).

4. Individual Autonomy and Rights

The predominant ethical principle in the controversy about physician-assisted suicide and euthanasia is personal autonomy or the rights of the individual. Miller (1981) describes three senses of autonomy at work in medical ethics. First, autonomy as free action implies that the action is voluntary and intentional. Second, autonomy as authenticity implies that the action is consistent with the individual's value system, character, and life plans. Third, autonomy as effective deliberation implies the action is considered when the individual initiates the decision, has knowledge of the consequences, and reaches an informed decision.

Two concepts are important when defining autonomy: the right to life as an inalienable right, and the right to life as a predominant right. Implied in the basic inalienable rights of life, liberty, and pursuit of happiness is the idea that these rights are nontransferable and God-given. As an inalienable right, the right to life implies the right to preserve and protect life (Allen *et al.*, 2006; Callahan, 1994; Feinberg,

1977). The right to life as a predominant right is also a human right, because it is connected with human well-being and belongs equally to all humans (Callahan 1994; Feinberg, 1977). The rights of life, liberty, and the pursuit of happiness are nontransferable rights, but the right to life is a precondition to the other rights.

The value of commutative justice from the human rights perspective provides a value-oriented approach on the autonomous rights of older adults in their attitudes toward physician-assisted suicide and euthanasia. Commutative justice defines relationships among a group's members. It respects the individual person's dignity and worth by seeking equality based on fair standards for reciprocity in human relationships. It also rejects the encroachment on others' rights. From a commutative value-oriented approach, the social worker in respecting the individuals' dignity and worth not only encourages self-determination of the older adults' choices but also empowers them to define themselves as people who have self awareness, life plans and values regarding their choices. It helps them to identify their conceptualization of death and the underlying values regarding end-of-life decisions. Utilizing a value-oriented approach in assessing the older adults' perspectives of death encourages individuals to create a biographical summary of their life and death history regarding end-of-life decisions. It is essential for the social worker to explore the older adults' biological and biographical context and meaning of life as well as exploring all treatment options regarding end-of-life decisions. Older adults need to know that they are not only free in making their decisions, but that they are informed and understand the consequences of all treatment options (Miller, 1998).

5. Autonomy and Culture

Commutative justice is considered to be intrinsic to social work, because social workers respect the inherent dignity and worth of all individuals and empower individuals to define themselves in the context of their cultural belief systems. Social workers treat each person in a caring, respectful manner mindful of individual differences and cultural and ethnic diversity.

Culture provides a sense of identity for individuals in their affiliation to the group. Whereas culture is usually understood as ethnic affiliation, it also includes one's religious affiliations, practices, and spirituality (Haley *et al*., 2002). Research studies (Blackhall *et al*.,1995; Werth *et al*., 2002) examined the culture-concept of autonomy regarding medical decision making among four groups of elderly: Asians, Hispanics, African Americans, and European Americans. These studies indicated that although there were differences attributed to religion, gender, and age, ethnicity was the most important factor in making major decisions. Asians and the Hispanics favored a more family-centered model in making medical decisions, whereas African Americans and European Americans favored an autonomous model. Role obligation or filial responsibility was identified as the most significant factor for decision making among the four groups of older adults.

Cultural influences regarding physician-assisted suicide and euthanasia are well documented, with studies highlighting different spiritual beliefs concerning disclosure and consent, family decision-making, and treatment decisions (Enes & Vries, 2004). Religion and intergenerational family ties play a major role for African Americans in making decisions regarding physician-assisted suicide and euthanasia. The majority of African Americans adhere to a Christian spirituality, with 83% claiming Protestant affiliation. While the Baptist, 14% identify as Catholic

(Ellison & Sherkat, 1990; Enes & Vries, 2004). Documented studies also indicate that Hispanic Americans have strong family and religious ties that urge them to offer instrumental and adult daily living care-giving as well as affective support within the immediate and extended family. This care giving crossed generational and intergenerational lines. In the year 2000, there were about 31 million Hispanic Americans residing in the United States, with one million of these Hispanic Americans age 65 years of age and over. The fastest growing group of Hispanics is the "old old" elderly, people age 85 and over. This will have a great impact on Hispanic adults in the next few decades as they face aging parents, and grandparents. In terms of religious affiliation, most Hispanics identify as Roman Catholic (Bastida, 1988; Cuellar, 1990; Enes & Vries, 2004; Haley *et al*., 2002).

Among Asians, the Chinese are the fastest growing population in the United States (Ferrans & Hsiung, 2007). A large part of this growth is attributed to a lower mortality rate and longer life expectancies for this ethnic group (Ferrans & Hsiung, 2007). Moreover, strong Confucian beliefs that emphasize filial piety and family responsibility affect their view on issues such as physician-assisted suicide and euthanasia (Gelfand & Barresi, 1987; Scharlach *et al*., 2003; Yeo & Hikoyeda, 1992). Because the Chinese elderly are very concerned about saving face, having respect for their physicians, showing family loyalty, and a sense of duty in completing life tasks, physician-assisted suicide and euthanasia are rarely spoken about. In fact, even discussions about end-of-life treatment options can be interpreted as disrespectful of the elderly in the Chinese-American community (Haley *et al*., 2002).

It is imperative that social workers who work with the elderly and the infirm are ethnically,

culturally, and spiritually competent. They need knowledge and awareness of ethnic beliefs and values before engaging in discussions about physician-initiated suicide, euthanasia, and/or end-of-life decisions when working with older adults. Ethnic and spiritual personal beliefs may or may not be congruent with the predominant ethnic cultural beliefs or the religious doctrines of organized religions, but knowledge of these beliefs will build awareness and sensitivity. The role of the social workers is to prevent and to eliminate domination, exploitation, and discrimination against any person or group on any basis whether cultural, ethnic, or spiritual.

6. Family Autonomy and Decision-Making

All individuals by virtue of their human nature have social needs. Human relationships enable people to meet their needs and provide an important vehicle for change. Autonomous decisions encompass the individual's values in the context of human relationships such as family and friends and involve personal responsibilities to others and to the good of society. Among the elderly population, two concerns are paramount. First, society has the burdensome responsibility of managing the quality of life of the ill and frail elderly while grappling with the escalating costs of health care. Second, many families cannot afford quality health care for their elders and provide much of the care themselves. The care-giving responsibilities for family members are stressful and costly (Haley *et al*., 2002; Mackelprang & Mackelprang, 2005; Pifer & Bronte,1986). A national study indicated that the burden of caring for the elderly led to depression among family caregivers, especially those caring for terminally ill patients (Emanuel, *et al*., 2000). Many elderly rely on their families as their major source of care-giving (Circirelli, 1997; Haley *et al*.,

2002). They perceive the interests of family as part of their own interests and are concerned with the impact their decision (about euthanasia or physician-assisted suicide) has upon the family unit (Emanuel *et al*., 2000; Hardwig, 1990). The complexity of the physician-assisted suicide and euthanasia debate has been heightened by the tension between the competing rights and autonomy of the elderly and their families. In addition, they may feel guilty for considering or promoting euthanasia or palliative care.

Contributive justice advocates for the elderly person, the family members, and the health care professionals as participants in determining the treatment options that serve all parties and promote the common good of society. Social workers recognize the value of human relationships as central to the profession (Congress, 1999). Social workers promote the general welfare and development of individuals, families, and communities. Contributive justice is utilized by promoting family autonomy, because family autonomy is based upon a common set of family values that is the common ground for family deliberation and decisions (Thomasma & Graber, 1991). Shared decision-making by the elderly and family members empowers the elderly to develop interdependence rather than dependence. Moody (1988) suggests family negotiation as the process of informed consent in shared dialogue among health care professionals, family members and the patient. Family members list the following issues as central for them when making end-of-life decisions for the elderly with chronic illness: attachment, cultural expectations, and avoiding institutional care (Haley *et al*., 2002). Individual family members make decisions based on their family values and commitments despite differences and disagreements among family members (Roberto,1999). Family loyalty and respect are the main values for

making end-of-life decisions, regardless of whether the decision was made by the individual for him/herself or for other family members (Leichtentriit & Rettig, 2001).

A research study by Terry *et al.* (1999) indicated that terminally ill patients preferred a proxy's choices to their own for the following reasons: Many of these patients believed that the proxy's judgment was better than their own. The relationship between the proxy and the terminally ill patients clouded the judgment of the terminally patients. Trying to please the proxy, the terminally ill patients valued the proxy's interests as being more important than their own. These reasons were based on emotional attachment and a long-standing history with the terminally ill patients. On the other hand, there are many reasons for decision-making by family members. Among them are one's concept of family, finances, age and health of the caregiver, geographical proximity, competing obligations, and stress of care giving (High, 2003).

Conversely, there are many barriers in making decisions about death among family members, including culture, education, knowledge of the health care system, and the delegating of all decisions entirely to the family (Haley *et al.*, 2002). Social workers seek to strengthen relationships among people at all levels in order to promote their well being. Contributive justice explores the avenues in relationships that empower older adults and their family members to become collaborative participants in making decisions about end-of-life care. Social workers understand that relationships between and among people are important vehicles for change. Therefore, social workers, in developing their expertise, are also challenged by the social work value of integrity that integrates authenticity and trustworthiness in engaging people in the

helping profession and in promoting their well being at all levels. This requires that social workers have clarity about their personal and professional value system regarding the issues of physician-assisted suicide and euthanasia.

7. Ethical Dilemmas for Health Care Professionals

The dilemma that challenges the health care professionals' ethics regarding physician-assisted suicide and euthanasia focuses on the following bioethical principles: Autonomy, Beneficence, and Non-maleficence. Arguments favoring physician-assisted suicide and euthanasia include the following:

- Autonomy: respects the individual's right to choose and to make his/her own decisions to preserve free choice and human dignity.

- Beneficence: Doing good means helping a suffering patient maintain control and end suffering in a compassionate manner.

- Non-maleficence: The inability to relieve suffering is interpretive as causing no harm, and destroying trust between the health care professional and the patient (Chaloner, 2007; Ersek, 2005; Marker, 2006; Rodgers, 1996).

Arguments against physician-assisted suicide and euthanasia include:

- Autonomy: Honoring the sanctity of life overrides the right of individuals to terminate life. Autonomy does not include the right to engage others in terminating life and unethical practices.

- Beneficence: Assisting an individual to terminate life is patient abandonment.

- Non-maleficence. To assist an individual to terminate life destroys trust and violates the ethical traditions of health care professionals (Chaloner, 2007; Ersek, 2005; Marker, 2006; Rodgers, 1996).

The two principles, beneficence, and non-malfeasance, are encompassed in the Hippocratic Oath and the Code of Medical Ethics. Physicians believe it is their professional duty to save life, because human life is sacred. This "sanctity of life" view is strongly held by many opponents of physician-assisted suicide and euthanasia (Hurst & Mauron, 2006). This principle originated from Judeo-Christian world view and is based on the belief that God is creator of all life and is sovereign over life. Human life is a gift from God over which humans have stewardship but not absolute control (Callahan, 1994). At the same time, sanctity of life is not solely a religious concept. Life always has a value, despite its quality or lack thereof, because life and the dignity and respect for the individual originate from the fact of just being human (Thomasma & Graber, 1991).

Proponents of physician-assisted suicide and active euthanasia use the concepts of medical invasiveness and self-determination in their arguments favoring the quality of life and death with dignity. Quality of life, they suggest, is more significant than the quantity of life; thus, the right of self-determination allows the individual to determine what it means to die a dignified death. In the theological sense, the quality of life is based on the sanctity of life principle that God is the creator of life, but it also favors human intervention in terminating life as an act of co-creating partnership with God. The secular perspective of the sanctity of life fosters the belief that an individual creates his /her own personal dignity and destiny (Callahan, 1994). Individuals do have the right

to a dignified death. This right includes controlling the invasive and aggressive medical technology that distorts death, and the restoration of death to its natural process, thereby deinstitutionalizing death.

Research studies indicate that the elderly prefer maintaining life, regardless of its quality. The value of life is increased when it is not related to health issues alone (Lawton, *et al*., 2001). However, the ethical dilemma for many elderly regarding decisions about end-of-life health care is the scarcity of their resources. Distributive justice commands that the goods of the society are distributed in the fairest way; therefore, the most seriously injured would have access to their basic needs. Reamer (1995) presents four main criteria for distributing scarce resources: equality, need, compensation, and contribution. These criteria challenge health care professionals and social workers to strive to ensure access to needed information, services, resources, and equality of opportunity. Reamer (1990) states that the "mission of the profession has been based on the enduring assumption that members of society assume an obligation to assist those in need, especially those who seem unable to help themselves" (p. 36).   Social workers seek to promote the responsiveness of organizations, communities, and social institutions to individuals' needs and social problems. Social workers have the ethical responsibility to promote the general welfare of people and their environments (NASW, 2003).

8. Legalization of Euthanasia: A Slippery Slope

One of the strongest arguments against legalization of physician-assisted suicide and active euthanasia contends that if these acts are legalized and initially restricted to the terminally ill, they will eventually extend to the vulnerable people in society, including the disabled, the senile, the mentally ill, and the chronically ill

elderly. The law, which now protects the lives of all people in society, will then sanction an easy and permanent solution to rid society of the burdensome and vulnerable people. Physician-assisted suicide and active euthanasia, rather than non-palliative care for the terminally ill, will become the preferred treatment and the expected duty of the physician to perform (Ersek, 2005, Gesundheit *et al*., 2006; Werth, 2002). The President's Commission Report (1982), *Deciding To Forego Life-Sustaining Treatment,* insists that the "slippery slope arguments must be carefully employed lest they serve merely as an unthinking defense of the status quo. Where human life is at issue, valid concerns warrant being especially cautious before adopting any policy that weakens the protections against taking human life" (p. 29). John Rawls makes the moral distinction between individual acts and social practices in that "certain acts may be deemed morally right in and of themselves, but such isolated cases do not provide sufficient warrant for the establishment of sound social policies" (Arras, 1982, p. 287).

In July 1981, the President's commission defined the concept of death, which led to the Uniform Determination of Death Act (UDDA). The UDDA states: "An individual who has sustained either 1. irreversible cessation of circulatory and respiratory functions, or 2. irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards" (G.P.O. Deciding to Forego Life Situation Treatment, 1982, p. 9). The commission concluded that in defining death, we also make a public statement on the treatment of all patients.

Two major landmarks in public policy regarding end-of-life decisions are the Patient Self-Determination Act of 1991 (PSDA) and the Diversity Committee for Last Acts 2001. The Patient Self-Determination Act requires that all hospitals, skilled nursing facilities, home health care agencies, hospice organizations, and health maintenance organizations serving Medicare and Medicaid patients must obtain information regarding the living will and power of attorney for health care. "Individuals have the right to make their own medical decisions and to formulate advance directives to effect those decisions when the individual is incapacitated" (G.P.O. Living Wills, 1990, p. 186). The Diversity Committee for Last Acts 2001 states "providers are well advised not to presuppose patients' views, beliefs, or motives based on any superficial knowledge or stereotyped beliefs" (Schmidt, 2001, p. 1). Social workers who are well informed about life and death issues in the light of cultural and religious beliefs and practices, advanced directives, and the legislation related to them, will be more competent in assisting clients to express their desires and to make choices that include their cultural and spiritual beliefs. Such knowledge enhances social work intervention by empowering the elderly to use their autonomous rights related to advanced directives while helping family members, through counseling, to negotiate difficult end-of-life procedures.

The moral problem of the slippery slope, which also contributes to the social climate perspective, is clearly an important issue. Justice includes both equality and equity and has two dimensions: individual rights and the common good of society. Thus, the potential of the slippery slope must be considered not only from the perspective of the individual, but from its effects on the society. The primary goals of social work services are to help people in need and to address social problems (Congress, 1999, p. 19). The social work value of service requires responsibility on the part of the individual and society as well upon society to look at underlying attitudes

regarding the basis of help. These two attitudes are "cause and effect" and "condition." The rationale for "cause and effect" service is based on analyzing the cause of the need. The question for service is, "What caused this to happen?" The rationale for "condition" is based on the fact that one is in need of service regardless of the cause of need. It is interested in providing a solution to existing conditions and alleviating the situations creating the conditions. The question for service is, "What can we do to help?" (Tropman, 1995).

Restorative justice seeks to reconcile conflicting parties to find common ground (Shiman, 2004). It considers the basic moral test of any community or society to be in the way in which the most vulnerable members are faring. The concept of restorative justice is further developed by John Rawls' conception of justice. In the Original Position, "the people in a society choose the principle that minimizes the worst possibilities for any group so that the greatest benefit of the least advantaged is provided and protected" (Rawls, 1971, p. 12). The ideal of social justice challenges social workers to advocate against injustices in society. Social workers advocate for living conditions conducive to the fulfillment of basic human needs and to promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice. Social workers pursue change with and on behalf of vulnerable and oppressed individuals and groups to address poverty, unemployment, discrimination, and other forms of social injustice. They also expand choice and opportunity, such as in end-of-life decisions, and they promote justice (NASW, 2003). Restorative justice seeks the common ground for all voices to be heard, in particular the "cry of the poor." Whereas physician-assisted suicide and euthanasia are actions

taken by individuals for their own good and they may be justified in particular circumstances, these actions may not be something that benefit the society as a whole.

9. Conclusion

In facing any ethical dilemma, social workers are obligated by the NASW *Code of Ethics* to incorporate the six core values of their profession--service, social justice, dignity and self-worth, importance of human relationships, integrity, and competence--in assessing the situation. The priority of social workers must be to enhance the client's quality of life and to encourage the exploration of end-of-life decisions within the cultural and spiritual context of the lives of the elderly. However, "social workers may not personally participate in an act of suicide when acting in their professional role" (NASW, 2003, p. 9). Furthermore, it is inappropriate for social workers in their professional role, to deliver, supply, or personally participate in the commission of an act of assisted suicide.

Integrating the core values of the social work profession with the various forms of social justice clarifies the issues surrounding the ethical dilemma of physician-assisted suicide and euthanasia. Commutative justice defines the individual autonomy of older adults' relationships as members within the group culture and fosters equality. Contributive justice advocates for the elderly, family members, and health care professionals in becoming participants in decision making. Distributive justice requires the fair allocation of resources; restorative justice seeks to reconcile conflicting parties to find common ground (Shiman, 2004). The social justice and human rights approach empowers social workers to protect the rights of the marginalized and people at risk, providing services without judging their worthiness. The social justice and human rights approach

challenges social workers to bring the concerns of the poor and the vulnerable, in this case older adults, to all levels, national and international, into concrete actions. Every program needs to have in its last analysis and main purpose to service the human person. Such programs should reduce inequalities, eliminate discrimination, and empower the individual to progress in human and spiritual development. Promoting the true development of people requires the desire, the right, and the responsibility to ensure justice for all people. Securing justice requires the desire, the right, and the responsibility to promote equality for every human person and to foster solidarity with all people in society.

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Forum Article
Coercing Conscience: Professional Duty or Moral Integrity

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Abstract

In response to a recent NASW document about conscience clauses, the author argues that framing an issue like abortion as one of personal versus professional values, or moral qualms versus professional duty, trivializes conscience. Respecting the conscience rights of professionals is important for the moral integrity both of the practitioners concerned and of the profession itself.

Key words: conscience, exemptions, integrity, abortion, values

"Does private conscience trump professional duty?" asks an editorial in the *Journal of Medical Ethics* (LaFollette & LaFollette, 2007, p. 249). The answer for any person of integrity is yes, it must. In this essay, I want to defend that answer, although it is not the one given by the editorial or by the National Association of Social Workers (NASW) in the recent statement from its Legal Defense Fund (2010).

The issue of coercing the conscience of professionals in the health and helping professions has come to the fore in recent years as a result of the discovery, invention, or promulgation of new rights in matters of life and death, and also sex, marriage, and family. Behaviors that were illegal or socially stigmatized for millennia have been declared legal and have become rights. This is not simply a victory for tolerance of, or bearing with, particular behaviors contrary to the views and values of the majority of the population. It is also a claim, supported by the force of law, for equal recognition and respect, subject to anti-discrimination measures equivalent to those that apply in the case of race, age, or sex. Insofar as such recognition demands the participation or collusion of professionals, even in actions specifically forbidden by those professions until recently, it is a source of increased state coercion in civil society.

For more than two millennia, physicians have sworn by the Hippocratic Oath not to engage or collude in practices like abortion, euthanasia, or assisted suicide that involve the deliberate taking of human life. In the twentieth century in the U.S., this ethic of aiming always to heal, never to harm, came

under intense pressure from the eugenics movement that, in alliance with the birth control movement led by Margaret Sanger (1922; 1932), sought to reduce the undesirable population of defectives, dependents, and delinquents - Sanger's "human weeds" - through birth control (Franks, 2005). This movement was taken up enthusiastically by the Nazis in Germany (Black, 2003). In revulsion at the serious violations of the Hippocratic ethic by Nazi physicians, the World Medical Association's (1948) Physician's Oath affirmed "I will maintain the utmost respect for human life from the time of conception, even under threat." The legally binding United Nations Declaration of Human Rights and the 1959 UN Declaration of the Rights of the Child affirm the rights of the child before as well as after birth (Joseph, 2009). These reaffirmations of universal rights of adults and children were a strong response to the eugenics movement in the U.S. and Germany and the horrors of World War II that discredited that movement for decades.

1. Intolerant Tolerance

In the space of just half a century, however, the millennia-old oath has been turned on its head, so that physicians, nurses, social workers, and pharmacists face coercion and risk losing their jobs for adhering to its ethic of life (for one poignant example, see Baklinski, 2009). What was until yesterday forbidden for health care providers as a matter of professional ethics becomes a duty enforced by threats to job, licensure, and career. An ethical obligation not to take life suddenly becomes a duty to take life, reversing more than two thousand years of professional ethics.

With astonishing speed, legal protections of children before birth have been swept away in either letter or spirit. UN officials have been attempting to pressure sovereign member states to establish abortion as a legal right

(Tozzi, 2008). Far from resisting these threats, professional associations have revised the Hippocratic and other oaths to eliminate the prohibitions on killing—whether through abortion, euthanasia, or assisted suicide. They have transformed their own professional ethics from codes forbidding abortion and other life-terminating measures to all but making direct or indirect participation in them a requirement of professional practice (American College of Obstetricians and Gynecologists [ACOG], 2007; Kaczor, 2008).

Many or most people in the United States, and especially orthodox and observant religious individuals and communities, continue to regard abortion in most circumstances as a grave evil, assisted suicide and euthanasia as morally impermissible, marriage as the proper context for sex and for raising the children that result from it, homosexuality as intrinsically disordered, and sexual behavior (of any kind) outside marriage as wrong. These are now the areas of greatest division in society, the battlegrounds of the culture wars in which state and civil society, professionals and their clients, elites and masses, are most commonly and sharply divided (George, 2001; Hodge, 2003; Neuhaus, 2009).

New rights, established mainly by judicial rulings, make previously forbidden behaviors lawful, thereby expanding the options for those who wish to engage in them. But what is optional behavior for clients or patients rapidly becomes mandatory for professionals in the form of participation or collusion in the newly permitted behavior. An argument for tolerating certain behaviors has become a case for intolerance--of those who refuse to be personally or professionally complicit in them (Pell, 2009).

2. Your Right to End Life and My Right not to Help You

One response is to acknowledge and protect the consciences of those practitioners who regard their own involvement in such behaviors as gravely evil. This is what conscience exemptions attempt to do. Freedom of conscience in these matters is often a matter of religious liberty and so, it is argued, protected by the First Amendment. You may have a legal right to an abortion but I have the right not to assist you in having one. Many physicians, nurses, and social workers participate directly or indirectly in providing abortions and do so with untroubled conscience. But what allowance should be made for those to whom the practice is abhorrent and who wish to continue to practice according to the Hippocratic Oath as understood for many centuries down to the last one? Whether in terms of abortion or assisted suicide, does your right to death (your own or your baby's) imply my duty to assist you?

The argument against such conscience exemptions for health care professionals (physicians, nurses, social workers) is typically framed as a conflict between an individual's (or institution's) right to refuse treatment and patients' rights to treatment. The client's right to treatment, to a full range of services, may be linked to professionals' willingness to provide them, especially in rural areas. As the chair of the ethics committee of the American College of Obstetrics and Gynecology put it, the "reproductive health needs" of women should trump the moral qualms of doctors (Bioedge, 2009).

Here it is noteworthy how the language of the anti-exemptionists—like that of abortion rights advocates generally— depends heavily on euphemism. Abortion is part of the "full range" of "reproductive health care" or of meeting "reproductive health needs," although it is anti-reproductive, is not (except in rare cases) about health, is seldom remotely definable as a medical need, and terminates

care (and life) for one of the two patients involved. (In obstetrics textbooks, traditionally, the physician is said to have two patients, the mother and her unborn baby. Abortion by definition is never safe for one of them.) This strategy of obscuring the reality of what is taking place through bland medical metaphors and descriptions is endemic to the discourse of abortion advocates, who talk of removing biological material or tissue rather than causing the death of the tiniest and most vulnerable persons among us.

Indeed as Brennan (2008) shows, "much of the success of the death culture depends upon the corruption of language in the form of dehumanizing stereotypes imposed on the victims and euphemisms designed to disguise what is done to them" (p. xv). The medical term "fetus," is never used when a mother is invited to see her baby's ultrasound image, only when abortion is under discussion. As philosopher John Finnis (2010) recently argued, "The word 'fetus' is offensive, dehumanizing and manipulative."

Proponents of abortion rights say they are not pro-abortion, but "pro-choice," as if the taking of innocent human life were a matter solely for the person responsible for the care of that life to decide. It is as if I were to say that I am not pro-slavery but simply defend your right to choose to buy and own slaves should you decide to do so. A law that upheld that right would not be neutral or pro-choice, but pro-slavery. (On the impossibility of state or legal neutrality in such grave moral matters, see Sandel, 2009.)

In this discourse, the personal is contrasted with the professional, the idea being that a professional has a duty to provide whatever services are legal and demanded by clients. The conscience of the professional is invariably given short shrift and subordinated to the supposed rights of the client to

treatment. I say "supposed" because it is not clear how the legal right to have an abortion in itself gives anyone a legal right to demand its provision, let alone legally obliging anyone else to carry it out. In a shift characteristic of contemporary rights discourse, a right to freedom from state interference (a "right to privacy") is transformed into a claim on public provision (Arkes, 2002).

In part, the failure of professional organizations like NASW to protect the conscience rights of their members is justified by an implicit rejection or trivializing of the very concept of conscience. In its place we find a contrast of public (or professional) and personal "values." Here values have no intrinsic authority or foundation beyond being the opinions or beliefs of those who hold them. If this is so, then why should the personal opinions (values) of a practitioner *not* be subordinated to those of the state that licenses and funds the professional or institution?

To see the logic of this position and how it corrupts ethical discourse in the professions, I want briefly to examine the concept of conscience in the context of abortion. This is far from the only issue at stake, but if a case for conscience exemptions cannot be made in the case of abortion, it cannot be made anywhere.

3. Conscience and Exclusion

Opponents of conscience exemptions give little or no weight to the gravity of requiring individuals either a) to act against their conscience, or b) to leave their profession or be denied admission to it and hence to its schools. But the choice to act against one's conscience can never be right. It is to choose to do what one believes to be wrong, and in the case of abortion, gravely wrong. For a Christian, it means to put one's immortal soul in jeopardy; for a Catholic Christian, it means

to excommunicate oneself from your Church and its sacraments.

In its hotly disputed Opinion #385, entitled "The limits of conscientious refusal in reproductive medicine," the ethics committee of the American College of Obstetricians and Gynecologists (2007) recommends the position that pro-life physicians must refer patients seeking an abortion to other providers, must tell patients in advance of their views though not explain or argue for them, and must in emergency cases involving the patient's physical *or mental* health, actually perform abortions. It treats conscience as one value among others, which means it can and should be overridden in the interest of other obligations that outweigh it in a given circumstance.

As Kaczor (2008) remarks, this peculiar account of conscience runs counter to the traditional understanding of the term, according to which "conscience is the supreme proximate norm for human actions precisely because it represents the agent's best ethical judgment all things considered." One could never be morally obliged to act against one's own conscience or best ethical judgment. It is hard to see how a notion of conscience as one value among others from which a professional should choose could be other than incoherent. On what ethical basis could such a choice be made?

Some opponents of conscience exemptions respond by saying, "Fine, if you cannot in conscience meet the expectations and duties of the profession, leave it or choose a different line of work." This may indeed be the only option facing conscientious individuals where no accommodation is made. Conscience also trumps career.
Exclusion of pro-life physicians, nurses, social workers, and pharmacists from their professions and the closing down of

institutions that respect life and adhere to Hippocratic ethics have practical consequences. But my argument here against exclusion does not depend on the empirical reality that religious professionals and institutions—e.g., faithful Catholic physicians, nurses, social workers, and pharmacists as well as hospitals and clinics—play an important role in the American health care system. Their exclusion would involve a tremendous loss of talent, knowledge, skill, aptitude, and dedication for the healing professions. It would also substantially reduce health care services of all kinds and therefore the access of patients to such services. The argument here, rather, is that the coercion of conscience of professional health care providers is morally corrupting for the profession and its practitioners. This is so in at least four respects.

First, compared with simply *allowing* the professional participation of members in abortion, *mandating* such participation makes the profession even more complicit in a culture of death that betrays social work's (as well as the medical and nursing professions') core values. It is a culture in which the dignity of the human person is restricted in ways that exclude precisely the most vulnerable and dependent members of society—born and unborn babies, those with severe physical and intellectual disabilities, those whose quality of life others deem inadequate.

Second, justifying such an abdication of the defense of human dignity as a core social work value entails a kind of self-deception. The view that the child in the womb is not a person or a human being seems not more but less and less tenable in light of scientific advances since Roe v. Wade. These show ever more clearly that the unborn child is a separate being with his or her own DNA and own principle of existence (George & Tollefsen, 2008; Lee, 1995). It seems a truth not easily evaded

without a level of self-deception that is itself morally corrupt, that the fetus is the baby we all once were and we are alive now in part because our mothers did not have us killed at that stage of our lives (George & Tollefsen, 2008).

In any case, *if* the profession as a whole accepted the evidence and logic of the position that children in the womb were as fully human as those with severe disabilities or those just born or close to death or suffering advanced dementia, but abortion remained a legal right of pregnant mothers, would NASW require its members to refuse participation, direct or indirect, in the taking of human life in any or all of these conditions? Or, on the contrary, would it still fail to defend either the most vulnerable among us or the conscience rights of its members?

Third, the idea that if an action is legally permissible and demanded by a client, the social worker (or other health professional) has the duty to provide or participate in providing the requested service itself represents a fundamental shift in the balance of rights and powers between professional and client. It strips the professional of her full moral responsibility and reduces her to a kind of machine or robot that delivers what the customer demands. The professional's right and duty to use her judgment about what is required or indicated or morally permissible in the situation is stripped away in favor of a kind of client "empowerment" that radically disempowers, even dehumanizes the social worker.

Fourth, forcing those opposed to the taking of innocent life at all stages of human development out of a profession that proclaims a mission of promoting human well-being and social justice requires those who justify such a stance to trivialize conscience itself. Supporters of abortion rights, with some

exceptions like the utilitarian ethicist Peter Singer (1999), deny that the child in the womb is a person or human being. But for the persons whose conscience is to be coerced in the absence of adequate legal protection, killing - the deliberate taking of innocent human life - is precisely the action in which they are being told to participate. Dismissing their moral objections as personal qualms reduces the seriousness of the matter to something like squeamishness at the sight of blood.

The kind of case against conscience clauses made by NASW, Hilary Rodham Clinton, and Planned Parenthood (Clinton & Richards, 2008) corrupts by trivializing conscience itself and reducing it to "personal values," something idiosyncratic that the physician, nurse, and social worker have to check at the door when professional duty calls. It reduces the first axiom of all ethics, to do good and avoid evil, to something dispensable in face of the requirements of one's profession. To exclude those who want to maintain their moral integrity in face of strong pressures to surrender it is to do further serious moral damage to the profession itself, as well as to the individuals and institutions excluded.

4. A Duty to Refer?

There are less draconian policy options. One idea is that the conscientious objector may be excused from direct involvement in a legal and available procedure like abortion, but must in the event of such refusal, refer the patient to others who are willing to perform it. The argument for mandatory referral may appear persuasive at first glance, when it is posed in terms of the patient's right to information about her options. But a refusal to refer a client to an abortionist is not the same as blocking her access to information. The fact that the mandatory referral alternative can be advanced as a reasonable solution—a

compromise that any reasonable practitioner should be willing to accept—is arguably itself an indication of a certain moral obtuseness on the part of opponents of strong conscience exemptions. It is not simply a disagreement on the moral significance of abortion. It is also a failure to take seriously the conscience and moral integrity of practitioners.

In the case of abortion, the matter at stake is the fundamental moral proscription on the intentional taking of innocent human life. This has been a basic principle of ethics for millennia, an exceptionless norm which binds the consciences of all in societies where conscience is acknowledged at all. To kill justly requires *at least* that the person not be, in a definable sense, innocent (as in capital punishment or enemy soldiers in a just war); or that the individual not be a fully human person (as has been argued by defenders of racism, anti-Semitism, and sexism, as well as abortion—see Brennan, 2000; 2008); or that killing not be the intent but an unintended, proportionate, and secondary side effect (as with deaths of some nearby civilians from the bombing of a military target—or with the foreseen but unintended death of the fetus resulting from some medical procedures aimed at saving a mother's life).

Of course, moral relativists, situationists, consequentialists, and ethical emotivists may deny the existence or binding nature of such a proscription on the killing of innocents. Singer (1999), the renowned if controversial ethicist and philosopher of animal rights, accepts that there is no moral difference between a fetus and a fully born infant but, in line with his denial of human exceptionalism, sees the intentional killing of either as justifiable in certain circumstances, even to save a healthy animal.
Here I will not take up the objections to these stances in moral philosophy, but simply note that *if* it is wrong to kill a person, then it is

also wrong to get someone else to do it. If it is, as I believe, a grave evil for me to murder my spouse, it is no less wrong to hire someone else to do it for me. If it is wrong for me to help you kill your inconveniently long-lived rich parents, it is also wrong for me to refer you to a professional hit-man.

Opponents of conscience clauses and exemptions sometimes pose the matter in terms of religious professionals' wanting to impose their views on clients or patients. This is a misunderstanding. None of the case for conscience exemptions has anything to do with imposing my will on the client. Patients and clients have an uncontested moral right to informed consent and informed refusal.

But this is not the issue. The client may find abortion morally permissible and it is certainly legally permissible at present in the United States. I respect the client's right under law to decide to have an abortion and will not condemn, moralize, or argue with her. My right not to participate in what I believe is grave wrongdoing does not imply or depend on a right to impose my belief on the client. "Conscientious objection, " as Pellegrino (2008) says, "implies the physician's right not to participate in what she thinks morally wrong, even if the patient demands it. It does not presume the right to impose her will or conception of the good on the patient" (p. 299).

Whether someone's right to engage in a behavior entails an obligation on anyone else's part to assist her in the process has important implications for all professionals, but especially those supposed to be helping or healing their clients. For any professional social worker from any faith tradition or none, such a legally mandated obligation is a serious potential threat to their conscience and as such, to their humanity as moral agents.

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Dual Relations and Beyond: Understanding and Addressing Ethical Challenges for Rural Social Work

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Abstract

Several authors have identified the special nature of ethical challenges faced by social workers who practice in rural areas.   The authors discuss specific areas of ethical risk for rural social work such as dual relationships, confidentiality, anonymity & self-disclosure, and competence. Appropriate strategies for strengthening ethical practice and minimizing ethical risk are presented.

1.   Introduction

For many years social workers who practice in rural settings have been aware that a heightened sensitivity to some sections of NASW's *Code of Ethics* (2008) is essential for maintaining ethical practice. Rural communities provide an environment in which the social worker is deeply involved in the community, professional expertise or supervision may not be present, individual social workers are widely known, confidentiality may be difficult to maintain, and relationships may be both complex and multiple (Burkemper, 2005; Daley and Avant 1999; Ginsberg, 1998; Ginsberg, 2005; Gumpert & Black, 2005; Miller, 1998; NASW, 2006).   These ethical themes are also consistent with those raised by Green, (2003) with regard to rural social workers in Australia, and those identified for rural psychologists (Helbok, Marinelli, & Walls, 2006). The context of rural practice presents increased

ethical risks for rural social workers and requires advanced understanding of ethical responsibility and a need to strengthen and emphasize ethics training for rural practice (Daley & Doughty, 2006; NASW 2006).

Although rural social workers have generally understood the importance of ethical risks they face for some time, increased attention has been paid to the ethics of rural practice since the early 1990s. Miller (1998) indicates that the 1993 revision to the NASW *Code of Ethics* that included principles on nonsexual dual relationships stimulated controversy because of the difficulty in avoiding these types of relationships in rural social work. The potential vulnerability and heightened risk for rural social workers that this revision highlighted mobilized the Rural Social Work Caucus to affect a change in the wording of the dual relationship standard in 1996 to better reflect the realities of rural practice.

The social work profession's experience with the *Code of Ethics* during the 1990's generated an increased level of interest in ethical practices among rural social workers and has subsequently led to a growing body of literature on the subject. This article draws on the conceptual and empirical work that has been done on ethics for rural social workers over the last twelve years to review the major ethical issues that have been identified and suggest some strategies that may be used to strengthen ethical practice. Indeed the purpose of this article is to provide a review of prior work that coalesces current thinking on rural social work ethics that may prove useful to rural social workers and social work educators alike.

2. Ethical Issues for Rural Practice

The *Code of Ethics* of the National Association of Social Workers (2008) is generally the accepted standard for ethical conduct for professional social work. NASW has 150,000 members and is the largest social work organization in the world (NASW, n.d.). Each member of NASW is required to adhere to the *Code of Ethics* as a guide to professional conduct (NASW, 2008) and the Council on Social Work Education identifies this code as the basis for teaching values and ethics in social work curricula (CSWE, 2003). Furthermore, almost one-half of the states reference the *Code* in regulating social worker behavior through their licensing regulations (Morgan & Carvino, 2006) and though not directly referenced, many more state regulations are strongly influenced by the *Code*.

The *Code of Ethics* identifies general principles that apply to social workers in all types of settings. While specific principles in this code appear to present special challenges in application for rural social work, there is general agreement that these challenges are not sufficient to define a separate code of ethics for practice in rural communities (Boisen & Bosh, 2005; Daley & Doughty, 2006). As Ginsberg (2005) indicates, "social work with rural populations and in rural areas is, ideally, simply good social work that reflects and considers the environment in which practice takes place."

It is in the reflection on and consideration of the rural environment that social workers need to be knowledgeable in order to maintain a high standard of practice. The growing body of literature on rural ethics has called for the profession to focus on this interface between the practice environment and the *Code* (Burkemper, 2005; Daley & Doughty, 2006; Strom-

Gottfried, 2005). Consequently, the specific areas of the *Code* that may prove more challenging for rural social workers are an important topic for further discussion.

3. Ethical Challenges: A Review of the Literature

The early discussions about ethical challenges for rural social work focused around the difficulty in avoiding dual relationships. More recently consideration has been given to additional areas of the NASW *Code of Ethics* where practitioners in rural areas may face ethical risks. The following section outlines the areas of ethical concern most appropriate for the rural environment including dual relationships, poor practice and competence, confidentiality, anonymity and self disclosure, and colleague related issues.

4. Dual Relationships

Undoubtedly, the dual relationship is an ethical principle that has received the greatest attention in rural social work (Boisen & Bosch, 2005; Burkemper, 2005; Daley & Doughty, 2006; Galambos, Watt, Anderson, & Danis, 2005; Galbreath, 2005; Green, 2003; Gumpert & Black, 2005; Miller, 1998; Strom-Gottfried, 2005; Watkins, 2004). Helbok, Marinelli, & Walls (2006) also identify multiple relationships as a potential area of concern for psychologists who practice in rural communities. Ethical issues of this type fall under the general category of boundary violations that include both sexual and non-sexual relationships between social workers and clients (Strom-Gottfried, 2000). But it is the non-sexual dual relationship that is the primary area of focus for boundary violations in the rural

literature. Sexual relationships are a specific type of dual relationship that is generally considered separately from dual relationships, likely because of the strong prohibitions against sexual contact in the *Code* and the perception that there are no circumstances in rural social work in which sexual relationships could be appropriately managed.

Dual relationships with clients are addressed in the *Code of Ethics* in sections 1.06 (a), 106 (b), and 106 (c) (NASW, 2008) and generally consist of social, family, or business relationships and exchanges in which there is potential for harm or exploitation of the client (Galbreath, 2005; Strom-Gottfried, 2000). Exchanges with clients involving barter also create the risk of exploitation and dual relationships (Strom-Gottfried, 2000) and are addressed in section 1.13 (b) of the *Code* (NASW, 2008).

This is an appropriate area of concern for rural social work. In a study of ethical violations reported to a social work licensing agency in a large state, Daley and Doughty (2006) report that boundary violations for rural social workers are alleged in nineteen and one-half percent of the reports. Allegations of boundary violations ranked second only to poor practice in frequency, although reports of boundary violations for rural social workers were slightly lower than those for social workers in urban practice. Fifty-two percent of the boundary violations for rural practitioners were for dual relationships (Daley & Doughty, 2006).

Examples of dual relationships include inviting clients to family or social functions like weddings or dinners. They also include transacting business with clients or their close relatives.

Relationships of this type may easily create confusion about the nature of the worker-client interaction and in which actions the social worker is fulfilling the professional role. When confusion about the professional relationship between worker and client occurs, there is increased potential for either harm or exploitation of the client. Bartering becomes problematic in the sense that it is often difficult to establish fair value in the exchange. It is much easier to assess good, fair, or bad value when the unit of exchange is monetary and the use of money is impersonal. Barter or a swap for tangible goods or services creates greater difficulties in either fair value or impersonality. Thus when barter is used, there is potential for exploitation and role confusion.

While the *Code of Ethics* does not prohibit either dual relationships or barter, it does place full responsibility on the social worker to prevent harm to clients (NASW, 2008) and the real challenge for the social worker in rural practice is how to manage the dual relationships that may not be avoidable. Martinez-Brawley (2000) points out rural communities do not permit the distance to develop the impersonality that may be common to social work in urban areas, and Reamer (1998) uses small or rural communities as examples of contexts in which dual or multiple relationships may be difficult to avoid. Rural social workers must relate to others in the community in fairly close terms, thereby making it more difficult for rural social workers to avoid dual relationships, presenting challenges for maintaining ethical practice.

5. Poor Practice and Competence

Poor practice and/or competence of social workers are ethical concerns for rural social work that have been raised in the literature by several authors (Burkemper, 2005; Croxton, Jayratne, & Mattison, 2002; Daley & Doughty 2006; Strom-Gottfried, 2005). Poor practice refers to failures in meeting accepted standards for clients in areas like evaluation of progress, appropriate use of supervision, and making appropriate referrals. Some may use different terminology and refer to this as a competence issue, but in a general sense, both poor practice and competence refer to either significant substandard performance by the social worker or lack of adequate preparation for the method used.

Poor practice may be an especially significant area of ethical risk. Daley & Doughy (2006), in their study of reports of ethical violations, identify poor practice as the area of greatest difference between rural and urban social workers. In this study, poor practice comprised 27.1% of the ethical complaints against rural social workers. Strom-Gottfried (2000) also found that thirty-eight percent of the NASW ethics violations in her study were for poor practice, most frequently the failure to use accepted treatment methods. For example, behaviors included in this category were misapplication of self-determination or boundaries, using techniques inappropriate to the age or condition of the client, misusing skills by yelling at or using derogatory language with a client, inappropriate termination or transfer procedures including premature termination, lacking insight or empathy for the effects of worker behavior on the client, failure to make appropriate referrals or case transfers, prolong care beyond what was needed, and failure to seek consultation and informed consent (Strom-Gottfried, 2000).

Poor social work practice is not an ethical violation per se, but when methods are used that violate generally accepted standards of practice, that do not conform to methods used by the profession, and where social workers lack appropriate training in the method or do not use supervision when needed, ethical violations may result. These are particularly thorny issues for rural social workers. Burkemper (2005), Croxton, Jayratne, & Mattison (2002), and Ginsberg (1998) all point to the independence in practice, broadened responsibilities, and the difficulties in obtaining supervision and continuing education in rural social work. Daley & Avant (1999) add that the rural social work labor force tends to have higher percentages of BSW educated workers and fewer MSWs with advanced credentials than in urban settings. All of this may result in social workers who are placed in situations for which they are not adequately prepared and appropriate supervision is not available (Daley & Doughty, 2006). The difficult dilemma they then face is to provide what service they can or to provide none at all (Croxton, Jayratne, & Mattison, 2002). Given these circumstances, it is small wonder that the rural social worker is at greater ethical risk for poor practice issues.

6. Confidentiality

Rural communities are often small communities with close relationships and exchanges between members. People and their cars are readily recognized, and their relationships and business tend to be widely known (Carlton-LaNey, Edwards, & Reid, 1999). In these circumstances it is often difficult to keep things confidential, as when a client is experiencing martial problems, dealing with a substance abuse problem (Ginsberg, 1998) or even

something as trivial as where one went to lunch or with whom.

Given the close and personal nature of interactions in small communities, it is not surprising that a number of authors have identified potential difficulties for rural social workers in maintaining client confidentiality (Burkemper, 2005; Daley & Doughty, 2006; Galambos, Watt, Anderson, & Danis, 2005; Green, 2003; Gumpert & Black, 2005; Strom-Gottfried, 2005). Helbok, Marinelli, & Walls (2006) also raise confidentiality as a concern for rural psychologists. Confidentiality is addressed in section 1.07 of the *Code of Ethics,* and maintaining confidentiality is a complex issue requiring sophisticated practice judgments by the social worker.

The primary concern for rural social work appears to be how the professional maintains confidentiality in this challenging environment in a way that is viewed as appropriate by both the social work profession and the rural community. Daley and Doughty (2006) suggest that rural social workers may already be finding ways to manage confidentiality appropriately. In their study they found that ten percent of the ethics complaints against rural social workers were for confidentiality violations and that this percentage was only slightly higher than that for urban social workers. Other authors identify strategies that rural social workers may be using to manage confidentiality effectively.

Burkemper (2005) and Strom-Gottfried (2005) indicate that the use of informed consent may help to reduce the risk of confidentiality violations in rural practice. Strom-Gottfried (2005) adds that explicit understandings with family and clients about how to manage information may also

help to minimize ethical risk. Gumpert and Black (2005) discuss the application of a culturally sensitive approach for rural practice as an alternative to a strict rule based interpretation of the Code of Ethics. The culturally sensitive approach that they found used by a significant percentage of the social workers in their survey involved the use of boundary crossing but not violations to effectively work with their clients and local agencies. One example of this is for the social worker to acknowledge information already existent through the community grape vine while not violating client confidentiality as way of establishing working relationships in the community and with community agencies.

7. Anonymity and Self-Disclosure

Strom-Gottfried (2005) identifies the tension generated between maintaining the impersonal professional self and the need to gain acceptance within the rural community in order to be effective. Both Ginsberg (1998) and Martinez-Brawley (2000) explain this in terms of the need for rural social workers to adapt to the norms of personal relationships in the rural community to gain the necessary acceptance to practice effectively. In the rural community there is an expectation that social workers be known as people in order to fit in to the community, because formal professional credentials are not as readily accepted as in urban practice. Failure to become known personally may result in a perception that the rural social worker some how feels better or superior to others. Once community members view the social worker in this way, it is likely that the level of cooperation will be limited, possibly affecting the social worker's effectiveness.

Unfortunately, personal disclosure is a double edged-sword for the social worker. Revealing too much or the wrong kind of information may also reduce the social worker's efficacy. For example, when the social worker is seen as too different from the norm or as having too many personal issues of her or his own, community members may question the professional's ability to understand their needs or provide help. In addition, when rural social workers need to seek help for personal or family needs, or exhibits some personal weakness (Green, 2003) this is often widely known because of the lack of anonymity within the community. Knowing this, a rural social worker may be reluctant to seek the help that is needed in order to maintain an image of professional competency. The result may be a conflict with the ethical provision of the *Code* (section 4.05 (b)) that requires social workers to seek help when problems or difficulties interfere with their performance and judgment (NASW, 2008; Strom-Gottfried, 2005).

Once again the primary issue is not so much that these ethical challenges exist, but how to manage these challenges. If the social worker is not open enough, it potentially raises issues with either competence (*Code* section 4.01) or misrepresentation (*Code* section 4.06). But when the social worker is too open with self-disclosure, this may raise the question of private conduct versus professional conduct (*Code* section 4.03) or affect the worker's level of competence (*Code* section 4.01). Similarly, familiarity with those in the community may inhibit the social worker from seeking help for personal or family problems lest such help seeking be widely known. Yet there is a clear responsibility for social workers to seek help when personal problems interfere

with the performance of their professional duties. Clear identification of these ethical dilemmas, assessment of the relative risks, and prudent action to manage these ethical dilemmas are clearly an important part of the rural social worker's repertoire.

8. Ethical Issues with Colleagues

While the complex, multiple, and overlapping relationships between social workers and clients in the rural community is frequently discussed, relatively little attention has been paid to the effects that the same kinds of relationships have on ethical practice with professional colleagues. As Martinez-Brawley (2000) indicates, close and personal relationships are necessary for survival in the rural community, but these relationships create a potential for ethical conflict between professionals in working with clients.

Green (2003, p. 217) also points out that because of the relationships that rural social workers have with other members of the community the ability to develop trusting and open relationships with their supervisors may be compromised. This may be due to the fact that in a close knit rural community the worker has friends or relatives who have other kinds of connections with the supervisor and this may affect the worker's ability to discuss sensitive material openly.

Provisions of the *NASW Code of Ethics* that address social workers' ethical responsibility to colleagues and practice setting responsibilities are found in Sections 2 and 3 of the *Code*. These sections emphasize the ethical obligation of the social worker to act in a professionally responsible manner. The *Code* is not prescriptive in this regard as it contains few dos and don'ts and leaves

considerable discretion to the social worker in managing potentially troublesome situations.

For the social worker in rural practice, this presents numerous ethical challenges. For example, section 2.01 (b) of the *Code* indicates that unwarranted negative criticism of colleagues should be avoided. While this may sound relatively easy to do, the lack of social distance and an overlapping network of relationships in a rural environment present numerous avenues in which a communication about a colleague may reach her/him directly or indirectly. As a result, rural social workers must be exceedingly careful about what they communicate about a colleague and think through the networks and avenues through which information may travel in order to minimize potential problems. Similar issues arise regarding the maintaining of confidential information shared by colleagues particularly in the course of seeking peer consultation (Code section 2.02). Given how easy it is for information to get back to people, and the overlapping personal, professional, and social relationships in the rural community, social workers must also be judicious in managing confidential information from colleagues.

Another area of concern for practice is section 2.11 of the *Code*. This section deals with the ethical obligation for social workers to address the ethical conduct of colleagues, seek resolution, provide assistance, and take appropriate action through formal channels (NASW, 2008). This aspect of ethical responsibility is an important aspect of the social work profession's efforts to improve the quality of practice and regulate incompetent or unscrupulous individuals. However, in the close knit rural community, social workers

usually understand that complying with expected behavior regarding the unethical conduct of colleagues may carry unpleasant consequences. These consequences may range from being placed in the uncomfortable position of having to see or interact with the offending social worker at work or in other social settings on a regular basis to attempts at retaliation through the local community or ethical counter complaints for lack of proper professional respect. Awareness of possible repercussions can make the rural social worker pause to think, to be reluctant, or even to fail to act.

Similar issues may arise in a rural community regarding social workers who have responsibility for evaluating the performance of others or who serve as administrators (sections 3.01 (d), 3.03 and 3.07 of the *Code*). Evaluations that are perceived in a less than positive light may be subject to negative reactions from subordinates that invoke community rather than agency networks. Administrators may be reluctant to advocate too hard for client groups or to push for additional resources for fear of angering powerful factions in the community.

9. Dodging the Ethical Traps and Strengthening Rural Practice

There appears to be consensus that characteristics of the social and professional networks in a rural community can create special ethical challenges for the social worker (Daley & Doughty, 2006; Galbreath, 2005; Ginsberg, 2005; Martinez-Brawley, 2000; NASW, 2006). Multiple types of relationships and increased client contacts in arenas outside of work are examples of factors that may increase risk in rural practice (Boisen and Bosh, 2005). But as Daley and Doughty

(2006) argue, rural social workers appear to be finding a way to handle many of these challenges at least as well as their urban counterparts. So what kind of framework and practical guidelines may the social worker employ to avoid the ethical minefields of work in the small community and strengthen the quality of practice?

There are several frameworks for ethical decision making presented in the social work literature. Examples include models developed by Congress's (1997); Dolgoff, Loewenberg, and Harrington (2005); Reamer, (2006); and Strom-Gottfried. All of these models present an ethical screening mechanism assessing benefits and risks for the social worker and the client in terms of professional service delivery. These models present questions and criteria useful to the social worker for evaluating ethical issues in the course of practice. For example Strom-Gottfried (2007) suggests asking questions like "Who will be helpful?, and "Why am I selecting a particular course of action?", whereas Dolgoff, Loewenberg, and Harrington (2005) suggest "To what extent will alternative actions be efficient, effective, and ethical?" and "Which alternative action will result in your doing the least harm possible?" The important question to be raised is to what extent these models and even part of the Code of Ethics are relevant for the context of rural practice.

We would argue that the Current NASW Code of Ethics is broad enough and the existing frameworks are sufficiently inclusive for effective use in the rural context. However, it is in the application of the Code of Ethics and ethical decision making models that the social worker needs to be especially attentive to provide

both appropriate and ethically based services. In their research Boisen and Bosch (2005) found that rural social workers were not using a separate code of ethics with respect to dual relationships, and Daley and Doughty (2006) found that rural social workers were managing ethical dilemmas at least as well as their urban counterparts. Both of these findings speak effective use of the current code by social workers in rural settings.

This should not be interpreted as meaning that in social work ethics one size fits all, especially with regard to rural practice. Clearly, given the literature on the subject, there are higher risks in some areas of the *Code* for rural social workers. Rather, it appears that it is in an overall perspective for applying and interpreting the *Code* that rural social workers should be especially attentive.

Gumpert and Black (2005) indicate that rural social workers appear more likely to use a relativistic or culturally sensitive, rather than a rule based approach in resolving ethical dilemmas. The culturally sensitive approach is similar to what Dolgoff, Loewenberg, and Harrington (2005, pp. 42) identified as ethical relativism in which ethical decisions are made based on either the context or the consequences that could result. Whereas the rule based approach is similar to the concept of ethical absolutism Dolgoff, Loewenberg, and Harrington (2005). The rule based approach tends to result in the social worker applying a stricter, more literal interpretation of the *Code*.

A culturally sensitive or relativistic approach to ethics appears reasonable for rural practice because it allows the social worker to make ethical decisions within the context of the rural community, whereas the more conservative rule based approach may be much more limiting or even counterproductive. For example, the social worker accepting goods or services from clients is discouraged by the *Code of Ethics*, yet it is common practice in rural communities for people to share produce and homemade products such as jelly with others. Refusal by the social worker to accept such gifts in small quantities may be considered offensive and rude, and could even affect the worker client relationship negatively. Technically this accepting the gift is a boundary crossing, but is generally not a boundary violation (Galbreath, 2005).

The authors suggest that it is appropriate for rural social workers to use a culturally sensitive approach in the interpretation of ethical behavior and in the application of decision making models. This permits the social worker to adapt appropriate ethical practices within the norms of the community and region and to work more effectively. Likely this will lead to some boundary crossings, where clients can still be protected by appropriate safeguards, but exploitation and harm resulting in ethical violations could still be avoided.

Thus, the rural social worker will need to add a culturally sensitive perspective as an overlay to any framework used for application of the *Code of Ethics*. This kind of approach is suggested by Gumpert and Black (2005) and in order to do this effectively it requires social workers to develop a deep understanding of their community context, history, traditions, and culture (Daley and Avant, 2004) . Given this overall approach, there are some specific steps that social workers can use to more effectively manage any potential ethical issues they identify.

10. Identify Potential Ethical Conflicts

Quite simply, ethical risks are hard to manage unless the social worker is aware that practice situations should be assessed in ethical terms, and ethical issues must first be identified as such (Burkemper, 2005; Reamer, 2006). In order to do this, the social worker must have a good working knowledge of the *NASW Code of Ethics* (Gumpert & Black, 2005). As discussed earlier, this knowledge should not be limited to the section that deals with worker-client relationships.

The social worker must then apply the principles outlined in the *Code* on a regular basis to all practice interactions. As the social worker develops experience operating in accordance with the *Code*, ethical behavior should become an integral part of practice. But some situations will raise questions, specific actions, or situations and will raise the question of whether or not this is an ethical issue. Prudence would dictate that a rational or reasonable personal standard be used. In other words, if this kind of question is raised, the situation or action should be treated as an ethical question, and it bears further investigation. Once the social worker reaches the conclusion that a potential ethical problem exists, effective management of the problem is imperative. So what are the best strategies for the rural social worker in managing this type of problem? Several strategies may apply including collecting more information, analyzing the situation further, or seeking consultation from professional peers or supervisors.

11. Seek Consultation and Supervision

Colleagues and supervisors are a good source of assistance in assessing the ethical risk of situations and may help to avoid ethical problems (Boisen & Bosch, 2005; Daley & Doughty, 2006; Dolgoff, Loewenberg, & Harrington, 2005; Galbreath, 2005; Reamer, 2006; Strom-Gottfried, 2005). The real value of supervision and consultation is the ability to develop an independent assessment of the situation for the social worker. Another professional opinion can add the benefit of different experience or skills and give another perspective on how the social worker's actions may be seen by others.

The difficulty for the rural social worker is that supervision and consultation are often more difficult to obtain than in an urban setting (Burkemper, 2005; Daley & Doughty, 2006; Ginsberg, 1998). The rural social worker tends to be more isolated from professional colleagues and supervisors and must often function more independently (Burkemper, 2005; Daley & Doughty, 2006; Galbreath, 2005; Ginsberg, 1998; Ginsberg, 2005). Thus, the social worker in rural practice must be more diligent and expend more time in getting essential supervision and consultation. This may be one of the biggest challenges for rural social workers but is essential in order to strengthen their ethical practice in small communities (Burkeper, 2005; Daley & Doughty, 2006; Strom-Gottfried, 2005).

Finding solutions for the difficulties in getting on site supervision require the rural social worker to use some creativity. The wider availability and increasing sophistication of interactive video and Internet as a mean of communication are effective ways to remove the distance barriers inherent in rural settings. The chief concern with these media lies in building in adequate safeguards to protect

client confidentiality. In addition, judicious use of the telephone may reduce the reliance on face-to-face supervision which is more difficult to get in rural communities. One area of particular concern with phone supervision may be the use of cellular telephones as they broadcast over open airways and these communications could not generally be considered confidential.

12. Use Informed Consent

The multiple and overlapping relationships in small communities clearly present an ethical risk because of the potential for confusion about which role social workers are acting in.   For example, is the social worker acting in a professional capacity, a neighbor, fellow church member, or in some other capacity? Confusion of this type can lead to ethical disputes especially when professional boundaries are blurred.

To address these types of risks, the use of informed consent and collaborative work to empower clients are appropriate practice approaches (Burkemper, 2005; Galambos, Watt, Anderson, & Danis, 2005; Gumpert & Black, 2005; NASW, 2008; Strom-Gottfried, 2005). What is suggested is that the role and limitations of the social worker be fully discussed with the client and that clients be empowered to make choices about services. This discussion should include some coverage of how confidential information, meetings in public places, and community conjecture about confidential client related matters are to be handled. Given the close knit fabric of the rural community confidentiality issues, choices for location of services, and service providers may be more likely to arise. Empowering clients by giving them informed choices can help to avoid service locations where the client's car could be

recognized, thus identifying them as a client. It may also help to avoid issues arising from the use of service providers for which the client has either some type of community connection or about which the client has heard negative information.

Social workers may also wish to consider how information received from colleagues should be addressed in order to avoid misunderstandings that may result in ethical complaints. Ethical principles that apply to colleague to colleague communications are somewhat different than worker to client communications, and not all information exchanged may be confidential. For example, a social worker may share information with a colleague or supervisor about a divorce, mental health issue, or chemical dependency that is affecting his or her work performance. The social worker who receives the information may be obligated to disclose some of that information to the agency, to a licensing entity, or to NASW. Some discussion about the limits of confidentiality that apply in discussions with colleagues may prove useful in preventing misunderstandings.

13. Documentation

Since the burden of demonstrating that appropriate professional boundaries were maintained is placed on the social worker (Boisen & Bosh, 2005; Galbreath, 2005), it is imperative that well documented records of one's work be kept (Reamer, 2006). Good documentation is sound professional practice (Reamer, 2006). Accurate and detailed records made contemporaneously can document the careful decision making process that the social worker used to act.

Records provide a good source of information to demonstrate that the social

worker gave careful consideration to doing what is best for the client. Records may also document that supervision or consultation was used as part of the process. Ultimately, documentation may be important because it can help protect the social worker from charges of malfeasance, misfeasance, or nonfeasance (Reamer, 2006).

14. Summary and Conclusion

Despite the heightened ethical risks faced by rural social workers, management of these risks is crucial to minimize problems. This manuscript identifies several aspects of practice in small communities to which the social workers may need to pay particular attention. The areas which tend to pose the greatest ethical risk for rural practice include dual relationships, poor practice and competence, confidentiality, anonymity and self-disclosure, and ethical issues with colleagues. To be effective, the rural social worker should be culturally sensitive to the community by using a culturally sensitive perspective as an overlay when applying a traditional ethical decision making framework. The manuscript also identifies some specific strategies for managing these ethical challenges once identified. Strategies such as identifying ethical conflicts, seeking consultation and supervision, working collaboratively and using informed consent, and documentation are common and effective ways of managing ethical challenges.

Ethical issues in rural practice arise, at least in part because of the context as rural communities are often described as close knit or like living in a fishbowl. So it falls to the social worker to act responsibility and set both clear and appropriate boundaries in their own practice (NASW, 2008). For example, the NASW Code of Ethics does not prohibit dual relationships, but it does place the burden on the social worker to develop the relationship in a way that neither exploits nor harms the client. This implies that when the social worker has to engage clients in a professional relationship where a dual relationship may exist, proper care must be taken to build in appropriate safeguards. One way to do this is by setting clear and appropriate boundaries. Especially in the rural community, setting appropriate boundaries proceeds from a strong understanding of the rural community and rural social work (Boisen & Bosch, 2005; Burkemper, 2005; Daley & Avant, 2004; Ginsberg, 2005; Gumpert & Black, 2005; Martinez-Brawley, 2000) in order to both deliver the best possible service and to navigate the cultural context of the rural community.

The concerns that rural social workers had about dual relationship sections of the *NASW Code of Ethics* in the 1990s have resulted in a healthy discussion of the ethical challenges of rural social work. This discussion has, in recent years, pushed beyond the bounds of dual relationships to include broader aspects of practice and strategies to manage unavoidable conflicts. Rural social workers already appear to have found ways to manage these conflicts with some degree of effectiveness (Daley & Doughty, 2006). In this sense, practice appears to be ahead of the literature. We still have much to learn about adapting ethical practice to rural social work. Hopefully the dialogue will continue to grow and expand our knowledge about this critical aspect of practice.

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The Emergence of the Breath of Life Theory

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Abstract

Using First Nations Elder and scholar Willie Ermine and colleagues' (Ermine, Sinclair, & Jeffery, 2004) concept of ethical space, this paper proposes a bi-cultural theory founded in First Nations ontology and physics' theory of everything called the breath of life (BOL) theory. BOL assumes that a set of interdependent principles known as the relational worldview principles (Cross, 2007) overlay an interconnected reality with expansive concepts of time and multiple dimensions of reality. Diversity in human experience is accounted for as culture and context shape the manifestation of each principle. The basic premise of the theory is that structural risks affecting children's safety and well-being are alleviated when the relational worldview principles are in balance within the context and culture of the community. Implications for social work policy and practice are discussed.

Key Words: First Nations, theory, structural risks, disadvantaged populations, children

1. Introduction

According to First Nations Elder and scholar Willie Ermine and colleagues (Ermine, Sinclair, & Jeffery, 2004), problems streaming across western and First Nations cultures require an ethical space where western and First Nations knowledge can coexist to inform solutions. First Nations child welfare is particularly well suited for an ethical space response as it sits at the shoreline of western and First Nations knowledge. The wholesale imposition of western child protection systems on First Nations over the past 50 years in Canada has failed dramatically (Royal Commission on Aboriginal Peoples [RCAP],

1996; Assembly of First Nations, 1993; Blackstock & Trocmé, 2005; Assembly of First Nations, 2007) and while traditional First Nations child care is incredibly rich, it has not fully contemplated the full range of colonial hazards facing First Nations children and families today.

Structural risks such as service inequities, poverty, poor housing, and substance misuse substantively account for the dramatic over-representation of First Nations children in child welfare care (Blackstock & Trocmé, 2005; Trocmé, MacLaurin, Fallon, Knoke, Pitman, & McCormack, 2006). These same factors have been linked to poor outcomes for

First Nations children in other areas such as education, health, and juvenile justice (RCAP, 1996; Assembly of First Nations, 2007). Child welfare approaches informed by western theoretical frameworks such as ecological theory, anti-oppressive approaches, and structural theory have not adequately addressed the structural risks undermining First Nations child and family well-being, suggesting that a new theoretical framework is needed.

This paper builds on the general nature of First Nations ontology (Blackstock, 2007; Blackstock, 2009) and the theory of everything (TOE) in physics (Greene, 2003; Blackstock, 2009) to present a new theoretical approach called the breath of life theory (BOL). As noted in Blackstock (2009), there are significant differences between First Nations and western worldviews particularly in relation to time, interconnection of reality, and the First Nations belief that simple principles often explain complex phenomena such as the universe or humanity. Physics' theory of everything departs from the ontological norms underlying many western social science theories by proposing that all matter and time in the universe can be explained by a small set of interdependent physical principles set at precise values (Greene, 2003). Social science has not seriously entertained a theory of everything for all humanity. As set out in Blackstock (2009), western social science theories are limited in scope, application, and time. They are, in effect, snapshots situated within a broader interconnected reality. The breath of life theory suggests that a theory of everything for humanity should be seriously explored in western theoretical scholarship. The holistic nature of TOE and its situation within expansive concepts of time and dimensions of reality means it is a better match for First Nations ontology than western social science theories (Blackstock, in 2009).

BOL assumes that a set of interdependent principles known as the relational worldview principles (Cross, 2007), described later in this paper, overlay an interconnected reality with expansive concepts of time and multiple dimensions of reality. Diversity in human experience is accounted for as time, culture, and context shape the manifestation of each principle. The basic premise of the theory is that structural risks affecting children's safety and well-being are alleviated when the relational worldview principles are in balance within the context and culture of the community.

Although BOL was developed in response to the structural risks related to First Nations child welfare, the assumptions and structure of BOL do not implicitly bind it to child welfare applications and consideration should be given to its relevance to other areas and cultures. It is important to emphasize that this paper and the BOL draw on the general character of both western and First Nations knowledge and there is significant diversity among both cultural groups that is likely not fully captured. The inclusion of culture and context as shaping factors in BOL should make it culturally relevant for most, but in keeping with the self-determination principles for effective research with Aboriginal peoples, no theoretical framework should be imposed on First Nations without their prior approval (Schnarch, 2004). For more detail on the underpinnings of BOL, readers are strongly encouraged to read my previous work setting the foundation for BOL by contrasting First Nations and western ontology and making the case as to why physic's theory of everything is more proximal to First Nations ontology than are many social science theories (Blackstock, 2009).

2. The Relational Worldview Principles

As noted earlier, the breath of life theory

incorporates interdependent principles for individual and collective safety and well-being set out by Native American child welfare expert Terry Cross in the relational worldview model (Cross, 1997; Cross, 2007). The principles are categorized in four domains (cognitive, physical, spiritual, and emotional) of personal and collective well-being:

1. COGNITIVE: self and community actualization, role, service, identity, and esteem
2. PHYSICAL: water, food, housing, safety, and security
3. SPIRITUAL: spirituality and life purpose
4. EMOTIONAL: love, relationship, and belonging

The breath of life theory predicts that, if the relational worldview principles are out of balance within the framework of community culture and context, then risks to the child's safety and well-being will increase. BOL also suggests that child welfare interventions geared toward restoring balance among the relational worldview models principles will result in optimal safety and well-being for the community and their children.

The relational worldview principles are derived from Abraham Maslow's hierarchy of needs (Cross, 2007). Maslow's work was, in turn, informed by the time he spent with the Blackfoot Indians in Canada (Coon, 2006). In effect, the hierarchy of needs was an early attempt at an ethical space concept (Ermine, Sinclair, & Jeffery, 2004). Maslow's hierarchy of needs assumes that understanding human needs is critical to understanding personal well-being (Huitt, 2004; Coon, 2006). Although Maslow emphasized the interconnection of needs, he also believed that some human needs were more foundational than others and that both the identified needs and hierarchal importance of those needs were valid across cultures (Hoffman, 1998). As shown in Figure 1, Maslow's hierarchy of needs is typically represented in an eight-level triangle with the most fundamental physical needs depicted at the bottom and the personal fulfillment needs of self actualization and transcendence at the top (Huitt, 2004).

Figure 1: Maslow's Hierarchy of Needs
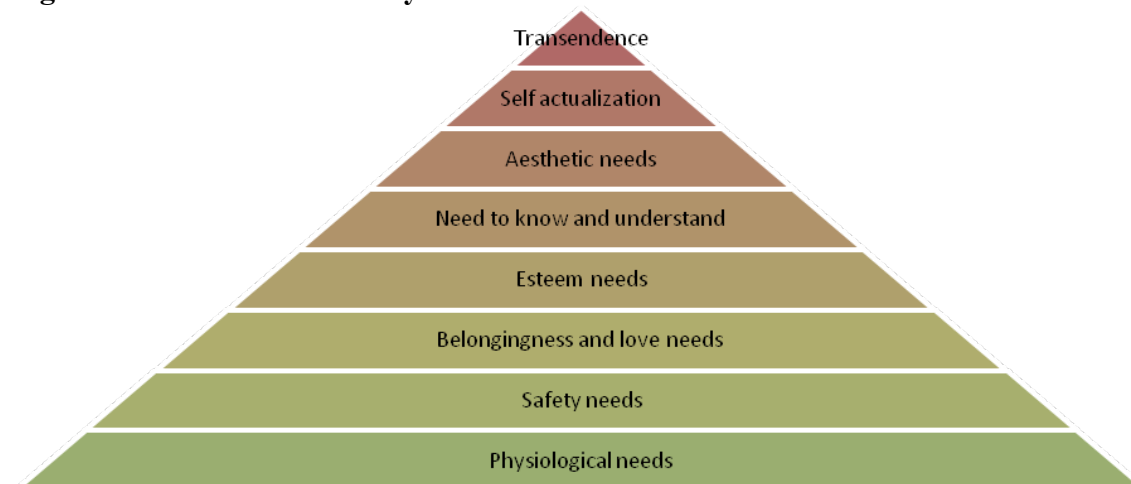
Blood First Nation scholar Billy Wadsworth (2008) explains that Maslow's interpretation of Blood perceptions of human and societal needs are not wholly reflected in Maslow's final model. Maslow did not fully incorporate Blood First Nation understandings of ancestral

knowledge, spirituality, and multiple dimensions of reality, nor did he fully situate the individual within the context of community (Wadsworth, 2008). For instance, if Maslow had more fully integrated Blood First Nations perspectives, the model would be centered on multi-generational community actualization versus on individual actualization and transcendence.

As shown in Figure 2, Native American scholar and child welfare expert Terry Cross (2007) reinterprets Maslow's hierarchy of needs through indigenous eyes to create the relational worldview principles. Cross (2007) argues that human needs are not uniformly hierarchical but rather highly interdependent in nature with cultural values and laws defining how balance is achieved on personal and collective levels.

Figure 2: Cross (2007) reinterprets Maslow's hierarchy of needs through Indigenous eyes

Shelter, safety, food, water and security

Love, belonging and relationships

Spirituality
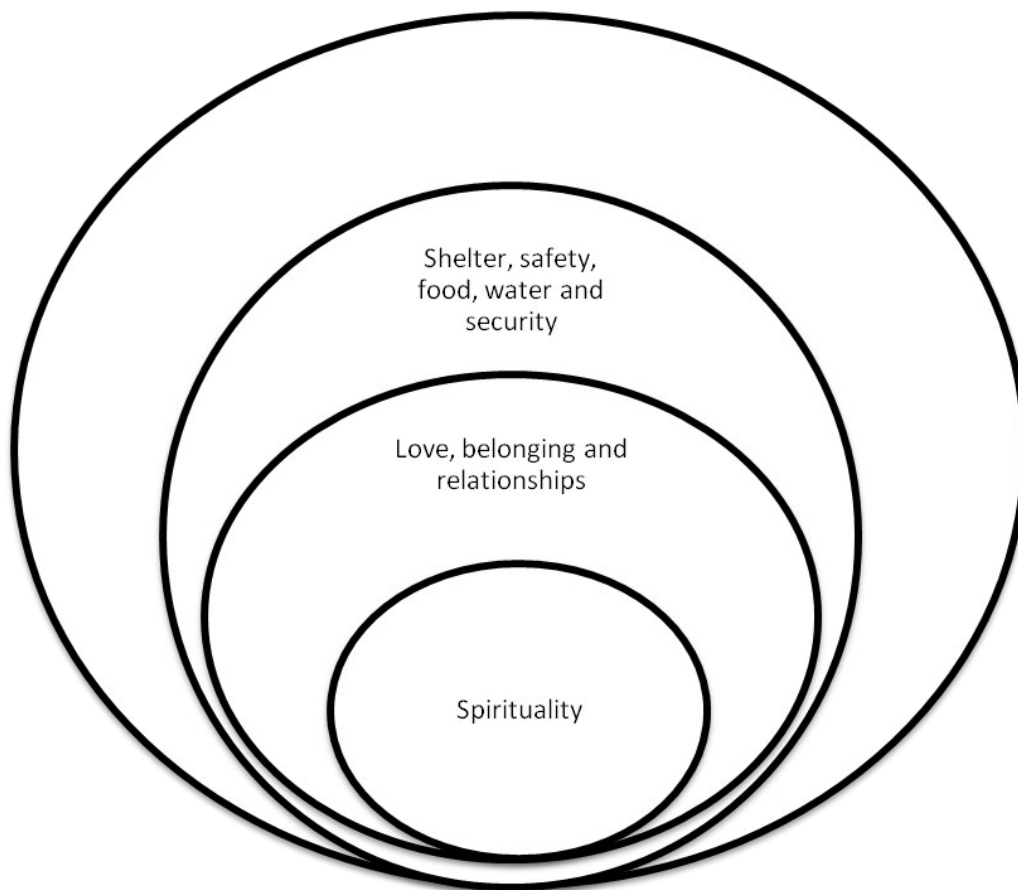
For example, Cross (1997) argues that physical needs are not always primary in nature as Maslow argues, given the many examples of people who forgo physical safety and well-being in order to achieve love, belonging, and relationships or to achieve spiritual or pedagogical objectives. The idea of dying for country is an example of this as men and women fight in times of war. Cross (1997) believes that spirituality is the unique force differentiating human life from other forms of life, defining our individual and collective experience. Spirituality should not be misinterpreted to mean organized religion

alone; rather it is a personally defined force that centers one's sense

of self, community, and world across time (Baskin, 2002).

For the purposes of the breath of life theory, Cross's worldview principles (2007) are reframed within the Medicine Wheel holistic model as shown in Figure 3. It is important to emphasize that although the beliefs underlying the Medicine Wheel are widely held among First Nations, the representation of those beliefs varies. Thus, the Medicine Wheel depiction is not recognized as culturally valid by all First Nations. The Medicine Wheel holistic model is based on an understanding that all things are affected by the interconnected domains of emotional,

physical, spiritual, and cognitive experience. When the relational worldview principles are situated in the holistic model, they are experienced within the four dimensions (physical, emotional, spiritual, and cognitive) and at all levels (personal, family, community, society, and world). Optimal well-being is achieved when the four dimensions of experience are in balance at individual, family, and collective levels. As will be discussed later, culture and context shape the manifestation of these needs.

Figure 3: Cross's worldview principles (2007) oriented in the holistic model
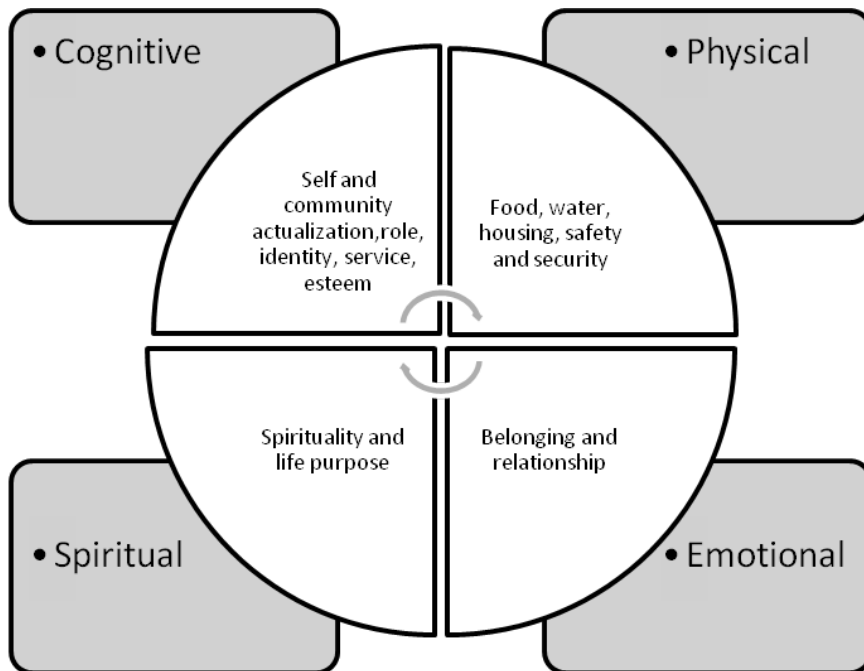
It is important to note that the principles in Cross's relational worldview model are based on indigenous oral history capturing patterns of human experience across millennia (Cross, 2007). Although more research is definitely required using both indigenous and western research, there is a growing body of evidence to support the principles. For example, the Canadian Incidence Study on Reported Child

Abuse and Neglect points to caregiver poverty, poor housing, and substance misuse as key drivers of the overrepresentation of children in the child welfare system (Trocmé, Knoke, & Blackstock, 2004). This aligns with Cross's principles in the physical dimension of experience. Cultural identity erosion and spiritual disconnection have been linked to heightened risk for stress related disorders and

substance misuse among Aboriginal peoples in Canada (RCAP, 1996; Chandler & Lalonde, 1998; Carriere, 2005; Chandler & Lalonde, 2004; Dell & Lyons, 2007) and positive spiritual connection has been linked with increased reunification rates of children in child welfare care (Bullock, Gooch & Little, 1998). Researchers have also linked poverty alleviation with improved mental health outcomes for Native American children (Costellano, Farmer, Angold, Burns, & Erkanli, 1997). These findings link with the worldview principles in the spiritual and emotional domains. Additionally, life experience has been linked to the multi-generational epigenetic changes (McGowan, Sasaki, Alessio, Dymov, Labonte, Szyt, Turecki, & Meaney, 2009) and multi-generational changes in behavior patterns (RCAP, 1996; Assembly of First Nations, 1993) relating to principles in the physical and cognitive domains.

The relational worldview principles are just one component of BOL. The next step is to situate those principles within a culturally shaped holistic and interdependent reality that gives rise to human diversity.

3. Accounting for Culture, Context, Multiple Dimensions of Reality and Time in the Breath of Life Theory

Nesting the relational worldview principles in an interconnected reality consistent with First Nations ontology requires several layers to be added to the model: (1) culture and context shape the manifestation of the principles; (2) the entire model is situated within an expansive concept of time called the seven generations concept; (3) multiple realities are acknowledged and utilized to inform the optimal values for the worldview principles and strategies to restore balance among the principles and (4) individuals are viewed within the context of their relationships to the world and others.

There is good evidence that culture and context matter when it comes to optimal well-being for First Nations peoples. For example, self determination as expressed by the congruency of services with the cultural identity of First Nations youth has been linked to lower suicide rates (Chandler & Lalonde, 1998) and higher levels of community socio-economic outcomes (Cornell & Kalt, 1992). Differing cultural child rearing practices have been found to influence substantiation rates in child welfare (RCAP, 1996; Earle-Fox, 2004; SNAICC, 2007) and First Nations status appears to influence social worker decisions to place children in care (Trocmé et al., 2006). Contextual factors such as colonization, social exclusion, geographic location, and service access have all been linked to differing levels of child maltreatment risk (RCAP, 1996; Irvine, 2004; Blackstock & Trocmé, 2005; Carriere, 2005; Loxley, De Riviere, Prakash, Blackstock, Wien, & Thomas- Prokop, 2005).

Humanistic diversity emerges in BOL as culture and context shape the manifestation of the relational worldview principles. For example, we all need food but what food is eaten, when it is eaten, and how it is eaten are highly dependent on cultural norms and contextual factors. Culture and context are therefore shaping factors for the principles that make the principles relevant to specific communities.

Once culture and context are taken into account in the shaping of the worldview principles, the principles must be set within the seven generation concept of time and appreciation for multiple realities. One of the most fundamental differences between First Nations and non-Aboriginal ontology relates to concepts of time. First Nations believe in expansive concepts of time where the past, present, and future are mutually reinforcing.

First Nations often consider their actions in terms of the impacts of the "seven generations." This means that one's actions are informed by the experience of the past seven generations and by considering the consequences for the seven generations to follow (Assembly of First Nations, 1993). If western child welfare followed First Nations ontology, it would need to assess child maltreatment based on the ancestral experience of that child and actively consider the consequences of intervention not only on that child but on the subsequent seven generations of children. This simply does not happen. At best, western child welfare considers the impacts of parental behavior and the impacts of child maltreatment on the child as he or she grows to adulthood and become a parent. The same pattern is apparent in western theories. Although some theories such as ecological theory and complexity theory include concepts of time, they are limited to one life cycle and therefore are not as expansive as the seven generation concept. BOL integrates the seven generations concept of time, meaning that the principles are influenced by historical factors and the today's actions taken today will have future impacts.

Many First Nations acknowledge plural realities of equal validity and realism, whereas westerners tend to view reality in terms of what they can see, feel, and hear. First Nations beliefs in alternate realities have often been misinterpreted by western social science scholars and practitioners as entirely fictional. As described earlier, leading research in physics echoes First Nations multidimensional views of reality, suggesting that multiple dimensions of reality are not only possible – they are probable (Hawking, 1988; Greene, 2003; Kaku, 2006). The idea of multiple dimensions of reality invokes the western ideological tug of war between spirituality and multiple dimensions of reality at one end and science and empiricism at the other (Campbell

& Moyers, 1991). These two realities were thought by many to be mutually exclusive, but for First Nations, and now increasingly western science, they are seen as indivisible (Campbell & Moyers, 1991; Hawking, 2005).

Credible First Nations traditional knowledge holders must be consulted on both the cultural context and multiple dimensions of reality elements of BOL. For the purposes of the breath of life theory, multiple and equally valid dimensions of reality are acknowledged. Some realities exist within cultural, spiritual, and contextual domains, whereas others are encoded into physical empiricism. The specific forms and meanings of alternate realities need to be interpreted within the context of distinct First Nations. Many First Nations will also have interventions to restore balance in alternate realities that should not be discounted as irrelevant or magical. These beliefs need to be respected and accounted for in the interpretation of the relational worldview principles and the mechanisms that set and restore balance among the principles.

One final important layer in the model is that structural risk must be considered within the context of individuals' relationships with others and the natural world. Human beings are interactive actors in an interconnected web of life that includes both other people and the natural world. The relational worldview principles are nested in this reality, and resolution of risk to children and their families may require the resetting of balance in domains that are not typical of social work or even the social sciences. For example, a healthy diet for a child may mean eliminating environmental toxins from the soil where traditional foods are harvested. Preserving a child's sense of security may mean strengthening a child's relationship with community and the natural world of their ancestors.
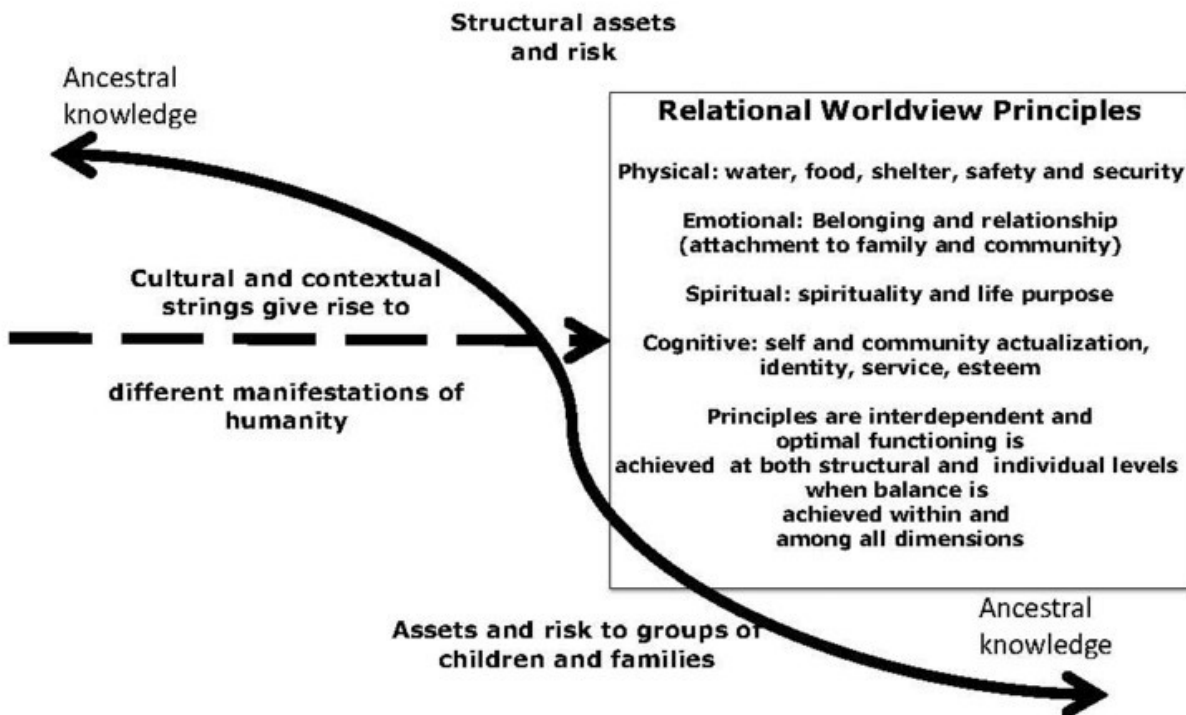
4. Summarizing the Breath of Life

Theory

As Figure 4 demonstrates, the breath of life theory provides a new way to conceptualize how a limited sequence of human constants known as the relational worldview principles

(Cross, 2007) interpreted within the culture and context of the community and expansive concepts of time and dimensions of reality can simultaneously influence risk sourced at a structural level and the intergenerational experience of First Nations children and families.

Figure 4: The Breath of Life Theory

By focusing on principles that apply both at the structural and individual levels, the breath of life theory reaches across the expanse of structural and individual social work foci, combining them into one coherent reality. Diversity among people can be accounted for by thinking of culture, time, and context operating in the breath of life theory in the same way that the vibrations do in string theory, diversifying the manifestation of the relational worldview principles at the level of individuals and groups. I hypothesize that the predictable impacts of structural factors can be

harmonized with the comparatively erratic patterns of individuals when individuals are viewed within collectives of family and community.

5. Testing the Breath of Life Theory

BOL is an emerging theory that requires more testing from both indigenous and non-indigenous research perspectives. Indigenous and western research methods should be jointly deployed in this effort. Out of respect for the importance of getting BOL correct

from an indigenous perspective, it was presented to indigenous audiences across Canada, Australia, and the United States for review prior to publication. The general consensus was that BOL was reflective of indigenous knowledge; however, more investigation by indigenous researchers and traditional knowledge holders is required. Indigenous research could compare the BOL model against First Nations oral histories to judge its validity as well as to research the mechanisms used to judge balance and restore balance across time. The effects of culture, time, and context on the principles would also be responsive to indigenous oral history investigations.

An outstanding challenge in the development of BOL will be to more specifically define the worldview principles and determine the value or range of values for each principle that produces optimal levels of well-being. This links directly to the question of how to measure and maintain balance among the interdependent set of relational worldview principles. Physics may help inform this challenge. Keep in mind that physics' standard model suggests that all matter and time are created by a limited number of physical constants set at precise values. If those values are altered then the universe as we know it will cease to exist (Greene, 2003). To put it another way, think of a series of oven dials controlling each constant in the universe. If you turn one slightly and disrupt the balance among the constants then the universe will alter considerably (Greene, 2003). I am arguing that the relational worldview principles stand as a similar set of constants existing in terms of human behavior (along the lines of the determinants of health concepts). The trick will be to determine at what value, or range of values, the child welfare oven dials should be set, and then to predict what happens in terms of structural and individual risk when one dial exceeds the optimal

threshold.

A secondary question is at what values do the principles represent an unacceptable level of risk? This may sound simple but as other researchers have demonstrated, it will not be. For example, Canadian Incidence Study on Reported Child Abuse and Neglect (CIS) data indicate that poverty is a key driver of neglect in First Nations children but uses source of income (e.g.: full time employment, social benefits) as a proxy measure for income given that child welfare workers are more likely to know source of income versus the amount of annual income (Trocmé et al., 2006). The problem is that these two are not necessarily conflated; for example, a person may be employed full time but earning minimum wage, resulting in an income that is equivalent to social assistance benefits. Context also makes a difference as factors such as the high cost of rent in urban centers may result in less disposable income for a person on social assistance than a similar person living in a rural area.

Although there is a need for culturally valid instruments to measure Cross's relational worldview principles embedded in BOL, the plethora of western instruments that already exist testing various aspects of the model evidence the possibility of creating such measures within First Nations contexts. For example, the western personal orientation survey measures self actualization, and research on attachment theory has given rise to the spiritual assessment inventory (Hall & Edwards, 2002). Environmental science has developed measures on the attachment to place (Vorkinn, 2001) and more recently the inquiry has extended to measuring attachment to space and place among indigenous populations (Semkin, 2005). Townsend and Kennedy (2004) provide a good synopsis of the variety of poverty measures, which although imperfect, are providing a reasonable basis for

public policy making. All this to say that over time, it is entirely plausible that culturally valid measures can be developed for the relational worldview principles.

First Nations knowledge suggests that there are a limited number of constants that govern reality in the social world and the determinants of health and social health movements seem to be moving along similar lines of thought. The fact that reliable and culturally valid instruments to test the values for all constants are not currently available should not thwart the entire model. Over time, empirical testing of the principles against their effect on well-being at structural and individual levels will better define the constants and establish a platform for testing them at different values.

6. Are the Determinants of Health a Western Substitute for BOL?

If the breath of life theory were conceptualized on western terms, the closest approximation would be to overlay the determinants of health onto ecological theory in such a way that achieving balance among an interdependent set of determinants of health across all dimensions of ecological theory is a marker for optimal functioning at individual, family, and societal levels. Further modifications would need to include expanding the scope of time for the model to include seven generations before and seven generations after and an appreciation for multiple dimensions of reality, culture and context.

Like BOL, the international determinants of health and determinants of social health movements embrace the idea that a universal set of needs underlies human well-being and development (Commission on Social Determinants of Health, 2007). Similar to Maslow's hierarchy of needs, both movements assume universal human needs must be met in the individual and social dimensions in order to achieve a basic level of personal health and well-being. However, the determinants of the health movements are nested in western ontology, privileging bracketed concepts of time, reality, and individualism.

There are differences between the determinants of health and Cross's (2007) worldview principles. As shown in Table 1, comparing the determinants of health promoted by the Public Health Agency of Canada (2007) with Cross's relational worldview principles suggests that the determinants of health focus more on how needs are met (e.g.: employment and income status) whereas Cross (2007) focuses more on the needs themselves (e.g.: water, food and housing). The determinants of health also do not explicitly emphasize spirituality and concepts of belonging and service for all people.

Table 1: Contrasting the Determinants of Health with the Relational Worldview Principles

Holistic Worldview Dimensions of Individual and Collective Wellbeing	Determinants of Health (Public Health Agency of Canada, 2007)	Relational Worldview Principles (Cross, 2007)
Physical	Income and social status Employment and working conditions Physical environments Biology and genetic endowment Health services Gender Health child development Culture*	Food Water Housing Safety Security
Emotional	Social support networks Personal health practices and coping skills* Culture*	Belonging Relationship Esteem*
Spiritual		Spirituality Life purpose
Cognitive	Education and literacy Personal health practices and coping skills* Culture*	Self actualization Community actualization Role Identity Service Esteem*

*Cross cutting determinants of health or relational worldview principles entered in multiple holistic worldview dimensions

The evidence base for each determinant varies and the Public Health Agency of Canada continues to pursue research to validate the list of determinants and refine optimal values for each. The World Health Organization (2007) agrees that the evidence base for individual determinants of health vary widely, with the strongest evidence supporting the health determinants relating to transport, health, water and food security, housing, and environmental factors such as radiation, energy, and urbanization. The assumption of the determinants of health movement that a limited number of principles have universal application to human health suggests that a similar concept could be applied in BOL. The breath of life theory substitutes the western determinants of health for the indigenous worldview principles and then situates the worldview principles in the seven generation concept of time and multiple dimensions of reality that are all given shape by the context and culture of the community in which the children under study find themselves.

Overall, the research on the determinants of

health can inform BOL particularly with respect to the relational worldview principles; however, the fundamental differences in the theoretical models means one cannot be substituted for the other.

7. It Takes a Community to Raise the Breath of Life Theory

As many social science theories are not testable, the role of others is often limited to investigating the application of the theory in different settings. Although in an early stage of development, the basic tenets of BOL are potentially testable, inviting a much more communal approach to theoretical development and testing akin to that pursued in physics and other western sciences. There are literally thousands of physicists all over the world developing and testing various elements of the theory of everything or its sub-component string theory. This communal theoretical development makes sense as scientists bring their respective strengths to the communal task of pursing a unified theory in physics. BOL also actively invites the involvement of others to debate, build on, and test, the theory and its applications in various contexts and cultures. Some of the areas for future scholarship include:

- Further defining the worldview principles and developing culturally based measures for each principle.
- Developing mechanisms to measure the interdependent impacts of the principles on risk experienced by First Nations children across varying dimensions of time and reality.
- Further development of the theory and testing using indigenous ontology and research methods.

- Analysis to test application of the theory across cultures and in different contexts such as health, justice, and education.

8. Conclusion

Inspired by Ermine's and colleagues' (Ermine, Sinclair, & Jeffery, 2004) concepts of ethical space and the tragic, longstanding overrepresentation of poor outcomes for First Nations children, BOL proposes a holistic approach for conceptualizing structural factors affecting First Nations children and families. The interpretation of the breath of life theory within the distinct cultures of First Nations peoples is embedded into the theory so as to avoid "pan Aboriginal" approaches that negate the rich diversity of Aboriginal cultures and languages. It comes at an important time when our current ways of thinking about structural risks have failed to stem the tide of First Nations children experiencing poor outcomes in child welfare and other areas.

So how does the breath of life theory differ from structural theory, ecological theory, and anti-oppression frameworks? This new theory assumes the world is indivisible and that everything across all time is important to understanding human experience. This theory goes beyond describing structural risk to identifying a series of constants that must be in balance in order to eradicate or reduce structural risk and its manifestation at the level of individuals and groups. BOL would agree that Bronfenbrenner's dimensions of reality (1979) are important but would argue one lifetime (Bronfenbrenner, 1989) is inadequate to truly understand the experience of intergenerational groups. This new theory embraces the value of ancestral knowledge not only in identifying the constants that govern our reality, but also the culture and context that give shape to different manifestations of

reality. It considers oppression as important only as a contextual factor—not as a focal factor—and provides a mechanism for restoring well-being: balance among the constants.

BOL introduces a First Nations perspective on social science. To fully understand the theory and its applications, some fluency in First Nations ontology is required. BOL invites western social science scholars to explore their current assumptions about knowledge and humanity from another worldview that situates human experience within expansive concepts of interdependence, time, and reality. It is an opportunity rarely presented in North American social science theoretical deliberation that is so dominated by western ontology and theoretical derivatives.

The implications of the theory are potentially significant. In the field of child welfare, if this new theory is proven correct, it would suggest that child welfare interventions should focus on restoring balance among the relational worldview principles instead of over-focusing on treating the way that the imbalance manifests at the level of individual children and families. BOL may also be useful in the development of child and family and community assessment tools aimed at identifying sources of structural risk and redressing its impacts.

With further testing, it may also have application in other disciplines where structural risk impacts on individual experience such as justice, health, and education. Importantly, even though the breath of life theory was developed based on general tenets of First Nations ontology, with proper cross-cultural evaluation it may inform structural interventions for other cultural groups.

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Letters to the editor

Journal of Social Work Values and Ethics, Spring 2011

Steve,

Congratulations on the new edition of the journal. Your dedications to Lisa were wonderful, and I am glad that I was a part of it. Great job.

Bob Rivas

Dear Editor,

Wow! What a difference in the last issue of JWSVE! I clicked on an article and it came up so much more reader-friendly. What a treat! I like to use the journal, of course, in my ethics class, and this new format makes it even easier.

Thank you!

Dr. Claudia J. Dewane
Associate Professor
Temple University Harrisburg

Schwalbe, M. (2007). *Rigging the game: How inequality is reproduced in everyday life*. New York: Oxford University Press.

Reviewed by: Stephen M. Marson, Ph.D.
Editor, *The Journal of Social Work Values and Ethics*

Michael Schwalbe is a master of the written word. I suspect that he could become another John Grisham. Instead of writing novels about legal issues, Schwalbe could write stories with sociological insights. Within *Rigging the Game*, he employs stories to explain complex sociological concepts. I seriously doubt that there is a better writer within social science. He must be applauded for his artistry of the written word! I suspect that all of us would love to have Schwalbe's writing talent. Schwalbe's intended audience includes those who are beginning to study sociology or those professionals or academicians who have an interest in the study of social inequality. Thus, many readers of *The Journal of Social Work Values and Ethics* would be intensely interested in this work. Social work professors will want their students to read this book.

His main objective is twofold. First, Schwalbe elucidates a theoretical perspective on socioeconomic inequality.   He explains how it emerges and how it is maintained.   *So What!!!* Thousands of books have been written with this objective! Schwalbe's major contribution is that he makes conflict theory immediately understandable and *even* enjoyable to read. There are many novel-like qualities to this bit of scholarship. Second, Schwalbe follows a Marxian tradition of setting up a call to action. That is, he proposes solutions to the "rigged

economic system." Thus, in many ways, it is a manual for the practice of macro social work.

Two points of particular interest can be made to help one decide on adopting this book for a course. First, Schwalbe's portrayal of the "rigged game" is a theoretical concept. He presents patterns within the capitalist economic structure to support the position that in the USA we have economic predestination. He begins with the assumption that the system is rigged, and demonstrates support by employing numerous observations.   In other words, "pulling up one's own boot straps" is not a reflection of reality. Some of his observations are profoundly compelling, and others are not. *However, that's not the issue!* "Is the game rigged?" turns out to be an empirical question. It is a testable hypothesis.

We know enough about the nature of our social and physical environment to acknowledge that some people can beat the rigged system by dumb luck. This is no surprise – for this is what three standard deviations from the mean often signify. The statistical question is this: Are the game-winners merely products of dumb luck or is the pattern of winning systematic? Probability theory suggests that approximately 2.5% of any population will beat a rigged game by luck, as illustrated in figure 1.
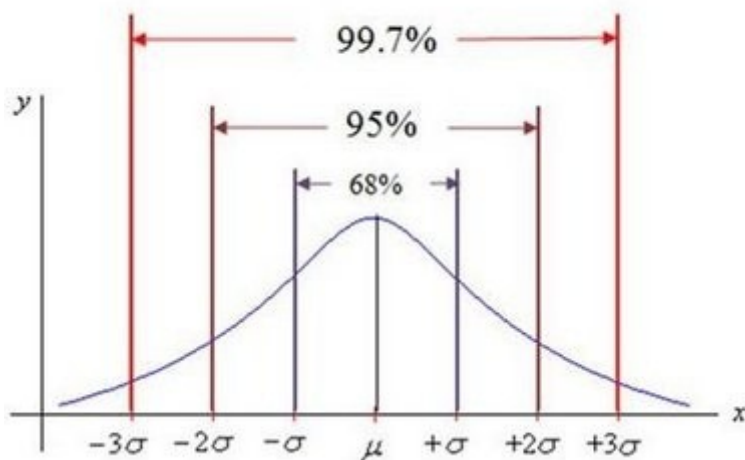
Here would lay the theoretical proportion of subjects who won a rigged game: 2.5% of the population.

In the end, we can test the existence of a rigged social stratification system by employing a 1-tail null hypothesis. The research hypothesis would read something like this:

> In a random sample of people over the age of 60, only 2.5% should move up two levels within a measure of socioeconomic strata.

If the results are statistically significantly (p < .05), then the game is rigged or not rigged – depending on how the null hypothesis is articulated. Nevertheless, Schwalbe has offered a major contribution by laying out a conflict theory that is testable.

Second, as most readers are aware, the Council on Social Work Education (CSWE) made a substantial change in curriculum standards. The "population-at-risk" (PAR) sector has been deemphasized. This reconfiguration has led to many heated discussions among social work faculty. Traditionally, the PAR curriculum placed greater emphasis on group rather than the environment in which the group exists. For example, because of the emphasis on PAR, social work education had deemphasized the study of poverty. Those

who are distressed about the de-emphasis on PAR fear that ignoring a group that has faced a history of discrimination is problematic. Although Schwalbe is not a social work educator, he provides the best framework for understanding why CSWE pursued the change. In addition, and what makes this book valuable to social work educators, Schwalbe lays out the perfect balance between studying PAR and the environment in which these groups exist. Faculty should examine how this book can be a valuable asset for reconfiguring their curriculum to comply with the new CSWE standards.

BOOK REVIEWS

EDITOR'S NOTE: Apparently, *The Journal of Social Work Values and Ethics* received two copies of *Progressive Community Organizing.* Because of my faulty record keeping, two reviewers received the book with me realizing it.   I decided to publish both!

Pyles, L. (2009). *Progressive community organizing: A critical approach for a globalizing world.* New York, NY: Routledge.

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

Loretta Pyles is an assistant professor of social welfare at Albany, State University of New York. Her background is in advocacy, organizing, and community based research. She was on faculty at Tulane, and was involved in the post-Katrina revitalization efforts. Dr. Pyles is active in developing community services for the twenty-first century.

Progressive Community Organizing: A Critical Approach for a Globalizing World is well written and clear. The author addresses community organizing in globalizing conditions. In a sense, Dr. Pyles brings Alinsky's methods into the modern world. The book is written as a guide for those who wish to become community organizers and/or for current organizers who seek to expand their skills. It emphasizes critical assessment and leans toward confrontational strategies.

In Chapter 1, she defines progressive community organizing as "Community organizing that works toward the liberation of oppressed and marginalized individuals and the transformation of social systems that perpetuate the oppression" (p. 15). She integrates critical theory and Alinsky to propose organizing strategies. In Chapter 2, "The self-aware organizer," Pyles discusses many of the issues an organizer must address, such as anger, fear, despair, burn-out, and co-

optation. She discusses how each of these may negatively affect an organizer. She goes on to discuss how persistence and clarity can help an organizer overcome these issues. She encourages organizers to find the joy in their work. In Chapter 3, "Theories and ideas for progressive organizers," she discusses many theoretical approaches to understanding social change. Pyles closes the chapter with an acknowledgment that these theories may be contradictory and confusing. This encourages the organizer to think of the theories as guides to help one understand social issues and needs for change. She suggests the organizer use the theories, but think of them in critical ways. Chapter 4, "Learning from social movements," and Chapter 5, "Critical organizing frameworks," review the history of several social movements and explain frameworks that have been used to shape organizing approaches. Pyles reports activities that took place in New Orleans following Hurricane Katrina.

Section II, "Tools for community organizing," discusses tools, strategies, tactics, and issues that an organizer must address in planning an intervention. Pyles covers major issues without belaboring them. She illustrates their use by discussing the organizing and activities of the "right to return campaign" that occurred in New Orleans post-Katrina. This section would

be very useful in a social work macro practice course.

Pyles closes the book with a section on entering and emergent issues in organizing. She discusses oppression and liberation with thoughts on developing solidarity. She addresses religious and spiritual issues and how these may affect organizing. The last chapter explores the impacts of globalization. It discusses global justice and localizing movements.

The use of post-Katrina activities strengthens the book by presenting practical experiences. I believe this book would be very useful in social work macro practice courses. It is clear, concise, and thorough. Although she leans

toward confrontational strategies, she does an excellent job of presenting most other approaches and encouraging critical thinking about the issues at hand. My only criticism is that the book pays only minor attention to consensus organizing. I accept that confrontation is often necessary, but most of my students are more comfortable with consensus approaches. I would recommend the book especially for undergraduates, but would supplement it with Eichler's (2007) *Consensus Organizing*.

Reference

Eichler, M. (2007). *Consensus organizing: Building communities of mutual self-interest*. Thousand Oaks, CA: Sage.

Pyles, L. (2009). *Progressive community organizing: A critical approach for a globalizing world.* New York: Taylor and Francis Group.

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

The book titled, *Progressive Community Organizing: A Critical Approach for a Globalizing World* (2009) consists of succinct chapters that provide insight into the social change process. The author, Loretta Pyles, is both an Assistant Professor of Social Welfare at the University of Albany, State University of New York (SUNY), and the Director of the Community and Public Service Program (CPSP) in Albany. Pyles has a background that consists of community engagement, advocacy, and post-Hurricane Katrina efforts. In order to develop this text, she has integrated her experience, empirical research studies, and various professional resources to convey the process of community organizing. As a result, the goals of this book include: explaining the historical and theoretical underpinnings of

community organizing, describing skills that can help promote social change, and communicating challenges community organizers experience as affected by globalization.

The Educational Policy and Accreditation Standards (EPAS) as outlined by the Council on Social Work Education (CSWE) promote competency-based curricula. In relation to these standards, this text includes several factors that can enhance the ability of social work students to engage in community organizing. First, the initial chapters address the concepts of self-evaluation, coping, and cultural competency. These chapters encourage the learner to recognize the impact of practice on the self and how biases and

preconceived notions can negatively affect goal attainment during social change. Second, the text expresses a historical and theoretical focus regarding social change that helps to highlight the concepts of empowerment, promoting leadership development, and mobilizing groups. Third, the author has provided material that can introduce students to pertinent language, decision-making strategies, and an initial understanding of funding to promote social change. Overall, Pyle allows the reader to apply the concepts of community organizing across cultural factors including spirituality, ethnicity, and geographically diverse locations.

Pyle includes several points that are strengths of this textbook, such as social movements that have taken place across populations. For example, feminist organizing that advocated against oppression; as well as disability rights movements to confront discriminatory practices such as forced sterilization. Understanding historical antecedents and the process of consciousness-raising can contribute to the competency development of social work students. Next, the overview about globalization and examples of global justice movements is a benefit of the text. Introducing students to these concepts may enable them to transition their thinking beyond the local environment to transnational occurrences and needs that can be addressed through the social work profession.

In conclusion, *Progressive Community Organizing: A Critical Approach for a Globalizing World* provides an introduction to several concepts and historical events relevant to social change. Further elaboration on topics such as globalization, strategies for change, and organizing coalitions and constituencies may enhance the learning experience of the reader in preparation for professional practice. Based on the overview of concepts throughout the chapters, questions for reflection, and case examples, it is recommended that this text would be beneficial as a supplemental teaching tool for undergraduate social work courses that focus on community organizing and social movements.

Book Review of *Women in Social Work Who Have Changed the World*

By Rasby Marlene Powell, Ph.D.
Professor of Sociology
University of North Carolina at Pembroke

Lieberman, A. (2010). *Women in Social Work Who Have Changed the World.* Chicago, Illinois: Lyceum Books, Inc.

Dr. Leiberman is a Chancellor's Club Teaching Professor of Social Welfare at the University of Kansas. She has published multiple books focusing mainly on effective social work practices. Her work emphasizes understanding diversity and building upon women's strengths. Dr. Lieberman has also collaborated on several federally funded family and children projects.

This book profiles 15 women social workers who have succeeded in contributing to profound changes in their communities and countries around the world. Although the author does not specify a particular audience, I believe this book is as suitable for a general audience as it is for an academic audience. Whether a person is simply interested in social justice or is trying to learn what practices are successful in diverse environments, this book is a good choice.

The book is organized into three parts. The first part focuses on five social workers who have gained positions that enabled them to create and change national and local policies. The second part features women who have created social change from the bottom up through community organizing. Part III presents the biographies of three women who have used their social work knowledge to bring great change to repressive and developing countries.

Although these women's social class, religious, and cultural backgrounds are diverse, their desire for social justice and the core values learned in their social work education connect them. All of the women claimed that their social work educations provided them with the knowledge of structure and application that prepared them to accomplish their goals. Each of the featured women overcame structural or personal obstacles to achieve their accomplishments. Some came from impoverished backgrounds; others worked in countries where women have few rights. All of them give credit for their stamina and courage to mentors. Many cited their mothers as mentors. Additionally, many credited inspiring teachers.

This book has multiple strengths. The writing style is clear, concise, and accessible to the general reader as well as the social work scholar. Although the biographies are short, they provide poignant and detailed accounts of various obstacles faced and successes earned by each woman. This allows readers to see "social work in action." In addition, the biographies clearly show that the women did not have a set "plan of action" for their work but remained open and flexible so they could afford themselves of opportunities. The results of their willingness to change courses when needed can inspire all of us who seek to

improve our communities. While I really enjoyed this book, I believe it would have been improved by the addition of a final chapter to tie the book together. As it is, the book just stops with the last biography. It would help students and general readers, alike, to summarize how what they have learned could benefit them in their own lives or careers.

 Overall, I would recommend this book and believe it can serve multiple purposes. I believe it would be a good addition to any social work practice course. In addition, this book would make an inspiring addition to gender studies courses. And finally, I believe that this book could be used successfully in political science courses to illustrate how the core values of social work can help craft good social policy.

Reviewed by Paul Dovyak, ACSW, LISW-S,
University of Rio Grande, Rio Grande, OH.

While serving as a BSW program director for more than thirty years, I have always maintained an agency-based clinical practice and various consulting supervision in the fields of case management, domestic violence, children's residential care, and adult developmental disabilities. In both the classroom and practice setting, students and practitioners appreciate the consideration and review of scenarios that tease the dilemma of applying the ethical code of social work practice. The author, Thomas Horn, MSW, is a Registered Social Worker (RSW) also having worked in a variety of social service settings for more than twenty years. He currently works with an inpatient forensic team in a large psychiatric hospital in Ontario and supervises social work students.

The format of this 118-page discussion workbook is to introduce 101 scenarios that attend to 25 categories of ethical practice, that is, boundaries, documentation, duty to client, supervision, and others. Each page describes a scenario followed by four to six questions to direct discussion and to consider variations to the scenario. I field-tested several of the scenarios in a sophomore and a senior level undergraduate class and was reminded of the differing effect of a text-driven story and a professor's tale of a practice dilemma. "Ashley is a social worker at a youth shelter with a teen-age girl who is again complaining of suicidal ideation. Savinna works at a secular family counseling center and frequently prays with her clients." A brief elaboration of each scenario follows. These scenarios are brief enough to recall for discussion, yet still contain enough of the elements to foster an assessment of the developing professional perspective in a student or agency staff population.

A select listing of Web links to social work codes of ethics is provided. (*The Journal of Social Work Values and Ethics* is referenced as one source of published articles on social work ethics.) The task of introducing the relevant Code of Ethics and applying the appropriate citations is the workbook portion of the text. There is a range of complexity of scenarios, with some being straightforward and fundamental in presenting the language of ethics. Concepts like integrity and self-determination are operationalized in a meaningful way in the scenarios. More complex scenarios could be developed for advanced ethical discussion. But if you need a resource to begin a discussion of ethics in a classroom or agency in-service, this workbook qualifies for Social Work Ethics 101.

BOOK REVIEW
Umbreit, M. & Armour, M. P. (2011). *Restorative justice dialogue: An essential guide for research and practice*. New York: Springer Publishing.

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

Mark Umbreit is a professor at the University of Minnesota, School of Social Work, on the St. Paul Campus. He is the founding Director of the Center for Restorative Justice & Peacemaking, as well as the National Restorative Justice Training Institute. Mark has been active in the restorative justice movement since the 1970's. He has played a supportive role in the development of the first Victim Offender Reconciliation Program in the United States in Elkhart, Indiana. He has served as a mediator, a trainer of mediators, and has helped develop restorative justice programs in the United States and several other countries. He has been very active in researching the effects of restorative justice services having published more than 140 articles, books, chapters, and monographs on the topic.

Marilyn Peterson Armour is an associate professor at the School of Social Work, University of Texas at Austin. She was the founding Director of the Institute for Restorative Justice and Restorative Dialogue in Texas. Much of her research has focused on families of murder victims. She is a trainer in restorative justice.

Restorative Justice Dialogue presents a thorough and comprehensive explanation and assessment of the current state of restorative justice in the world. It explains the restorative justice methods and presents the most recent research supporting this approach. The opening chapter presents the basic philosophy of restorative justice, its antecedents, and its historical development. Restorative justice

critiques the current justice system for dehumanizing both victims and perpetrators. It proposes to engage victims, perpetrators, and the community in resolving the conflict and developing appropriate restitution. The antecedents of restorative justice are historical approaches to justice in the Western world and community approaches to justice in several tribal societies. Restorative justice began to emerge in the 1970s as a movement to reform the justice system. The book discusses four general types of restorative justice: victim offender mediation, group conferencing, circles, and various derivatives from its approaches. All of these approaches have in common the bringing together of victims and offenders in the presence of a third party facilitator. The goal is to restore the humanity of all parties. Chapter 2 links restorative justice values to core social work values. It persuasively argues that restorative justice enacts basic social work values. Along with the value and dignity of individuals, restorative justice is concerned with cultural sensitivity and empowerment.

Chapter 3 addresses the spirituality embedded in restorative justice. Because of its focus on humanity and healing, restorative justice is closely linked to many spiritual traditions. Many of the restorative justice techniques use rituals or adaptations of rituals to set aside the meeting as a healing place.

The authors do an outstanding job of presenting research from many countries to explain what we know and what we do not know about the effectiveness of restorative

justice practices. They present a very balanced summary of the research that has been done. Overall the research suggests that both victims and the wrongdoer are satisfied with the practices, and feel that they have received justice. The evidence on recidivism is less clear. More research is needed to determine under what conditions restorative justice will affect recidivism. It is clear that some of the impacts of restorative justice are not amenable to quantitative in linear research. Perhaps some of its most important impacts in terms of restoring dignity and respect are not measurable in usual quantitative data.

The book stresses the importance of the facilitator. The facilitator must be neutral, sensitive, nonjudgmental, and willing to deal with profound human pain. There is controversy as to whether the facilitator should be professional or a community volunteer. The authors include thought on the advantages and disadvantages of both approaches.

The chapter on cultural sensitivity is excellent. It provides a very balanced understanding of the many issues involved in mediating in multicultural situations. The restorative justice movement, according to the authors, has seen an over representation of white, middle-class males. A white, middle-class male mediator is highly likely to be seen as a power figure by persons from other cultures. The restorative justice movement and individual mediators must address all of the issues involved in race, class, sexual orientation, religion, and other factors that divide communities. Mediators must understand cultural differences, especially when the victim and the wrongdoer are from very different cultures. The book provides examples of how mediation failed because mediators failed to prepare participants for culturally different ways of communicating.

The book is rich in detail and thorough in its presentation of research evidence. I believe it would be useful in social work curricula both in helping students understand the value and utility of restorative justice, and in explicating core social work values. Many of the techniques reviewed would be useful in social work practice outside restorative justice. I strongly recommend the book to those who seek a deeper understanding of restorative justice, as well as to those who seek to improve their abilities to work in conflictual situations. Much social work practice involves conflictual situations and situations in which persons have suffered severe harm, emotional and physical. Restorative justice techniques would be very helpful in many of the situations. I would also recommend the book to policy makers. It could help them understand why current approaches to social justice are ineffective.

I want to stress how thorough and well balanced this book is in presenting what we know and what we do not know about restorative justice. One can derive several ideas about how we should move forward in understanding the conditions under which this approach can be useful, and for whom the approach can be useful. I believe as restorative justice develops and refines its techniques and approaches, it will make significant contributions to stronger communities and our just treatment of both victims and wrongdoers.

BOOK REVIEW
Gazzaniga, M. S. (2005). *The ethical brain*. New York: Dana Press.

Reviewed by: Stephen M. Marson, Ph.D.
University of North Carolina at Pembroke

When I first received this book as an assignment to review, I was intrigued by the title.   Upon reading the Acknowledgments and the Preface, I was disturbed by the seemingly political bias. In several locations within *The Ethical Brain*, emphasis is placed on the fact that Michael S. Gazzaniga was appointed to President Bush's Bioethics Council. My interest in reading this book rapidly waned. I suspect many readers will have a similar reaction. However, such a reaction would be an error. The book is not politically biased. In fact, the substance of the book appears contrary to the philosophical foundation of our current administrative policies addressing stem cell research, cloning, and gene mapping. Thus, *The Ethical Brain* is not political propaganda and is very much worth reading.

Who should read it? Gazzaniga does not indicate his intended audience; however, it is clear this book would be appropriate for anyone with a college education and an interest in the subject matter. Psychiatrists and most psychologists will find the reading and information too elementary. However, lawyers – particularly defense lawyers – will find the book to be a valuable resource as a foundation to ask the *right* questions during criminal trials and plea bargaining negotiations. Prosecutors will find the book a useful guide to learn strategies and legal theory likely to be used by sharp defense attorneys. Most importantly, judges need to read this book in order to identify legal theory with sound scientific support. The author does a particularly good job of evaluating scientific research, thereby separating the good from the bad.

The author presents several key concepts that will enable defense attorneys to plan effective legal strategies. Scattered throughout the book is the concept of free will. Although the author declares that he is a Catholic, he does not allow his religion to interfere with his interpretation of scientific studies. Based on the biochemistry of the brain, Gazzaniga leans toward accepting a deterministic perspective. His perspective is fresh and very unlike the material presented to me while being educated by Dominican nuns and priests. He presents a concept of "free don't" rather than "free will." When criminal acts become an option, people are most apt to make their final decision on the basis of what *not* to do rather than what to do. In outlining the decision-making process, Gazzaniga clarifies that the cognitive management of options is not simple; however, it remains understandable if the observer is patient.

Perhaps the most important dimension of Gazzaniga's presentation is his unfolding of the future of brain research and intervention (i.e., prescription drugs) on the legal community. Two examples are particularly salient. First, Gazzaniga addresses the future of brain imaging as the ultimate lie detector. He writes: "Neuroscientists are beginning to be able to identify biases in emotional responses to images, and lawyers are eager to use such evidence in court" (page 107).
  Second, he offers an illustration of commercial usage with legal implications when he writes (page 115):

> Dave Schraer, an engineer, is
> working on a new and

improved ATM machine that will be able to detect your mood. The hope is that ATMs will be able to use advertising (tailored to your mood of the day) in order to replace the ATM fees now paid by the consumer. If you are feeling sad as you approach the ATM, you may see an ad for the antidepressant Zoloft, but if you appear angry or annoyed when viewing the ad, the ATM will know you don't want to see it again.

Throughout the entire book, Gazzaniga paints a picture of the not so distant future of jurisprudence in which deception through lying can be eliminated. In many ways, Gazzaniga's presentation reads like science fiction similar to Orwell's *1984*. However, in Gazzaniga's presentation he is able to explain how the science works and debate the ethics of the scientist's ability to get into the head of the defendant – without his/her cooperation or consent.

Based on exponential growth in the quality and quantity of neuroscience research, the nature of criminal prosecution will radically change. In fact, Gazzaniga suggests that the process of collecting evidence will change to such a degree, the system will be unrecognizable using today's standards. Is there any way of stopping or slowing down the change? The author emphatically states no. Judges will *not* be in a position to reject neuroscience as a method of acquiring evidence. They will find some of their decisions will have an impact on past cases that will be retried or reviewed by higher courts. I envision court dockets will become quite messy.

I strongly recommend that practicing attorneys and judges read this book. Defense attorneys need to read it to create a strategy and a theory, while prosecutors must read it to develop a response. Gazzaniga suggests initially prosecutors will face many difficulties in winning their cases when neuroscience is presented. Judges must understand the foundations of neuroscience research to make decisions regarding what evidence should be allowed. Some legal precedence has been made prior to this book's publication. Thus, law school libraries should adopt this book. Most psychiatrists and psychologists will be familiar with the material presented and will find the material too elementary. However, social workers who have little background in neuroscience, and who may be called upon to testify in court, need the information within this book to employ as a frame of reference in testifying. Thus, university libraries that include holdings for social work, psychology, and human services should purchase this book.