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CONTENTS

EDITORIAL

James G. Daley

Welcome to our fourteenth issue of Advances! For the past six years, this journal has been offering top quality articles that whet the appetite of the reader and incite a drive to deeper explore the vital information given.

We have provided regular issues, such as this issue, and special topic issues in each Spring. Therefore the reader has received the best of both worlds: a wide range of topics and one topic explored in great detail. This Spring we will be offering a special issue on the theories of Human Behavior in the Social Environment. The sixteen articles in the special issue will critique different theories, analyzing the history and evidence base for each theory. It will be a great contribution!

This issue is filled to the brim with fascinating articles that explore and explain topics vital to social workers regardless of their focus of practice. Darcy Siebert tackles a tough topic, maximizing the response rates in survey research, and demonstrates successful strategies to do survey research effectively. Rosenwald and Hyde explore a rarely researched issue: do the political ideologies of social workers influence their behavior with clients. Melissa Taylor offers an intriguing discussion of the comfort level and activity of social workers in mental health when dealing with involuntary clients. Diane Green describes the challenges and importance of assessing spiritual well-being and then meticulously reports her research efforts to create a scale that helps social workers better understand their client's view of his or her mental, physical and spiritual well-being. Jane Woody challenges us all to incorporate prevention into our practice and the vital role that educators have in bringing this vital concept to the classroom. Sharon Moore and her colleagues enlighten us on the experience of clients receiving hunger service assistance, how the clients can appear challenging, and several practical tips on how to be most effective with the clients. David Westhuis and his colleagues offer a very nice review of the debate on distance education, concerns about online technology, and their research findings from offering a research course in two options: as an online course and as a traditional classroom course. Johansen and Ouellette eloquently advocate for improving the partnerships between agencies and faculty and offer a framework called "the learning community" as a way to make better mutual learning experiences occur.

As can be seen by my brief overview of the issue, the reader has a vast range of insightful articles to choose from. Each article engages the reader in thinking deeper about important aspects of our every day practice. Spirituality, prevention, collaboration, self awareness, expanding our world view are just a few of the topics within this issue. I invite you to sit back in your most comfortable chair, cup of coffee or hot chocolate in hand, and begin to read these fascinating articles. Let the life long learning begin!

MAXIMIZING RESPONSE RATES IN SURVEY RESEARCH: ISSUES AND METHODS

Darcy Clay Siebert

Abstract: *Collecting accurate data is a challenge for researchers, and securing sufficient response rates can be especially difficult, particularly when asking respondents to reveal sensitive information. This paper will review the relevant literature and illustrate the issues by reporting the methods used to collect data for Work and Well Being: A Study of North Carolina Social Workers. By following a rigorous protocol, the study achieved a 75% response rate (N=751), a sample that was representative of the population, and minimal response bias. The results highlight the ways in which social work researchers can explore difficult substantive arenas and yet achieve an excellent response.*

Key words: *Research Method; Surveys; Response Rate*

INTRODUCTION

Collecting accurate data is a challenge for researchers, and securing sufficient response rates and accurate responses in survey research can be especially difficult, particularly when requesting sensitive information. At times, participants place a good deal at risk by answering survey questions; for example, respondents revealing stigmatizing illnesses might lose friends if their answers were exposed, or professionals asked to disclose unethical behavior would fear losing their jobs if their responses were made public. It is not surprising that research participants are reluctant to respond to questionnaires that ask questions about sensitive topics, yet sensitive topics are at the heart of much social work research. This paper will review the issues involved in conducting survey research, including response rates, sample representative ness, and item non response, giving particular attention to the collection of sensitive data. Issues will be illustrated by presenting the methods used for Work and Well Being, a survey of 1000 actively practicing members of the North Carolina chapter of the National Association of Social Workers (NASW) that included a number of questions of a sensitive nature.

This survey study explored the extent of alcohol and other drug (AOD) use, depression, and burnout among social workers, examined demographic and other, sensitive correlates (e.g., sexual abuse history), and analyzed the ways in which these variables impaired respondents' professional practice (e.g., provided inadequate client care or had inappropriate relationships with clients).

Darcy Clay Siebert, Ph.D., is an assistant professor at Florida State University, School of Social Work University, Tallahassee, FL. This research was funded by the National Institute on Alcohol Abuse and Alcoholism. A version of this paper was presented at the annual meeting of the Society for Social Work and Research.

SURVEY DESIGN

Previous studies find that self-report is frequently more accurate than proxy report (Fowler, 1995), and this may be particularly true when collecting sensitive data, as these sensitive events or behaviors are frequently so private or covert as to be unknown to others. A variety of self-report methods have been used in past research to elicit information – telephone interviews, face-to-face interviews, group-administered questionnaires, and computer-assisted methods are all documented in the literature. Previous studies that compare methods of collecting sensitive data find that respondents report more truthfully in self-administered questionnaires than in other kinds of self-report (Harrison, 1995; Turner, Lessler, & Gfroerer, 1992). Because methods that minimize personal contact are most likely to produce accurate and complete results, researchers frequently use mail surveys to collect data about substance abuse (Trinkoff & Storr, 1997) and other sensitive issues (Deutsch, 1985; Sherman & Thelan, 1998). Participants whose identities remain anonymous are likely to feel safer than those who participate confidentially, and when anonymity is guaranteed there may be little or no response bias (Rouse, Kozel, & Richards, 1985; Trinkoff & Storr, 1997). Following the literature, Work and Well Being utilized a cross-sectional, anonymous mailed survey design.

DATA COLLECTION METHODS

Participants in all kinds of surveys may be influenced by the details of the data collection plan. For Work and Well Being, data collection strategies, modified from Dillman (2000), were employed to maximize the response rate while reducing item nonresponse and social desirability bias, thus improving the likelihood of obtaining a representative sample and accurate data.

Respondents were sent an initial, brief letter of introduction to the study, as suggested frequently by survey researchers (Dillman, 2000; Mangione, 1995; Murphy, 1993; Salant & Dillman, 1994). This introductory letter prepared respondents for the questionnaire, and endorsements lent credibility to the purpose of the study. The letter was printed on stationery from the Dean's Office at the university's School of Social Work, and the Dean, the Executive Director of the State Chapter of the NASW, the President of the State Society of Clinical Social Workers, and the Principal Investigator, signed it. A notice prominently placed in the State NASW newsletter also described and endorsed the study. Survey researchers agree that marketing materials and cover letters should be persuasive and well written (Bourque & Fielder, 1995; Dillman, 2000; Mangione, 1995) to facilitate higher response rates.

University stationery was used for all letters to respondents, as the survey research literature is clear that research sponsored by recognized research institutions may be more credible to respondents and enjoy higher response rates (Dillman, 2000). This may be particularly true for studies collecting sensitive information from respondents who appreciate assurances of methodological rigor, so that affiliation was prominently advertised in study materials.

A cover letter was included with the initial mailing of the questionnaire and all subsequent follow-up mailings. This letter was one page long, easy to read, personally signed in

blue ink, and printed on institutional letterhead. It included a compelling first sentence, explained why the study was important, and clearly explained the procedure for returning completed surveys. Respondents were told how they were chosen randomly for participation, emphasizing the importance of their participation while clearly stating that it was voluntary. Of particular importance for this study was the assurance of anonymity and the clear explanation of the methods that would insure this protection. Respondents must be satisfied that their anonymity is guaranteed, particularly if they perceive risk attached with revealing information. To accomplish this, the specifics of that protection were offered in sufficient, but not lengthy, detail (Bourque & Fielder, 1995; Dillman, 2000).

Finally, the project contact person, phone number and email address were included in case the respondents had any questions about the study (Foddy, 1993; Mangione, 1995; Salant & Dillman, 1994).

Because the mailing schedule can also affect response rate, reminders and subsequent mailings were sent according to a specific timetable (Mangione, 1995). Commemorative postage stamps rather than metered or business reply stamps were utilized to increase the response rate by placing "subtle pressure" on respondents to return the questionnaire, helping them differentiate the survey from junk mail, and requiring the post office to return un forward able envelopes (Choi, Pack, & Purdham, 1990; Mangione, 1995; Salant & Dillman, 1994; Shiono & Klebanoff, 1991). Large mailing envelopes were used to avoid folding the questionnaire (Mangione, 1995). Also, all correspondence was personalized by printing the respondents' names on the introduction and cover letters, outgoing envelopes, and return postcards, as studies regularly have found that this technique slightly improves response rate (Dillman, 2000).

This study did not provide incentives to respondents (e.g., money or trinkets), as the literature provided no evidence that this would be helpful to increasing response rate for a survey of professionals (Asch, Jedrziewski, & Christakis, 1997). In addition, respondents being asked for particularly sensitive information could have been offended by the notion that their private and important information would be worth only the small token or other incentive that is typically included in survey studies. Potential participants must be given an exceedingly good reason for participating, such as appealing to an aspect of self-interest or demonstrating the study's importance to an issue that is meaningful for them (Bourque & Fielder, 1995; Dillman, 2000; Mangione, 1995). Along with a statement of the study's importance to the social work profession, an offer to send respondents a summary of the survey results was included in the cover letter, as this is regarded as a helpful motivator, particularly for professional respondents (Murphy, 1993).

QUESTIONNAIRE

The project also followed recommendations for reducing item non response. An attractive and easy-to-follow questionnaire was designed, including good quality printing, balanced arrangement of the questions on each page, easy-to-read font style and size, numbered questions, consistently marked instructions, sequential ordering of response options, clean-looking formatting with lots of blank space on each page, and good quality paper (Bourque & Fielder, 1995; Dillman, 2000; Mangione, 1995; Salant & Dillman, 1994).

Only necessary questions were asked, and in only as much detail as was necessary for the study (Mangione, 1995). The questionnaire did not begin with the most sensitive questions (Foddy, 1993; Mangione, 1995), and questions about respondents' own behavior were preceded with questions about other people's behavior in the same content area (Foddy, 1993; Mangione, 1995). The wording of questions was typically brief and without too much detail, usually below the ideal 20-word recommended maximum (Foddy, 1993). Also clear instructions and indications about why the questions were being asked were provided (Mangione, 1995).

The traditional suggestions for decreasing the difficulty of questions were also followed – not asking two questions as if they were one (i.e., double-barreled), avoiding qualifying phrases and difficult words or phrases, avoiding multiple ideas or subjects within one question, excluding negative phrases or instructions within a question, and avoiding the inclusion of both present and past tense, or singular and plural cases (Foddy, 1993).

Social desirability bias is a concern, as it can undermine the validity of measures through consistent under-reporting of behaviors and other attributes. Respondents may want to make themselves look good, or they may simply want to protect themselves from looking bad (Fowler, 1995). Clearly, this kind of bias was likely in this study, the questionnaire included explicit questions about behavior that could compromise respondents' careers and/or licenses. It was possible that respondents would consciously or unconsciously distort their responses in order to protect their personal self-images. To help lessen this bias, a statement emphasizing the need for honest and accurate responses was made in several places, as were assurances of anonymity. The ranges of response options for sensitive questions were increased (e.g., including very high upper limits for drinking and drug use measures), as respondents are typically more comfortable selecting the correct option if it does not seem to be the most extreme response possible (Foddy, 1993; Fowler, 1995; Mangione, 1995). For other sensitive topics such as income, the detail in response categories was minimized because respondents are generally more comfortable answering questions in which the response categories are broad rather than narrow (Foddy, 1993; Fowler, 1995).

Finally, as is regularly recommended in the literature, participation in the study should not require a burdensome length of time; this is especially germane for respondents who are asked for sensitive information that might generate uncomfortable feelings while they are responding (Bourque & Fielder, 1995; Dillman, 2000).

TIMELINE

Dillman (2000) has very specific recommendations for data collection timelines, and these recommendations were followed for Work and Well Being. Data were collected between July and September. Initially introductory letters notified all recipients of their selection to participate and briefly described the study and its significance. Questionnaire packets were mailed three days later, and each included a cover letter, a stamped reply envelope that was addressed to be returned to the School of Social Work, and a return postcard that was stamped and personalized with the respondent's name and address. This postcard, to be returned separately from the questionnaire and mailed to a different address, allowed respondents to check a box confirming either

that they returned their questionnaire under separate cover or that they did not want to be part of the study and wished to be taken off the follow-up mailing list. This system allowed the tracking of responses without having a name attached to a specific questionnaire. Previous studies (Gilbert, Longmate, & Branch, 1992; Trinkoff, Eaton, & Anthony, 1994; Trinkoff & Storr, 1997) experienced proportional numbers of returned postcards and returned questionnaires, always receiving slightly more usable questionnaires than confirmatory postcards (Summers & Price, 1997).

Subsequent mailings were sent to non responders at two-week intervals for the next eight weeks, alternating between reminder postcards and replacement questionnaire packets. When the post office returned several undeliverable letters during the first few weeks of the study, every attempt was made to locate respondents' new or corrected addresses.

RESULTS

Response Rate

By the end of the study, 822 (82%) of the social workers had responded to the mailings. Of this total, 75 (7.5%) had returned postcards or left voice mail or email messages stating that they did not wish to participate in the study. Additionally, 12 respondents were not locatable and three questionnaires were removed as unusable. From the original sample of 1000, 751 usable questionnaires were received, yielding a survey completion rate of 75.1%. For ease of interpretation, Table 1 presents the timeline information and the cumulative totals of reply cards received, questionnaires received, and respondents who declined participation.

Table 1. Timeline and Cumulative Totals of Responses for Work and Well Being

Date	Activity	Reply cards received	Usable questionnaires received	Declined participation
7/11	Intro letter mailed to 1000 SWers			
7/14	Initial packets mailed to 1000 SWers			
7/27	Reminder postcards mailed	379	358	22
8/10	Replacement packets mailed	610	560	37
8/23	Revised reminder postcards mailed	724	675	53
9/07	Final packets mailed	760	706	59
9/28	None	805	740	71
10/15	Final totals	822	751	75

Note. 592 respondents requested a summary of the study's results.

Demographic Comparison to Target Population

No demographic data were available about the population of North Carolina members of NASW, so demographics were compared with the national NASW membership to explore whether the study sample was similar to the population of NASW members. Data from the recent Practice Research Network survey (PRN, 2000) and population data from the 1995 profile of the NASW membership from *Who We Are: A Second Look* (Gibelman & Schervish, 1997), were compared with the data from this study. The study sample over represented women and African-Americans while under representing Hispanics and those over 60 years of age compared to the national membership. It should be noted that because the NASW does not promise confidentiality when collecting personal information from its members, the usefulness of those comparisons may be somewhat compromised. Statistical testing for significant differences was not conducted due to the unavailability of the raw data and differences in item construction, data collection methods, sample sizes, and reporting. Table 2 summarizes these data.

Table 2. Demographic Comparisons of the 1995 NASW Membership, the PRN Survey, and the Study Sample

Item	1995 NASW (N=153,814)	Study Sample (N=751)	PRN Sample (N=1620)
Gender (female)	79.4%	83.8%	79%
Ethnicity			
White	87.9%	88.1%	89%
African American	5.7%	9.1%	5%
Hispanic	2.8%	0.7%	3%
Asian	1.8%	0.4%	1%
Native American	0.6%	0.4%	1%
Other	1.3%	1.3%	2%
Age			
40 years or younger	38.0%	36.0%	21% (under 40)
41-60 years	51.0%	59.0%	70% (40-59)
61 years or older	10.0%	5.0%	9% (60+)

Item Nonresponse

Because the questionnaire was lengthy, containing 84 questions, nonresponse is reported in categories of questions. Illicit drug use or improper prescription drug use questions had a mean item nonresponse of .81% (i.e., each question was answered by an average of 99.19% of respondents). Drinking items' mean nonresponse was

2.7%, while trauma history questions (e.g., history of sexual abuse) averaged 2.1% item nonresponse. Impairment items asking about the negative professional consequences of mental health or AOD problems (e.g., having improper relationships with clients, providing inadequate client care) sustained the highest mean nonresponse at 3.4%. These mean percentages include all missing data, including those that were not purposeful – for example, items unanswered because questionnaire pages were stuck together when received by return mail.

Response Bias

To explore potential nonresponse bias, early and late responders were grouped, coding the first 100 respondents as "1" and the last 100 respondents as "2," comparing them on outcome measures and on demographic characteristics.

This typical method for identifying non-response bias presumes that nonresponders are more similar to late responders than to early responders (Trinkoff & Storr, 1997).

Chi square tests revealed no differences between early and late responders on ethnicity, marital status, sexual identification (e.g., heterosexual female, homosexual male), and highest degree earned. One-way ANOVAs revealed no differences between early and late responders on age, income, or years of social work experience. Thus, demographically, there were no significant differences between the groups on these variables.

Standardized measures were used to assess AOD use, depression, and burnout, and these were complemented with single-item self-assessment items. Both an index and a single-item self-assessment scale measured impairment. One-way ANOVAs were conducted on these variables, and no differences were found between early and late responders on any of the alcohol or other drug use variables, the burnout scale, or the impairment index. Chi square tests also found no differences for self-reported depression status or burnout status. Two statistically significant differences occurred between early and late responders – late responders were more likely to report stronger agreement with the statement "I have worked when I was too distressed to be effective" and to have scored higher on the Center for Epidemiological Studies Depression scale (Radloff, 1977). Following the argument that nonresponders are more similar to late rather than early responders, nonresponders may have been more likely to experience depression symptoms and professional impairment. Funding limitations precluded follow-up with nonrespondents to determine actual differences between them and the sample. It is clear, however, that respondents experiencing depressive symptoms and professional impairment required more contacts before responding to the questionnaire than those respondents who did not report higher scores on the CES-D and single-item impairment measure.

DISCUSSION

It is difficult to conduct research on issues that are stigmatized by society, especially problems like alcohol and other drug use in which denial is a characteristic defense (Haack & Hughes, 1989). This difficulty may be compounded when asking for sensitive information from respondents who have a good deal to lose if the information was inadvertently revealed, such as this sample of professionals whose careers and licenses may rest on their good reputations. Because stigma prevails, both participant nonresponse and item nonresponse are possible.

Despite these difficulties, survey research, including that which asks respondents for sensitive information, can be rigorous. Following well-researched guidelines resulted in an excellent response rate despite the intrusive questions asked in this study of social workers. The wisdom about how to do this well runs broad and deep in the scientific literature, yet there are many examples in the literature of studies that fail to meet (or even address) the recommendations for sound survey research. Past researchers who deviated from recommended procedures experienced poor response rates when surveying professionals on this topic. For example, Hughes and colleagues (1992) conducted a survey of physicians' alcohol and other drug use that utilized an excellent sampling strategy, sound measures, and most methods that followed the literature. However, they did not follow recommended timelines for their mailings (Dillman, 2000), and they achieved a 59% response rate.

However, in studies that paid careful attention to the details of survey administration, and in particular followed the recommendations in the literature for follow-up mailings, helping professionals were willing to provide sensitive information. McAuliffe and colleagues (1991) surveyed physicians and medical students, and then compared their alcohol use and abuse with previously surveyed samples of pharmacists and pharmacy students. The investigators carefully followed the methods recommended in the literature – e.g. guaranteed anonymity and follow-up mailings at two-week intervals, and their methods were rewarded with response rates of 76% for pharmacists, 67% for pharmacy students, 70% for physicians, and 78% for medical students. Trinkoff and Storr (1997, 1998a, 1998b, 1999) surveyed nurses about their alcohol and other drug use utilizing methods that were the template for Work and Well Being, and of the 5706 nurses eligible to participate in their study, 4438 (78%) returned usable questionnaires.

Respondents in rigorous studies also appear to provide more accurate information, as the rates of alcohol and other drug (AOD) abuse reported were even higher than those in less meticulous studies. For example, while Hughes and colleagues (1992) reported an 8% lifetime (AOD) abuse rate, McAuliffe and colleagues (1991) found that 17% of their sample of physicians reported drinking too much currently. Trinkoff & Storr's study of nurses found that past-year use for all substances was 32%, and 17% of respondents reported past-year binge drinking (Trinkoff & Storr, 1997, 1998a), higher than the national average. The current study of social workers found even higher rates of AOD use, despite using the same measurement strategy as Hughes (1992) and Trinkoff and Storr (1997). Twelve percent of the sample was at serious risk of AOD abuse, 28 percent reported binge drinking dur-

ing the past year, and 21 percent had used drugs illegally since becoming a social worker (Siebert, 2003). In addition, the lifetime rate of depression reported by social workers was three times the national average for women (Siebert, 2004) and the lifetime burnout rate reported was 75% (Siebert, in press). Fifty two percent reported some kind of professional impairment as a result of their own AOD or mental health problems at some time in their lifetimes (Siebert, 2005).

Insuring that the content of a questionnaire is believable and important to potential participants is a key feature in maximizing response rates in all kinds of survey research, and this may be especially important for respondents who are reluctant to reveal sensitive information. While the literature frequently recommends the use of brief questionnaires to guard against low response rates and item nonresponse, the length of the questionnaire may be less of an issue if the content is persuasive to the respondent. This study's 10-page, 84-question instrument exceeded typical recommendations for length, yet it still achieved an excellent response, making the case that compelling content may keep a respondent's attention even for a lengthy questionnaire.

Nevertheless, the potential for underreporting is always an issue for topics in which denial is powerful, as demonstrated by differences in this study's early and late responders. Surveys asking for sensitive information would be wise to plan for multiple follow up contacts with respondents, as many of the social workers experiencing depression and professional impairment would not have been included in the Work and Well Being data if only one or two follow ups had been implemented, thus lowering the response rate and the prevalence rates for these important variables.

Another useful strategy for addressing underreporting is to utilize multiple measures for sensitive variables, giving respondents multiple opportunities to report accurately and to check the consistency of those responses within a particular topic. This tactic was particularly valuable for this survey's sample of social work professionals, many of whom likely utilized some of the same standardized measures (e.g., the CAGE) with their clients that were included in the questionnaire. Finally, item nonresponse may also be less of a problem if items are well-constructed and meaningful to respondents (Dillman, 2000; Mangione, 1995).

In summary, those of us who conduct survey research must improve our ability to capture accurate information about the very difficult issues that face our clients and practitioners. The effort required to improve response rates is costly and time-consuming, but effective with a variety of populations (Dillman, 2000) and well worth the effort. We also need to aspire to higher standards for reporting our response rates accurately – the usable number of responses divided by the total number selected in the sampling – not response rates that are calculated exclusive of respondents that can't be located or who are deemed ineligible after the fact. Rather than avoiding the study of sensitive issues or continuing to be complacent about inaccurate reporting, poor survey response rates, and substantial item nonresponse, we owe it to ourselves and to our clients to become more rigorous in our methods, improving the accuracy of our findings and providing practitioners with the valuable information they need to provide better services.

Author's Note:

Address correspondence to: Darcy Clay Siebert PhD, assistant professor, Florida State University, School of Social Work, University Center C, Tallahassee, FL 32306-2570. dsiebert@.fsu.edu.

References

Asch, D. A., Jedrziewski, M. K., & Christakis, N. A. (1997). Response rates to mail surveys published in medical journals. *Journal of Clinical Epidemiology, 50*(10), 1129-1136.

Bourque, L. B., & Fielder, E. P. (1995). *How to conduct self-administered and mail surveys* (Vol. 3). Thousand Oaks, CA: Sage Publications.

Choi, B. C. K., Pack, A. W. P., & Purdham, J. T. (1990). Effects of mailing strategies on response rate, response time, and cost in a questionnaire study among nurses. *Epidemiology, 1*, 72-74.

Deutsch, C. J. (1985). A survey of therapists' personal problems and treatment. *Professional Psychology: Research and Practice, 16*(2), 305-315.

Dillman, D. A. (2000). *Mail and Internet surveys: The tailored design method.* New York: John Wiley & Sons.

Foddy, W. (1993). *Constructing questions for interviews and questionnaires:Theory and practice in social research.* Cambridge: Cambridge University Press.

Fowler, F. J. (1995). *Improving survey questions: Design and evaluation* (Vol. 38). Thousand Oaks: Sage.

Gibelman, M., & Schervish, P. H. (1997). *Who we are: A second look.* Washington, D.C.: NASW Press.

Gilbert, G. H., Longmate, J., & Branch, L. G. (1992). Factors influencing the effectiveness of mailed health surveys. *Public Health Reports, 107*(5), 576-584.

Harrison, L. D. (1995). The validity of self-reported data on drug use. *Journal of Drug Issues*(25), 91-111.

Hughes, P. H., Brandenberg, N., Baldwin, D. C., Storr, C. L., Williams, K. M., Anthony, J. C., & Sheehan, D. V. (1992). Prevalence of substance abuse among US physicians. *JAMA, 267*(17), 2333-2340.

Mangione, T. W. (1995). *Mail surveys: Improving the quality* (Vol. 40). Thousand Oaks, CA: Sage Publications.

McAuliffe, W. E., Rohman, M., Breer, P., Witshak, G., Santangelo, S., & Magnuson, E. (1991). Alcohol use and abuse in random samples of physicians and medical students. *The American Journal of Public Health, 81*(2), 177-182.

Murphy, C. A. (1993). Increasing response rates of reluctant professionals in mail surveys. *Applied Nursing Research, 6*(3), 137-141. PRN. (2000). *Demographics* [World Wide Web]. National Association of Social Workers Practice Research Network. Retrieved August 25, 2002, from the World Wide Web.

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Journal of Applied Psychological Measurement, 1977,* 1, 385-401.

Rouse, B., Kozel, N., & Richards, L. (Eds.). (1985). *Self report methods of estimating drug abuse: Meeting current challenges to validity* (Vol. Research Monograph 57). Rockville, MD: National Clearinghouse for Alcohol and Drug Information.

Salant, P., & Dillman, D. A. (1994). *How to conduct your own survey.* New York: John Wiley & Sons.

Sherman, M. D., & Thelen, M. H. (1998). Distress and professional impairment among psychologists in professional practice. *Professional Psychology: Research and Practice, 29*(1), 79-85.

Shiono, P. H., & Klebanoff, M. A. (1991). the effect of two mailing strategies on the response to a survey of physicians. *American Journal of Epidemiology, 134*, 539-542.

Siebert (2003). Denial of AOD use: An issue for social workers and the profession. *Health and Social Work, 28(2),* 89-97.

Siebert (2004). Depression in North Carolina social workers: Implications for practice and research. *Social Work Research, 28*(1), 30-40.

Siebert (2005). Help seeking and AOD use among social workers: Patterns, barriers, and implications. *Social Work, 50*(1), 65-75.

Siebert (In press). Personal and occupational factors in burnout among practicing social workers: Implications for researchers, practitioners, and managers. *Journal of Social Service Research.*

Summers, J., & Price, J. H. (1997). Increasing return rates to a mail survey among health educators. *Psychology Reports, 81*(2), 551-554.

Trinkoff, A. M. (1998a). Substance use among nurses: Differences between specialties. *American Journal of Public Health, 88*, 581-585.

Trinkoff, A. F., Eaton, W. W., & Anthony, J. C. (1994). The prevalence of substance abuse among registered nurses. *Nursing Research, 40*(3), 172-175.

Trinkoff, A. M., & Storr, C. (1997). Collecting substance use data with an anonymous mailed survey. *Drug and Alcohol Dependence*(48), 1-8.

Trinkoff, A. M., Storr, C. L., & Wall, M. P. (1999). Prescription-type drug misuse and workplace access among nurses. *Journal of Addictive Diseases, 18*, 9-17.

Trinkoff, A. M., & Storr, C. L. (1998b). Work schedule characteristics and substance use in nurses. *American Journal of Industrial Medicine, 34*, 266-271.

Turner, C. F., Lessler, J. T., & Gfroerer, J. C. (1992). *Survey measurement of drug use: Methodological studies.* Washington, DC: National Institute on Drug Abuse, Department of Health and Human Services.

POLITICAL IDEOLOGIES OF SOCIAL WORKERS: AN UNDER EXPLORED DIMENSION OF PRACTICE

Mitchell Rosenwald
Cheryl A. Hyde

Abstract: *This article explores relationships between social workers' political ideologies and the effects on practice. Self-administered surveys from 294 licensed social workers in a mid-Atlantic state generated quantitative and qualitative data on whether and to what extent their ideologies influenced professional practice. Findings suggest that while social workers largely believe that their political ideology is separate from their practice, those who identified with more liberal political ideologies claim they used their ideologies more in practice than those who were more conservative. Additionally, strategies for monitoring political ideology in practice are shared. Implications for practice include the need for practitioners' increased awareness of their political ideologies and the profession's responsibility for establishing venues in which the ideology – practice link can be explored and debated.*

Key words: *Political Ideology; Political Diversity; Practice*

INTRODUCTION

Examining the diversity of social workers' political ideologies, and how these views relate to social work practice, is an under explored area of study (Hodge, 2002; Linzer, 1999; Rhodes, 1992; Rosenwald, 2004). Despite the profession's call for respect of political beliefs (NASW, 1999), the often unquestioned assumption remains that social workers subscribe to liberal values and positions (Hodge, 2002; O'Neill, 2003; Social Work Speaks, 2000). Without much empirical attention to social workers' political ideologies, and except for the occasional argument that social workers ought to act on their ideological beliefs that presumably support social change (Abramovitz, 1993), the effects that political ideology could have on practice has not been examined.

This article presents results from an exploratory study on the political ideology of social workers.

Using quantitative and qualitative data, analysis focuses on how one's political ideology affects practice. Two questions are explored: (1) do social workers incorporate their political ideologies into practice; and (2) what strategies do social workers employ to manage political ideology in practice? Responses are analyzed from the perspectives of how social workers believe political ideology affects their practice. Implications for social work practice also are discussed.

Mitchell Rosenwald is Assistant Professor, School of Education and Human Development, Binghamton University and Cheryl A. Hyde is Assistant Dean of Field and Continuing Education, School of Social Administration, Temple University, PA.

POLITICAL IDEOLOGY AND SOCIAL WORK PRACTICE

Ideology is a "system of independent ideas ... held by a social group or society, which reflects, rationalizes and defends its particular social, moral, religious, political and economic institutional interests and commitments" (Theodorson & Theodorson, 1969, p. 195). Political ideology is often conceptualized on a continuum, typically from "radical left" to "radical right," with "liberal", "moderate" and "conservative" views arrayed between the two ideological ends (Brint, 1994; Knight, 1999; Lowi & Ginsberg, 1994). To further capture the complexity of political ideology, three criteria may be superimposed on this continuum: the degree to which government should be involved in effecting social change, the substantive areas that government should address, and the speed in which government-induced social change should occur (Diamond, 1989; Knight, 1999). Brint (1994) further differentiates political ideology by contrasting economic issues (support for capitalism, support for a welfare state) and social issues (support for civil liberties, support for civil rights).

While the stereotype of social work is that of a liberal profession, some studies challenge this monolithic view of social workers. Even though research suggests that most social workers favor a generally liberal orientation, findings indicate variation in political ideology, and its correlates (e.g. political party, political values), ranging from "liberal" to "conservative" (Abbott, 1988, 1999; Hodge, 2002; Reeser & Epstein, 1990). This diversity of political ideology, however, remains largely unacknowledged within social work (Rosenwald, 2004).

Perhaps because this ideological variation is not well-recognized, the impact of one's ideology on practice also tends to be ignored. Yet as Linzer (1999) suggests in several illustrative scenarios, political ideology can be a powerful determinant in how a social worker understands and resolves a given situation:

> A feminist-oriented social worker may be tempted to support a single woman's moving out of her parents' home to her own apartment even though strong cultural factors mitigate against it. An abortion-rights social worker may try to persuade a pregnant teenager not to have her baby. ... A hospital social worker that believes in taking full advantage of modern medicine's resources may have difficulty respecting the right to self-determination of a patient who refuses a life-saving blood transfusion for religious reasons (p. 25).

Empirically, Csikai's research (1991) suggests that social workers' personal bias and religiosity affected their attitudes on euthanasia and assisted suicide. Lev-Wiesel and Friedland (1999) found that most Israeli social workers had difficulty working with clients whose political ideologies differed from their own. Studies that examined related professions, such as psychology, noted that the ideologies of both therapist and patient, and their interactions, contributed to the therapist's judgment (Gartner, Harmatz, Hohmann, & Larson., 1990; Kelly, 1990). Specifically, clinicians tended to minimize pathologizing their patients who shared the clinicians' own political orientation. The study presented here extends this research.

METHOD

Data for this exploratory study are from a self-administered survey that collected quantitative and qualitative information on political ideology and its effects on practice, as well as basic demographic information (e.g., gender, race, age, educational level, licensure level, income, and primary social work function). Participants were selected through a proportional random sampling of a membership list from a mid-Atlantic state social work licensure board. The survey was mailed to 558 licensed social workers. The first 300 returned and completed surveys were used, though 6 were later eliminated because of insufficient information, resulting in an N of 294 (52.6% response rate).

The primary component of the survey was Abbott's 40-item Professional Opinion Scale (POS) (1988), which included four subscales: Respect for Basic Rights (BRSS), Sense of Social Responsibility (SRSS), Commitment to Individual Freedom (IFSS), and Support of Self-Determination (SDSS) (Abbott, 1988). Higher POS scores correspond with greater liberalness (1 = more conservative to 5 = more liberal) (Abbott, 1988). Greater liberalness includes favoring the separation of church and state, government's intervention and protection of citizens' rights, and institutionally-based change (Brint, 1994; Dolgoff & Feldstein, 2003; Lowi & Ginsberg, 1994; McKenna, 1998). The POS was based, however, on 1985 NASW policy statements and did not reflect some current policy positions. As a corrective measure, the first author added three questions that concerned faith-based initiatives, gay and lesbian rights, and services to illegal immigrants (Clark, 2002; Social Work Speaks, 2000) to the POS. These three questions, combined with the 40-item POS, comprised a "POS+3" scale. In addition, a seven-point Likert scale item was included that asked participants to self-rank their political ideology on a scale from radical left ("1") to radical right ("7"). Therefore, political ideology was measured using the POS, the subscales, the POS+3 and self-ranking.

"Practice effect," the dependent variable, was measured quantitatively by four questions created by the authors: "Can you separate your political views from your professional practice?" (1=All of the time to 4 = Not at all); "How difficult is it to separate your political views from your professional practice?" (1 = Very difficult to 4 = Not difficult at all; "Do you use your political views in your practice to persuade the clients, organizations, and/or communities with whom you work?" (1 = All of the time to 4 = Not at all) and "How important to you is it that the clients, organizations and /or communities with whom you work share the same political views as you?" (1 = Very important to = Not important at all). Participants also were asked to provide comments on these items. Finally, two open-ended items asked respondents to comment on whether they "ever decided to not work with a client, organization or community because of differences in political views" and how they "handle differences in political views between yourself and the clients, organizations and/or communities with whom you are working." Reliability was assessed using Cronbach's alphas for the POS, the POS+3 and the four subscales. The POS's reliability (α = 0.85), was consistent with Abbott's reliability findings (1988; 1999; 2003). Reliability increased slightly for the POS+3 (α = 0.86). The Self-Determination Subscale (SDSS) had moderate reliability (α = 0.65), while the Basic Rights Subscale (BRSS), Individual Freedom Subscale

(IFSS) and Social Responsibility Subscale (SRSS) had good reliabilities of 0.71 to 0.78. These internal reliabilities were consistent with Abbott's subscale internal reliabilities (1988; 1999). Descriptive and bivariate statistical analyses were used to understand the range of and reasons for variance in political ideologies and practice effects. Data from open ended questions were coded and analyzed according to the process of analytic induction (Huberman & Miles, 1994). Using this approach, themes were identified and compared with other findings, so that broader analytical refinement could occur. Theme identification occurred when at least twenty percent of participants' responses contributed to the theme. Themes were clustered around similar subjects, which became the basis for thematic memos. These memos, in turn, were linked to the quantitative findings for interpretation.

RESULTS

The study's sample (N = 294) was predominantly female (85.6%), white (80.1%), middle aged (*M* = 45), heterosexual (93.7%), and Democratic (78.1%), with an average income in the $40,000 and $49,999 range. The single largest religious affiliation was Protestant (36.1%); overall, there was a moderate religious or spiritual identity (M=1.92 with 1 = Very religious/spiritual to 4 = Not religious/spiritual at all). Most participants held master degrees in social work (83.6%), worked full-time (72.9%), and were in clinical/direct practice (52.6%). All participants held licenses, with 59.8% holding the highest clinical license (LCSW-C). On average, participants had 13.37 years of licensed social work experience. Participants primarily worked in either public (36.6%) or non-profit settings (35.5%).

Overall, respondents' political ideologies were more liberal than conservative, with mean scores of 158.38 (out of 200) for the POS and 167.95 (out of 215) for the POS+3. Respondents were most liberal on the Self-determination subscale and least liberal on the Individual Freedom subscale. Results from the self-ranked political ideologies indicated a slight liberal leaning among respondents in that 40.6% chose "liberal" and 34.4% chose "moderate" rankings (for more complete discussion, see Rosenwald, 2004).

How Does Political Ideology Influence Practice?

Table 1 presents descriptive statistics for the four items representing practice effect. Over 90% of the participants reported that they could separate their political ideologies from their practice all or some of the time. Most participants (82.6%) believed they had either no or little difficulty in separating their political ideologies from practice. A majority of participants (67.3%) reported that they were not likely to use their political views to persuade their clients, organizations or communities. Finally, 60.2% of the participants reported it was not important that the clients, organization and/or communities with whom they worked shared their political views. Overall, these findings suggest that political views were not incorporated in practice.

Table 1. Frequencies for Practice Effect Items

Practice Effect Item	N	Percentage
Separating Political Views from Practice [a]		
All of the time	123	43.9%
Some of the time	138	49.3%
A little of the time	7	2.5%
Not at all	12	4.3%
M = 1.67, SD = .73		
Difficult to Separate Political Views		
Very difficult	8	2.8%
Somewhat difficult	41	14.5%
A little difficult	102	36.0%
Not difficult at all	132	46.6%
M = 3.27, SD = .81		
Use Political Views to Persuade		
All of the time	2	0.7%
Some of the time	35	12.7%
A little of the time	53	19.3%
Not at all	185	67.3%
M = 3.53, SD = .74		
Importance of Sharing Political Views		
Very important	8	2.9%
Somewhat important	40	14.3%
A little important	63	22.6%
Not important at all	168	60.2%
M = 3.40, SD = .84		

[a] Nineteen participants reported "most of the time" on their surveys. These responses were alternately scored as "All of the time" and "Some of the time."

Respondent comments support these findings, as most indicated that their political ideologies played no role in, and did not apply to, their practices: "Politics or political positions are not up for dialogue in therapy. It's their session not my forum" [166] and "It's not my place to impose my political views on my clients; it would be inappropriate and in my opinion indicate poor boundaries to do so" [112]. Some respondents cited particular instances of keeping ideology out of practice:

> I can [separate my political views from practice]. For instance, I personally do not believe in abortion, but I have no problem with someone who does. [82]
> As a gay man, I have worked effectively with clients who despise gays. We are called to heal not convert to one personal political perspective. [267]
> I mostly worked 1-1 with clients and would just listen as they expressed racist points of views, told about their girlfriends getting abortions or whatever. All grist for the therapy mill.... [165]

Nonetheless, acknowledging and exploring the role of political ideology in practice was important for a number of respondents. One reason appeared to be if the social worker sensed a conflict between the client and him or herself:

> I acknowledge the "Elephant" in the room (the difference) and tell them I respect their views and ask that we look together to see if the problem at hand is being positively impacted and what we can do to enhance that. [228]
> If it is an issue that appears to be getting in the way of our work together – and the client has some level of insight, I will bring the issue up in order to bring it into the open and thus decide together how to deal with it." [90]

Respondents indicated that when they believed they had incorporated their political ideologies into practice, they did so with specific criteria in mind. The most frequently mentioned rationale was "harm:"

> I would identify those clients' beliefs that I perceived as harmful to women and children and ask the client how he came to that point of view. Then I would listen to gain an understanding of his point of view. [205]
> I do not to need to change their views unless their actions/ decisions will hurt another's life/dignity. [243]
> I do occasionally express my views briefly if an issue arises in therapy which I see as a potentially harmful to others (e.g., racial discrimination) but I do not get into a power struggle. [155]

Certain respondent characteristics increased the likelihood that political ideology would affect practice. While there were no significant differences for ideological effects by demographic characteristics, there were some significant correlations between political ideology and measures of practice effect, as presented in Table 2. Increased liberalness on aggregate political values (POS, POS+3, overall self-ranked political ideology), on the Individual Freedom subscale (IFSS), and the Social Responsibility subscale (SRSS), were significantly correlated to a greater likelihood of having ideology influence practice. This respondent illustrates the reported connection between liberal beliefs and ideology influencing practice: "Institutions are biased against women and minorities – [I] try to empower these clients to navigate systems" [11].

Table 2. Correlations of Practice Effect and Political Ideology

Practice Effect Item	Self-Ranked Political Ideology	Basic Rights Subscale	Individual Freedom Subscale	Self-Determination Subscale	Social Responsibility Subscale	Professional Opinion Scale	Professional Opinion +3 Scale
Can separate views	-.090	-.001	.131a	.064	.168b	.134a	.140a
N	(274)	(263)	(245)	(255)	(252)	(218)	(216)
Difficulty separating views	.231c	-.112	-.165b	-.122	-.154a	-.149a	-.165a
N	(277)	(266)	(247)	(258)	(254)	(219)	(217)
Use views to persuade	.193b	-.104	-.190b	-.047	-.158a	.204b	-.217b
N	(269)	(259)	(240)	(249)	(246)	(211)	(209)
Important to share values	.236[a]	-.101	-.101	-.112	-.208b	-.201b	-.198b
N	(275)	(264)	(247)	(255)	(250)	(217)	(215)

[a] $p < .05$ (2-tailed)
[b] $p < .01$ (2-tailed)
[c] $p < .001$ (2-tailed)

Managing Political Ideology

A number of strategies were employed by those respondents who desired to keep political views and practice distinct. Some used internal control strategies that regulated the practitioners' thoughts and behaviors to minimize countertransference:

> I believe and I have been told that I am exceptionally empathetic, and I have worked hard to become self-aware so that I respect and work with my clients' differences. [156]
>
> [I h]ave to monitor myself to keep neutral and allow client to reach own place. [89]
>
> I've had a few occasions when it was very difficult (i.e., a client with a tattoo saying "White Power"; a client who was an anti-choice protestor). I had to keep an objective view and look at underlying issues for each client. [92]

Others relied on external control strategies, such as workplace policies, the constraints or requirements of their positions, and supervision:

> When you sign on to work for an organization with a particular religious/political stance, you are obligated to respect that stance, or you leave. I signed on, and touted the "company line." [35]
>
> In the public sector, your views must be neutral. [190]
>
> If the differences are not relevant to the clients' work, I "handle" them in supervision. [250]

Many participants attempted to avoid or minimize ideological dissonance, or have their own ideology affirmed, by belonging to organizations that shared their political views:

> As far as organizations/communities are concerned, I join those organizations/ communities which I feel will further my particular wishes/beliefs/prejudices. [179]
> Joining other organizations like 700 Club, NACSW [National Association of Christian Social Workers] that support my views; [and] donat[ing] money and time. [6]

This "same view" practice effect was highly correlated with self-ranked political ideology, such that respondents with more liberal views were more likely to desire this similarity ($rs = .236$, $p < .001$) (see Table 2). This respondent indicated that his employer's labor practices violated her own beliefs: "I was told to keep my opinions to myself. I did and I left. I was not aware of [hospital's] below living wage for their ancillary employees until I had been working there for a while" [170].

When ideological differences arose, respondents indicated that "agreeing to disagree" was an important strategy. One wrote, "...I feel compelled to express my discomfort with expressed ideas. 'I will agree to disagree with you...', but I make it very clear that, that is separate from the person with whom I am working" [172]. Another respondent said, "I always work toward the win-win situation: what are our respective missions or values, and what scenario will best serve our common interests" [162]. A third stated, "Let them know that not everyone share their views, etc. and the importance of respecting differences" [111].

A final strategy for negotiating political ideology and practice concerned ending the relationship with the client and making a referral if necessary:

> I am honest and open about my own political views so that they (clients) can choose whether (or how) to continue our relationship. If my views cause a direct conflict with my responsibilities that cannot be resolved through respectful dialogue, I go elsewhere (or refer the client to a better "match"). [156]
> To best support a client I try to take them wherever they are – barring someone with such an extreme (ex: racist with no exceptions) beliefs whom I'd pass to someone else. [137]
> [M]y political views are informed by my Christian identity – by the Bible so the issue is more how do I handle differences between what I believe in the Bible and the beliefs/political views of my clients, agency, etc....If there is a time when my beliefs will negatively impact my practice (i.e. with a homosexual client), I will refer them to someone with that expertise. [260]

A few respondents also provided examples when the termination of the clinical relationship, because of ideological differences, was initiated by the client. One respondent reported, "I have had clients litmus test me. I am a pastoral counselor and sometimes clients call and request a Christian counselor. Usually if I meet with them they feel comfortable that I will support their views. Other times, they can tell/sense I am not conservative 'enough.'" [242] Another stated, "I recently lost a client (her choice) because of GLBT [gay, lesbian, bisexual and transgendered]-friendly material in our waiting room!" [22]

STUDY LIMITATIONS

This study has several limitations that circumscribe generalizability. Because the sampling frame was licensed social workers in one particular state, the results of the study can not be generalized to non-licensed social workers in that state or to other social workers from other geographic areas. Additionally, there may be an overrepresentation of social workers who are interested in the topic of political ideology, and an overrepresentation of clinically-oriented (rather than macro) social workers. The four practice effect items were originally intended as a scale but weak reliability precluded aggregating the four items into a "practice effect" scale. Finally, more specific exploration into how political ideology's manifestation in practice, for example through the use of practice vignettes, is warranted.

IMPLICATIONS FOR PRACTICE

This exploratory study provides insights into the relationship between political ideology and social work practice. Most respondents indicated that they rarely, if ever, brought their ideologies into practice. Those respondents, however, with more liberal views were less likely to keep ideology and practice distinct. Respondents employed a number of strategies for addressing the effect of political ideology on in their practices, including belonging to "same view" organizations, managing potential transgressions through supervision and self-monitoring, referring clients when political differences undermined the clinical relationship, and articulating criteria for when ideology could be used.

In terms of criteria, the prevention of "harm" was a crucial factor in expressing or acting on one's political ideology. In this case, "harm" was understood as an action or potential action that threatens some aspect of social justice. Social justice, in turn, often is informed by one's political ideology. Therefore an "unjust" or "harmful" act, as viewed through a particular ideological lens, needs to be challenged or addressed. One dilemma, however, is that "harm" for one person may not so for another. This can result in a conflict between worker and client around such issues as expressing racist, sexist, or homophobic language; abortion as an option for an unwanted pregnancy; or dependence on welfare benefits. Such conflict has the potential to erode the practitioner – client relationship.

The decision of when and how to prevent "harm," even when a conflict is likely to occur, is a version of the broader tension between client self-determination and the pursuit of social justice. Because most of this study's respondents claimed to keep their political ideologies out of their practices, it may be that client self-determination is viewed as paramount. Aside from legally-mandated referral for suicidal and homicidal ideation, consideration of and interventions based upon political ideology in any form is seen as manipulative and therefore antithetical to self-determination. Participants who stated they "objectively" listen and honor their clients' perspectives also noted that this was easy because the stated goal is to focus on the client, regardless of any differences (i.e., prejudiced client, differences in abortion). Yet for those respondents who incorporate their political ideologies into their practices, the ethical standard of

social justice was a more important touchstone. For these workers, political ideology (theirs) is a curative to a potentially harmful situation. When such situations arise, it is acceptable to gently challenge a client's "harmful" actions, make a referral when the "harm" can not be resolved, and not join or even quit a "harmful" organization.

This tension about the use of political ideology in practice also reflects the debate of objectivity versus subjectivity in social work practice (Abramovitz, 1993; Linzer, 1999; Loewenberg, Dolgoff & Harrington, 2000; Rhodes, 1992). Interestingly, all of these authors argue that social workers cannot achieve full objectivity in their practice. In contrast, the majority of the participants believed that maintaining objectivity regarding one's political ideology is crucial. This may suggest that social workers need to become more self-aware of the influence of political ideology on practice. For those respondents that indicated that political ideology affected their practices, monitoring of countertransference and articulating guidelines for using political ideology in purposeful ways is critical.

Discussing these issues in individual and peer supervision would assist social workers in this task. Social workers might have continuing education training on political ideologies and their relation to practice. Professional organizations also need to provide venues for recognizing the range of political ideologies held by social workers, as well as the implications that political ideology has for practice. If, however, social workers believe that they need to develop, belong to, or practice in organizations that reflect a particular ideology, then the profession as a whole will become balkanized. The health of the profession may depend on the ability of social workers with various political viewpoints engaging in constructive examination and debate regarding the role of political ideology in practice and the profession.

Author's Note:

Address correspondence to: Mitchell Rosenwald PhD, assistant professor, School of Education and Human Development, Binghamton University, PO Box 6000, Binghamton, NY 13902-6000; mrosenwa@binghamton.edu.

References

Abbott, A. A. (1988). *Professional choices: Values at work.* Silver Spring, MD: National Association of Social Workers.

Abbott, A.A. (1999). Measuring social work values: A cross-cultural challenge for global practice. International Social Work, 42(4), 455-470.

Abbott, A. A. (2003). A confirmatory factor analysis of the Professional Opinion Scale: A values assessment instrument. *Research on Social Work Practice, 13*(5), 641-666.

Abramovitz, M. (1993). Should all social work students be educated for social change? Pro. *Journal of Social Work Education, 29*, 6-11.

Brint, S. (1994). *In an age of experts: The changing role of professionals in politics and public life.* Princeton, NJ: Princeton University Press.

Clark, E.J. (2002). Faith-based initiative discussed. *NASW News, 47* (November), 1, 10.

Csikai, E. L. (1999). The role of values and experience in determining social workers' attitudes toward euthanasia and assisted suicide. *Social Work in Health Care, 30*, 75-95.

Diamond, S. (1989). Spiritual warfare. Boston: South End Press.

Dolgoff, R., & Feldstein, D. (2003). Understanding social welfare (6th ed.). Boston: Allyn and Bacon.

Gartner, J., Harmatz, M., Hohmann, A., & Larson, D. (1990). The effect of patient and clinician ideology on clinical judgment: A study of ideological counter transference. Psychotherapy, 27, 98-106.

Hodge, D. R. (2002). Does social work oppress Evangelical Christians? A "New Class" analysis of society and social work. *Social Work, 47*, 401-414.

Huberman, A. M. & Miles, M. B. (1994). Data management and analysis methods. In N. Denzin & Y. Lincoln (Eds.) *Handbook of qualitative research* (pp. 428-444). Thousand Oaks, CA: Sage.

Kelly, T.A. (1990). The role of values in psychotherapy: A critical view of process and outcome effects. *Clinical Psychology Review, 10*, 171-186.

Knight, K. (1999). Liberalism and conservatism. In J. P. Robinson, P. R. Shaver & L. S. Wrightsman (Eds.) *Measures of political attitudes* (Vol. 2, pp. 59-158). San Diego: Academic Press.

Lev-Wiesel, R., & Friedland D. (1999). Role perception among social workers living in politically uncertain areas. *International Social Work, 42*, p. 67-68.

Linzer, N. (1999). *Resolving ethical dilemmas in social work practice.* Boston: Allyn and Bacon.

Loewenberg, F. M., Dolgoff, R., & Harrington, D. (2000). *Ethical decisions for social work practice* (6th ed.). Itasca, IL: F. E. Peacock.

Lowi, T. J., & Ginsberg, B. (1994). *American government: Freedom and power* (3rd ed.). New York: W.W. Norton and Company.

McKenna, G. (1998). *The drama of democracy: American government and politics* (3rd edition). Boston: McGraw Hill.

National Association of Social Workers. (1999). *Code of ethics of the National Association of Social Workers.* Retrieved from www.socialworkers.org/pubs/code/code.asp on May 12, 2003.

O'Connors, K. & Sabato, L.J. (2000). *American government: Continuity and change.* New York: Longman.

O'Neill, J. V. (2003/February). GOP victories shift agenda on Hill. *NASW News. 48,* pp. 1, 8.

Reeser, L.C. & Epstein, I. (1990). *Professionalization and activism in social work: The sixties, eighties, and the future.* New York: Columbia University Press.

Rhodes, M. L. (1992). Social work challenges: The boundaries of ethics. *Families in Society, 73*, 40-47.

Rosenwald, M. (2004). *Exploring political ideologies of licensed social workers.* Baltimore: University of Maryland, Unpublished dissertation.

Sargent, L.T. (1995). *Contemporary political ideologies: A comparative analysis.* Fort Worth: Harcourt Brace College Publishers.

Social Work Speaks. (2000). *National Association of Social Workers policy statements 2000-2003* (5th edition). Washington, DC: National Association of Social Workers.

Theodorson, G. A. & Theodorson, A. G. (1969). A modern dictionary of sociology. New York: Thomas Y. Cromwell Company.

Wagner, D. (1990). *The quest for a radical profession.* Lanham, MD: University Press of America.

SOCIAL WORKERS AND INVOLUNTARY TREATMENT IN MENTAL HEALTH

Melissa Floyd Taylor

Abstract: *Involuntary treatment is often a reality in mental health social work. The current research examined 330 mental health social workers' involvement in and opinions about involuntary treatment as part of their primary job functions. Varieties of involuntary intervention and typical frequency were investigated. The most often cited areas of involuntary treatment experience proved to be mandated outpatient counseling and emergency hospitalization. In general, participants reported a high level of support for the existence of involuntary intervention, both in "idea" and "implementation." The study also explored the attitudes social workers have about these sometimes "ethically-complex" social work interventions and how these attitudes may have changed over the life of their practice careers due to practice experience and personal growth, job changes, and exposure to the reality of mental illness.*

Key words: *Involuntary Treatment; Mental Health Practice; Ethical Dilemmas*

INTRODUCTION

Reamer (1995) has called social work "among the most value-based of all professions" (p.3). In such a value-rich atmosphere as mental health social work, all job tasks and interventions are, to some degree, infused with values and therefore have the potential for value collisions and professional dissonance (Taylor, 2002). Interventions characterized as "involuntary," however, may prove to be especially problematic for social workers in mental health since psychiatry has been called "virtually the only medical specialty that includes coerced, involuntary treatment" (Shore, 1997, p. 325). For the current study, involuntary treatment refers to mandated services, both inpatient and outpatient, that are provided to consumers, often despite their wishes to the contrary.

Social work and allied authors (Bentley, 1993; Bentley & Taylor, 2002; Dewees, 2001; Kutchins & Kirk, 1997; Taylor & Bentley, in press) have pointed out the incongruity—and perhaps, incompatibility—between the increasing emphasis on involuntary treatment interventions and social work's historical stance and current Code of Ethics which allows for restriction of self-determination only when risk is "foreseeable and imminent" (NASW, 1997). Dewees (2001) urges social workers to recognize the "contestability" of the medical hegemony they have begun to accept as inevitable and points out the incompatibility of this medical dominance with social work's primary focus on strengths and empowerment. Other social work writers strongly disagree with this perceived incompatibility between social work values and involuntary or beneficent treatment interventions (Murdach, 1996;

Melissa Floyd Taylor PhD is an assistant professor at the Department of Social Work, University of North Carolina, Greensboro.

Rosenson, 1993) and cite the consumers' right to treatment as an important area for social work support, not just the right to refuse treatment (Mizrahi, 1992). Still others suggest that taking for and against positions in this debate distracts the mental health community from more important questions about the state of service delivery in the mental health arena (Saks, 2002).

Opinions aside, for many mental health practitioners, using coercive and involuntary treatments has become part and parcel of their job duties. These practitioners may regularly hospitalize consumers under involuntary orders or facilitate court orders for medication and outpatient treatment. At the least, many practitioners are increasingly faced with negotiating difficult practice decisions with consumers who present for treatment under court mandate. A reflection of this phenomena is the expansion of content on involuntary practice in the fifth edition of Hepworth, Rooney and Larsen's (1997) *Direct social work practice: Theory and skills,* a classic social work practice text. While literature exists in the social work and allied fields around the issues of involuntary treatment and the stakeholders in its implementation (Motlong, 1997; Dennis & Monahan, 1996; Solomon, 1996; Wilk, 1994,1988a, 1988b; Abramson, 1991, 1989; Scheid-Cook, 1991), there has been less attention paid to the deliberations and trepidations that involuntary treatment creates in practitioners. The current study sought to explore what social workers think about involuntary treatment, what they do in "real-life practice" situations and how both of these things have changed over the course of their practice lives. A goal of the study was to add to the knowledge base of social work practice with persons who have serious mental illness and the nature of involuntary services delivery.

METHODOLOGY

Sample

A systematic random sampling technique was used to recruit 750 participants who were listed in the *Register of Clinical Social Workers, 11th Edition* (NASW, 2001). The National Association of Social Workers (NASW), the professional organization that publishes the Register, is the largest professional social work organization with 155,000 members (Gibelman & Schervish, 1997). A total of 320 usable surveys were returned which related to a response rate of 44.4%.

Instrumentation

An instrument was created for the purposes of this study. Copies of the instrument can be obtained from the author. The instrument covered three areas, involuntary treatment, self-determination and professional dissonance (the feeling state that occurs when values and job tasks conflict). Only the results of the involuntary treatment portion of the instrument are described here. Two series of seven questions explored both participants' exposure to and comfort with, specific involuntary tasks. Four of these seven questions concerned seeking or facilitating an order for involuntary inpatient or outpatient commitment, or involuntary medication. The other three questions

concerned actually providing mandated inpatient or outpatient psychiatric and substance abuse services. Participants first indicated their level of comfort in providing the seven services, using a Likert-type scale ranging from "totally uncomfortable" to "totally comfortable." Two items directed participants to rate their level of agreement with involuntary treatment both in theory and in implementation and their comfort level over time with involuntary treatment. Participants were invited to write a few words about how their comfort level has changed over the years of their practice. A final question was completely open-ended inviting participants to share "anything else" about involuntary treatment

The instrument was pilot-tested with an interdisciplinary group of mental health professionals working in the psychiatric pavilion of a large medical center. The four professionals were asked to answer the items and identify any that were unclear or problematic. A panel of seasoned social work researchers also reviewed the instrument prior to data collection.

Data analysis

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

IMPORTANT FINDINGS

Demographics

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

Involuntary treatment experience

The majority of respondents had worked with involuntary clients at some point in their careers, with only 10.3% (n = 33) participants responding that they had never worked in this area. Over half of participants (52.8%, n =169) reported working with involuntary clients "a little," while, 36.6% (n = 117) had worked "a lot" with these types of clients. Participants were then asked to endorse the areas of involuntary treatment in which they had participated. Approximately a third of participants (31.3%, n = 100) had provided services to clients mandated to take medication, 52.2%(n = 167) had worked with clients who were involuntarily hospitalized. Thirty-five percent (n = 112) participants had provided involuntary substance abuse services, while the most participants (62.8%, n = 201), had provided mandated outpatient counseling.

Opinions on involuntary treatment

None of the participants totally disagreed with the idea of involuntary treatment, though 14.1% (n = 45) either disagreed or were unsure. Interestingly, the vast majority of participants, 82.9% (n = 265) either agreed or totally agreed with involuntary services for people with mental illness. There was little variation between the former question about involuntary treatment in theory and the next question about the reality of implementing involuntary treatment. Most participants 74.4% (n = 238) either agreed or totally agreed with the actual implementation of involuntary services, with 1.3% (n = 4) of participants, totally disagreeing, and 18.8% (n = 60) either feeling unsure or disagreeing.

Involuntary Treatment Tasks: Comfort

Tables 1 and 2 summarize participant responses about the frequency of their involvement and their comfort level with particular involuntary interventions. It should be noted here that participants who indicated they had never worked with involuntary clients did not, as a rule, fill out the comfort/frequency sections.

Table 1. Frequency of Involuntary Treatment Tasks

	Never		*Frequently*		*Very Frequently*
Variable	1	2	3	4	5
Involuntary med	58.8%	24.1%	5%	3.1%	1.3%
Emergency hosp	19.7%	50.3%	12.2%	6.9%	5%
Outpt commitment	45%	25.9%	10.9%	5.9%	2.5%
Testifying	60%	22.2%	6.9%	1.9%	1.9%
Inpatient services	43.8%	20.6%	8.4%	5.6%	13.4%
Substance services	48.1%	22.2%	9.4%	6.9%	3.4%
Outpatient services	26.9%	35.6%	16.9%	10%	5%
N = (all tasks)	967	643	223	129	104

There were, therefore, for each of these fourteen questions, between 17 to 70 participants who declined to answer. The N at the bottom of the tables refers to the total number of participants responding in that category, across interventions. Study respondents indicated the greatest amount of comfort with emergency inpatient hospitalizations 33.8% (n = 108) with the next most comfortable intervention being the actual provision of services to involuntarily hospitalized consumers (28.8%, n = 92). The two interventions most uncomfortable to participants were seeking or facilitating an involuntary medication order as well as testifying for commitment at a hearing (13.8%, n = 44), with the provision of involuntary substance abuse services coming in as next most uncomfortable (11.9%, n = 38). A total involuntary treatment comfort score was computed for each participant by totaling their seven responses, with a possible 35 points indicating total comfort with each of the seven interventions. These scores ranged from 2-35, with a mean score of 19.42 (SD = 8.80). Approximately 75% of respondents had a score of 20 or higher. It is important to again remember that some participants seemed to only endorse the interventions they had direct experience with and 6.6% (n = 21) participants did not provide any data at all. With this in mind, though, it is still possible to interpret these results as indicating that the majority of participants are more comfortable than not with involuntary interventions in general, especially those that relate to involuntary hospitalization and outpatient counseling.

Table 2. Comfort Level with Involuntary Treatment Tasks

	Totally Uncomfortable		*Comfortable*		*Totally Comfortable*
Variable	1	2	3	4	5
Involuntary med	13.8%	19.4%	18.1%	17.2%	13.1%
Emergency hosp	3.4%	8.1%	18.8%	24.7%	33.8%
Outpt commitment	7.5%	5.3%	19.4%	17.8%	20%
Testifying	13.8%	17.8%	20%	13.1%	15%
Inpatient services	5.9%	8.1%	17.5%	16.9%	28.8%
Substance services	11.9%	17.2%	20.6%	15.6%	11.9%
Outpatient services	4.7%	10.6%	23.1%	25.6%	23.4%
N = (all tasks)	195	309	440	419	467

Involuntary Treatment Tasks: Frequency

When examining the participants' responses regarding the frequency of specific involuntary interventions in their professional life, it becomes apparent that the majority of this sample of social workers does not encounter involuntary treatment with great frequency. This sheds a different light on the data regarding comfort as it would seem that many participants may have answered these questions with regard to how comfortable they *would* be in providing these services instead of from actual experience. Accordingly, the most highly endorsed involuntary intervention, provid-

ing inpatient psychiatric services, was very frequently experienced by 13.4% (n = 43) of participants. The next most frequently experienced interventions were facilitating involuntary emergency hospitalizations and providing mandated outpatient services, both endorsed at "very frequently" by 5% of participants (n = 16). By contrast, each involuntary intervention had *never* been experienced by a range of 19.7% (n = 63) participants for emergency hospitalization to 60% (n = 192) participants for testifying at a commitment proceeding. Hence, the involuntary frequency total score that was computed by summing these seven questions had a range of 2-31, with an average score of only 12.33 (SD = 5.53). Approximately 75% of respondents had a score of 15 or below.

Involuntary Treatment: Change Over Time

After rating their level of comfort with and the frequency of specific involuntary interventions in their clinical practice, participants were asked to rate any change in their comfort with involuntary treatment over the course of their career. Choices ranged from "much less comfortable" to "much more comfortable." Thirty-five percent of participants (n = 112) indicated there had been no change, while 17.2% (n = 55) participants were much more comfortable and 24.1% (n = 77) were more comfortable. Only 2.8% (n = 9) participants were much less comfortable and 7.5% (n = 24) described themselves as less comfortable. In sum, 41.3% of participants were more or much more comfortable, 35% had not experienced a change, and only 10.3% were much less or less comfortable with involuntary treatment since beginning their careers.

Participants were next asked to write a few words about how they felt their attitudes about involuntary treatment had changed, over time, if they had. A total of 183 (57.2%) participants wrote in answers for this question. Keeping in mind that the majority of participants were *more* comfortable with involuntary treatment over time, as indicated by quantitative data results cited above, three major themes emerged from responses to the open-ended questions. The first, and most pervasive theme dealt with professional *experience or personal growth* over time. A secondary theme concerned *changes in job or clients* served. A final theme dealt with participants' attitudes changing because of their exposure to the *reality or impact of mental illness*. A sample of responses with their respective coding categories is displayed in Table 3.

It should be mentioned that while the majority of responses clearly fell into one of the three categories, five multi-faceted responses were coded into double categories. Additionally, 14% (n = 26) of responses could not be categorized, typically stating "little experience or no opportunity for involuntary intervention" (.05%, n = 9) or dealing with specialized situations in states, or agencies or comments regarding law changes. From the open-ended data coding it became apparent that the number one reason participants cited for their change in comfort with involuntary treatment was experience, both professional and personal. Ninety-seven responses fell into this category, accounting for 53%. The second category of job or client change contained 17.48% (n = 32), responses (while the third category,

change caused by increased understanding of the reality of mental illness, accounted for 16.39% (n =30) of responses.

Table 3.
Major Themes of Attitude Change Over Time with Qualitative Responses

1.**Professional Experience or Personal Growth**	Example Quotes:
	Increased experience and comfort with roleI'm more comfortable dealing with resistance
	More experience/seeing positive change
	More exposure and practice
	Comfort level has increased with practice and supervision-Obtaining a dose of reality
	Greater experience in the profession
	Skill and knowledge base have improved
	Experience builds confidence
2.Changes in Job or Clients Served	Example Quotes:
	I'm just in a place I can choose NOT to do it
	I no longer work with these type of clients
	I'm in a private setting with little back-up
	Administrator since 1990
3.Exposure to Reality or Impact of Mental Illness	Example Quotes:
	The patient benefits from it
	Seriousness of the issues
	Patients are sicker
	Clients have more potential for violence
	Seeing the number of homeless mentally ill Patients today breaks my heart
	Worked with clients so unreachable

Open-Ended Question

A second open-ended question was included at the end of the questionnaire section on involuntary treatment asking participants to record "anything else about involuntary treatment" that they might like to say. These data were analyzed in the same way as the previous open-ended question. The emerging themes were labeled and responses were then enumerated based on these coding categories. A total of 181 (56.6%) participants wrote in responses. The first, most obvious category included participant responses that spoke to the critical situations that precipitate involuntary treatment. This first category was named "Protection from Dangerousness" and contained the

largest percentage of responses at 35.91% (n = 65). Typical responses included words such as "danger to self and others," "gravely disabled", "ill," and "safety" and seemed to capture the concern that people who are in crisis situation need to be protected by treatment whether it is in accordance with their wishes or not. A second category that emerged as distinct from this one included statements about how "necessary," "essential" and "warranted" involuntary treatment is. This second category was named "Necessary Treatment" and contained about 25% of responses (n = 47). These responses largely expressed agreement with involuntary treatment for people who need treatment and were typically less qualified by the "dangerousness" standard. The following is an example of this type of response:

> I think if those who disagree with involuntary medication/hospitalization actually work/live in clients' lives or families for a few hours [they] would agree meds do change improve their [patients/clients] lives. I can't understand an attorney or any idiot looking in clients'/patients' tormented eyes and fight against hospitalization/meds. At that moment the torment is too great for the patient/client to make a rational decision.

A third category included complaints regarding the system supports around involuntary treatment as well as suggestions for improving the system. This third category was labeled "Service System Problems" and contained 22.10% (n = 40) of responses. These responses varied in specific recommendations but several included concerns with the short-term, crisis-stabilization nature of treatment today: "inpatient care so brief and cursory," and, "conditions haven't been conducive to healing."

Finally, a subset of responses were clearly opposed to involuntary treatment, either inpatient or outpatient and were concerned with the issues of justice involved. This final category was named "Opposed to Forced Treatment" and contained 20.44% (n = 37) of responses. Responses here indicated the feelings of conflict that some participants believed involuntary treatment presented to other values they held, such as self-determination.

DISCUSSION AND RECOMMENDATIONS FOR FUTURE INQUIRY

One of the main contributions of the current study is the subject matter. As Dennis and Monahan (1996) point out, involuntary treatment has been with us in one form or another for centuries and it shows no signs of going anywhere. It is therefore, essential that social workers have a body of empirical knowledge to inform practitioner and agency response. Also, in this way, the debate in the literature about involuntary treatment takes on a more practical form, moving out of theoretical taking of positions and into an inventory of actual intervention issues. Hopefully this will lead to the refinement of involuntary treatment interventions and the addition of creative alternatives that may be less problematic ethically such as advanced treatment directives (Rosenson & Kasten, 1991).

One interesting result of the current research was the finding of participants' overwhelming support of involuntary treatment. Respondents generally reported that they had become *more* comfortable with involuntary treatment over the years and largely attributed the change to their increased practice experience and maturity. Also associated with increased comfort was their exposure to the reality and

severity of untreated mental illness and the strengthening of attitudes about the injustice of allowing someone to "languish in their illness." Study participants also underlined the necessity of involuntary treatment, particularly in life and death situations, cited some system problems associated with its implementation as well as wisdom about dealing with its repercussions in practice. Many of the social workers who indicated high levels of comfort and agreement with involuntary treatment interventions had little actual experience with these interventions, begging the question (for future inquiry) of what would happen to their attitudes were they to consistently deal with these issues.

The findings about involuntary treatment are important because they speak to the changing face of social work intervention in an era when outpatient commitment laws, including mandated medication and case management services are being urged as a solution to untreated consumers (Torrey & Zdanowicz, 1999). New social workers entering mental health systems for people with mental illness need to be equipped to deal with the special challenges inherent in involuntary interventions. Frustrating system problems cited by some participants when dealing with involuntary consumers point to a need for mental health policy and practice setting changes.

Future inquiries into involuntary treatment attitudes should delineate the different types of involuntary treatment interventions prevalent in mental health treatment today. Lack of specification of involuntary interventions was evident in the fact that most of the participants in the current study indicated that they were thinking of emergency life and death situations and/or mandated outpatient counseling when responding to questions about agreement and comfort with involuntary treatment. In other words, attitudes about "treatment-need" interventions (for example, medication for a non-dangerous but ill consumer) were not extensively captured. This could account for the surprisingly high level of approval for involuntary treatment. Specifically, outpatient commitments such as those described in New York's Kendra's Law (Moran, 2000), involuntary medication and electro-convulsive treatments are all areas of involuntary intervention that should be separated in future attempts to capture attitudes about specific involuntary treatments in mental health practice.

A limitation of the current study is the sampling frame. The Clinical Register, while enabling the researcher to capture seasoned social workers, does not necessarily include those social workers "in the trenches" in mental health service delivery with reluctant consumers due to the high proportion of listees who are in private practice. A future study should focus on capturing this group in order to move the discussion of involuntary treatment in the social work practice literature more firmly into "real-life issues" versus ideological debate.

Author's Note:

Address correspondence to: Melissa Floyd Taylor PhD, Assistant Professor, Department of Social Work, University of North Carolina, Greensboro, P.O. Box 26170, Greensboro, North Carolina 27402-6170.e-mail: mftaylo2@uncg.edu.

References

Abramson, M. (1989). Autonomy vs. paternalistic beneficence: Practice strategies. Social Casework, 70(2), 101-105.

Abramson, M. (1991). Ethical assessment of the use of influence in adult protective services. *Journal of Gerontological Social Work, 16*(1/2), 125-135.

Bentley, K. J. (1993). The right of psychiatric patients to refuse medications: Where should social worker's stand? *Social Work, 38,* 101-106.

Bentley, K. J. & Taylor, M. F. (2002). Assisted outpatient treatment/commitment: A step forward or backward for mental health systems and clients? In H. J. Karger & J. Midgeley (Eds.), *Controversial issues in social policy, (2nd Ed.).* Boston: Allyn and Bacon.

Colorado State University. (2002). *Writing@CSU: Writing guides.* [Webpage]. Available: http://writing.colostate.edu/references/research/content

Dennis, D. L. & Monahan, J., (Eds.). (1996). *Coercion and aggressive community treatment: A new frontier in mental health law.* New York: Plenum Press.

Dewees, M. (2002). Contested landscape: The role of critical dialogue for social workers in mental health practice. *The Journal of Progressive Human Services 13*(1), 73-91.

Gibelman, M., & Schervish, P. H. (1997). *Who we are: A second look.* Washington, DC: NASW Press.

Hepworth, D. H., Rooney, R.H., & Larsen, J. (1997). *Direct social work practice, 5th Ed.* California: Brooks/Cole.

Kutchins, H., & Kirk, S. A. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders.* New York: The Free Press.

Mizrahi, T. (1992). The right to treatment and the treatment of mentally ill people. *Health and Social Work, 17*(1), 7-12.

Moran, M. (2000). Coercion or caring? *American Medical News, 43,* 26-31.

Motlong, W. K. (1997). Clinician view of the use of influence in social work practice. (Doctoral dissertation, Loyola University, 1997). *Dissertation Abstracts International, 58,* (09A), 3724.

Murdach, A. D. (1996). Beneficence re-examined: Protective intervention in mental health. *Social Work, 41,* 26-31.

National Association of Social Workers. (1997). *Code of ethics.* Washington, DC: Author.

National Association of Social Workers (2001). *Register of Clinical Social Workers, 11th Ed.* Washington, DC: Author.

Reamer, F. G. (1995). *Social work values and ethics.* NY: Columbia University

Press.

Rosenson, M. K. (1993). Social work and the right of psychiatric patients to refuse medication: A family advocate's response. [Point and Viewpoint]. *Social Work, 38,* 107-112.

Rosenson, M. K., & Kasten, A. M. (1991). Another view of autonomy: Arranging for consent in advance. *Schizophrenia Bulletin, 17*(1), 1-7.

Saks, E. (2002). *Forced treatment and the rights of the mentally ill.* Chicago: University of Chicago Press.

Scheid-Cook, T. L. (1991). Outpatient commitment as both social control and least restrictive alternative. *The Sociological Quarterly, 32*(1), 43-60.

Shore, M. F. (1997). Psychological factors in poverty. In L.M. Mead (Ed.), *The new paternalism: Supervisory approaches to poverty* (pp. 305-329). Washington, DC: Brookings Institution.

Solomon, P. (1996). Research on coercion of persons with severe mental illness: In D. L. Dennis & J. Monahan (Eds.) *Coercion and aggressive community treatment* (pp. 129-145). New York: Plenum Press.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory, 2nd Ed.* Thousand Oaks, CA: Sage Publications.

Taylor, M. F. (2002). *Professional dissonance among social workers: The Collision between values and job tasks in mental health practice.* (Doctoral Dissertation, Virginia Commonwealth University, 2002). *Dissertation Abstracts International, 63*,(05A), 2000.

Taylor, M. F. & Bentley, K. J. (in press). *Changing conceptualizations of mental health and mental illness: Implications of "brain disease" and "behavioral health" for social work.* Social Work in Mental Health.

Torrey, E. F. & Zdanowicz, M. T. (1999). Hope for cities dealing with the mental illness crisis. *Nation's Cities Weekly, 22*(16), 2-3.

Wilk, R. J. (1988a). Implications of involuntary outpatient commitment for community mental health agencies. *American Journal of Orthopsychiatry, 58*(4), 580-591.

Wilk, R. J. (1988b). Involuntary outpatient commitment of the mentally ill. *Social Work, 33*(2), 133-137.

Wilk, R. J. (1994). Are the rights of people with mental illness still important? *Social Work, 39*, 167-175.

INVESTIGATION OF THE FACTOR STRUCTURE OF THE MENTAL, PHYSICAL AND SPIRITUAL WELL-BEING SCALE

Diane L. Green

Abstract: *The importance of mental, physical and spirituality in coping with violence is becoming increasingly recognized. As such, scales measuring these constructs are instrumental in assessment of clients from a holistic and strengths perspective, the foundation of social work. This article examines the factor structure of the Mental, Physical and Spiritual Well-being scale. The MPS is a 30 item, easy to administer, self report measure. The MPS was administered to 175 crime victims to assess whether or not the three factor structure fits the data from the sample. Exploratory statistical procedures were used to reduce data through principle component analysis identified three factors with eigenvalues greater than 1.0 and a cumulative variance of 57%. Recommendations are made for utilizing this brief self-report instrument in assessing victims of crime and training social workers and other practitioners.*

Key words: *Physical Well-Being; Mental Well-Being; Spiritual Well-Being; Crime Victims*

INTRODUCTION

The main focus of conventional coping theories has been on the management of stress (Folkman, 1997). Folkman (1997) has recently modified transaction coping theory to include the occurrence of both distress and positive adaptation. She postulates that stressful encounters eventually result in adaptation and that research needs to consider the variable of positive adaptation.

Positive adaptation and ensuring the quality of life for victims of crime in society today is a major challenge facing victim service providers and policy makers. For this reason, gaining a better understanding of well-being of victims of crime has become a growing concern for researchers. Well-being is a useful and appropriate outcome measure because well-being scales do not force the victim to look solely at the negative effects of the criminal act. Ory, Williams, Lebowitz, Robins, Salloway, Sluss-Radbaught, Wolfe & Zarit (1985)

defined well-being as the impact of changes in cognition and behavior, subsequent need for care, and the ability to cope. This definition recognizes that behavioral and cognitive changes do not have the same impact on all individuals. The term well-being takes into accounts concepts such as life satisfaction, absence of feelings of anger or guilt, physical health, emotional health, happiness, lack of anxiety, lack of depression, spiritual health and control over one's situation (George & Gwyther, 1986; Parkes

Diane L. Green PhD is an associate professor at the School of Social Work, Florida Atlantic University, FL.

& Pillisuk, 1991). Additionally, spiritual well-being has been demonstrated as a significant factor in coping with traumatic events (Baumeister, 1991; McIntosh, Silver & Wortman, 1993). Traumatic events may trigger changes or questioning of one's religious belief and faith. However, there has been little research about the role that spiritual faith plays in the recovery or adaptation of a traumatic event. Kennedy (1998) conducted a study examining the extent that women of sexual assault report a change in the role of faith. The results of the study indicate a significant increase ($p < .0001$) in the role that spirituality played in the aftermath of a sexual assault.

Much of the literature on well-being has been conducted with the chronically and terminally ill population. Well-being is often referred to in this body of literature as quality of life. There are many findings from the well-being literature with other populations that can translate into the victim population. DeHaes and Knippenberg (1985) stated that research on quality of life (well-being) can be meaningful in several ways: "it can provide insight into reactions and it can enhance the methods by which supportive care can be promoted and organized" (p. 809). Most authors include physical, psychosocial and spiritual well-being (Ferrell, 1992). Polinsky (1994) utilized physical, psychological and social functioning as related specifically to treatment concerns of cancer patient's problems and concerns. There are several domains in which well-being or quality of life researchers have developed for studying the impact of the illness on a population however, the study and application with victims of crime has not been conducted.

Well-being is a multidimensional framework with specific domains. The well-being in each domain is readily affected by change within another domain. Examining the well-being framework will enhance the understanding of potentially positive dynamics associate with the recovery process. As such, subjective well-being is often thought of with three indicators: spiritual, physical and mental.

Among the traumatic losses that may occur when one is the victims of a crime is a crisis in faith and questioning of spirituality. In the death of a child, parents can become angry and question why an innocent child was taken. A woman who is the victim of rape may question her faith in a higher power as a protector. Victims who have lost a loved one may find it difficult to return to church without reliving the funeral (Johnson, 1997). Another issue for victims may be that their rabbi, priest or other religious leader, in an effort to provide support, tells them about the importance of forgiveness. These types of statements can be very distressing and lead to the development of anger and rage. Janoff-Bulman (1992) stated that people often operate on the basis of the underlying assumptions about the way the world is and why things happen. She further explained that when these assumptions are challenged, as they often are following a crime, the victim is left with no sense of control, often resulting in anger and depression. There is a paucity of research surrounding the spiritual effects on victims of crime. Spiritual beliefs can aid victims in the acceptance of the crime and assist the victims with coping. A sense of spirituality can often help with guilt and blame that the victim imposes on himself or herself (National Organization for Victims Assistance, 1998). Having spiritual beliefs can readily facilitate adapting to possible outcomes of the criminal justice process. As individuals look for the meaning of life, a sense of spirituality can lead to a regrouping of resources, priorities can

change and a renewed personal commitment to living a productive and content life can occur.

Victimization is a stressful event resulting in significant levels of psychological distress (Atkeson, Calhoun, Resick, and Ellis, 1982; Burnam, Stein, Golding, Siegel, Forsythe, and Telles, 1998, Frieze, Hymer, and Greenberg, 1987, Kilpatrick, Best, Veronen, Amick, Villeponteaux, and Ruff, 1995). Exposure to such stress often carries a risk of depression, anxiety, posttraumatic stress. Unique challenges exist for victims of crime due to the uncertain nature of the criminal justice process. Studies have consistently shown that the effects of crime are pervasive and deleterious to the victims' emotional health (Green, Streeter & Pomeroy, 2005; Norris and Kaniasty, 1994). One area of the victim's mental health that is particularly salient in understanding their responses to the crime event is the amount of depression exhibited. As Kilpatrick (1997) pointed out, virtually all victims of violent crime exhibit some level of depression. Norris and Kaniasty (1994) found that symptoms of depression were exhibited initially following the crime as well as three, nine, and fifteen months post crime. The most prevalent classification of psychological injury in crime victims' cases in PTSD (Sabbagh, 1995). Additionally, many crime victims describe experiencing high levels of anxiety, depression, and anger. (Kilpatrick & Falsetti, 1994).

An additional consequence of victimization is physical injury. About 1.5 million women and more than 800,000 men are raped or physically assaulted by an intimate partner in the United States (Tjaden and Thoennes, 2000). The types of injuries range from bruises to deadly gunshot sounds (Campbell, Webster, Koziol-McLain, Block, Campbell, Curry, et al. 2003; Heise and Garcia-Moreno 2002; Plichta 2004; Tjaden and Thoennes 2000). Resnick (1997) found that physical injuries as a result of crime may lead to heart attacks, fractures, sexually transmitted diseases, chronic infection and systemic disorders. Violence can often result in an impairment of physical functioning and may result in an increased use of unhealthy behaviors (e.g. smoking, drinking, and lack of sleep). The medical costs of treatment of victims are 2.5 times greater than that of non-victims (Resnick, 1997).

As the forgoing research indicates, crime victims have been shown to suffer from a variety of psychological, emotional, and physical problems. As such, this study examined the factor structure of the Mental, Physical and Spiritual Well-being scale.

METHOD

Sampling

The subjects for this study were victims of crime. "Crime victims" included individuals encountering the crime event or an individual within the immediate family for crimes resulting in death. Violent crime victims were those adult individuals (18 years or older) who had encountered the following crime(s), as categorized from offense codes recorded by a County Sheriff's office in the incident report: homicide, assault, aggravated assault, sexual assault, aggravated sexual assault, elder abuse, manslaughter, intoxication manslaughter, aggravated robbery, family violence and intoxication assault. Non-violent crime victims were those adult individuals who experienced the following crimes: theft,

robbery, burglary, and domestic disturbance. Participants were part of a victim assistance program and after approval from the IRB were solicited through a Texas county sheriff's office and juvenile court staff. They responded first to questions concerning demographic information. The MPS Scale followed during a personal interview which was part of a research study on the stress and coping process for victim of crime. The set of questionnaires usually took no longer than 20 minutes to complete. Consent was obtained from the participants before they responded to the questionnaire and data collection occurred within four to six weeks of the initial crime event.

Instrument

The Mental, Physical and Spiritual Well-being Scale is a 30-item scale that measures overall well-being through the incorporation of mental, physical and spiritual subscales. Each of the subscale scores range from 5 to 50, with higher scores indicating greater well-being. Vella-Brodrick and Allen (1995) found the scale to have good psychometric properties. They found over a one month interval the Mental subscale has a test-retest reliability of .94, the Physical subscale has a test-retest reliability of .81 and the Spiritual subscale has a test- retest reliability of .97. Coefficient alphas are .75, .81, and .85 respectively. The discriminative validity of the Mental, Physical and Spiritual Well-being scale was explored using one hundred and seventy-eight participants from different activity groups (e.g. tennis, bushwalking) with 77.3% of the cases being correctly classified into their actual activity group.

Data Analysis

To extract the initial factors, a principal component analysis was used. Typically dimensions of interest to social science are often not dimensions expected to be uncorrelated, therefore an initial orthogonal rotation was done. The initial Promax solution demonstrated that the variables were indeed uncorrelated. While Promax, oblique rotation, is computationally faster than orthogonal and makes linkages of the variables with the factors clear, it makes the distinction between factors more difficult (Hair, Anderson, Tatham, and Black, 1995). As the goal was to identify the meaning of the different factors, Varimax rotation was used following the oblique rotation. To eliminate error variance that would be included along with common variance at this stage, Kaiser's criterion was applied prior to factor rotation. Therefore, only those factors with eigenvalues of 1.0 or greater were retained. To minimize the number of loadings on a factor, orthogonal rotation using a Varimax procedure was utilized. This procedure simplified the structure thus making it more interpretable and it maintains independence between rotated factors (Stevens, 1996; Hair, et.al., 1995).

RESULTS

Demographics

For this study, 175 victims of crime from a Texas county were sampled. Participants included 60 men and 115 women. Participants had an average age of 35.4 (SD = 10.3)

years and eighty-six were victims of violent crime while 89 were victims of nonviolent crime. They were primarily Caucasian (48%) followed by African Americans (36%) and Hispanics (16%). This study found that only thirty percent of the participants were victims of a prior crime. The majority of victims were married (49%), while thirty-three percent were never married.

Factor Analysis

Using principal-component analysis with varimax rotation, the 30 items were reduced to a three factor solution. Means, standard deviations, and alpha coefficients for scale scores are provided in Table 2. Scale score means are similar to previous estimates. Hudson (1982) recommends a reliability coefficient of .60 from nomothetic research. In this study, scale scores have acceptable internal reliability (.78, .82, .83). Some item scores showed slight degrees of skewness and kurtosis however were not extreme. Even though confirmatory factor analysis is based on assumptions of multivariate normality, it has been shown that the maximum likelihood and generalized least squares estimation procedures are fairly robust with moderate violations (Anderson & Gebring, 1988). Consequently, it was unnecessary to compute data transformation.

Table 1. Demographic Information

Variable		Frequency	Percentage
Gender			
	Male	60	34.3
	Female	115	65.7
Ethnicity			
	Caucasian	84	48.0
	African-American	63	36.0
	Hispanic	28	16.0
Marital Status			
	Married	85	48.6
	Divorced	22	12.6
	Widowed	6	3.4
	Separated	4	2.3
	Never Married	58	33.1
Victims of Crime			
	Yes	52	29.7
	No	123	70.3

Type of Crime			
	Violent	86	49.1
	Non-violent	89	50.9

Table 2. Mental, Physical and Spiritual Well-being Scale: Means, Standard Deviations and Alpha Coefficients

	Mental Subscale	Physical Subscale	Spiritual Subscale
M	30.67	26.02	29.63
SD	2.80	4.02	2.33
α	.83	.82	.78

The results of the present study provide information about the stability of the factor structure of the MPS Well-being Scale (Vella-Brodrick and Allen, 1995). The correlation matrix was factorable due to the Kaiser-Meyer-Olkin measure of sampling adequacy at .85 and the Bartlett test of sphericity at 4158.52 ($p < .000$). A principal component analysis was run as the extraction method. There were three valid factors explaining 57% of the variance (Table 3).

Table 3. Factor Structure, eigenvalues, and % Variance Mental, Physical and Spiritual Well-being Scale

Factor	Eigenvalue	% of Variance	Cumulative %
I	5.63	25.46	25.46
II	3.30	21.00	46.46
III	2.40	11.04	57.50

Table 4. Factor loadings for 30 item MPS Well being Scale

Item # and abbreviated content	Factor 1 (physical)	Factor 2 (spiritual)	Factor 3 (mental)
Lethargic/tired recently	**.82**	.26	.11
Diet or gain or lose weight	**.78**	.28	.21
Stomach aches and/or indigestion	**.76**	-.24	.19
Constipation past year	**.73**	.18	.08
Suffered nausea/vomiting	**.71**	.17	.21
Suffer diarrhea at least monthly	**.50**	.22	.29
Aches/pains in last month	**.46**	.15	.05
Awaken rested	**.43**	.13	.26
Headaches in past year	**.39**	.27	.22
Feet/hands warm enough generally	**.31**	.05	.26
Use of prayer/meditation for inner peace	.26	**.68**	.13
Enhance spiritual development last year	.28	**.66**	-.04
Meditate, pray, yoga	.24	**.58**	-.07
Discuss matters of spirit	.18	**.56**	.13
Visit places of culture, art, creativity	.21	**.52**	-.10

Reach out for spiritual help	.08	**.52**	.07
Read/study about spirituality	.12	**.45**	.08
Self analysis for moral behavior	.15	**.42**	.20
Believe in life after death	.07	**.38**	.15
Discuss ethical/moral issues	.24	**.32**	.22
Think before acting	.14	-.02	**.67**
Improved home or office environment	.09	.21	**.65**
Read novels	.04	.09	**.62**
Engage in games for mental stimulation	-.01	.21	**.50**
Watch documentaries	-.12	.22	**.44**
Watch, read or listen to news	.03	.18	**.38**
Collect info prior to judging	.09	-.09	**.36**
Write for pleasure	.13	.28	**.34**
Share insights	.18	.24	**.33**
Watch tv/quiz programs	.07	.14	**.31**

In interpreting the items which loaded on each factor, the .30 is a generally accepted minimum factor loading because it indicates that approximately 10% of the variance for the corresponding variable has been explained by a factor (Tinsley and Tinsley, 1987). Using these criteria, three factors collectively explained the items on the MPS Well-being Scale.

Factor 1 was comprised of items related to physical well being. The items which loaded on factor 2 were descriptive of characteristics of spiritual well being. Factor 3 was made up of items which had to do with mental well being. Table 4 provides the factor loadings for the MPS Well being Scale.

CONCLUSIONS

Well-being is a useful and appropriate outcome measure for use with crime victims for several reasons. First, it cam be used when comparing victims of different types of crime, and second, well-being scales do not force the victim to look solely at the negative consequences of crime. The results of this study provide information about and support for the stability of the factor structure of the Mental, Physical and Spiritual Well-being Scale. These factors provide a framework for assessing well-being from a strengths perspective. From this perspective, social worker's can assess crime victims by measuring positive outcomes as well as distress experienced form the crime event. Additionally, this study provides information about the nature of well-being and the underlying common constructs. In sum, the results suggest a wide range of well-being that can be conceptualized as three constructs that consist of spiritual, physical and mental aspects.

Studies demonstrating the effects of coping strategies on well-being are exciting and challenging. Previous empirical research has focused mainly on the relationship between stressor and outcome, with little emphasis on positive outcomes (Eden, 1990). Feelings of shock, depression, isolation, being emotionally overwhelmed, distrust, anger, and anxiety are often the manifestation of the impact of crime on victims. Research studies summarized by Kilpatrick and Resnick (1993) identified a range of problems associated with victimization including: medical complications, financial difficulties, anxiety, depression, posttraumatic stress, and loneliness. These problems can greatly

impact the victim's well-being. By including the positive end of the emotional well-being spectrum in research programs, we not only increase our understanding of the good life and happiness, we also broaden our knowledge of the processes underlying emotions more generally. We must first understand the concept of subjective well-being enabling us to develop effective interventions that can assist in the improvement of the victim's well-being.

This study had several limitations. The fact that subjects were self-selected and only consisted of those who had reported that crime to the authorities restricts generalizability of the findings. Financial and practical constraints limited the ability to utilize random selection of victims. The selection process was dependent upon those names provided by the service provider. However, effort was taken to recruit a diverse sample (type of crime, ethnicity, etc.). The selection process did result in a higher number of women participating than men and the sample consisted of ethnic differences that were not similar to the state ratios of crimes reported by these ethnicities. While results should be interpreted with caution due to the limitations, the study provides tentative implications for social work. Social work views individuals within a holistic framework and as such, it is appropriate to conduct research on victims from this perspective. Social workers need to be aware if the effects that a sense of loss of control can have on victims challenging their most fundamental assumptions. Developing and understanding of the mental, physical and spiritual well-being of victims will assist practitioners with the recovery process and is paramount to the development of effective interventions. Social work practitioners are likely to encounter victims of crime, as research has shown "individuals with mental health problems are more likely to have been victims of violence and victims of violence are at a greater risk of developing major mental health care problems" (Kilpatrick, 1997, p.7).

Contributing to the growth in victim services is a new public concern for the well-being of survivors in the aftermath of crime. Constitutional amendments for victim rights, new crime victim legislation, court decisions and case law, together with a new body of academic knowledge, demonstrate the changing response to victimization. *Funds are available to cover moving and relocation or home security expenses if law enforcement or a mental health provider certifies that the expenses are necessary for the security or mental well being of the victim. This is one reason providers must be able to assess the well-being of victims to enhance their recovery process.* More research needs to be conducted on issues confronting victims of crime and how to enhance effective positive coping strategies and how to optimize well-being. Research needs to address the effect of the criminal justice system on the victims' recovery process and factors that contribute to victims' mental, spiritual and physical well-being. Additional research is needed to determine if the three underlying constructs are stable across sample and populations. Future research should also test the applicability of the MPS Scale with racial-ethnic victims. Preliminary steps have been taken to validate the well-being construct, however, multiple studies are needed regarding the applicability of measures and findings. Scholars have focused primarily on human weakness in producing psychological and measurement strategies of individual human differences. Thus the plethora of measurement on depression, anxiety, anger, etc. With using these same

techniques to develop and test tools to measure human strength, clinicians can begin to construct a positive psychological framework facilitated by the client's preexisting strengths.

Author's Note:

Address correspondence to: Diane L Green, Ph.D, associate professor, School of Social Work, Florida Atlantic University, 5353 Parkside Drive, Jupiter, FL 33458. E-Mail: dgreen@fau.edu

References

Anderson, JC. & Gebring, D. (1988). Structural equation modeling in practices: a review recommended two step approach. *Psychological Bulletin, 103,* 411-423.

Atkeson, B., Calhoun, K., Resick, P. & Ellis, E. (1982). Victims of rape: Repeated assessment of depressive symptoms. *Journal of Consulting and Clinical Psychology, 90,* 1-13.

Baumeister, R.F. (1991). *Meaning of Life.* New York: Gilford Press.

Burnam, M., Stein, J., Golding, J., Siegel, J., Forsythe, A. & Telles, C. (1998). Sexual assault and mental disorders in a community population. *Journal of Consulting and Clinical Psychology*

Campbell JC, Webster D, Koziol-McLain J, Block C, Campbell D, Curry MA, et al. (2003). Risk factors for females in abusive relationships: results from a multi-site case control study. *American Journal of Public Health, 93,* 1089–97.

DeHaes and Knippenberg (1985). Spirituality and Quality of Life in Gynecologic Oncology Patients. *Cancer Practice,* 6 (6) 333 -345.

Eden, D. (1990). Acute and chronic job stress, strain and vacation relief. *Organizational Behavior rand human decision processes, 45,* 175-193.

Frieze, I.H., Hymer, S., & Greenberg, M.S. (1987). Describing the crime victim: psychological reactions to victimization., *professional psychology: research and practice, 18*(4),

Folkman, S. (1997). Positive psychological states and coping with severe stress. *Social Science Medicine,45,* (8), 1207-1221

George, L.K. & Gwyther, L.P. (1986). Caregiver well-being: A multidimensional examination of family caregivers of demented adults. *The Gerontologist, 26,* (3), 252-259.

Green, D.L., Streeter, C., & Pomeroy, E. (2005) A Multivariate Model of the Stress and Coping Process. *Stress, Trauma and Crisis. 8(1), 61-73.*

Hair, J.F., Jr., Anderson, R.E., Tatham, R.L., & Black, W.C. (1995). *Multivariate Data Analysis: With Readings.* New York: Macmillan.

Heise L, Garcia-Moreno C. (2002).Violence by intimate partners. In: Krug E, Dahlberg LL, Mercy JA, et al., editors. *World report on violence and health.* P. 87-121. Geneva (Switzerland): World Health Organization.

Hudson, W.W. (1982). Simplified multiple regression for applied behavioral science. *Journal of Applied Behavioral Science, 18,* (4), 505-513.

Janoff-Bulman, R. (1992). *Shattered Assumptions.* New York: Free Press

Johnson, K. (1997). Professional help and crime victims. *Social Service Review, 71,*(1), 89-110.

Kennedy, J.E. (1998). Changes in spirituality and well-being among victims of sexual assault. *Journal for the Scientific Study of Religion, 37,* (2), 322-329.

Kilpatrick, D., Best, C., Veronen, L., Amick, A., Villeponteaux, L. & Ruff, G.(1995). Mental health correlates of victimization, A random community survey. *Journal of Consulting and Clinical Psychology, 53,* 866-873.

Kilpatrick, D. (1997). Implications for clinical practice and public policy. *Health Impact of Interpersonal Violence, 23,* (2), 79-85.

Kilpatrick, D. & Falsetti, S. (1994). The psychological adjustment of recent crime victims in the criminal justice system. *Journal of Interpersonal Violence, 9,* (4), 450-461.

Kilpatrick, D.G. & Resnick, H.S. (1993). PTSD associated with exposure to criminal victimization in clinical and community populations. In Davidson, J.R.T. & Foa, E.B. (Eds.) *Post rTaumatic Stress Disorder: DSM IV and Beyond.* (114-143). Washington D.C.: American Psychiatric Press

McIntosh, D.N., Silver, R.C., & Wortman, C.B. (1993). Religion's role in adjustment to a negative life event: Coping with the loss of a child. *Journal of Personality and Social Psychology, 64,* 812-821.

Norris, F. & Kaniasty, K. (1994). The psychological experience of crime: A test of the mediating role of beliefs in explaining the distress of victims. *Journal of Social and Clinical Psychology, 10,* 239-261.

Ory, M.G., Williams, T.F., Lebowitz, B., Robins, P., Salloway, J., Sluss-Radbaught, T., Wolfe, E. & Zarit, S. (1985). Families, informal support & Alzheimer's disease: Current research and future agendas. *Research on Aging, 7,* (4), 623-643.

Parkes, S.H. & Pillisuk, M. (1991). Coping in stressful episode: The role of individual differences, environmental factors, and situational characteristics. *American Journal of Orthopsychiatry, 61,*(4), 501-509.

Plichta SB. (2004). Intimate partner violence and physical health consequences: policy and practice implications. *Journal of Interpersonal Violence,19,* (11), 1296–323.

Polinsky, M.L. (1994). Functional status of long term breast cancer survivors: Demonstrating chronicity. *Health and Social Work, 19,* (3), 165-174.

Resnick, H. (1997). Medical and mental health outcomes. *Behavioral Medicine, 23,* 63-79.

Sabbagh, L. (1995). Stress sign often missed in victims of violent crime. *The Medical Post.* www.mentalhealth.com/mag1/p51-ptsd.htm.

Stevens, J. (1996). *Applied Multivariate Statistics for the Social Sciences.* Mahwah, NJ: Lawrence Erlbaum Publishers.

Tinsley, H.E. & Tinsley, D.J. (1987). Uses of factor analysis in counseling psychology research, *Journal of counseling psychology, 34*(4), 414-424.

Tjaden, P & Thoennes, N. (2000). Extent, nature, and consequences of intimate partner violence: findings from the National Violence Against Women Survey. Publication No. NCJ 181867. [cited 2006, Jan 27]. Available from: URL: www.ojp.usdoj.gov/nij/pubs-sum/181867.htm. Washington (DC): Department of Justice (US).

Vella-Brodrick, D.A. & Allen, F.C. (1995). Development of psychometric validation of the MPS scale. *Psychological Reports, 77,* 659-674.

PREVENTION: MAKING A SHADOW COMPONENT A REAL GOAL IN SOCIAL WORK

Jane D. Woody

Abstract: *Although need, opportunity, and funding for prevention programs are currently increasing, social workers do not appear to be leaders in this area of practice. Their lack of initiative in prevention will not likely change until social work education incorporates concepts from prevention science into the curriculum. This article: identifies and explains major prevention concepts and principles; discusses their congruence with social work's historical roots and current curriculum policy; and offers thoughts on integrating prevention values and content into both generalist and advanced courses. An appendix of resources is included to encourage faculties to consider how prevention could fit in the overall design of their programs.*

Key words: *Prevention; Social Work Education; Prevention Science; Public Health; Curriculum*

INTRODUCTION

In the wake of the 1960s and 1970s community mental health movement, a few voices called for social work to get involved in prevention (Rapoport, 1961, as cited in Levine, Allen-Meares, and Easton, 1987; Meyer, 1974). By the 1980s, interest in teaching the theory of primary prevention surfaced (Bloom, 1981; Bowker, 1983), along with discussion of its importance in the schools (Levine, Allen-Meares, & Easton, 1987). Schools of social work apparently did not act on this interest and did not incorporate basic preventive concepts (Black, 1985, as cited in Siefert, Jayaratne, & Martin, 1992). Therefore, it is not surprising that prevention is not currently an obvious priority in practice areas dominated by social work. For example, of the 76 presentations listed for a recent conference on child sexual abuse, not one mentioned prevention or any related concept in the title (Midwest Conference on Child Sexual Abuse, 2003). Similarly, prevention is still not a priority in social work education. A recent survey found that of 70 MSW programs (71% response), almost 45 percent offered no formal training in primary prevention, although 42 percent claimed that they incorporated the content into the curriculum (Diaz & Kelly, 1991).

While many of the practices and programs of the profession can and do encompass preventive efforts, social workers often do not conceptualize them as such. This situation is likely due to what is missing in social work education; namely, most programs have not incorporated principles that derive from prevention science. The social work knowledge base implies preventive goals but may not label them as such. For example, students may learn about interventions such as parent-training and family support,

Jane D. Woody is a Professor at School of Social Work, University of Nebraska-Omaha, Omaha, NE.

but probably in the context of treatment options for specific clients. And in learning about and implementing well-established government programs, students may not realize that these programs were initially developed to achieve the preventive goal of promoting child health and social competence (e.g., Head Start; Medicaid; Women, Infants, Children's Program).

It appears that the profession has largely forgotten its early advocacy of prevention measures and commitment to change social environments and government policies--social work concepts that are clearly congruent with current preventive science models. For example, in reviewing the history of social work, Reynolds (1963) cites the profession's concern with the public regulation of life and health, advocacy of occupational standards, development of settlement houses as a means of raising the health level through organized neighborhoods, and provision of hospital services to assist unmarried pregnant teens and address venereal disease. In addition, early social work theorists saw the preventive potential of policies; for example, Gil (1973) argued that mothers' wages could bring improvement in child development and reduce the "incidence and prevalence of physical and mental illness, mental retardation, and various forms of deviance in social and psychological functioning" (p. 82). Historically, social work values and philosophy have long been aligned with prevention. It is now time to teach prevention theory as a valued component, rather than an unnamed shadow in the social work curriculum.

Recently, social work educators who have discussed roles for practitioners in promoting social and public health and prevention advise university faculties to emphasize the knowledge and skills needed for community practice and social workers to retool their practice skills to become effective in new community partnerships that are pursuing prevention goals (Poole, 1997; Poole & Van Hook, 1997). In the health care field, Berkman (1996) wants social workers to be part of a team that addresses "the needs of patients for preventive, curative, and rehabilitative services." She recommends that MSW programs teach a specific theoretical framework for health care practice that focuses not on psychopathology but on adaptive capacities "with the goals of preventing maladaptive behavior and enhancing recovery" (p. 547).

Without more knowledge about prevention, social workers may not be attuned to new perspectives of their clients and communities. Today, prevention is much more a part of the public consciousness than in the past, primarily because of the mass media coverage of health issues and public health initiatives. The daily news often includes information about lifestyle choices and/or environmental risks associated with such public health problems as automobile accidents, heart disease, stroke, lung cancer, depression, unwanted pregnancy, and sexually transmitted infections.

It is time to give prevention a well defined place in the social work curriculum for both masters' and baccalaureate programs. This addition is essential if we expect students to allot time in their future practice for the goal of primary prevention and if the profession is to play a role in the many initiatives that are underway to address health and mental health prevention (e.g., National Technical Assistance Center for Children's Mental Health). This article discusses basic prevention theory, concepts, and practice principles and comments on their application to existing social work

curricula. Although it offers general thoughts about making selected prevention concepts explicit in the social work curriculum, faculties should explore this issue in depth and determine how prevention could fit into the overall design of their programs.

BASIC PREVENTION THEORY AND CONCEPTS

Prevention science draws heavily from the public health model that posits multiple contributors to disease and different levels of prevention/interventions. This model emphasizes disease control, prevention of disease states, and the promotion of health for the whole society; it stands in contrast to the medical model that typically emphasizes diagnosis and treatment of the individual with disease symptoms. Health promotion centers not simply on reduction of symptoms but also on promotion of positive health. For example, a prevention program for children at risk of mental health problems would pursue not only the prevention of or reduction in such symptoms as depression or anxiety but also the promotion of positive functioning in all areas of the child's life.

Prevention is compatible with the educational policy of the Council on Work Education (CSWE), which states that one of the many purposes of social work is "preventing and alleviating distress" (CSWE, 2001, 1.0) as a way of enhancing social functioning; the policy further indicates that the various purposes should encourage "curricula and teaching practices at the forefront of new and changing knowledge bases of social work and related disciplines" (CSWE, 2001, 1.2). The practical issue is to determine which prevention concepts are appropriate for social work students.

An early project to infuse prevention into the graduate social work curriculum at the University of Michigan developed three specialized prevention courses (Siefert et al., 1992); however, not all programs can offer this degree of specialization. Drawing on the philosophy and principles of this project, the following section briefly explains selected basic prevention concepts that could be integrated in the social work curriculum: (1) models of preventive services; (2) epidemiology, causation, and risk; and (3) the multidisciplinary framework and theory base for multiple levels of intervention. The discussion includes comments on how these concepts can fit into existing social work curriculum areas. As will be evident, incorporating relevant prevention concepts will require an added focus not a large change in the content of courses.

MODELS OF PREVENTIVE SERVICES

Discussion

Social work students typically learn that the medical model focuses on the individual and the progression and treatment of disease in contrast to the broader systems framework that focuses on the interaction between persons and systems. With this background, students are poised to understand two important models of prevention: the public health model, which is seen as more applicable to physical disease in populations, and the continuum of care model, which is seen as more applicable to behavioral and mental health disorders in clinical settings. Figure 1 aims to show the interface

between both models, and is an adaptation of the continuum of care model, which comes from a report of the Institute of Medicine (IOM). (Nitzkin & Smith, 2004).

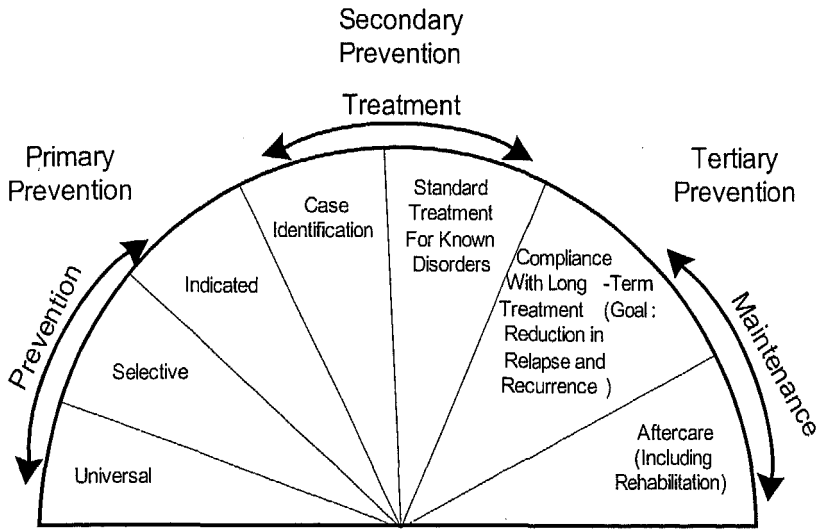

Figure 1. Continuum of Care Model

The public health model posits three levels of prevention—primary, secondary, and tertiary—that are linked to the course of the disease process in populations (Bloom, 1981); more recently, the opinion is that the boundaries between these three levels are not entirely clear (Blair, 1992). The continuum of care model covers the full range of health care services—prevention, treatment, and maintenance; for behavioral disorders in clinical settings, this model is considered more practical than the public health level of prevention since patient interviews during treatment are the source of "identifying risk factors and detecting early-stage disease" (Nitzkin & Smith, 2004, p. 5).

Figure 1 offers an adaptation that links the public health levels of prevention to the continuum of care. Primary prevention, which takes place before any biologic onset of disease, is equivalent to prevention on the continuum of care; the focus is on protective measures to prevent or forestall disease and on health promotion; definitional differences are often based on whether the author focuses on social versus medical dimensions (Blair, 1992). Within the continuum of care primary, prevention services can be "universal" or useful or applicable to everyone in a given population (e.g., childhood immunization or pre-natal care for all pregnant women). "Selective" measures target persons/subgroups at above-average risk (e.g., smoking cessation programs for all smokers). "Indicated" measures target persons/subgroups that are at extremely high risk or have symptoms/abnormalities not yet meeting diagnostic criteria (e.g., case management/counseling for young children with school behavior problems). Note that all of the targets for primary preventive measures consists of groups not yet diagnosed with a disease or behavioral/mental health disorder (Nitzkin & Smith, 2004).

Secondary prevention (encompassing Treatment in Figure 1), which takes place when underlying risks or incipient symptoms appear, aims for early detection and treatment to arrest or eliminate the disease. This goal often translates to reducing the duration of the disorder; and, as shown on Figure 1, some theorists have argued for relabeling secondary prevention as "treatment activities" (Blair, 1992). Tertiary prevention (encompassing Maintenance in Figure 1), which takes place when symptoms are such that disease is diagnosed, aims to prevent complications and limit disability; and, as shown on Figure 1, others have described this level of intervention as "rehabilitation" (Blair, 1992; Nitzkin & Smith, 2004).

With the growing incidence and cost of chronic illnesses that are determined by multiple factors, the continuum of care centers on their predictability, prevention, and management. (Berkman, 1996). Pro-active screening, assessment, and case finding, whether in clinical settings or population groups, are essential to early intervention. And ongoing case management and secondary and tertiary population-based interventions are essential to promote compliance with treatment, screen for additional complicating factors (e.g., psychological or family issues), and connect people with needed community resources that can prevent relapse, and promote rehabilitation and health.

It is important to note that measures to promote health, not just efforts to eliminate disease or mental health problems, can also fit into the integrated public health-continuum of care framework. Health includes "life satisfaction, appropriate achievement of developmental milestones (such as developing social skills, completing school) and attainment of normative adult social functioning (establishment of a family, community engagement, career attainment, financial security)" (University of Michigan, 2006, p. 1).

As noted above, a final issue within prevention science is whether programs should emphasize clinical or population-focused interventions. Clinical prevention is more focused on illness and services for individuals, such as developing clinics for impoverished persons or home-care services for the elderly. Some believe that population-based practice is once again becoming important in public health (Keller, Schaffer, Lia-Hoagberg, & Strohschein, 2002); an example would include media advertisements or system policies designed to prevent child abuse, family violence, substance use, etc. A practical position is that both types of interventions are important for effective preventive efforts (Blair, 1992).

Application to the Curriculum

The blended perspective of prevention as shown in Figure 1 would readily fit in the generalist level of the social work curriculum. This framework would apply to various courses and is compatible with the social work value of promoting effective functioning for individuals, families, and the larger social systems. Social work educators could use the content in Figure 1 to encourage discussion of the need for prevention programs, as well as for services that treat symptomatic individuals and families, and to remind students that well-established social services and policies were originally part

of preventive efforts (e.g., crisis hot lines, information about domestic violence posted in women's public restrooms, mandated parent training for divorcing couples, etc).

Learning about prevention models can expand students' understanding of alternative models of service that go beyond community or clinic-based treatment, which too often become a "wait and watch" system (wait for severely troubled clients to appear and watch the no-shows, cancellations, and early terminations). A 50 per cent no-show rate has been reported for child psychotherapy (Kazdin, 1996). Most of the helping professions, including social work, emphasize essential clinical services; yet, this focus renders primary prevention an afterthought not a goal to consider in all program planning. For example, the funds allocated for mental health services in the schools are often used to contract for treatment of individual disruptive students by local agencies or practitioners whose methods may lack proven effectiveness (Pelham & Massetti, 2003). In contrast, recent model programs have demonstrated that school-based preventive services can effectively promote urban children's mental health (Atkins, Graczyk, Frazier, & Abdul-Adil (2003).

Discussion of prevention in generalist courses is compatible with social work's philosophy of the need for multi-system intervention and change to promote social functioning. As students learn about the traditional methods of social work (casework, group work, and community practice), they realize that these are applicable to all social system targets—from the individual to the total society. When the goals of prevention and health promotion become part of the curriculum, students can readily see a new application of practice methods that target potentially all social systems. Once basic prevention models are clearly delineated as a part of generalist human behavior and practice courses, students can understand how social work practice skills would fit in the design and delivery of programs that promote prevention goals. As Bloom (1983) says, an added benefit of including this content is the optimism that it embodies.

EPIDEMIOLOGY, CAUSATION, AND RISK

Discussion

According to public health theory, the state of health/mental health is a product of the interaction of the host, environment, and agent, although this model is most appropriate for infectious disease for which there is a single agent of transmission such as a virus (McLeroy, Bibeau, Steckler, & Glanz, 1988). In the classic early public health approach to infectious diseases, such as typhoid, the target of intervention was the environment and the intervention was sanitation engineering that reduced the toxic environmental conditions. Data about the host, environment, and agent are revealed through epidemiological research.

Epidemiology, broadly defined, is "the basic science for public health"; it describes and analyzes "causes of social and psychological health and illness," including patterns and interpretations that can suggest hypotheses for intervention and prevention (Bloom, 1981, p. 170). Epidemiological research uncovers facts about prevalence rates, morbidity, mortality, and the distribution of disease or other negative outcomes in the population, thus identifying both risk and protective factors. For example, public health specialists have often reported research showing

that "the very poor are at highest risk for many pathological conditions, including mental disorders" (Albee & Ryan, 1998, p. 445). The research also has established multiple interacting contributors for many diseases and behavioral disorders.

Epidemiological findings are typically available in "existing data sources (such as vital statistics, state and national health surveys, medical and administrative records)" (Gielen & McDonald, 2002, p. 415). Indicators of prevalence and impact on health in a population and high-risk subgroups help identify which problems are most important for which groups and suggest what factors could be used to determine measurable program objectives. Policy documents can help identify problems to address and targets for change; for example the United States Public Health Services publication *Healthy People 2010* gives data on major national health problems and some high risk subgroups (United States Department of Health and Human Services [USDHHS], 2000). Additional theory and research literature can shed light on further behavioral and environmental factors that contribute to a given problem.

Application to the Curriculum

Epidemiological analysis that encompasses the interaction of host, environment, and agent is compatible with various theoretical frameworks taught in social work programs: social systems, the social ecology model, and/or the biopsychosocial model, all of which serve as the basis for understanding human behavior in the social environment; social work curricula often refer to these multiple levels as micro, meso, and macrosystem influences (Poole, 1997). At the generalist level social work courses could cover the multi-factorial public health explanation of causality as a metatheory that is compatible with other theoretical frameworks taught in human behavior courses. An introduction to epidemiological research can expand students' knowledge of research methods and provide a basis for additional prevention concepts in advanced courses. An assignment might be for student groups to search for epidemiological data around a particular health/mental health problem, e.g., diabetes, depression, etc.

MULTIDISCIPLINARY FRAMEWORK AND THEORY BASE FOR MULTIPLE LEVELS OF INTERVENTION

Discussion

Prevention science draws extensively on the disciplines of public health (investigators and environmental specialists), physicians, nurses, social workers, health educators, and psychologists, with additional contributions coming from community and organizational representatives. The multidisciplinary approach is essential for accessing relevant theories to explain the etiology and epidemiology of health and illness and practice principles appropriate for the design, delivery, and evaluation of effective prevention programs (Smith & Bazini-Barakat, 2002). Social workers are highly involved in the interdisciplinary process, but mostly in the context of case management teams that assess, plan, and provide treatment services. The profession, however, has much to contribute to multidisciplinary prevention activities.

With the interdisciplinary approach already embedded in the practice of social work, Poole (1997) believes that social work education, with its ecological and social systems theory base, is in a good position to transmit additional theory that will better train social workers to address community health problems and design appropriate interventions. This task calls for an multidisciplinary framework that allows for a "'comprehensive theory' of the problem based on the interactive effects of intrapersonal, interpersonal, organizational, community, cultural, and public policy factors and a comprehensive 'theory of intervention' with potential points of intervention and appropriate strategies" (Poole, 1997, p. 166).

Table 1, reprinted from Poole (1998, p. 373), offers a social ecology framework for health promotion/education.

The overview shows that preventive programs can draw on multiple theories that explain human and systems behavior in terms of certain change processes, specify targets of change, and posit strategies to achieve change. Any one or more of the ecological levels may contribute to a problem and consequently be a target for change.

The summary format of Table 1 makes it easy to see that various disciplines have contributed to the theories and change strategies. The content summarized here can serve as a review of theories and strategies covered in the social work curriculum, introduce new theoretical concepts, and highlight the contributions of other disciplines, some of which may be unfamiliar to students. Note the intrapsychic and interpersonal theories that draw from developmental and social psychology and from sociology. Regarding the organizational, community, and public policy levels, the disciplines of sociology, social work, and political science all clearly contribute to these theories and strategies.

Although the content of Table 1 was designed to apply to health promotion efforts, it has broad application to all intervention levels of the combined public health and continuum of care models shown previously in Figure 1—primary prevention, treatment, and maintenance. For example, with the aftercare process that is part of maintenance for substance abusing clients, various ecological levels could be targeted to promote rehabilitation (e.g., intrapsychic cognitive/social learning-based relapse prevention, interpersonal social support groups, community-based incentive programs such as job training, etc.).

Application to the Curriculum

Close analysis shows that many of the theories and practice strategies listed in Table 1 are part of the social work curriculum. Nonetheless, seeing a comprehensive overview of many theories can help students further internalize theoretical concepts and hone practice skills in general as well as see their application to prevention. To achieve this goal, students need educational activities that apply the range of strategies to prevention projects.

Advanced level human behavior and clinical and macro practice courses would be appropriate for introducing the broad ecological framework of Table 1. A learning objective could be to give students practice in applying multiple theories to a public

health problem already identified through epidemiological analysis as appropriate for prevention. An assignment could ask students to use Table 1 as the basis to "brainstorm" ideas (not evaluate their feasibility) for planning a prevention initiative. The instructor could illustrate the assignment by offering a brainstorming example relevant to the course.

Table 1. A Social Ecology Framework for Theories Related to Health Promotion and Health Education* Part One

Ecological Level	Change Processes	Theories or Models	Targets of Change	Strategies and Skills
Intrapersonal	Psychological	Value expectancy Attitude change Social learning theory Control theories Personality theories Attribution theories	Developmental processes Knowledge Attitudes Values Skills Behaviors Self-concept, self efficacy Self-esteem	Tests and measurements Program planning Educational approaches Mass media Social marketing Skills development Resistance to peer pressure
Interpersonal	Psychosocial	Network theory Social support theories Role theory Social influence models Social comparisons	Social networks Social support Families Work groups Peers Neighbors	Enhancing social networks Changing group norms Enhancing families Social support groups Increasing access to normative groups Peer influence
Organizational	Organizational	Diffusion of innovations Stage theories Leadership theories Organizational climate Organizational culture Leadership	Norms Incentives Organization culture Management styles Organization structure Communication networks	Organizational development Incentive programs Process consultation Coalition development Linking agents

Table 1A Social Ecology Framework for Theories Related to Health Promotion and Health Education Part Two*

Community	Cultural and social	Cultural change theories Social change theories Community development Diffusion of innovation Community power Community decision making	Area economics Community resources Neighborhood organizations Community competencies Social and health services Organizational relationships Folk practices Governmental structures Formal leadership Informal leadership	Change agents Community development Community coalitions Empowerment Conflict strategies Mass media
Public Policy	Political	Policy development theories Political change theories Political parties Citizen participation Bureaucracies	Legislation Policy Taxes Regulatory agencies	Mass media Policy analysis Political change Lobbying Political organizing Conflict strategies

Note. From *Community building: Renewal, well-being, and shared responsibility* (p. 373) by P. L. Ewalt, E. M. Freeman, & D. L. Poole (Eds.). Washington, DC: National Association of Social Workers. Copyright 1998, by National Association of Social Workers. Reprinted with permission

For example, the following ideas are for a community-wide initiative to address, at all ecological levels, the problem of high rates of adolescent sexually transmitted infections (STIs).

> One program component at the intrapsychic level could develop media messages directed to the entire adolescent population in the community (universal target) to influence attitudes and values about intercourse and use of protection. Another intrapsychic level intervention could offer high-risk females (selective target) a psycho-educational group to develop assertiveness/skills. At the interpersonal level; a preventive program might provide all parents in the community school system (universal target) information on how to talk effectively with their children about sexual risks. At the organizational level, a preventive initiative might aim to implement a school-based health clinic that will offer sexual health services to students in a neighborhood with high rates of STIs (indicated target). At the community level, a preventive initiative might aim to develop a transitional neighborhood's economic resources so as to help high-risk youth (selective target) see opportunities to achieve positive personal life goals. Finally, an initiative at the public policy level could lobby for a governmental policy to mandate that public school sex education programs (universal target) include information about protection during sexual intercourse.

This discussion has briefly explained three basic prevention concepts and commented on applying these to required generalist and advanced level courses. The goal is not

to turn students in to prevention or public health specialists; rather, they should learn early on how the philosophy and practice of prevention fit and have a place in their chosen profession.

PRINCIPLES AND PRACTICE OF PREVENTION

The next set of selected principles is relevant to prevention practice as well as to other social work roles. Again, these are congruent with many concepts and strategies taught in both generalist and advanced social work practice courses. Some may already be mentioned in various courses; however, these principles merit explanation in regard to prevention and health promotion. They would readily fit into courses that deal with populations at risk or specialized practice settings (e.g., health, mental health, substance abuse, child welfare, family violence, sexual issues, minority populations, school social work, etc.). CSWE educational policy specifies that curricula should "integrate content on populations-at-risk" and . . . "present content on the dynamics of such risk factors and responsive and productive strategies to redress them" (CSWE, 2001, 4.2). Faculties should review their program and courses to decide how best to integrate selected prevention principles. To promote this dialogue, ten principles are briefly discussed here.

1. Outreach, access, and engagement designate processes necessary to bring prevention services to a large segment of the population or to identified at-risk or symptomatic individuals. These principles emphasize that prevention is pro-active as opposed to reactive. The idea is to anticipate and address the barriers to obtaining services that vulnerable, underserved groups experience, rather than wait for patients or clients to present themselves.

Several strategies are used to enhance outreach, access, and engagement. Given that stigma is still associated with mental illness and many physical illnesses, use of low-stigma settings is the choice for prevention programs. Access is expanded and stigma reduced when prevention programs are offered in settings such as schools, primary healthcare facilities, community centers, the workplace, recreation programs, places of worship, etc. Another strategy, use of indigenous natural helpers, has the added benefit of helping with the management of resources, as prevention programs need to reserve highly trained professionals for the most complex services. Indigenous helpers are those who have regular contact with large numbers of persons, ranging from those who could benefit from health promotion to those who are symptomatic. Teachers, parents, daycare workers, and church members are examples of indigenous helpers who have been part of recent prevention programs; for example, a camp-based health program in Michigan enlisted "migrant farm workers to provide culturally appropriate health education, advocacy, outreach, referral, and follow-up services" (Poole & Van Hook, 1997, p. 2).

2. As with all social work practice, sensitivity to local/cultural norms/practices is an important principle in the planning, delivery, and evaluation of all types of prevention programs. This principle applies to the methods used for outreach, access, engagement, stigma reduction, and appropriate adaptations in intervention methods and aims to increase the likelihood that services will be meaningful and successful

with the targeted groups. For example, an asthma education program was adapted to make it culturally relevant for African American adults and was located in a church setting, which research has identified as a context central to many African Americans (Ford & Edwards, 1996).

3. Education and consultation are practice methods that have wide application in prevention programs. Educational efforts can aim to: inform a general population group (such as a mass media campaign on the risks of smoking, alcohol, and drug use in pregnancy); inform an adolescent population or teachers about mental health; teach symptomatic individuals, such as heart attack survivors, about follow-up health practices; or train indigenous or professional workers for their role in prevention programs. Consultation is the process whereby a highly trained professional provides expertise and support to enable front-line indigenous or professional helpers to better carry out their role in a prevention program.

4. Identification of both risk and protective factors is central to prevention programming. Epidemiological, psychological, and sociological research contributes to this identification process. Prevention specialists draw from research findings on a particular problem area to gain knowledge of risks and protective factors. For example, research has identified children who are early starters of aggressive behaviors at high risk for delinquency or drug abuse, whereas a protective factor is a positive family environment that includes supervision, consistent discipline, and communication of family values (Kumpfer & Alvarado, 2003).

5. Risk screening is an important part of prevention that aims for early identification of persons within a larger population who display risk behaviors; once identified, these individuals can receive selective or indicated prevention efforts. Many types of screening methods are possible. For example, prevention programs have taught primary health care personnel in clinics and emergency rooms, classroom teachers, daycare workers, and other natural helpers to screen children for signs of physical abuse, behavioral/emotional symptoms, or other risk characteristics. Screening tools might include brief behavioral, emotional, or symptoms checklists that could be routinely administered in certain settings or as a part of a media health campaign or a health fair.

6. Risk reduction is a principle that aims to reduce risk, either for a large population group, a known risk group, or a group with specific problem behaviors/symptoms. Programs can help reduce risk by: promoting health behaviors that keep people out of high risk category (smoking education campaigns to prevent teens from starting to smoke); lowering existing risk (campaigns to decrease the risk of second-hand smoke for adults and children); and reducing actual problem behaviors or disease risk (e.g., smoking cessation programs that arrest disease symptoms that may be in progress and lower the risk of serious disease).

7. Community capacity building is the process of fostering "conditions that strengthen communities that enable them to plan, develop, implement, and maintain effective community programs," such as identifying and addressing "social and public health problems" (Poole, 1997, p. 163). This process contrasts with programming that is driven, developed, and administered by professionals, a "top-down" approach that critics

say can weaken community potential. A goal is to create or revitalize community action structures—councils, commissions, committees, and task forces. These channels allow for citizen participation, decision-making, and social action. Professionals are needed to build, support, and provide internal maintenance for the functions of these structures.

An important strategy for community capacity building is to foster development of community team building/partnerships; these are advocated for establishing effective comprehensive and primary health care programs. Partnerships are coordinated networks that include community members, health care providers, and various social service professionals. These partnerships can serve many functions: involve community members in program design and delivery, increase access and outreach, encourage community ownership of health issues and solutions, export training and skills beyond traditional professional boundaries, and create new structures that can integrate and sustain new systems of care. Social work's repertoire of skills in community practice is applicable to this goal. But to become relevant to prevention programs, skills may need to be honed or expanded to include grassroots organization and constituency building, budgeting and resource packaging, training and consultation, outcome evaluation and cost analysis, marketing, and skills in facilitating task groups (Poole & Van Hook, 1997).

8. Evidence-based interventions have become important in the practice of all of the helping professions and are a central feature of health promotion and prevention programs. Government agencies are mandating that public funds be spent only on "effective programs as found on their lists of scientific programs" (Kumpfer & Alvarado, 2003, p. 459). Data are available that identify the most effective interventions for various problems, most often based on rigorous, randomized controlled trials. "Intervention frameworks that are based on epidemiological and developmental research documenting risk and protective factors, recognize the common concurrence of multiple problems, and involve family-, peer-, school-, and community-focused components appear more effective, in general, than single-problem, single-component designs" (Bierman, 2003, p. 526). Prevention science emphasizes the use of such research to specify a desired outcome that reduces risk or promotes protective factors. This focus allows selection, implementation, and evaluation of whether an evidence-based strategy is effective in achieving the program's proposed outcomes. Because of government mandates and competition for funds, prevention programs must give strong emphasis to evidence-based interventions. Their use can also help cut costs because they offer a manualized protocol for assessment and outcome measures, delivery of the intervention, training workers, etc. Besides evidence about specific interventions, researchers have also identified general principles of effective prevention programs (Nation, et al., 2003).

9. Evaluation research, while recommended for all types of service programs, is a hallmark of health promotion and prevention programs. With funding sources demanding accountability, all aspects of a program must be evaluated, including the processes of outreach, screening, training and consultation, record-keeping, and overall integrity and fidelity of the selected evidence-based intervention. Cost-analysis and

indicators of sustainability are also part of the evaluation needed. The evaluation research should document which program components were effective (including the size of behavioral change or effects), which were modified, and which proved ineffective.

10. Sustainability of programs refers to the goal of maintaining and continuing the operation of prevention programs. Sustainability is linked to the capacity of "locally existing structures that enable organizations to maintain, enhance, and expand their use of effective practices and systems" (Sugai, 2003, p. 533), rather than depend on temporary external supports such as grants and external consultants. Resources for sustaining programs include: guiding policies, specialized knowledge and skills, competent management, fiscal supports, and ongoing process and program evaluation. For example, one school mental health prevention program included functions that would be ongoing with existing resources: trained teachers for mental health roles, developed the capacity of families to sustain positive change, and initiated an effective school procedure for dealing with disruptive behavior (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003).

This brief discussion is only a starting point for how important prevention practice principles can fit into existing social work courses. It is likely that the curriculum already covers some of these principles and strategies, such as in relation to clinical, administrative, and community practice. One of the best teaching tools for any advanced course is to have one assignment that requires students to review and analyze an effective or model health or mental health prevention program. Many such programs are available that deal with depression, HIV-AIDS, substance abuse, adolescent pregnancy, school drop-out, and other child/adult health and mental health risks (for examples, see Appendix: Resources). The analysis required in the assignment should reflect prevention concepts that are relevant to the particular course, for example, clinical practice, planning, research, etc. Other prevention assignments as suggested in the discussion above can bring concepts and principles to life, show students how the roles and strategies that they are learning are relevant to prevention, and inspire them to include prevention in their future practice.

CONCLUSION

The philosophy, knowledge base, and practice skills taught in social work education programs are compatible with prevention and health promotion. Unfortunately, the models and practice principles that derive from prevention science are not explicit in many social work programs. On just one aspect, skills for building and participating in community partnerships, "there appears to be a great divide between what faculty are teaching students in academia and what practitioners are doing in the field" (Poole, 1997, p. 163). Social work educators must do a better job of preparing students for prevention practice. Integrating prevention content into courses will provide students with an added lens for viewing the content of all courses.

When courses articulate prevention as a value and goal for social work practice, students will be better prepared for the complex professional roles awaiting them in the community. They can be knowledgeable collaborators with agencies and programs that pursue prevention. They can participate in efforts to build

community partnerships and action structures to support community prevention goals. They can serve as clinical and consultation/education specialists for specific programs. They can examine their employing agency's mission and foster dialogue about whether prevention is or should be part of that mission. They can assume major roles in the design, delivery, and evaluation of proposed and funded health promotion/prevention programs.

Author's Note:

Address correspondence to: Jane D. Woody, Professor, School of Social Work, University of Nebraska-Omaha, Omaha, NE 68182-0293. Email: jwoody@mail,unomaha.edu. Thanks are due to Richard C. Furman and Henry D'Souza for their thoughtful review of this manuscript and helpful comments.

References

Albee, G. W., & Ryan, K. (1998). An overview of primary prevention. *Journal of Mental Health, 7,* 441-449.

Atkins, M. S., Graczyk, P. A., Frazier, S. L., & Abdul-Adil, J. (2003). Toward a new model for promoting urban children's mental health: Accessible, effective, and sustainable school-based mental health services. *School Psychology Review, 32,* 503-514.

Berkman, B. (1996). The emerging health care world: Implications for social work practice and education. *Social Work, 41,* 541-551.

Bierman, K. L. (2003). Commentary: New models for school-based mental health services. *School Psychology Review, 32,* 525-529.

Blair, A. (1992). The role of primary prevention in mental health services: A review and critique. *Journal of Community & Applied Social Psychology, 2,* 77-94.

Bloom. M. (1981). *Primary prevention: The possible science.* Englewood Cliffs, NJ: Prentice-Hall.

Bloom, M. (1983). Introducing primary prevention in human behavior courses. In J. P. Bowker (Ed.), *Education for primary prevention in social work* (pp. 38-53). New York: Council on Social Work Education.

Bowker, J. P. (Ed.). (1983). *Education for primary prevention in social work.* New York: Council on Social Work Education. Council on Social Work Education. (2001). *Educational policy and accreditation standards.* Alexandria, VA: Author.

Diaz, Y. E., & Kelly, J. A. (1991). AIDS-related training in U. S. schools of social work. *Social Work, 36,* 38-42.

Ford, M. E., & Edwards, G. (1996). An empowerment-centered, church-based asthma education program for African American adults. *Health & Social Work, 21,* 70-75.

Gielen, A. C., & McDonald, E. M. (2002). Using the PRECEDE-PROCEED planning model to apply health behavior theories. In K. Glanz, B. K. Rimer, & F. M. Lewis (Eds.), *Health behavior and health education: Theory, Research, and Practice.* San Francisco: Jossey-Bass.

Gil, D. (1973). *Unraveling social policy.* Cambridge, MA: Schenkman Pub. Co. Kazdin, A. E. (1996). Dropping out of child psychotherapy: Issues for research and implications for practice. *Clinical Child Psychology & Psychiatry, 1,* 133-156.

Keller, L. O., Schaffer, M. A., Lia-Hoagberg, B., & Strohschein, S. (2002). Assessment, program planning, and evaluation in population-based public health practice. *Journal of Public Health Management Practice, 9*(5), 30-43

Kumpfer, K. L., & Alvarado, R. (2003). Family-strengthening approaches for the prevention of youth problem behaviors. *American Psychologist, 58,* 457-465.

Levine, R. S., Allen-Meares, P., & Easton, F. ((1987). Primary prevention and the educational preparation of school social workers. *Social Work in Education,* 9, 145-158.

McLeroy, K., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective for health promotion programs. *Health Education Quarterly, 15,* 351-378.

Meyer, C. H. (Ed.) (1974). *Preventive intervention in social work.* Washington, DC: National Association of Social Workers.

Midwest Conference on Child Sexual Abuse. (2003). Conference Program. Middleton, WI: Author.

Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybold, D., Morissey-Kane, E., & Davino, K. (2003). What works in prevention? *American Psychologist, 58,* 449-456.

Nitzkin, J., & Smith, S. A. (2004). *Clinical preventive services in substance abuse and mentalhealth update: From science to services.* DHHS Pub. No. (SMA) 04-3906. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Pelham, W. E., & Massetti, G. M. (2003). Commentary: Expanding on effectiveness. *School Psychology Review, 32,* 536-540.

Poole, D. L. (1997). Building community capacity to promote social and public health: Challenges for universities. *Health & Social Work, 22,* 163-171.

Poole, D. L. (1998). Building community capacity to promote social and public health: Challenges for universities. In P. L. Ewalt, E. M. Freeman, & D. L.

Poole (Eds.), *Community building: Renewal, well-being, and shared responsibility* (p. 373). Washington, DC: National Association of Social Workers.

Poole, D. L., & Van Hook, M. (1997). Retooling for community health partnerships in primary care and prevention. *Health & Social Work, 22,* 2-5.

Reynolds, B. C. (1963). *An uncharted journey: Fifty years of growth in social work.* New York: Citadel.

Siefert, K., Jayaratne, S., & Martin, L. D. (1992). Implementing the public health Social Work Forward Plan: A research-based prevention curriculum for schools of social work. *Health & Social Work, 17,* 12-27.

Smith, K., & Bazini-Barakat, N. (2002). A public health nursing practice model: Melding public health principles with the nursing process. *Public Health Nursing, 20,* 42-48.

Sugai, G. (2003). Commentary: Establishing efficient and durable systems of school-based support. *School Psychology Review, 32,* 530-535.

U. S. Department of Health and Human Services (2000). *Healthy people 2010. Vol 1.* McLean, VA: International Medical Publishing, Inc.

University of Michigan. (2006). Michigan Prevention Research Training Program Brochure. Retrieved February, 9, 2006, from http://www.mprt.isr.umich.edu/

Appendix: Resources

Registries and Web Sites

Center for Substance Abuse Prevention's National Registry of Effective Prevention Programs (www.samhsa.gov/csap/model programs).

Center for Substance Abuse Prevention's Decision Support System (www.preventiondss.org).

Centers for Disease Control and Prevention's Guide to Community Preventive Services (www.thecommunityguide.org).

National Alliance for the Mentally Ill (NAMI). A grassroots, family and consumer, self-help, support, education, and advocacy organization dedicated to improving the lives of children and adults living with severe mental illnesses (www.nami.org).

National Technical Assistance Center for Children's Mental Health. Georgetown University Center for Child and Human Development (www.gucchd.georgetown.edu).

Society for Prevention Research's International Registry of Prevention Trials (Brown, H. Mrazek, P. & Hosman, C. (1998, December). *International classification of prevention trials.* Paper presented at the Workgroup Meeting on the International Classification of Prevention Trials, Washington, DC.

Western Center for the Application of Prevention Technology (www.westcapt.org).

Recent Publications on Prevention Theory and Programs

Atkins, M. S., Graczyk, P. A., Frazier, S. L., & Abdul-Adil, J. (2003). Toward a new model for promoting urban children's mental health: Accessible, effective, and sustainable school-based mental health services. *School Psychology Review, 32,* 503-514.

Botvin, G. J., & Griffin, K. W. (2002). Life skills training as a primary prevention approach for adolescent drug abuse and other problem behaviors. *International Journal of Emergency Mental Health, 4,* 41-48.

Cooper, B. (2002). Thinking preventively about dementia: A review. *International Journal of Geriatric Psychiatry, 17,* 895-906.

Davis, N. J. (2002). The promotion of mental health and the prevention of mental and behavioral disorders: Surely the time is right. *International Journal of Emergency Mental Health, 4,* 3-30.

Hollon, S. D. (2002). Treatment and prevention of depression. *Psychological Science, 3,* 39-77.

Hollon, S. D., Munoz, R. F., Barlow, D. H., et al. (2002). Psychosocial intervention development for the prevention and treatment of depression: Promoting innovation and increasing access. *Biological Psychiatry, 52, 610-630.*

Kendrick, T., Tylee, A., & Freeling, P. (Eds.) (1996). *The prevention of mental illness in primary care.* New York: Cambridge University Press.

Kumpfer, K. L., & Alvarado, R. (2003). Family-strengthening approaches for the prevention of youth problem behaviors. *American Psychologist, 58,* 457-465.

Noam, G. G., & Hermann, C. A. (2002). Where education and mental health meet: Developmental prevention and early intervention in schools. *Development & Psychopathology, 14,* 861-875.

Van Acker, R., & Talbott, E. (1999). The school context and risk for aggression: Implications for school-based prevention and intervention efforts. *Preventing School Failure, 44,* 12-19.

Wolchik, S. A., Sandler, I. N., Millsap, R. E., et al. (2002). Six-year follow-up of preventive interventions for children of divorce: A randomized controlled trial. *Journal of the American Medical Association, 288,* 1874-1881.

Wolfe, D. A., McMahon, R. J., & Peters, R. D. (Eds.). (1997). *Child abuse: New directions in prevention and treatment across the lifespan.* Thousand Oaks, CA: Sage.

EFFECTIVELY WORKING WITH CHALLENGING CLIENTS WHO RECEIVE HUNGER SERVICE ASSISTANCE: CASE EXAMPLES AND EIGHT RECOMMENDED GUIDELINES

Sharon E. Moore
Cynthia A. Moore
Jacquelyn Monroe
Renee Campbell-Mapp

Abstract. *Those who provide services for people who experience food insecurity come into contact with people who do not always present themselves courteously and favorably. Using case examples from the food bank industry, the authors of this paper will: (1) discuss why people sometimes behave discourteously when seeking assistance from human service professionals; (2) give case examples of how social workers could properly respond to these situations and, (3) give recommendations for effectively working with this client population.*

Among the beautiful aspects of the profession of social work are the myriad of settings in which one can practice and the diversity of people for whom services are provided. This includes those who provide services for the diverse group of people who experience poverty, food insecurity, and hunger. Poverty measurements, although often criticized by many for being too liberal, are typically established by the federal government's Health and Human Services department (Department of Health and Human Services, 2005). Food insecurity, which is directly tied to poverty, is evident whenever: 1) the availability of nutritionally adequate and safe foods is limited or uncertain, or 2) the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain (e.g., avoiding having to scavenge through dumpsters for food or selling blood for food) (Derrickson & Brown, 2002; Kempson, Keenan, Sadani, & Adler, 2003; Seavey & Sullivan, 2001). This insecurity then results in hunger, oftentimes on a chronic basis for many individuals (Nord, Andrews & Winicki, 2002). Seeking social services to meet this unmet need may be the only option for some of these individuals despite the fact that reliance on governmental and social agency support is often associated with humiliation, dehumanization, denigration, depression, and shame (Belle, 2003). Therefore, it is not surprising to find that not all people who seek assistance for hunger relief present themselves courteously and favorably. This small group of clients who demonstrate negative behavior, however, must be examined in the context of their circumstances. The person-in-environment perspective asserts that a person's actions and behaviors are influenced by their environment (Longress, 2000). The professional helper has the responsibility of creating an environment where

Sharon E. Moore, Ph.D., L.C.S.W. is Professor at Raymond A. Kent School of Social Work, University of Louisville, Louisville, KY 40292. Cynthia A. Moore, M.S.W. is Agency Relations Manager, Greater Pittsburgh Community Food Bank, 1 North Linden Street, Duquesne, PA 15110. Jacquelyn Monroe, Ph.D. is Associate Professor at The Ohio State University; College of Social Work, Columbus, OH 43210. Renee Campbell-Mapp, Ed.D works at Wesley House Community Services, Inc., 803 E. Washington St., Louisville, KY 40214.

clients feel safe, respected, and valued (Brille & Levine, 2005). Therefore, it becomes incumbent upon human service providers to consider external and internal factors that may impact client behavior during service delivery.

This paper is intended to fill in gaps in knowledge about the extraneous and intrinsic factors that impact upon client persona and how social workers and others who provide human services, such as students and volunteers (Poindexter, Valentine & Conway, 1999), can be more effective in responding to difficult clients who need assistance with the issue of hunger. Using two case examples from the food bank industry, the authors of this paper will: (1) discuss why people sometimes behave discourteously when seeking assistance from human service professionals; (2) give case examples of best practices with this type of client; and, (3) give recommendations for effectively working with this population.

POVERTY, FOOD INSECURITY, AND HUNGER IN AMERICA

Although the United States is one of the wealthiest industrialized countries, and rich in food in the world, millions of Americans remain in poverty and suffer from food insecurity (Belle, 2003; Biggerstaff, Morris & Nichols-Casebolt, 2002). According to the 2005 Health and Human Services poverty guidelines, a family of three or five, whose annual income is at $16,090 or $22,610, respectively, is considered impoverished (Department of Health and Human Services, 2005). In 2001, over 31 million or 11.3% of Americans lived below the poverty line. In 2001, Second Harvest, a national network and the largest organization of food banks and food rescue programs in this country (Bernstein, 2001; Biggerstaff, Morris & Nichols-Casebolt, 2002), conducted a study in which 32,759 people from 32 states were interviewed regarding the issue of hunger. The study found that approximately 11 million households, or over 36 million people, have limited access to adequate food resources (Sullivan & Choi, 2002). Of the 36 million people who have hunger issues, 14 million are children 18 years of age and under (Biggerstaff, Morris & Nichols-Casebolt, 2002). Each week approximately seven million people receive food from food banks and food rescue programs (Sullivan & Choi, 2002). Although most of these individuals are from persistently low income or no income families, some of these individuals include former six figure tech workers who have been laid off (Berner & Zellner, 2003), families of military personnel (*"Pantries Provide Backup for Some Military Families,"* 2004), and unemployed college graduates (Berner & Zellner, 2003).

The issue of hunger among United States residents was further detailed by the 2004 Sodexho USA Hunger and Homelessness Survey which found that among the 1,139 U.S. cities with populations of 30,000 or more, 56 percent of those who seek emergency food assistance were families, 34 percent of adults who seek hunger assistance services held jobs, and sadly, an average of 20 percent of requests for emergency food went unmet over the past year (U.S. Mayor Newspaper, 2005). A significant number of the households researched in 1998 by the Current Population Survey Food Security Supplement (CPS-FSS) found that 66% of the households classified as food insecure experienced this on a re-occurring basis for the year, while 20% experienced food insecurity on a frequent or chronic basis during the respective year (Nord, Andrews,

& Winicki, 2002). Fortunately, there are a variety of agencies that provide private food assistance. They include food banks, homeless shelters, soup kitchens, and food pantries. Food banks are charitable organizations that receive food from a variety of places and subsequently distribute that food to shelters, soup kitchens, and food pantries. These agencies and organizations then distribute the food to those in need. Food pantries provide non-prepared food and groceries to those in need, who then prepare the food at home. Soup kitchens, which are also referred to as emergency kitchens, provide prepared meals to clients, while emergency shelters provide clients with shelter and a daily meal on a short-term basis (Tiehen, 2002). Most of these food relief agencies are faith-based (Cashwell, Bartkowski, Duffy, Casanova, Molnar, & Irimia-Vladu, 2004).

FACTORS THAT INFLUENCE CLIENT BEHAVIOR

Historically and presently, American society has been punitive towards the less fortunate. The poor, disadvantaged, and people who seek social work assistance have been and are often blamed for their plight and are targets of oppression (Early & GlenMaye, 2000). Although a formal social welfare system now assists those in need and the less fortunate, these individuals still meet with resistance and disparaging attitudes sometimes when seeking assistance with problems and unmet needs (Poindexter, Valentine & Conway, 1999). The authors submit, therefore, that the client is not always at fault for having a negative attitude towards human service professionals. Not every helping professional is unbiased or free of preconceived ideas about their clients, especially those clients who are poor. Some actually hold very negative attitudes towards clients (Rehner, Ishee, Salloum & Velasues, 1997). Some view the poor and people with low-incomes as lazy, unconcerned, and undeserving. Creating environments and learning experiences that help people to be sensitive to the needs of disadvantaged populations is in part why the social work curriculum focuses on populations at risk (CSWE, 1994). Whatever the condition that necessitates clients to seek help, social workers and other skilled helpers should remember that it takes a lot of courage, pride, and inner-strength for many people to admit that they need help and then to seek services. Helping professionals have given themselves a challenge. Under their own volition they have sought the necessary training and credentials to work with clients who are in need. By doing so, they have indicated a willingness to work with all types of people, some of whom will not always appear to appreciate what is being done on their behalf.

Besides the attitudes and actions of some insensitive and/or biased service providers, there are a number of circumstances that can account for a client's negative behavior towards a service provider. For instance, a primary familial role is the socialization of children to societal expectation, norms, and shared values (Hutchison, 1999). Extending simple courtesies such as "thank you", "please" or "excuse me" by parents and significant others is something that is taught. Not all individuals, however, are taught these courtesies as children and therefore do not subsequently offer these courtesies as adults on a regular basis. For the exceptional client who does not come from a persistently impoverished background,

he or she may exhibit negative behaviors because of pride. Having to resort to human service agencies to have one's basic needs for food met by others can be a humiliating and dissonant experience. Consequently, these individuals may lash out inappropriately out of shame, frustration, or because they may have unrealistic expectations about the services that food service agencies will provide. Others may act in a discourteous manner due to negative life situations (i.e., persistent poverty, child abuse, domestic violence, mental illness, chemical addiction, etc.) from which they have not recovered. As a result, some of these individuals may have unresolved issues that get acted out when they seek assistance. For example, there are times when people are not coping well with life situations, are ill and experiencing feelings of discomfort, are tired and irritable by the time they reach the agency as a result of transportation challenges, or are just plain stressed. Stress is probably the number one mitigating factor for unfavorable behaviors of clients seeking hunger assistance.

Poverty and all of the ails that accompany it breeds stress. Stress can result in a number of negative behaviors, especially when it is compounded by food insecurity and the resulting hunger it produces. According to Ulrich (2002), impoverished individuals suffer from a gamut of negative conditions and environmental demands. Ulrich suggests that the individual who seeks hunger assistance may also be in need of money for clothing, safe and noise-free housing, transportation, child care provisions, utilities, and automobile expenses, just to name a few. This high level of stress may then present itself as hostility towards the service provider when seeking to fulfill one of these unmet needs.

It is only normal for the human body to respond to the alarms it sends off (i.e., seeking food when hungry) (Perry, 2001). This alarm may exacerbate the stress level for food pantry users, however, when hunger needs are not swiftly met because the food pantry is only available on certain dates, at certain locations, and at certain times (Wallace, 2003) or when clients have to wait for extended periods of time in inclement weather. The individual's lack of control of his or her environment may then lead to poor self-regulation and an inappropriate response (Perry, 2001). An individual who demonstrates healthy regulations possesses the capacity to tolerate distress associated with an unmet need (Perry, 2001). Development of a healthy regulation, however, comes with time and assurance that these needs will be satisfactorily met in a timely manner like it is for a crying hungry baby who is soothed and fed by a loved one when hungry (Perry, 2001). This is not always the case for individuals living with food insecurity and hunger. Hunger, or the physical feeling of discomfort that results from being food deprived (*"Role of Clinicians in Helping Patients to Achieve Food Security,"* 2002), is a reality for millions of Americans on a daily basis.

A Case Example – Mrs. Price

The following real case illustrates the kind of situation a social worker may encounter when working with food bank clients who exhibit difficult behavior. The authors make recommendations for effective client relations when dealing with such a situation. The case is based upon an experience that one of the authors had while serving for four years as a

volunteer at an organization that provides food products to agencies that address the issue of hunger within their communities. The names of the organization and client have been changed to protect anonymity.

The United Community Food Bank Center is a non-profit agency, located in a major metropolitan area, which serves as a distribution center for over 400 member agencies that supply prepared and unprepared food to hungry individuals and families. The venues through which clients receive their food include soup kitchens, emergency shelters, and food pantries. Mrs. Price is a 45-year-old White, divorced female who is the mother of four children ages 17, 15, 8, and 6. All of her children reside with her. They occupy a three-bedroom apartment and receive federal housing rent subsidy that covers their rent expense. Her only income is the Supplemental Security Income (SSI) of $545.00 that she receives monthly as a result of a car accident that left her permanently disabled. She does not know the whereabouts of her former husband and does not receive any financial support from him. They were divorced four months before the birth of her youngest child. The government food stamp assistance of $497.00 per month that she receives does not adequately cover her family's monthly food need. Therefore, she supplements her food stamp assistance with food items that she receives from a local food pantry that receives food product from the United Community Food Bank Center. She has used this community food pantry for the past six months since being referred here by a neighbor.

Mrs. Price complained to a neighbor that she was upset about the type of groceries that were being distributed by the food pantry, stating that "there was nothing in the bag and very little in previous bags that could be used." She further asserted that the pantry staff sometimes asked her invasive questions about the father of her children and that she felt looked down upon by staff because of her low income status. During a heated argument with the social worker, who served as the pantry distribution manager at the time of her last distribution of food, she profusely used profanity and threatened to turn the agency in to the Better Business Bureau. She had to be asked to leave and was subsequently escorted from the food pantry. She vowed to never return and has not been seen since. The social worker was very irate about the incident. She suggested that her staff refer Mrs. Price to another food pantry should she return.

Discussion of Mrs. Price

Many individuals were taught to believe that an individual's economic limitations stem from their own personal deficits, that the economically disadvantaged are exceptions in an other- wise functional set of social arrangements, and that these individuals will become productive contributors to society, capable of personal responsibility by receiving counseling, education, socialization, acculturation, and rehabilitation. When social workers hold these beliefs, mutually produced, authentic communication is often hampered during the helping relationship (Rose, 2000). They also become agents of social control, maintaining the inequitable status quo by placating an otherwise dangerous population of "have-nots" (Wood & Middleman, 1989, p. 26).

In this case, it is important for the social worker to realize that Mrs. Price might see the social worker as a control agent who is maintaining the status quo or she may be angry about her position in life. Although it is sometimes difficult to pause when a client is being difficult, it is important to do so. The social worker must not be defensive and realize that discourteous client behavior is not necessarily a result of any action on the part of the helping professional. They should take time to gain a better understanding of the client's feelings. It is also important that the social worker not interrupt, argue, or pass judgment on the client (Finn & Jacobson, 2003). Active listening is perhaps the most important skill of communication. According to Finn and Jacobson (2003), "Active listening calls on us to shed our own agendas and resist the temptation to leap to interpretation too soon" (p. 203). When the client does express affects in words, the worker can make congruent statements, such as in this case: "it must be hard trying to take care of four children all by yourself", or "not being able to get the quality of food that you think you should must be frustrating" or "it must feel awful to think that people are meddling in your personal business when you are just trying to get help feeding your family." This skill helps to communicate to the client the social worker's understanding of and empathy towards the client's dilemma. The social worker does not need to feel that he/she is necessarily agreeing with the client or submitting to inappropriate behavior, but instead is simply helping to prevent a sensitive situation from escalading.

Mrs. Price is facing several challenges. Even though Mrs. Price's primary concern is food insecurity, it is important for the social worker to understand the comprehensiveness of her situation. Hence, the social worker can also use the skill of partializing the client's situation. Partializing involves taking the whole client situation, breaking the many components of the big problem into smaller parts, and verbalizing them. For instance, it is important not only for the social worker to realize, but to dialogue with Mrs. Price about the strengths and hardships of being a 45-year-old, divorced, single parent who is disabled with four children to care for. Further discussion about the adequacy or inadequacy of her Supplemental Security Income and food stamps should also take place. This skill helps the social worker to better understand the impact of the myriad of problems faced by the client and communicates to the client that the social worker has an understanding of the problem. At that point an exploration of resources and referrals can take place.

In Mrs. Price's case, any one or a combination of these variables may have caused her response to the social worker. There are times when a person's behavior is not a result of their present experience. For instance, Mrs. Price was stressed over not being able to sufficiently provide for her family; she expressed shame of having to use a food pantry and she was experiencing interpersonal conflict(s) with her children. Her outburst was a release of frustration that was clearly related to stress regarding her personal life and not anger about the food that she received. The social worker may have missed an opportunity to assess her situation and make appropriate referrals.

A Case Example - Ms. Young.

Ms. Young is a 25-year-old, homeless African-American woman living in transitional housing. She has five children ages 6, 5, 4, 3, and 2. Ms. Young had her first child when she was 18 years old. Her only source of income is TANF. She has not yet applied for food stamp assistance. She became homeless after leaving the residence that she shared with a boyfriend who became abusive. Ms. Young had many challenges when she began to access the homeless services community. She and her five children were forced to rely on family members who really did not want to help her. She was always afraid that someone would tell her former boyfriend where she and the children were. She feared that her homeless status would be reported to the Cabinet for Families and Children and that her parental rights would be terminated. Ms. Young's only mode of transportation was public transportation.

Ms. Young was advised to apply for emergency food assistance through her local food pantry. The food products that she would receive would be designed to hold her over until she could be granted food stamps while she was living in transitional housing. Ms. Young scheduled an appointment to apply for food assistance, but was told that she would have to wait for two days until the next regularly scheduled food distribution date. She was given an 8:30 A.M. morning appointment. Ms. Young had arranged childcare so that she could attend her appointment, but the childcare provider was late, forcing Ms. Young to arrive one-half hour late to her food assistance appointment. Upon arrival, Ms. Young was visibly upset, frowning, and wearing noticeably wrinkled clothing. The food assistance worker agreed to see Ms. Young even though she was late. At the beginning of the meeting with the food assistance case manager, Ms. Young began to talk aggressively to the worker and discussed everything that had gone wrong for her that morning. Ms. Young began to speak loudly, frown more, cry, and even pace back and forth in the room.

Discussion of Ms. Young

The case manager made a decision to provide the client with services and employed effective social work practice skills while doing so. First, the case manager used the skill of positioning. Positioning is intended to provide a social-emotional environment congenial to connection and rapport (Hepworth, Rooney & Larsen, 2002; Wood & Middleman, 1989). He warmly introduced himself and turned his body to position himself to look at the client as the client was talking. The case manager then made eye contact with the client and gave her occasional nods and unobtrusive "uh-huhs" that told her that she was being observed and encouraged to say more (Finn & Jackson, 2003; Wood & Middleman, 1989). When the client observed that the worker was listening and encouraging, and not discouraging her from saying more, she relaxed and took her seat. The social worker then began to convey to the client that he was in touch with her feelings by telling her that he understood that it is indeed often difficult to find reliable childcare when appointments need to be met. The client was then able to relax and give attention to what she was there to accomplish--receiving food assistance. After a discussion of other stressors in her life and possible ways in which

they could be addressed, the session ended positively with both the client and social worker departing from each other in a relaxed and congenial manner. The client left the social worker feeling satisfied and respected. The social worker was able to honestly and directly speak to the client's mistrust and invite the client's participation in a way that built mutual trust and understanding (Finn & Jacobson, 2003).

RECOMMENDATIONS FOR SOCIAL WORKERS AND OTHER HUMAN SERVICE PROVIDERS

To be effective with clients it is necessary to use good verbal and nonverbal communication skills, to treat clients in a fair and equitable manner, and to create a supportive environment for food distribution. To this end, it is suggested that social workers and other human service providers:

1.Know your clients. Take the time to get to know some of the personal nuances about your clients. Many of them come to your agency on a continuous basis. As a result, you have the opportunity to observe their demeanor. Over time you should become familiar with how to best approach a particular client. You can use an ice-breaker to make the client feel welcomed each time they come for service. Ask about the client's general state of well-being, thereby conveying a sense of caring about the client while simultaneously observing their nonverbal response. This could help you to understand how best to approach and respond to them.

2. *Attend to communication.* Be aware of the nonverbal messages that you may be sending to your clients. Two-thirds of all communications are nonverbal (Brille, 2005). Non-verbal communications include tone of voice, gestures and movements, physical appearance, and environment. Sometimes a client's behavior may be in response to the non-verbal signals that you are sending. Human service professionals are not unlike others who at any given time may have a myriad of roles and responsibilities that they are juggling. As a result, they may be experiencing stress and unknowingly project this feeling onto the client (Poindexter, Valentine & Conway, 1999). This may be particularly evident when working in overcrowded environments, such as food pantries, where there are often long lines of people who are sometimes frustrated with having to stand in line in various weather conditions to receive service and who as a result sometimes conduct themselves in discourteous ways.

3. *Elicit feedback.* The authors suggest that it is helpful to elicit and then give serious consideration to client's feedback regarding their perception of how welcoming you and your agency are. Negative feedback should not be viewed as threatening, but should be considered an avenue and opportunity for agency modification and growth (Germain, 1994). From time-to-time it is necessary to do a critical analysis of the services that you are providing and how well you are providing them. A client's comments about the quality and type of food received may provide valuable feedback about the usability and suitability of the food that is distributed. Perhaps there are other recipients who share but do not express their sentiments. Sometimes clients take the food that is being distributed only to later throw away what they cannot use. Receiving clients' feedback may help eliminate food waste that could be used by others.

Being responsive to client feedback can also prevent client dissatisfaction overall and avoidance by others of the agency (Goodman & Blanchard, 1998).

4. *Check your rules.* Have reasonable rules and guidelines that clients are expected to follow. If an individual refuses to comply with the rules of your agency, rather than argue, tell them to come back at another time or refer them to another agency. You must expect to receive the same respect from your clients that you give to them, thereby discouraging negative client behavior. It is appropriate to ask a verbally abusive client to leave the agency. Allowing bad behavior to continue will signal to other clients that inappropriate behavior is acceptable and/or tolerated. In the future, other clients may respond similarly when disgruntled.

5. *Keep a structured environment.* Maintain a supportive but businesslike environment. Once you have distributed the food products, ask the client to leave the facility. Allowing clients to congregate sometimes creates problems. For any number of reasons, clients may not want to leave the food distribution site immediately after they have received their product. While congregating, it is not uncommon for clients to compare the food that they receive. This can cause problems for the social worker if all clients do not receive the exact same product(s). Questions may arise regarding client favoritism.

6. *Be consistent.* Unless your distribution is a "shop through", be consistent with what you give to all clients. Some food distribution programs allow clients to pick from items that have been made available for distribution, hence the term "shop through". This is done in an effort to eliminate food waste by clients who receive food and non-perishables that they do not want or can not use. If clients do not have that option and/or if food distributed is predetermined, then it is very important to ensure that all receive the same items. There will be times, however, when food and non-perishable items will need to be distributed according to the need of the client. For instance, families with infants may receive diapers and infant related products that are not given to those who do not have infants. Senior citizens and medically ill persons may be given food supplements such as Ensure. If this is sometimes done, be sure to explain this practice to all clients. This will also eliminate the appearance of favoritism.

7. *Respect the privacy of the client.* Do not subject clients to unnecessarily invasive questions regarding their personal belongings or interpersonal relationships. Remember, for most people, being in a position of needing food assistance is very humbling. Being subjected to questions about their private lives is both intrusive and unnecessary. For instance, it would be inappropriate for the social worker to ask a client questions about the reason for a divorce, the paternity of their children, or how much they pay for clothing. Yet, the authors have witnessed that members of vulnerable groups are sometimes subjected to such dehumanizing inquiries by helping professionals.

8. *Be considerate.* Consider the client's plight as if you were the recipient. Sometimes clients become upset about the quality and quantity of the food that they receive. Insist that agency personnel in charge of food product procurement choose quality items for distribution. Distribute food product as if you were in need of this service and were going to be the recipient. Some clients may be justified in their criticism of the hunger services that they receive and in the manner in which it is distributed to them.

The following is a checklist that the authors feel may be useful to help ensure that you have attended to the prescribed recommendations for treating clients fairly and ensuring that you have created a non-judgmental environment where they will feel welcome, supported and valued as an individual while receiving hunger service assistance.

Have you:

1. ____ Referred to the client by name while also using an icebreaker, such as asking them about their experience with getting to your agency, to make them feel welcome to receive services?
2. ____ Paid attention to your non-verbal behavior while you interacted with the client?
3. ____ Asked the client for their feedback about the quality of services that they receive from your agency?
4. ____ Applied the same rules and guidelines for receiving services to all clients?
5. ____ Maintained a business like environment and established a no loitering policy?
6. ____ Ensured that all clients receive the same food product unless otherwise indicated beforehand?
7. ____ Taken care to respect client privacy by not asking unnecessary personal questions?
8. ____ Distributed to type and quality of food that you would want to receive if you were the recipient?

DISCUSSION AND CONCLUSION

People are not always capable of meeting their own basic human needs. There are millions of people in this society who chronically lack necessary food. This is most unfortunate considering that this country is one of the most prosperous in the world. In the modern world in which we live, life has been complicated by a number of factors. Many circumstances, both extraneous and internal to the individual, such as unemployment and underemployment, mental illness, sicknesses of various types, divorce, and homelessness cause people to be among those who seek assistance for relief of hunger. Life appears to be more stressful as people consider the threat and implications of nuclear war, the possibility of the solvency of the social security system, high divorce rates, and feelings of alienation and isolation that often accompany technological advances such as e-mail (Woodside & McClam, 1998). As a result, many people can no longer count on mutual aide and support from family and friends, as people are in constant flux and transition.

Two of the authors have first hand experiences in the food bank industry, one as a volunteer and the other as a paid professional. We have often witnessed clients behave in ways that at first glance indicated that they were not appreciative of the service(s) that they were receiving. Upon further investigation, we learned that there were a myriad of reasons for their behaviors. Being economically disadvantaged creates untold stress and strain that

perhaps only those who have experiences a lack of resources can truly understand. Often, the poor and disadvantaged are expected to be grateful for social welfare services regardless of the type that is being offered and the manner in which it is presented (Atkinson & Hackett, 2004). This is unfair and unreasonable to expect of them.

Social workers and others who provide hunger relief are doing much more than providing food to hungry people. They are often meeting self-esteem and ego needs of people, most of whom, if at all possible, would ordinarily rather not find themselves in this predicament. The authors hope that the readers of this article will have a better understanding of the issues that cause negative behaviors among some clients who have food insecurity. Having this understanding, along with employing a compassionate, kind, firm, and empathetic response to disgruntled people during service provision, may go a long way towards effectively addressing inappropriate behaviors among clients who receive hunger services.

Author's Note:

Address correspondence to Sharon E. Moore, Ph.D., L.C.S.W. is Professor at Raymond A. Kent School of Social Work, University of Louisville, Louisville, KY 40292. e-mail: Semoor02@louisville.edu.

References

Atkinson, D.R., & Hackett, G. (2004). Counseling diverse populations (3rd Ed.). Boston, MA: McGraw-Hill.

Belle, D. (2003). Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly, 27*(2), 101-113.

Berner, R. & Zellner, W. (2003). Driving the SUV to the food pantry. *Business Week*, 3830, 68.

Bernstein, A. (2001). Already, a crush at the soup kitchens. *Business Week,* 3759, 74 .

Biggerstaff, M.A., Morris, P.M., & Nichols-Casebolt, A. (2002). Living on the edge: Examination of people attending food pantries and soup kitchens. Social Work, 47(3), 267-277.

Brille, N.I., & Levine. J. (2005). *Working with people: The helping process* (8th ed.). Boston, MA: Allyn and Bacon.

Cashwell, S.T., Bartkowski, J.P., Duffy, P.A., Casanova, V., Molnar, J.J., & Irimia-Vladue, M. (2004). Private food assistance in the deep south: Assessing agency directors' knowledge of charitable choice. *Journal of Sociology and Social Welfare, 31*(2), 157-177.

Council on Social Work Education. (1994). *Commission on accreditation handbook of accreditation standards and procedures.* Alexandria, VA: Authors.

Department of Health and Human Services (DHHS). (2005). *Federal Register, 70*(33), 8373-8375.

Derrickson, J.P. & Brown, A.C. (2002). Food security stakeholders in Hawaii: Perceptions of food security monitoring. *Journal of Nutrition Education & Behavior, 34*(2), 72-84.

Early, T.J., & GlenMaye, L.F. (2000). Valuing families: Social work practice with families from a strengths perspective. *Social Work, 45*(2), 118-130.

Finn, J.L. & Jacobson, M. (2003) *Just practice: A social justice approach to social work.* Peosta, IA: Eddie Bowers Pub Co.

Germain, C. (1994). Human behavior and the social environment. In R. Reamer (Ed.), *The foundations of social work knowledge* (pp. 88-121). New York, NY: Columbia University Press.

Goodman, J., & Blanchard, A. (1998). The true cost of poor service. *Electric Perspectives*, 23(6), 50-60.

Hepworth, D. H., Rooney, R.H., & Larsen, J. (2002). Direct social work practice: Theory and skills. Pacific Grove, CA: Brooks/Cole.

Hutchison, E.D. (1999). *Dimensions of human behavior.* Thousand Oaks, CA: Pine Forge Press.

Kempson, K., Keenan, D.P., Sadani, P.S., & Adler, A. (2003). Coping strategies identified by limited-resource individuals versus nutrition educators. *Journal of Nutrition Education & Behavior, 35*(4), 179-188.

Longress, J.F. (2000). *Human behavior in the social environment.* Itasca, IL: F.E. Peacock Publishers, Inc.

Nord, M., Andrews, M. & Winicki, J. (2002). Frequency and duration of food insecurity and hunger in U.S. households. *Journal of Nutrition Education & Behavior, 34*(4), 194-201.

Pantries Provide Backup for Some Military Families. (2004, December 23). *USA Today.*

Perry, B.D. (2001). Self regulation: The second core strength. *Early Childhood Today, 16*(3), 20-21.

Poindexter, C.C., Valentine, D., & Conway, P. (1999). *Essential skills for human services.* Belmont, CA: Wadsworth.

Rehner, T., Ishee, J., Salloum, M., & Velasues, D. (1997). Mississippi social workers' attitudes towards poverty and the poor. *Journal of Social Work Education, 33*(1), 131-142.

Role of Clinicians in Helping Patients Achieve Food Security. (2002). *Nutrition in Clinical Care, 5*(4), 149-151.

Rose, S.M. (2000). Reflections on empowerment-based practice. *Journal of Social Work, 45*(5), 403-412.

Seavey, D., & Sullivan, A.F. (2001). Household food security study summaries. Boston, MA: Center on Hunger and Poverty, Brandeis University.

Sullivan, A.F., & Choi, E. (2002). Hunger and food insecurity if the fifty states: 1998-2000. Boston, MA: Center on Hunger and Poverty, Brandeis University.

Tiehen, L. (2002). Use of food pantries by households with children rose during the late 1990s. *Food Review, 25*(3), 44-49.

Ulrich, C. (2002). High stress and low income: The environment of poverty. *Human Ecology, 30*(4), 16-18.

U. S. Mayor Newspaper. January 10, 2005, 72(1). Retrieved from the World Wide Wed on 12/24/05 from http:www.usmayors.org/uscm/us_mayor_newspaper/documents/01_10_05/

Wallace, N. (2003). Maps show mismatch between locales of a city's food pantries and their clients. *Chronicle of Philanthropy, 15*(8), p.29.

Wood, G.G. & Middleman, R. (1989). *The structural approach to direct practice.* New York, NY: Columbia University Press.

Woodside, M. & McClam, T. (1998). An introduction to human services (3rd ed.). Pacific Grove, CA: Brooks/Cole.

A COMPARATIVE ANALYSIS OF ON-LINE AND CLASSROOM-BASED INSTRUCTIONAL FORMATS FOR TEACHING SOCIAL WORK RESEARCH

David Westhuis
Philip M. Ouellette
Corey L. Pfahler

Abstract. *Research comparing courses taught exclusively in traditional face-to-face settings versus courses taught entirely online have shown similar levels of student satisfaction. This article reports findings from a comparative study of student achievement in research skills from classes using two different instructional formats. One group used a classroom-based instructional format and the other group used an online web-based instructional format. Findings indicate that there were no statistically significant differences between the two class formats for eight out of eleven outcome student performance activities and ten out of 13 pedagogical strategies. There were large effect size differences based on class format on four of the student performance activities and for student satisfaction with six of the pedagogical methods. When statistically significant differences were found, it was determined that student performance on learning activities and satisfaction with pedagogical methods were higher for the students in the traditional class. The findings support the conclusions of several studies concerning the effectiveness of online teaching. Limitations and implications for further studies are also suggested.*

Key words: *WEB-based instruction, social work research, distance education,*

Distance education has become an integral component of today's higher education system. Distance education is defined as any formal approach to learning in which the majority of the instruction occurs while the educator and the learner are at a distance from one another (Verduin & Clark, 1991, p.8). For the purpose of the article, distance education, online education, Web-base instruction, and technology-supported instructional environments will be used interchangeably to reflect the use of computer technology and advanced communication networks as the primary means for delivering instructional materials.

Approximately two-thirds of the accredited four-year colleges and graduate schools complement traditional campus based courses with courses offered via the Internet (Perrin & Mayhew, 2000). Many research studies have concluded that student learning, performance, and achievement in distance education classes is comparable to that of students enrolled in traditional campus-based classes (Dalton, 2001; Kleinpeter & Potts, 2003; Knowles, 2001; Rivera & Rice, 2002; Tucker, 2001; Ouellette & Chang, 2004; Patracchi, Mallingr, Engel, Rishel, & Washburn, 2005). Courses offered via

David Westhuis, Ph.D., is Associate Professor, Philip M. Ouellette, Ph.D., ACSW, is Associate Professor, and Corey L. Pfahler, M.S.W., is a doctoral student at the Indiana University School of Social Work, Indianapolis, Indiana.

Internet allow colleges to reach individuals who wish to advance their education, but who would otherwise be unable to take courses offered in a traditional classroom setting due to constraints of time, location, or lack of other resources (Perrin & Mayhew, 2000; Tucker, 2001). While much research has concluded that online learning environments have yielded positive outcomes related to student learning, performance, and achievement in other professions, less research has been conducted in social work on how to implement online courses effectively and how to evaluate online courses.

This article reports findings from a comparative study initiated to examine social work student achievement in a social work research course that used two different instructional formats. One group of students was taught research utilizing a face-to-face, classroom-based instructional format and the other group of students was taught online using web-based instructional methods. Findings indicated that there were statistically significant differences in both student performance and student satisfaction between the two groups but for a number of comparisons there were no differences. In addition, empirical findings support the conclusions of several other studies concerning the effectiveness of web-based teaching and learning. Limitations and implications for further research initiatives are suggested. To begin our discussion, we will review the literature in three areas: (a) distance education in social work courses and programs in general, (b) the use of distance education methods for teaching research skills, and (c) the evaluation of distance education in social work education.

LITERATURE REVIEW

Social work educators have had substantial concerns regarding the use of technology to provide distance education to students (Knowles, 2001). Educators have cited possible negative impact on social integration, role modeling, mutual monitoring, and social distance as reasons for not utilizing distance education in social work education programs (Knowles, 2001). However, over time and with research progressively providing more and more positive feedback concerning use of distance education, social work programs are increasingly embracing use of distance education to provide courses to students (Dalton, 2001; Knowles, 2001; Macy, Rooney, Hollister, & Freddolino, 2001; Seabury, 2003). Approximately 20% of social work programs now offer distance education courses (Dalton, 2001; Macy et al., 2001).

As distance education has become more widely utilized in social work courses, the number of studies evaluating the use of distance education has increased. The majority of research performed has yielded positive results when comparing distance education to traditional education (Dalton, 2001; Kleinpeter & Potts, 2003; Knowles, 2001; Macy et al., 2001; Ouellette & Chang, 2004; Seabury, 2003).

A number of social work classes taught by distance education have been evaluated. Courses concerning social work policy, substance abuse, human behavior in the social environment, social welfare history, practice methods, and field instruction have all been taught via distance education and evaluated (Macy et al., 2001). The integration of technology for teaching many social work courses has often been used as a way to enhance classroom-delivered content (Ouellette, 1999). Some have reported that students enrolled in distance education courses acquire comparable knowledge

and skills when compared to students taught in traditional classrooms (Kleinpeter & Potts, 2003; Petracchi, et al., 2005). Macy et al., (2001) reported that among students enrolled in distance education courses for social work, 77% indicated that the quality of instruction was comparable to traditional courses, and 78% felt that distance education met their learning needs. One study compared results of a web-assisted practice course with a practice course using face-to-face instruction. This study found no statistically significant differences between the two groups on assignments, a midterm exam, and a videotaped exam project (Petracchi, et al. 2005). Another study found no statistically significant difference in actual interviewing skill acquisition at the completion of a practice course taught entirely online in a Web-based instructional environment versus the same course taught in a face-to-face classroom instructional environment (Ouellette, Westhuis, Marshall, & Chang, 2006).

Many instructors are teaching courses through traditional face-to-face instructional means and supplementing course work with online materials using course management software such as WebCT. Wernet, Olliges, and Delicath (2000) surveyed 39 students in a social work education course concerning the use of WebCT in the course as its course management platform. All students responded that they found the course materials and the course website helpful. Rivera and Rice (2002) evaluated student satisfaction and performance in an undergraduate introductory course in management information systems. Three sections of the class were offered; traditional, web-based, and a hybrid section that utilized traditional means of delivering lectures, assignments and tests, while using WebCT to deliver course materials and conduct discussions. Results of the study indicated no significant difference in student achievement across the three sections. However, student satisfaction was significantly higher in the traditional and hybrid sections of the course.

Other studies have indicated that web-based learning has been found to enhance teaching methods of traditional classroom-based courses. One study evaluated student satisfaction regarding use of the web to enhance learning in a mental health course. Students in this study strongly supported the use of web-enhanced teaching for the course and reported that the online environment enhanced their learning (Knowles, 2001). McShane (2004) reported findings from a qualitative research study that examined the teaching self-concept of university professors who combine online and traditional methods of teaching. Several themes emerged from the results of McShane's analysis. The professors reported that use of the web to enhance traditional teaching allowed for the development of a stronger rapport between students and professors. They also stated that using both online and traditional instructional methods of communication enabled them to get to know the students better, and interact with students with more ease. An additional benefit to using web-enhancement that was reported was that using the web encourages conscious planning and teaching of course materials. Professors stated that this increased consciousness promoted active implementation of methods that would best integrate online and face-to-face teaching. Professors further stated that utilization of the web to enhance teaching increased the proficiency of teaching and allowed for additional ways to teach and reach students. Utilization of web-enhancement allowed for the benefit of the immediacy and physical proximity of face-to-face teaching while also allowing students to be linked to multiple resources.

Distance Education and Social Work Research Courses

Some of the major objectives of social work research courses are to teach students how to use and evaluate quantitative and qualitative research, collect data, analyze data, and interpret data (Steckler, Farel, Bontempi, Umble, Polhamus, & Trester, 2001). Studies have shown that use of distance education to teach social work research methods is a promising approach (Dalton, 2001; Steckler et al., 2001).

Dalton (2001) compared three sections of a social work research methods course. One section of this course utilized in the comparison was a distance education course. After controlling for extraneous demographic variables, such as the participants' race, no significant differences were found between the online section of the course and the other sections.

Steckler and colleagues (2001) examined the use of a web-based model to train public health professionals to use qualitative research and evaluation methods. Results of the evaluation indicated no specific changes in knowledge or beliefs concerning qualitative methods. However, participants' self-efficacy increased, and self-reported perceptions of skills in data collection demonstrated significant changes. Participants reported that they found the information provided valuable and the teaching methods used to be satisfactory. This study demonstrates that use of computer technology and web-based instruction to teach qualitative methods is a promising approach. Participants reported that they found the information provided valuable and the teaching methods used to be satisfactory. Evaluation of this study demonstrates that use of computer technology and web-based instruction to teach qualitative methods is a promising approach.

A technology-supported training environment was also used to enhance the development of research skills of minority researchers in the children's mental health field. This Web-based training initiative provided a unique context for minority students to experience the actual research process as well as provided them with the necessary supports that beginning researchers require (Ouellette & Briscoe, 2002).

Evaluation of Distance Education in Social Work

The benefits of utilizing distance education in social work education are numerous. One of the greatest benefits of distance education is the flexibility that it allows students. Utilization of distance education provides educational access to students who otherwise may have been unable to attend more traditional classes (Knowles, 2001). Universities theorize that by utilizing distance education, they will be able to save money. As more students are able to access distance education, class sizes will increase, while overhead for the university will remain the same (Valentine, 2002). Additional benefits of distance learning may include promotion of self-directed learning, the potential for enhancing relationships and mentorship, and integration of the capabilities of technology and the vast resources of the Internet (Jurczyk, Kushner-Benson, Savery, 2004; Knowles, 2001; Valentine, 2002).

While the benefits to utilizing distance education are numerous, there are several issues to consider when utilizing distance education (Knowles, 2001; Macy et al.,

2001; Steckler et al., 2001). Knowles (2001) identifies several of these issues as: concerns about student academic performance, issues related to quality and accrediting standards, loss of face-to-face interaction, types of courses suited for online learning, loss of relationship building and mentorship, student adjustment to alternative learning, proper training for faculty teaching distance education, access to technology, and technical and institutional support. Other issues that merit consideration include thorough evaluation of student learner characteristics; students' age, gender, ethnicity, culture, professional experience, learning style, and motivation are important variables to consider in the implementation and evaluation of distance education (Macy et al., 2001). Faculty concerns and characteristics should be considered as well. The instructional style and characteristics of the instructor will substantially impact the delivery of course materials. The teaching style, pedagogy, of different courses should be considered. Methods that may be effective for teaching one course may be ineffective for teaching a different course (Macy et al., 2001). Types of technology, access to technology, and competence in utilizing technology of faculty and students should be considered in implementing and evaluating distance education. The effect of technological difficulties on the successful outcomes of courses should be evaluated as well (Macy et al., 2001).

With very few exceptions, students utilizing technology in distance education have similar learning outcomes when compared to students in a traditional classroom (Dalton, 2001; Kleinpeter & Potts, 2003; Knowles, 2001; Macy et al., 2001; Seabury, 2003). Students have cited several advantages to utilizing technology in distance education; the ability to link resources in many different formats, efficient in delivering course materials, resources can be available from any location at any time, flexibility, encourages independent and active learning, and can provide supplementary materials for use in traditional classes (McKimm, Jollie, & Cantillon, 2003). Disadvantages to utilizing technology in distance education as reported by students are as follows; problems accessing appropriate computer equipment, affordability of necessary equipment to access technology, quality and accuracy of course material may vary, and some students may feel isolated (McKimm, Jollie, & Cantillon, 2003).

In sum, the literature in distance education appears to suggest no significant difference between social work courses taught in a technology-supported instructional environment with traditional face-to-face classroom instructional settings. In addition, evaluation studies have identified teaching styles, pedagogical methods, accessibility, and learner characteristics as some of the important issues to consider in distance education courses. While the success of distance education compared to more traditional classroom education has been well established (Abels, 2005; Dalton, 2001; Kleinpeter & Potts, 2003; Knowles, 2001; Rivera & Rice, 2002; Seabury, 2003, Steckler et al., 2001), little research has been performed to evaluate how to improve distance education courses by making the learning experience more effective for students (Macy et al., 2001). More research appears needed to further investigate student achievement and student satisfaction with respect to medium-specific pedagogical strategies and assignments.

METHODOLOGY

Description of the Study

This study was initiated to investigate student achievement and student satisfaction with respect to medium-specific pedagogical strategies and assignments. This will further advance our understanding on how students learn research skills in a totally Web-based instructional environment compared to a classroom-based instructional setting. For this investigation, we defined a Web-based instructional environment as a course that uses solely Internet resources and Web-based instructional strategies to teach course content. A classroom-based environment is defined as a course taught entirely in a face-to-face classroom setting with supporting materials provided both in the classroom and some online via OnCourse, a course management software program.

Goals of the Study

The goal of this study was to compare the efficacy of learning outcomes in these two class formats. The study compared student achievement in these two groups on eleven identical topic specific assignments throughout the semester. It also compared their satisfaction on 13 pedagogical issues for the classes. The students' knowledge on two specific content areas, single subject designs, and program evaluation were measured at the start of the course by completing pretests. This was followed by assessing student learning throughout the semester on the basis of the grades they received on 11 assignments and tests. Identical assignments and tests were used for both groups. In addition, at the end of the class, each student was ask to rate their satisfaction with the 13 specific pedagogical issues (Noted in Table 3) such as quality of lecture and online content, professor's ability to communicate, professor's ability to adapt to different learning styles, professor's ability to use technology, and several other classroom processes.

Study Participants

The participants in this study consisted of students from a large mid-west university enrolled in two sections of an undergraduate social work course in research methods. The number of students enrolled in the traditional course was 24 and the number of students enrolled in the web-based section was 27. Students self selected which class format they wanted to take and also volunteered to participate in the study. Ninety-four percent of the students were females and six percent were males. Approximately 78% were Caucasians and 22% were minorities. Most of the minorities were African American.

Course Description & Format

The course used for this research initiative was an undergraduate social work course on research methods. The same instructor taught both sections of the course during the same fall semester. The research course was the second in a series of classes that all Bachelors in Social Work (BSW) students take to meet their requirement for research.

The focus of the class was on program evaluation and single subject designs. The two sections utilized the same text books and class materials. The following describes the class format used for each of the two class sections of the same course:

Course #1: Traditional Classroom Instruction

This section of the course was offered via a three hours per week, face-to-face, classroom environment that used a lecture/discussion instructional format which included individualized hands-on assignments and collaborative group assignments. Testing was accomplished via-multiple choice exams using questions selected by the instructor from the text book publisher's test bank, and administered online. All lecture material was posted online for students to review. Tests were also taken online and online discussion forums were used to prepare for major assignments.

Course #2: Web-based Instruction

This section of the course was offered in a Web-based instructional environment. Students were expected to access the Web-based virtual classroom every week and access online lecture material, participate in weekly discussion groups via an electronic discussion forum and complete group and individual based assignments. The web-based instruction was delivered using Oncourse. Oncourse is a server-based, course management software product that allows students to have access to a number online communicative resource such as class email, asynchronous discussion forums, and synchronous chat room facilities as well as online course materials. Assignments and exams were delivered through Oncourse and graded using an online grade book. Students completed assignments and turned them in to the instructor via the Oncourse class email system. Lectures notes and PowerPoint presentations were provided via Oncourse. Similar pedagogical methods were for both the classroom-based instructional environment enhanced with Web-based instruction and the Web-based course. Table 1 describes how pedagogical methods were used and delivered for each course.

Instruments

The instruments utilized to evaluate the learning outcomes of students for each of the courses consisted of multiple choice exams using questions selected by the instructor from the publisher's test bank, grades on six class assignments, grades for classroom participation and discussion forum participation and their satisfaction on 13 classroom process variables.

Data Collection

Data were collect throughout the semester on the various assignments and test for each class. An end of semester survey administered online gathered the data from the two classes on their ratings of the 13 classroom process variables.

Method of Statistical Analysis

Student performance was evaluated by comparing exam scores and assignment grades for the two class format using the Mann-Whitney U test. Comparisons were also done using the Mann-Whitney U test on the applicable classroom process variables. The goal was to determine if there were significant differences in student performance between classes and with their comfort with the classroom processes. Nonparametric test were used because the class sizes were below 30 and did not meet the requirement of a normal distribution needed for a parametric test (Rosenthal, 2001). Nonparametric test were used since the class sizes were below 30 and it was thought it would be difficult to meet the requirement of a normal distribution needed for a parametric test. Several of the outcome variables were also ordinal level and thus not appropriate for parametric statistics. Effect sizes (Cohen's d) were also computed to assist in helping to determine the magnitude of the differences between the groups since sample size was small and thus statistical power low. Effect size allows one to characterize the magnitude of the difference between the two classes rather than a raw difference score or a simple percentage difference. Cohen (1988) suggests that an absolute value effect size of 0.20 to 0.49 can be considered small, effect sizes of .5 to 0.79 to be medium, and an effect size of 0.80 and above to be large. "The effect size hypothetically could run the gamut from -3.70 to +3.70, although the most commonly reported effect sizes are in the 0 to 1.5 range." (Bloom, Fischer, & Orme, 2006, p. 350)

Table 1: Pedagogical Methods Used

Pedagogical Methods	Course #1 – Traditional Classroom Instruction	Course #2 - Web-based Instruction
Online Discussion Forums	None	Weekly
Classroom Discussion Groups	Weekly	None
Online Tests and Quiz	Two online test	Two online test
Use of Email Between Student and Professor	Weekly Use	Daily Use
Online Lecture and Resource Materials And Readings	Same materials Available to both Classes	Same materials Available to both Classes
Feedback on Graded Assignments from Professor	Feedback Provided via Face to Face Communication in the Classroom and notes on assignments	Provided via Discussion Forums, Emails and notes on assignments

Non-grade Experiential Exercise to Apply Learning Content	Done during classroom time	Done via Weekly Discussion Forums
Lecture Content	Provided in classroom	Text based Information provided via website
Use of Visual Presentation, i.e. PowerPoint, etc	Presented in Classroom	Available on website for viewing and downloading
Graded Assignments	Six Graded Assignments Completed Outside the Classroom	Six Graded Assignments Completed offline
Method of Submission of Assignments	Submitted Electronically via the Course Website	Submitted Electronically via the Course Website
Course Orientation	Student and Faculty Introduce self in Classroom and Review Syllabus in Classroom	Orientation Paper downloaded from website and students introduce selves to fellow discussion group members

Due to the multiple statistical comparisons (26) it was also decided to adjust the requirements for statistical significance based on the Bonferroni standard. Thus, the new requirement for statistical significance was changed from .05 to .0021.

Results

Student Performance

Student performance was evaluated by comparing exam scores and assignment grades. The goal was to determine if there were significant differences in student performance between classes. Statistical analysis utilizing the Mann-Whitey U revealed that at the start of the class there was no significant difference in the scores on the pretests on knowledge of program evaluation and single subject design content between the classes at the .0021 alpha level.

Statistical analysis utilizing Mann Whitney U revealed that there was a significant difference between the classes (p=>.0021 level) for the scores on the post program evaluation exam, post single-subject exam and the group grade for discussion forum participation.

In these areas the students in the classroom-based course scored higher but difference was small enough that it would not have changed the overall class grades from an A to a B. On eight other comparisons of graded assignments there were no statistically significant differences. Table 2 outlines results between the two classes.

The effect sizes for the 11 theses outcome variables ranged from .04 to -.99. Negative effect values in Table 1 indicate that the traditional class had higher scores on a variable than the online class. The absolute value of seven effect sizes were lower than

Table 2: Comparison by Learning Activity

Learning Activity	Mann Whitney U Test	P	**Mean scores (Standard deviation)		Effect Size
			Web-based	Traditional Class	
Group Grade for Discussion Forum Participation	122.00	0.00 *	93.74 (4.00)	97.58 (3.60)	-.99
Program Evaluation Exam	125.00	0.00 *	92.30 (5.37)	97.13 (4.37)	-.97
Single Subject Exam	145.50	0.00 *	58.37 (11.33)	69.58 (13.54)	-.89
Program Evaluation Proposal	214.50	0.04	91.07 (5.10)	94.08 (2.83)	-.71
Single Subject Evaluation Question	269.00	0.21	97.04 (3.95)	98.33 (3.19)	-.35
Pretest Grade Single Subject Design	266.00	0.27	47.26 (13.32)	51.00 (13.04)	-.28
Measurement Plan for Single Subject Design	286.00	0.47	94.07 (4.16)	95.17 (4.13)	-.26
Single Subject Evaluation Project	314.00	0.85	89.67 (6.70)	90.71 (3.88)	-.18
Pretest for Program Evaluation	306.50	0.74	59.07 (13.66)	61.04 (16.10)	-.13
Intervention Plan for Single Subject Design	321.00	0.95	94.00 (3.10)	93.92 (3.37)	.02
Grade for Attendance and Discussion Forum	310.50	0.80	94.14 (4.83)	93.94 (6.56)	.04

* Note: Statistical Significance level was set at the .0021 level. It was adjusted from .05 to .0021 based on Bonferroni method for the study due to the multiple comparisons.

** Mean scores could range from 0-100%

0.50 and thus would be considered small based on the Cohen (1988) standard. One variable had a medium effect size, grade on program evaluation proposal (ES = -.71) and three had a large effect size differences using the Cohen criteria. The three variables with large differences included; single subject exam scores (ES = -.89), program evaluation exam grade (ES = -.97), and the grade for group discussions (ES = -.99). The traditional class scored higher than the online class for these three variables. These are also the variables found to statistically difference between the two class formats.

Table 3 presents results of student's rating of satisfaction with various pedagogical components of the classes. Statistical analysis of student's rating of satisfaction between the two classes utilizing the Mann-Whitney U statistic revealed a significant difference at the .0021 alpha level for three of thirteen areas; professors ability to create a feeling of community, professor's use of course management software for course materials, and professor's organization and preparedness for the class. A lower mean score indicates a higher level of student satisfaction. The scores could range from one, which indicated "excellent level of satisfaction", two above average, three average, four below average and five unacceptable level of satisfaction. In each of three statistically significant areas, student satisfaction was higher for the classroom-based course than the online class. But, based on the mean class scores one can see that students still rated their satisfaction in these three areas as above average.

A review of the effect sizes from Table 3 indicates that for six of the 13 comparisons there were small differences using the Cohen standard, two had medium differences, and five had large differences. All medium and large effect size differences indicated that the traditional class students reported greater satisfaction for the respective variables than the totally online class members

Table 3: Comparison of Student Satisfaction

Question	Mann Whitney U Test	P	Mean scores (Standard deviation)		Effect Size
			Online	Traditional Class	
Professor's ability to create a feeling of community	130.50	.001*	2.130 (.76)	1.375 (.65)	1.06
Professor's organization and preparedness	166.50	.001*	1.583 (.72)	1.041 (.20)	1.01

Professor's communication ability	170.50	.004	1.583 (.72)	1.087 (.29)	.90
Professor's use of Oncourse for course materials	179.00	.002*	1.541 (.78)	1.041 (.20)	.88
Rate small group discussion or discussion forums	140.50	.005	2.875 (1.15)	1.952 (1.02)	.83
Rate lecture/online material	204.00	0.052	2.083 (.78)	1.666 (.57)	.61
Fairness of course policies, grades, and procedures	201.50	0.039	1.666 (.70)	1.291 (.56)	.59
Professor's ability to adapt to different learning styles	206.00	0.23	1.739 (.81)	1.454 (.60)	.40
Relevance of written assignments	233.00	0.22	1.833 (.82)	1.541 (.66)	.38
Professor's use of technology for course objectives	243.00	0.27	1.583 (.77)	1.333 (.57)	.36
Professor's availability for consultation	217.00	0.32	1.478 (.67)	1.272 (.46)	.36
Professor's timely return of assignments	262.00	0.686	1.250 (..54)	1.304 (.56)	.29
Relevance of tests	251.50	0.76	2.652	2.695	-.04

* Note: Statistical Significance level was set at the .0021 level. It was adjusted from .05 to .0021 based on Bonferroni method for the study due to the multiple comparisons.

Discussion

The result of this study indicates that there were no statistically significant differences between the two class formats for eight out of eleven outcome student performance activities and ten out of thirteen pedagogical strategies. There were large effect size differences based on class format on four of the student performance activities and for student satisfaction with six of the pedagogical methods. When statistically significant differences were found, it was determined that student performance on learning activities was higher for the students in the traditional class. Students also reported greater satisfaction with pedagogical methods. These finding do not support the findings of previous literature stating that online learning is as effective as traditional learning. The researchers believe that this statistical difference in student performance occurred for several reasons. First, while the online class had access only to Oncourse for lecture materials, assignments, exams, and communication tools, the traditional classroom-based section had access to the same Oncourse materials and communication tools in addition to the face-to-face communication with peers and instructor. In this situation, the traditional class was at a communicative advantage. They were able to communicate with the professor and peers during class time, in addition to class email and online discussion groups for answering questions and sharing information. This result does support the findings of several studies concerning the effectiveness of online teaching (Knowles, 2001; McShane, 2004; Potts, 2005; Rivera & Rice, 2002).

Limitations

Limitations of this study include the lack of random assignment to the two different class formats and the small sample size. Student variables such as access to technology, knowledge of web technology, and motivation may have affected student selection of class type and it is unclear if they affected student performance as well as selection. The small sample size and the lack of variability in demographic, primarily Caucasian females sample, makes it difficult to generalize the findings to other student groups.

A further limitation that may have negatively impacted the performance of students in the online section is that this was the first time this class had been taught online. Other difficulties that may have impacted the online section include the design of the Web-based instructional environment for presenting course materials and the lack of consistent instructional support provided to students.

IMPLICATIONS FOR FUTURE RESEARCH

Research comparing courses exclusively taught in traditional face-to-face methods versus courses taught entirely online has shown that students in both types of classes report similar levels of satisfaction and perform similarly. Future research should take into account variables such as the technology being used, specific learner characteristics, faculty concerns and characteristics, pedagogical strategies, content areas of courses, and administrative and broader community issues. In order to accurately assess student performance and achievement in an online and/or a classroom-based

research class, further studies should be done to examine specific pedagogical strategies used for teaching research skills. For example, one section of the course would be taught strictly in the classroom using entirely traditional teaching methods with students having no access to online materials as addendums to lecture materials. The second section of the research class would be taught completely in a Web-based instructional environment using only pedagogical strategies conducive to an online context. A third section would examine how combining both classroom-based instruction with online pedagogical strategies would impact learning outcomes with respect to specific research skills. The classes should have the same instructor, course content, course materials, assignments, and be allotted the same time frame for the completion of assignments. Comparing three sections of the course would allow for more accurate evaluation of student performance as well as the extent to which pedagogical strategies impact learning outcomes.

Author's Note:

Address correspondence to David Westhuis, Ph.D., is Associate Professor at the Indiana University School of Social Work, Indianapolis, Indiana, 46202. (E-Mail: dwesthui@iupui.edu).

References

Abels, P. (2005) *Distance Education in Social Work: Planning, Teaching, and Learning.* New York, NY: Springer Publishing Company

Bloom, M., Fischer, J., Orme, J.G. (2006). *Evaluating Practice: Guidelines for the accountable professional (5th Edition).* Boston, MA: Allyn & Bacon

Cohen, J. (1988) *Statistical power analysis for the behavioral sciences.* Hillsdale, NJ: Lawrence Erlbaum.

Dalton, B., (2001). Distance education: a multidimensional evaluation. *Journal of Technology in Human Services, 18*(3/4), 101-115.

Jurczyk, J., Kushner-Benson, S., & Savery, J., (2004). Measuring student perceptions in web-based courses: A standards-based approach. *Online Journal of Distance Learning Administration, 6*(4), np.

Kleinpeter, C., & Potts, M., (2003). Teaching practice methods using interactive television: A partial replication study. *Journal of Technology in Human Services, 22*(1), 19-27.

Knowles, A., (2001). Implementing web-based learning: Evaluation results from a mental health course. *Journal of Technology in Human Services, 18*(3/4), 171-187.

Macy, J., Rooney, R., Hollister, C.D., & Freddolino, P., (2001). Evaluation of distance education programs in social work. *Journal of Technology in Human Services, 18*(3/4), 63-84.

McKimm, J., Jollie, C., & Cantillon, P., (2003). Web based learning: Clinical review: Abc of learning and teaching. *British Medical Journal, 326*(7394), 870-873.

McShane, K. (2004). Integrating face-to-face and online teaching: academics' role concept and teaching choices. *Teaching in Higher Education, 19*(1), 3-16

Ouellette, P., Westhuis, D., Marshall, E., & Chang, V. (2006). The acquisition of social work interviewing skills in a Web-based and classroom instructional environment: Results of a study. [Special Issue] *Journal of Technology and Human Services., 24*(4), 53-76

Ouellette, P. & Chang, V. (2004) The acquisition of social work interviewing skills in a Web-based and classroom instructional environment: Preliminary Findings. *Advances in Social Work, 5*(1), 91-104

Ouellette, P. & Briscoe, R. (2002). Walking through the fire: Integrating technology to enhance the research skills of minority mental health student researchers. *Journal of Technology in Human Services, 19*(2/3), 91-107

Ouellette, P. (1999). Moving toward technology-supported instruction in human service practice: The "Virtual Classroom". *Journal of Technology and Human Services, 16*(2/3), 97-111.

Patracchi, Mallingr, Engel, Rishel, & Washburn (2005). Evaluating the efficacy of traditional and web-assisted instruction in an undergraduate social work practice class. [Special Issue] *Journal of Technology and Human Services. 23(1/2/3/4), np*

Perrin, K., & Mayhew, D., (2000). The reality of designing and implementing an internet based course. *Online Journal of Distance Learning Administration, 3*(4), np.

Potts, M.K.(2005). Measuring the distance: Evaluation of distance education in social work. In P. Abels (Ed.). *Distance Education in Social Work: Planning, Teaching, and Learning.* (pp. 97-117). New York, NY: Springer Publishing Company

Rivera, J., & Rice, M., (2002). A comparison of student outcomes and satisfaction between traditional and web based course offerings. Online *Journal of Distance Learning Administration, 5*(3), np.

Rosenthal, J. A., (2001). *Statistics and Data Interpretation for the Helping Professions.* Belmont, CA: Brooks/Cole.

Seabury, B., (2003). On-line, computer-based interactive simulations: Bridging classroom and field. *Journal of Technology in Human Services, 22*(1), 29-48.

Steckler, A., Farel, A., Bontempi, J., Umble, K., Polhamus, B., & Trester, A., (2001). Can health professionals learn qualitative evaluation methods on the world wide web? A case example. *Health Education and Research, 16*(6), 735-745.

Tucker, S., (2001). Distance education: Better, worse, or as good as traditional education? *Online Journal of Distance Learning Administration, 5*(5), np.

Valentine, D., (2002). Distance learning: Promises, problems, and possibilities. *Online Journal of Distance Learning Administration, 5*(3), np.

Verduin, J.R., & Clark, T.A. (1991). Distance educa;tion: The foundation of effective practice. San Francisco: Jossey-Bass.

Wernet, S. P, Olliges, R. H., Delicath, T. A. (2000). Postcourse evaluations of WebCT (Web Course Tools) classes by social work students. *Research on Social Work Practice, 10*(4), 487-504.

INTEGRATING LEARNING COMMUNITY PRINCIPLES AND STRATEGIES FOR ENHANCING ACADEMIC AND SOCIAL AGENCY PARTNERSHIPS IN SOCIAL WORK EDUCATION

Pamela Johansen
Philip M. Ouellette

Abstract. *Social work education has a long history of placing emphasis on experiential learning through required field experiences. There is, however, considerable concern regarding the fragmentation in social- work education programs between what is taught in the classroom versus what is taught in internship programs by field instructors. New ways to conceptualize and enhance the coordination gap between academia and field agencies are needed. This article provides an overview of the concept of a learning community, its relevancy to social work education, and provides examples of learning community strategies that have the potential of enhancing better linkages between faculty and field instructors. Specific suggestions for the development of learning communities are included. Learning community principles and its accompanying strategies may be one way to better conceptualize and bridge the coordination gap that is frequently confronted by the conflicting realities of dual training systems in social work education.*

Key *words: Collaboration, University/community partnerships, learning communities, networking strategies field instruction*

As in other human service professions like health care and teaching, social work has a long history of placing educational emphasis on experiential learning through required field experience. This emphasis on dual instruction systems is designed to connect the social work theories presented in university classrooms with the "real life" social work practice in community agencies. Curriculum models require that students complete a series of courses designed to link theory, practice and social work policy. Social work education programs connect with local public and private agencies that provide the field practicum or internships. The extent to which quality social work practice skills are developed is largely dependent on the nature of the partnerships that are established between university faculty and agency-based field instructors.

There is, however, considerable concern regarding the fragmentation in social work education programs between what is taught in the classroom versus what is taught in internship programs by field instructors (Bogo & Globerman, 1999; Bogo & Vayda, 1998; Jarman-Rohde, McFall, Kolar, & Strom, 1997; Reisch & Jarman-Rohde, 2000; Rogers, 1996; Rohrer & Smith, 1992; Wayne, Bogo, & Raskin, 2006). Some studies have indicated that students often report field experience as the most meaningful component

Pamela Johansen, Ed.D., LCSW, is an assistant professor, School of Social Work. California State University, Chico, Chico, CA. Philip M. Ouellette, Ph.D., ACSW, is an associate professor, Indiana University School of Social Work, Indianapolis, Indiana.

of their education, but they are at a loss to make connections between theoretical and practical experience (Bogo & Vayda, 1998; Campbell-Evans & Maloney, 1997; Fortune, McCarthy, & Abramson, 2001; Reisch & Jarman-Rohde, 2000). Coordination and the establishment of close working relationships between University faculty and agency field instructors are crucial to the successful application of dual instructional systems in social work education (Bennett & Col, 1998; Bogo & Globerman, 1999; Reisch & Jarman-Rohde, 2000). Establishing linkages and collaborative relationships between University faculty and field instructors continues to be a challenge today due to the increased demand to accomplish more with fewer resources. For example, human service organizations must deal with increasing social problems while managed care and welfare reform policies limit financial resources (Bogo & Vayda, 1998; Cree & Macaulay, 2000; Jarman-Rohde, et al, 1997; Lacerte, Ray, & Irwin, 1989; Reisch & Jarman-Rohde, 2000). Social work education programs must increasingly meet university standards for research and scholarly activities while at the same time maintaining a high standard for pedagogical activities (Bogo & Vayda, 1998; Jarman-Rohde et al, 1997; Reisch & Jarman-Rohde, 2000; Ruffolo & Miller, 1994; Wayne, Bogo, & Raskin, 2006). The differing work realities of both the academic institution and the human service organizations contribute to increasingly divided perceptions of conflicting priorities and purpose (Bogo & Vayda, 1998; Eraut, 1994; Forte & Matthews, 1994; Marsick, Bitterman, & van der Veen, 2000; Reisch & Jarman-Rohde, 2000).

The purpose of this article is to address the need for integration of theory and practice in social work education programs and to explore strategies that would enhance better linkages between faculty and field instructors. The increased demands during times of greater needs and fewer resources is a threat to the shared mission of social work practitioners and educators. Collaboration is necessary not only to create effective training programs for social workers, but to address community issues of poverty, oppression, and human well-being. Strategies based on learning community theories may be one way to enhance academic and social agency partnerships for training social work practitioners. What follows is an overview of the concept of learning communities and its relevancy to social work education. Examples of learning community strategies and a proposed model for the development of better linkages between universities and field agencies is proposed.

THEORETICAL BASIS: LEARNING COMMUNITIES AND EXPERIENTIAL LEARNING

Learning in the context of "real life" and connecting the world of academia to the world of work are not new ideas. Concerned with a need for educational reform and criticizing traditional education as static and fragmented, John Dewey advocated for the reconnection of classroom learning with "real life" experiences. Dewey emphasized the need to connect "mind to material" and the need for learning to be active and student focused (Thigpen, 1994).

Alexander Meikeljohn is considered the "father of learning community movement" (Beck, 1999, p. 11). Drawing heavily on the theoretical ideas of John Dewey and motivated by concern about fragmentation in American colleges, Meikeljohn organized

the Experiential College in Madison, Wisconsin from 1927-1932. He argued that education had become removed from the larger world of the community, resulting in "intellectual isolation" (p.7).

The ideas proposed at the Experiential College have been applied to many other settings. Although the conceptual framework of a learning community has many forms and definitions, five common themes appear significant for effectiveness. Collaboration, cooperation, interconnectedness, non-hierarchical relationships, and shared responsibility are considered important ingredients for the successful creation of an effective learning community (Collins, 1993; Eraut, 1994; Fox, 1997; Marsick, Bitterman & van der Veen, 2000; Ruffolo & Miller, 1994). A theme throughout the literature on learning communities, regardless of form, is the need for shared objectives and values of all involved participants (Gheradardi, Nicolini & Odella, 1998; Marsick, Bitterman & van der Veen, 2000).

This paradigm requires a major shift in the way we conceptualize academic and agency-based training opportunities in social work education. It has a direct impact on the very nature of the working relationships between participants in the dual system of training. It moves us away from thinking of knowledge acquired in university-based instructional settings as superior to knowledge acquired from direct practice setting (Campbell-Evans & Maloney, 1997; Rogers, 1996; Stein, 2003). A creative and problem-solving thinking process between all training partners allows for a much broader exploration of ideas in multiple contexts. The importance of human relationships is an essential component of an effective learning community.

CHALLENGES FOR THE EFFECTIVE ESTABLISHMENT OF LEARNING COMMUNITIES IN SOCIAL WORK EDUCATION

To ensure that linkages between the university and field agencies are maintained, faculty members in some schools of social work are assigned field liaison duties as part of their overall teaching function (Bogo & Vayda, 1998; Jarman-Rohde et al, 1997; Stein, 2003). These assignments require faculty to periodically visit field agencies and field supervisors and attempt to develop linkages between what is taught in the classroom and what is learned in field placements. Although the field liaison function may be considered an important part of the overall teaching responsibility of a faculty member, the implementation of this role has serious challenges. University systems provide greater rewards for scholarship and research activities as opposed to community service (Gibbs & Locke, 1989; Noble & Severson, 1995). The field liaison role tends to be time consuming, leaving less time for focus on activities traditionally valued in the retention tenure and promotion process (Bogo & Vayda, 1998; Jarman-Rohde et al, 1997; Noble & Severson, 1995). This may result in a situation where field liaison assignments are delegated to part-time or newer faculty members (Wayne, Bogo, & Raskin, 2006). The low status/high time demands of field director/coordinator and field liaison roles may result in high turnover in these positions.

For faculty members to be acutely aware of agency practices and to actively participate in the assessment and training needs of students placed in agencies, a strong professional inter-organizational relationship must evolve between university faculty

and agency representatives. The extent to which this occurs varies considerably among different faculty members and field instructors. Establishing quality university-agency professional relationships is a serious challenge for many Schools of Social Work (Bogo & Globerman, 1999; Bogo & Vayda, 1998; Jarman-Rohde et al, 1997; Reisch & Jarman-Rohde, 2000; Rogers, 1996; Rohrer & Smith, 1992; Wayne, Bogo, & Raskin, 2006).

Barriers to building successful community partnerships revolve around the issue of time and distance. Faculty members are consistently challenged by issues of time and distance due to teaching, research, and other scholarly obligations that often take precedence over other tasks (Bogo & Vayda, 1998; Noble & Serverson, 1995; Wayne, Bogo, & Raskin, 2006). Professionals serving as field instructors in agencies have similar demands. In a world of increasingly serious budgetary and financial restraints, more needs to be done with less. Time constraints make it extremely difficult for faculty and agency representatives to come together on a regular basis for meaningful partnership to evolve (Bogo & Vayda, 1998; Rosenblum, 1997; Wayne, Bogo, & Raskin, 2006).

Distance is another factor that impedes relationship building between the faculty and field instructors. In many cases, students are placed in communities and agencies that are not easily accessible to the University faculty members. Travel time for regular field visits in these cases is not only time consuming but also represents considerable financial costs to the School (Jarman-Rohde et al, 1997).

Students experience similar time and distance restraints. Due to increased costs of education today, many students are compelled to work to supplement their incomes if they are to remain in school. For example, full time students often have family responsibilities. Not only must students fulfill the academic requirements of the program, they must also maintain some form of employment activity to meet financial responsibilities (Jarman-Rohde et al, 1997; Reisch & Jarman-Rohde, 2000; Wayne, Bogo, & Raskin, 2006; Wolfson, Magnuson, & Marsom, 2005).

In addition to the issue of time and distance, there is an assumption of commonality of purpose between university social-work programs and community agencies as well as a belief in interdependence and interconnectedness between the groups. In reality, "universities give lip service to equal partnerships" (Leader, as cited in Forte, & Matthews 1994, p.230). The current system is often characterized by feelings of isolation and competition by all participants (Bogo & Vayda, 1998; Forte & Matthews, 1994; Rohrer & Smith, 1992; Ruffolo & Miller, 1994; Skolink & Papell, 1994). Developing effective collaborative communities of learning will not only require a renewed commitment from all involved participants to work toward common objectives and outcomes (Bogo & Vayda, 1998; Marsick, Bitterman & van der Veen, 2000; Ruffolo & Miller, 1994), but it will also require that all parties be ready and willing to experiment with new and innovative linkages strategies that go beyond what is traditionally done and yet are coherent with learning community principles.

EXAMPLES OF SUCCESSFUL LEARNING COMMUNITIES IN SOCIAL WORK EDUCATION

There are examples of effective learning communities connecting social work field agencies and university social work programs. The programs share a strong commitment to forming communities of open communication and shared leadership, commitment to mutual goals and objectives and understanding of the need for reciprocity between university social work programs and field agencies.

A number of agency/university partnerships have been established to prepare social workers for practice with specific client populations or public service organizations (Breitenstein & Rycus, 1997; Briar-Lawson, Schmid, & Harris,1997; Reilly & Petersen, 1997; Scharlach & Robinson, 2005; Young,1994) Many partnerships have been organized around Title IV-E training grants to prepare social workers for public child welfare practice. Funding, including student stipends and financial incentives for universities and agencies have helped motivate these collaborative efforts.

Nevada has developed a strong network of university-agency partnerships in child welfare (Reilly & Petersen, 1997). The university is deeply integrated in community social work practice not only through field internships, but in ongoing training for practicing social workers and foster parents. The program is based on a strong commitment to "shared governing structure" (p. 21) in which faculty and community agencies develop training content to meet the needs of child welfare. Community members are actively involved in university committees. Faculty members serve as board members of community social work agencies. Careful ongoing evaluation considers the needs of the university, the agencies, and the students in the context of the greater community. Aware of the special needs of non-traditional students who are less likely to form natural social networks, cooperative groups are formed using a cohort model. Increased use of technology allows commuter students ongoing communication and contact with other students, faculty members and the community. Credibility and understanding are developed by a strong commitment of the university to recruit and hire faculty with direct social work practice experience. The authors note these partnerships were not formed easily. Problems noted include faculty resistance to the amount of time necessary to commit to collaboration, agency distrust of university faculty as "unknowledgeable" and a history of failed relationships between the different parties (p. 23). It was acknowledged that the trust and commitment necessary to form the current learning community had taken many years to develop. It was also noted that having stable faculty and agency supervisors allowed for the informal and formal relationships to develop.

Young (1994) described another example of a statewide system of cooperative partnerships in Pennsylvania, again, utilizing Title IV-E funds. In this model, university faculty members worked in agency settings to provide clinical supervision of student interns and agency child welfare social workers. Practicing social workers in the community were recruited to serve as university adjunct faculty. Focus was on clarifying communication, roles and expectations.

More recently, university/community partnerships have been established to address the need for social work practitioners in gerontology. Scharlach and Robinson (2005) describe a partnership between California university social work programs and agencies serving older adults. Similar to IV-E programs in the focus on competency based learning and the inclusion of student stipends, this program utilized a "training coordinator" position. The training coordinator was an agency employee designated to work directly with field directors, liaisons, and instructors. The authors noted a need for support from higher administration, including agency directors, university directors, and deans for effective collaboration.

In contrast to IV-E and gerontology programs utilizing grants and student stipends, Noble and Severson (1995) describe an innovation university/community partnership developed to address the problems of inmate mental illness and suicide in Louisiana state-run correctional institutions. This program evolved through "chance meeting of a social work dean and community judge" (p. 85). Faculty members were recruited to work directly in correctional institutions in assessment and program evaluation. Although grant monies were not involved and the project focused on traditional teaching, research, and service expectations for the faculty involved, release time was provided by university administration. The authors noted a need for "buy in" from administration in universities and community organizations, as well as a need for the development of trust and mutual respect. The university/community collaboration resulted in ongoing opportunities for student internships, expansion of social work curriculum in response to identified needs, faculty research opportunities, and community benefits. The authors concluded that the direct involvement of social work faculty and interns in the community seemed to contribute to a more positive image of social workers.

Another model of university/community partnership operating without outside funding involved the use of single systems design to integrate field practice, research, program evaluation, and self reflection (Garcia & Floyd, 1999). Designed as a collaborative effort by a field director and research instructor, this program used a self-assessment instrument integrated throughout the curriculum including the field component. Faculty, students, field instructors, and clients were involved in student assessment. This model was unique in its use of existing resources as opposed to reliance on external funding or additional personnel.

These programs illustrate the potential for common objectives, shared leadership, collaboration, reciprocity, conflict management, and ongoing communication reflective of learning community principles. These ideas can be used to evaluate, develop, and enhance mutually beneficial partnerships between University social work programs and community service organizations. The following is a proposed model for the development of learning communities.

IMPLICATIONS FOR PRACTICE: A MODEL FOR COLLABORATION

Borrowing the ideas developed by Reamer's "social work ethics audit" (2000), the authors propose that individual social work programs conduct a "learning community

audit" as a starting point. Development of learning communities in social work education will need to begin with open communication between involved parties (Bogo & Globerman, 1999; Bogo & Vayda, 1998). One strategy proposed to open discussion between students, university faculty and field instructors in agencies and to work toward shared objectives is the use of focus groups (Campbell-Evans, & Maloney,1997; Rosenblum, 1997; Scharlach & Robinson, 2005). Such meetings could serve to initiate the process of establishing a vision of shared meaning and consequently lead towards the development of trusting relationships, as well as a belief in inclusion in the decision making process. Focus groups could be structured to evaluate existing collaborations, identifying both strengths and barriers to be addressed. The focus group learning community audit would facilitate reflection and problem-solving. Several questions would be addressed in a focus group learning community audit. (1) What are we trying to accomplish? (2) Who decides what is important? (3) How can we share resources? (4) What's in it for me? (5) What worked, did not work in the past? (6) How do we maintain ongoing partnerships and planning?

Shared objectives/values: What are we trying to accomplish?

The learning community audit would need to openly address objectives and values, without assumption of commonalties. Consistent with learning community ideas, there would be a need for social work faculty and agency practitioners to begin with negotiation of shared goals and objectives. Commitment to a common mission of training competent social work practitioners might allow for exchange of knowledge and feedback across academic and agency organizations (Bogo & Vayda, 1998; Ruffolo & Miller, 1994; Skolink & Papell, 1994).

Shared leadership: Who decides what is important?

The learning community audit would evaluate the extent to which social work education programs involve agency practitioners in program evaluation and planning. Considerations could include field instructors' involvement in curriculum planning and revision. Having current social work practitioners actively involved could allow curricula to be developed with sensitivity and relevance to specific needs of service regions. More active involvement with social work program development could allow agency practitioners to become more familiar with social work education and accreditation standards (Bogo & Vayda, 1998; Jarman-Rohde et al, 1997; Reisch & Jarman-Rohde, 2000; Stein, 2003).

Collaboration: How can we share resources?

The learning community audit would explore opportunities for collaboration, providing mutual benefits for agencies, student learning, and faculty research/service expectations. Student research and practice assignments might be coordinated with special needs of community social service agencies (Jarman-Rohde et al, 1997). These might include program evaluations, needs assessments, and community resource directories. Student and

faculty connections might be enhanced by assignment to faculty mentors and emphasis on a cohort model. Students would enter and progress through the curriculum as a group.

Reciprocity/Buy in: What's in it for me?

An important component of the learning community audit is the discussion and evaluation of potential costs and benefits for the involved parties. Busy practitioners may need incentives to commit more time to social work education activities. Incentives and social connections might be provided by university faculty presented in-service trainings, recruitment of field instructors to act as adjunct faculty members, continuing education units, and access to university facilities (Bennett & Col, 1998; Rohrer & Smith, 1992). Incentives for faculty members to work directly with agencies and field instructors might be necessary. Some researchers have suggested the assignment of "field specialists" may be a more effective means to allow university/agency collaboration and development of mutually beneficial relationships (Bennett & Col, 1998). Field specialists are faculty members hired to function primarily as field liaisons, as opposed to the model where the faculty field liaison role is part of regular teaching assignments. Field committees might include full-time faculty members, practitioners, and adjunct faculty, carefully selected to work together as links between university and agency placements. Mindful selection of field practice committees may allow relationship development, shared knowledge, and decision making. Incentives for faculty members might include research opportunities and access to current information about services and current practice issues (Bogo & Globerman, 1999; Bogo & Vayda, 1998; Noble & Severson, 1995; Stein, 2003).

Conflict, history: What worked, did not work in the past?

The learning community audit would be an opportunity for participants to reflect on shared history and expectations. Establishing effective learning communities requires a willingness to address conflict. The ability to start by acknowledging what has not worked in the past may be the first step towards establishing cooperative partnerships between multiple systems (Noble & Serverson, 1995; Marsick, Bitterman & van der Veen, 2000; Scharlach & Robinson; 2005). A true commitment to collaborative and cooperative community partnerships may require understanding of the varying cultures of the different participants, including university faculty members, students, and agency representatives. Willingness to educate one another in differences requires a belief in the potential of differences as an asset in learning (Briar-Lawson, Schmid & Harris, 1997; Noble & Severson, 1995; Skolink & Papell, 1994).

Communication: How do we maintain ongoing partnerships and planning?

The learning community audit would be an opportunity to evaluate and plan communication strategies for ongoing networking and information sharing. Individual programs should assess existing systems and processes, as well as consider innovative strategies for enhanced communication. Effective learning communities

require ongoing communication and collaboration beyond the initial focus group/audit plan. With today's computer technology and advanced communication networks, much can be done to further investigate how technology could be used to enhance faculty field liaison functions and ongoing communication between faculty, students, and agency practitioners. The integration of technology in higher education has grown considerably in the last few years, especially in the area of distance education. Experience has shown that the most favorable outcome of integrating technology in higher education has been its positive impact on the issue of time and distance (Ouellette, 1999). Technology-supported educational environments have provided some students with access to educational opportunities that were otherwise not available to them just a few years ago. Not only has technology served to bring education to a whole new stream of adult learners, it has also served to revolutionize how educators and students alike view teaching and learning. In the last decade, the discussion of "what is learned" and "how it is learned" has never been challenged to the extent it has been since the introduction of technology in the field of education (Barr & Tagg, 1995; Bednar, Cunninham, Dufy, & Perry, 1991; Cooper & Mueck, 1990; Huff & McNown-Johnson, 1998).

A technology-supported field liaison activity may not change how social work students learn social work practice in the field, but it may change how we teach these skills and how professional relationships can be enhanced between faculty and field instructors. A technology-supported liaison will undoubtedly change the economics and the way faculty liaison functions are delivered to community agencies. The use of technology shows the promise of making it easier and less expensive to produce high quality field learning experiences for social work students, especially for those at a distance (Forte & Matthews, 1994; Jarman-Rohde et al, 1997; Reisch & Jarman-Rohde, 2000; Wolfson, Magnuson, & Marsom, 2005).

SUMMARY AND CONCLUSIONS

Developing collaborative and cooperative learning communities between faculty, field instructors, and students have the potential to enrich social work education programs. Integrating strategies based on learning community principles has the potential to create a learning environment that is in keeping with basic social work values and is aligned with social work practice. Implementing learning community audits using focus groups may serve as an initial starting point to help social work programs assess and plan collaborative partnerships unique to community needs and resources. In addition to the use learning community audits, the continued advances in computer technology and improved communication networks show much promise as a medium that could enhance the way we deliver educational experiences to students and improve the nature of existing university-agency partnerships. For example, integrating today's low cost, internet-based, desk-top video conferencing technology (Wu, Fox, Bulut, Uyar, & Altay, 2004) to carry out field liaison functions would greatly enhance the nature and the quality of the relationships between faculty, field instructors and students as well as deal with the barriers of time and distance. In addition, the use of web-based evaluation tools would provide a means

to acquire immediate and consistent feedback as to student progress while in the field as well acquiring data to be used for a variety of research activities.

Despite the many challenges involved in achieving effective egalitarian working partnerships between universities and agency-based partners, the strategies presented above show much promise in creating an educational environment conducive to the development of a true learning community. Strong collaborative working relationships between students, faculty, and field instructors provide for mutually supportive and beneficial opportunities for all parties involved.

Author's Note

Address correspondence to: Pamela Johansen, Ed.D., LCSW, Assistant Professor, School of Social Work. California State University, Chico, Chico, CA 95929-0550. e-mail: *PJohansen@csuchico.edu.*

References

Barr, R. & Tagg, J. (1995) From teaching to learning: A new paradigm for undergraduate education. *Change,* 13, 163-172.

Beck, L. G. (1999). Metaphors of educational community: An analysis of the images that reflect and influence scholarship and practice. *Educational Administration Quarterly, 35 (1),* 13-17.

Bednar, A. K., Cunninham, D., Dufy, T. M., & Perry, J. D. (1991). Theory into practice: How do we link? In G. J. Anglin (Ed.) *Instructional technology: Past, present, and future.* Englewood, CO: Libraries Unlimited.

Bennett, L. & Col, S. (1998). Social work field instructor satisfaction with faculty field liaisons. Journal of Social Work Education, 34(3), 345-353.

Bogo, L. G. & Globerman, J. (1999). Interorganizational relationships between schools of social work and field agencies: Testing a framework for analysis. Journal of Social Work Education, 35 *(1), 265-275.*

Bogo, M. & Vayda, E. (1998). *The practice of field instruction in social work (2nd ed).* New York: Columbia University Press.

Breitenstein, L. R. & Rycus, J. (1997). Pennsylvania's comprehensive approach to training and education in public child welfare. Public Welfare, 55(2), 14-21.

Briar-Lawson, K., Schmid, D., & Harris, N. (1997). Improving training, education, and practice agendas in public child welfare. *Public Welfare, 55*(2), 5-7.

Campbell-Evans, G. & Maloney, C. (1997). An alternative practicum curriculum: Exploring roles and relationships. Pacific Journal of Teacher Education, 25(1), 35-53.

Cooper, J. & Mueck, R. (1990). Student involvement in learning: Cooperative learning and college instruction. *Journal on Excellence in College Teaching,* 1, 68-76

Cree, V. E., & Macaulay, C. (2000). Transfer of learning in professional and vocational education. London and New York: Routledge.

Collins, H. M. (1993). The structure of knowledge. Social Research, 60(1), 95-217.

Eraut, M. (1994). *Developing professional knowledge and competence.* London: Taylor and Francis Group.

Forte, J. A. & Matthews, C. (1994). Potential employer's view of the ideal undergraduate social work curriculum. Journal of Social Work Education, 30(2), 228-241.

Fortune, A. E., McCarthy, M., & Abramson, J.S. (2001). Student learning process in field education: Relationship of learning activities to quality of field instruction, satisfaction, and performance among MSW students. Journal of Social Work Education, 37(1), 111-124.

Fox, S. (1997). Situated learning theory versus traditional cognitive learning theory: Why management education should not ignore management learning. *Systems Practice, 10 (6),* 727-744.

Garcia, J. A. & Floyd, C. E. (1999). Using single system design for student self-assessment: A method for enhancing practice and integrating curriculum. Journal of Social Work Education, 35(3), 451-461.

Gheradardi, S., Nicolini, D., & Odella, F. (1998). Towards a social understanding of how people learn in organizations. Management Learning, 29(3), 273-298.

Gibbs, P. & Locke, B. (1989). Tenure and promotion in accredited graduate social work programs. Journal of Social Work Education, 25(2), 126-133.

Huff, M.T. & McNown-Johnson, M. (1998) Empowering students in a graduate-level social work course. Journal of Social Work Education, 34(3), 375-385

Jarman-Rohde, L., McFall, J., Kolar, P., & Strom, G. (1997). The changing context of social work practice: Implications and recommendations for social work educators. *Journal of Social Work Education, 33*(1), 29-46.

Lacerte, J., Ray, J., & Irwin, L. (1989). Recognizing the educational contributions of field instructors. Journal of Teaching in Social Work, 9(1/2), 99-113.

Marsick, V., Bitterman, J., & van der Veen, R. (2000). *From learning organization to learning communities: Towards a learning society.* Information series No. 382. Center on Educational Research and Improvement, Washington, D.C. (ERIC Document Reproduction Services, No ED 440 294).

Noble, D. & Severson, M. M. (1995). Marriages of convenience and purpose: Social work education and the community unite. *Journal of Social Work Education, 31*(1), 82-94.

Ouellette, P. (1999). Moving toward technology-supported instruction in human service practice: The "Virtual Classroom". Journal of Technology in Human Services, 16(2/3), 97-111.

Reamer, F. G. (2000). The social work ethics audit: A risk-management strategy. Social Work, 45(4), 355-366.

Reisch, M. & Jarman-Rohde, L. (2000). The future of field education in the United States: Implications for field education. *Journal of Social Work Education, 36*(2), 201-215.

Reilly T. & Petersen, N. (1997). Nevada's university-state partnership: Comprehensive alliance for improved services to children and families. Public Welfare, 55(2), 21-28.

Rogers, G. (1996). Training field instructors British style. Journal of Social Work Education, 32(2), 265-277.

Rohrer, G. E.,& Smith, W. C. (1992). Field instructor benefits in education: A national study. Journal of Social Work Education, 28(3), 363-370.

Rosenblum, A. F. (1997). Developing partnerships between social work programs and the professional community: An exploratory study of field advisory groups. Journal of Teaching in Social Work, 14(1/2), 111-125.

Ruffolo, M. C. & Miller, P. (1994). An advocacy/empowerment model of organizing: Developing university-agency partnerships. Journal of Social Work Education, 30 (3), 310-317.

Scharlach, A. E. & Robinson, B. K. (2005). Innovations in gerontological social work education: The consortium for social work training in aging: Schools of social work in partnership with county departments of adult and aging services. *Journal of Social Work Education, 41*(3), 427-440.

Skolink, L. & Papell, C. P. (1994). Holistic designs for field instruction in the contemporary social work curriculum. *Journal of Social Work Education, 30*(1), 90-96.

Stein, H. D. (2003). *Challenge and change in social work education: Toward a world view.* Alexandria, VA: Council on Social Work Education.

Thigpen, C. (1994). Meikeljohn and Maritain: Two views on progressive education. Teachers College Record, 96(1), 86-101.

Wayne, J., Bogo, M., & Raskin, M. (2006). The need for radical change in field education. *Journal of Social Work Education, 42*(1), 161-169.

Wolfson, G. K., Magnuson, C.W., & Marsom, G. (2005). Changing the nature of discourse: Teaching field seminars online. *Journal of Social Work Education, 41*(2), 355-361.

Wu, W., Fox, G., Bulut, H., Uyar, A., & Altay, H. (2004). Design and implementation of a collaboration web-services system. *Journal of Neural, Parallel & Scientific Computations, 12*, 391- 406.

Young, T. M. (1994). Collaboration of a public child welfare agency and a school of social work: A clinical supervision project. *Child Welfare, 73*(6), 659-672.