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Subscription Rates: *Advances in Social Work is* published twice each year (Fall and Spring) by Indiana University School of Social Work. Annual subscription is US $30.00 for United States, $40 for international subscriptions. Individual issues cost $15 each. The price includes postage by surface mail.

Order Information: Payment may be made by check or money order in U.S. funds to *"Indiana University School of Social Work."*

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 ISBN 1-4251-0328-6

10 9 8 7 6 5 4 3

Advances in Social Work
Vol.6, No.2.....Fall 2005

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THE SECRET STRENGTH OF SOCIAL WORK: STORY GATHERING

James G. Daley

This issue of Advances in Social Work continues the rich tapestry of conceptual and empirical work by a diversity of social work authors published in our journal issues. Dulmus and colleagues provide an intriguing exploration into how social workers view our mission. Taylor spotlights a sorely neglected population, involuntary clients, and the ethical and complex issues of providing social work services to them. Anderson and colleagues bring films into the classroom as an education enhancer and offer us a practical strategy for using films in many aspects of social work education. Wilkerson & Ouellette describe an innovative family-centered intervention for adolescents at risk. Bennett & Marshall tackle a very tough arena, adolescent sex offenders, and offer practical clinical tips for effective practice with this population. Finally, Hodge outlines the careful groundwork for a new measure of spirituality: the spirituality competence scale. Each article is distinctive and expands our knowledge of that area. Scholars and clinicians give us insights that can make us more knowledgeable providers.

In looking back on our previous powerful issues of Advances, I am struck by the range of serious work conducted to refine our profession's many areas of practice and advocacy. We have had a collection of top experts contemplate the future of social work (Spring 2005 issue), educators probe into aspects of educational assessment (Spring 2004 issue), and will have distinguished authors discuss theories of human behavior in the social environment (HBSE) in the Spring 2007 issue. We have had authors discuss the power of local community partnerships (Besel et.al., 2004) , using different intervention strategies such as bibliotherapy (Vodde et.al., 2003), friendships (Furman et.al., 2003), and poetry (Furman et.al, 2002). We have had numerous social work education innovations discussed. An article I personally found highly intriguing was Besthorn & Saleebey's (2003) challenge to expand HBSE so we connect closer to nature. In short, my time as editor so far has been filled with fascinating manuscripts that inform about our profession and what we can do with and for clients.

Another hat I wear, besides editor, is educator. I teach BSW, MSW, PhD classes with a focus on practice skills development. Each class seeks to enrich their skills and confidence. I hammer on evidence-based practice, protocols, outcome assessments, and knowing what you are doing with clients. Students comply and get more and more confident as the semester progresses. I have great pride in my students as they enter the work force.

But I notice a skill that they have and yet this skill is not spotlighted. This skill isn't usually part of textbooks but is done in spite of all the training. This skill is *story gathering.* Many students come into my classes already respecting and prioritizing the stories of clients. They rationalize it as "building a relationship" or "assessing the problem" but I suspect social workers are natural story gatherers. I recognize that there are specialty areas called narrative inquiry (Frank, 1998) or narrative therapy (Kelley, 1996; White & Epston, 1990). I am not inferring that social work students comply

with any regimen or theoretical framework. It would be fascinating to teach more about these formalized approaches. I am simply saying that social work students excel as listeners and gatherers of the stories and struggles of clients and their families.

Of course, once they have gathered the stories, we encourage students to dissect, categorize, and link pieces to different action or treatment plans for intervention. The wholeness of the story and the power of the story within the client's life can sometimes be lost in our rush to put the client's issues into neat boxes (Frank, 1998). I wonder if we are removing or disguising an already existing skill.

This editorial does not have an action plan. The purpose of this editorial is to offer one editor/educator's suggestion. Perhaps we should acknowledge more that many social work students have a strength entering the program. We should be careful to nurture that strength. The story gatherers should be welcomed and not re-directed. Perhaps social workers, once they graduate, use this skill in many practice settings. I simply ask that this skill be given its due.

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PERSPECTIVES ON THE MISSION OF THE SOCIAL WORK PROFESSION: A RANDOM SURVEY OF NASW MEMBERS

Catherine N. Dulmus
Lessi L. Bass
Shelia G. Bunch

Abstract: *Individuals with MSW degrees and who were members of the National Association of Social Workers (NASW) in the United States (N=862) were surveyed and asked what best represents the social work profession mission for them. They were provided with 7 pre-selected choices (i.e., advocacy; lobbying; social justice; community organization; clinical work with individuals, families, and groups; advancement of the social work profession; or other) from which to choose one response. Over 66% of those responding chose clinical work with individuals, families, and groups as the mission of the social work profession. With the complex problems facing societies today will social work be at the forefront of the challenge or have we turned away from our historical mission of promoting social justice? This paper focuses on the findings from this research study and discusses its implications for social work education and the social work profession, as well as those individuals whom social workers serve.*

Key Words: *profession, mission, social justice, social work education, NASW*

The social work profession prides itself in its commitment to serve clients who are disenfranchised, marginalized and oppressed. From its inception, social work has demonstrated this commitment to advocate for "the least among us" (Haynes and White, 1999) as evidenced by the work of Jane Adams and Mary Richmond (Byers & Stone, 1999). Social work students are taught through our historical roots how the profession's mission and organizing values include social justice. This traditional mode of helping exemplifies the uniqueness of the profession and is what sets social work apart from other helping professions. Though professional social workers are increasingly choosing clinical and/or private practice over public social services (Wodarski, in press), does such a change in practice settings demonstrate an abandonment of the profession's traditional mission of social justice?

Merriam-Webster (1989) defines mission as a task assigned; a specific task with which a person or a group is charged. The National Association of Social Workers (NASW, 1996) states that the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, op-

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pressed, and living in poverty. NASW (1996) further states that:

> An historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living. Social workers promote social justice and social change with and on behalf of clients. 'Clients' is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice (p.1).

All professions have missions that drive their ideals and practices (McMahon, 1996). The mission of the social work profession is rooted in a set of core values that social workers have embraced throughout the profession's history. Social work's foundation is built on a unique purpose and perspective that includes service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. This constellation of core values reflects what is unique to the social work profession (NASW, 1996). Regardless of which population or practice setting that social workers provide services in, the core values should be present and the mission of the profession should remain constant.

There has been discussion that the profession of social work has turned its back on its original mission to serve the underprivileged (Specht & Courtney, 1994), having migrated to private practice and work with the middle class. Walz and Grove (1991) attribute some of the transition from the original mission to cultural, political and economic trends and to the value systems of a new generation of middle class social workers who lack exposure to poverty and other social ills. Certainly, social workers have expanded their practice roles and settings, but does this constitute a change in how they view the mission of their profession? In considering the mission of social work, all considerations of social justice rest on a core belief that every human being is intrinsically valuable. Social work educational programs are charged with focusing on the promotion of social and economic justice. Social justice involves the idea that in a perfect world, all citizens would have identical "rights, protection, opportunities, obligations, and social benefits" (Barker, 1995, p. 354). Similarly, economic justice concerns the distribution of resources in a fair and equitable manner. Social work education programs are required to provide "an understanding of the dynamics and consequences of social and economic justice, including all forms of human oppression and discrimination" (CSWE, 1992a, p. 6; CSWE, 1992b, p.8). The Council on Social Work Education (CSWE) went a step further in 1994 mandating that content on social and economic justice be a central component of the social work curriculum (CSWE, 1994).

The NASW Code of Ethics supports the concept of social justice when it stresses that social workers' ethical responsibility to the broader society is to advocate and work for people's general welfare. They specifically state that "social workers promote social

justice and social change with and on behalf of clients" (NASW, 1996). Thus, social workers are expected to seek social justice, a condition described by Barker (1995) in which all members of a society have the same rights, protection, opportunities, obligations and social benefits.

Our professional code of ethics and social work education curriculum statements continue to emphasize the traditional and historical mission to promote social and economic justice. However, traditional thinking about the mission of social work appears to be in conflict with the current emphasis on clinical practice (Wakefield, 1988). In an effort to explore how practicing social workers view the mission of their profession, the following survey research study was conducted among master level social workers in 3 states.

METHODOLOGY

Sample and Data Collection

Members from four chapters (Maryland; New York State; New York City; North Carolina) of the National Association of Social Workers (NASW) with Master=s degrees in Social Work (MSW) were randomly selected to participate in this study. A sample of convenience, these states were selected for the sample as they were of particular interest to the researchers as they had previously practiced social work in these states. Two thousand mailing labels from NASW that were randomized and equally selected from the 4 chapters (500 per chapter) were purchased. An anonymous questionnaire designed by the authors for this study was mailed to each participant for completion, along with a letter explaining the study, and a self-addressed stamped envelope to return the questionnaire in. A 43% response rate was obtained, with 862 completed questionnaires returned. The sample (N=862) includes 27% of the responses coming from the Maryland Chapter, 21% from the New York City Chapter, 29% from the New York State Chapter, and 23% from the North Carolina Chapter. Data was collected in the spring of 1999. SPSS was used for data analysis.

Questionnaire development

A 24-item questionnaire was developed by the researchers for this study. Researchers formulated item questions and then received feedback from colleagues as to specific question content and overall questionnaire design. Modifications to test questions were incorporated as indicated from the pilot testing among these 5 colleagues. In addition to demographic information, the questionnaire included quantitative questions related to the participant's educational background, practice experience, and views as to the social work profession's mission. In regard to practice experience, questions specifically targeted their current social work position as to the setting (i.e., nonprofit; for profit) and field of practice (i.e., public mental health; health care; consultant; public welfare; private practice; educator; school;other). Additional questions asked if they called themselves a social worker, if they would belong to NASW if malpractice insurance was not available through the organization, if they would pick social work

again as a career choice if they had to do it over again, and lastly, their views as to the mission of the social work profession. When asked how they viewed the mission of the social work profession, respondents were provided with 7 pre-selected choices and instructed to choose one (advocacy; lobbying; social justice; community organization; clinical work with individuals, families, and groups; advancement of the social work profession; other).

Demographic Characteristics

Details related to the characteristics of the sample are provided in Table 1. Overall, the majority of the sample was female and Caucasian. In relation to age, 55% were under the age of 50, with 6% reporting they were over 70 years of age. Years in the field ranged from 44% with less then 10 years of social work experience to10% with over 30 years in the field.

Initial Results

With 98% of the sample answering the mission question, results indicated that over 66% of respondents chose clinical work with individuals, families, and groups as the mission of the social work profession, 13% social justice, 11% advocacy, 4% advancement of the profession, 3% community organizing, 2% other, and less than 1% lobbyist (see Table 2).

The researchers were also interested in how strongly participants identified with the profession and their satisfaction with social work as a career choice. When asked if they called themselves a social worker 90% of respondents reported yes. When asked if they had it do over would they again pick social work as their career choice, 20% of respondents reported no and 6% stated they were unsure. Furthermore, 20% of respondents stated they would not belong to NASW if it did not offer group malpractice insurance.

Further analysis

Further analysis on how respondents answered the profession's mission question was conducted. The responses of social justice, community organizing, lobbying, and advocacy were re-coded into one variable (hence forth referred to as social justice); advancement of the profession and other responses re-coded into a second variable (other), and clinical practice with individuals, families, and groups left as a single variable. Chi square analysis was conducted and no significant differences were found for demographic variables of age, gender, locality (chapter membership), if respondent held an associate's degree in human services, undergraduate major, years since obtaining the MSW degree, if degree was obtained in an advanced standing program, what setting (profit or nonprofit) their first social work position was in after completing their MSW degree, if they called themselves a social worker, or if they would pick social work again as a career choice.

TABLE 1: Characteristics of Sample (N=862)

Characteristic	n	%
Age		
20-29	80	9.3
30-39	140	16.2
40-49	250	29.0
50-59	261	30.3
60-69	79	9.2
70+	52	6.0
Gender		
Female	656	80.3
Male	161	19.7
Race (n=777)		
African-American	60	7.7
Asian American	7	.9
American Indian	2	.3
Caucasian	678	87.3
Hispanic	18	2.3
Other	12	1.5
Years in social work field (n=860)		
0-2	141	16.4
3-5	112	13.0
6-10	126	14.7
11-15	120	14.0
16-20	107	12.4
21-25	98	11.4
26-30	71	8.3
31+	85	9.9
Current social work position (n=859)		
Nonprofit	488	56.8
For-profit	253	29.5
Not employed in a social work position	75	8.7
Retired	43	5.0
Employment setting (n=743)		
Public mental health	192	25.8
Private practice	183	24.6
Health care	125	16.8
Public welfare	60	8.1
School	55	7.4
Educators	33	4.4
Consultants	21	2.8
Other	**74**	**10.0**

TABLE 2: Social Work Profession's Mission (N=848)

Mission	n	%
Advocacy	91	10.7
Lobbyist	3	.4
Social justice	111	13.1
Community organization	23	2.7
Clinical work	563	66.4
Advancement of profession	36	4.2
Other	21	2.5

In relation to their concentration in the MSW program respondents were provided 9 pre-selected choices (child & family; administration; community organization; clinical; aging; health; mental health; casework; other) from which to choose one. Significant differences were found for this variable (chi square = 76.332, df =16, p<.001) indicating an overrepresentation of individuals whose MSW concentration was clinical or mental health selecting clinical practice with individuals, families, and groups as the profession's mission. In relation to those who identified social justice as the profession's mission, significant differences were found (chi square = 21.462, df = 6, p = .002) indicating an overrepresentation of individuals whose MSW concentration was administration or community organization.

Though not significant for the variable of years since obtaining their MSW, those in the 3-15 years range since obtaining the MSW degree tended to be higher in identifying clinical practice with individuals, families, and groups as the profession's mission.

Participants were also asked what their current social work employment setting was. They were instructed to pick one choice from a selection of eight (mental health; health care; consultant; public welfare; private practice; educator; school; or other). Significant differences were found for this variable (chi square = 77.930, df =14, p=.000) indicating an overrepresentation of individuals identifying clinical practice as the mission of the profession among those whose current social work employment setting was mental health, private practice, or school.

Limitations

This survey research study utilized a self-administered questionnaire. Though the sample was randomized, it was selected from a limited geographic region and only included members of NASW with MSW degrees. Utilizing limited available information from NASW, the sample characteristics of gender and ethnicity were comparable to the sampling frame of NASW 1999 membership. That year females comprised 80% of the membership, with ethnicity breaking down as 3% Hispanic, 7% African American, and 86% Caucasian (B. Corbett, personal communication, September 3, 2002). Additional limitations of this study included the lack of a standardized instru-

ment with good validity and reliability for data collection, as well as the constraints within the instrument used. Respondents were allowed to choose only one answer from a pre-selected list of potential missions of the social work profession. A different approach might have captured a more complex view.

DISCUSSION

Implications for the profession

With the complex problems facing societies today, will social work be at the forefront of the challenge or have we turned away from our historical mission of promoting social justice? The results of this study, though limited in interpretation and generalizability, certainly are worth noting as over 66% of those surveyed chose clinical work with individuals, families, and groups as the mission of the social work profession. Only 13% selected social justice as the profession=s mission. Even when combining social justice with community organization, lobbying, and advocacy the total percentage was 27%, which is considerably less than the 66% that selected clinical work. Certainly clinical work with individuals, families, and groups can be one vehicle utilized to achieve social justice, though some in the profession would question its effectiveness to do so. Jacobson (2001) argues that "social workers make excellent clinical practitioners and the profession should continue to train people for this work, however therapy is not a particularly useful intervention for alleviating poverty, building sustainable communities, or generally improving outcomes for disadvantaged people-- goals at the core of the social work mission" (p. 53).

Implications for social work education

This initial study begs for replication and further exploration. If future research concurs, the social work profession should exam its mission and organizing values and how the mission and values are taught to social work students and to understand how practicing social workers view clinical work as our mission. Furthermore, the Council on Social Work Education (CSWE), the accrediting body established to oversee social work education, should ensure standards in regards to our mission. Specht and Courtney (1994) admonish CSWE for leaving large gaps in the education of professional social workers and further criticize social work educators for failing to provide leadership for the profession stating; " As social work has drifted into the field of psychotherapy, most schools of social work have drifted along with it. Some schools have actively pushed the profession further in this direction " (p. 149). Certainly the need for social workers providing mental health services is substantial as currently the majority of professionals providing such services are social workers (Wodarski, in press). It is not the motive of the authors to discredit this field of practice within the profession, but to recognize that we are a profession made up of multiple roles within multiple practice settings and systems and our mission of social justice must be reflected in them all. The flexibility to practice in multiple settings is one of the strengths of the profession and we must find a way to keep the mission of social justice central to our work with

all clients. Haynes (1998) states:

> We must strengthen our commitment both to help individuals clinically as well as to intervene or advocate for more expansive and humane social welfare policies. While we broaden our client base and our fields of practice, we must not lessen our attention to disadvantaged clients and public social services. We must not lose sight of nor reduce the value of those attributes of our profession that distinguish it from other professions (p. 509).

In addition to CSWE standards, it is essential that social work educators not only teach evidence-based approaches to working with a variety of populations and systems, but also provide students with a firm grounding in our mission. Longres and Scanlon (2001) question if social justice is defined consistently within the profession though "CSWE standards and NASW principles generally proceed from the belief that social justice is definable, desirable, and possible" (p. 448). CSWE must be clear in its definition of social justice, its presence within our mission, and its place within curriculum standards so that social justice is taught consistently across programs. Though integration of the profession's mission throughout the curriculum would be best, Haynes (1999) questions if we can assume this will be achieved. He proposes a theoretical framework that integrates social work professional values with the "personal, social, and political value dimensions of students" that is taught in a separate course in the social work curriculum in lieu of the assumption that these values will be integrated throughout the curriculum (p. 48). Both approaches speak to the importance of students being provided a firm grounding in our mission. Failure to do so may result in the profession of social work being indistinguishable from other helping professions, which could lead to its distinction.

CONCLUSIONS

This study provides initial findings as to how practicing social workers view the mission of their profession. Future research should further refine measurement and replicate the study to also include expanded geographic regions and non-members of NASW. The expansion of this line of research is important as such findings could have profound implications for clients. If indeed professional social workers view clinical work as the profession's mission, who will be the voice for those individuals and client groups who are disenfranchised, marginalized and oppressed? Since the inception of our profession this has been our charge. Did we give it up along the way? If additional research concurs such, it may be time to formally redefine the mission of the social work profession. But do so with caution, as such redefinition will not only have a substantial impact on our profession and social work education, but also on the clients we serve.

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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*

BACKGROUND

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 (Taylor & Bentley, 2004; Bentley & Taylor, 2002; Dewees, 2002; Kutchins & Kirk, 1997; Bentley, 1993) 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 (2002) 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; Rosenson, 1993) and cite the

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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 degree 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) of 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. 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) of 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 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

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%
Outpatient commit.	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, providing 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) of 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.

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 role
	I'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

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% of responses. The second category of job or client change contained 17.48% (n = 32), of responses. The third category, change caused by increased understanding of the reality of mental illness, accounted for 16.39% (n =30) of responses.

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, prompting 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.

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USING FILMS TO TEACH SOCIAL WELFARE POLICY

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Abstract: *Because social welfare policy tends to be among the least-preferred courses in the social work curriculum, using contemporary films to augment the course content may help students gain awareness of the nature of the relationship between micro- and macro-level social work. Films may also help to bring abstract policy concepts into a more grounded and focused format. The purpose of this article is to explore the use of contemporary film in teaching social welfare policy courses by presenting three films as case examples along with suggested discussion questions for each. The article concludes by discussing a framework and criteria for the selection and use of films for social work curricula.*

Key Words: *Social welfare policy, contemporary film, social work pedagogy*

INTRODUCTION

Many social work students complain that social welfare policy courses are "dull and boring" (Dobelstein, 2003, p. 6), while others express feeling overwhelmed by the complex landscape of social welfare problems (Gilbert & Terrell, 2002); still others express feelings of inadequacy in tackling often-intractable social problems (Anderson, in press). Students' disinterest in policy combined with their feelings of inadequacy in tackling macro-level problems challenge social welfare policy faculty to offer substantive supportive curricula to help students to master policy-related knowledge and skills.

Local and national newspapers may be used to help students gain current perspectives about contemporary social problems and the debates that occur around proposed solutions. Additionally, television news programs such as "60 Minutes," or "Meet the Press," may be viewed to increase students' awareness of social problems and the influence of economics and politics on those problems. Contemporary films may also be used to facilitate students' understanding of social problems, as films provide opportunities for students to empathize and identify with characters (Grodal, 1997). Well selected films may be useful since they ground abstract social policy concepts in real life contexts enabling students to engage with the subject matter. Put simply, films help put a human face on social problems that may seem abstract, complex, and

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overwhelming to students unfamiliar with macro-level social issues.

The purpose of this article is to explore the use of contemporary film in teaching social welfare policy courses. It will do so through three primary methods. First, we discuss the relevance that films have for higher education in general, and social work in particular. Second, we present three films as case examples, including assignments and exercises used to increase students' understanding and application of social welfare policy concepts. Third, the appropriateness of each of the films is analyzed by applying criteria for film selection and use (Downey, Jackson, Puig, & Furman, 2003). The final section explores the implications of using film for social work education.

THE USE OF FILM IN HIGHER EDUCATION

Popular films are widely viewed by today's young adults. Films often address human behavior and social issues relevant to the helping professions. Due to their wide appeal and ability to intellectually engage college-aged students, several health and mental health disciplines have begun to use popular films in their various curricula.

Psychiatry, for example, has used film to instruct medical students and psychiatric trainees regarding cultural awareness. Psychiatry training programs have used films to increase cultural competence by identifying differences and similarities between the culture in the film and the trainee's own culture and by identifying issues relevant to delivering services to this population (Bhugra, 2003).

In addition to cultural competency, the medical field has also advocated for the use of film to teach medical students about intoxication and withdrawal syndromes. In a recent study, more than 90% of medical students believed that movie clips helped them to identify substance related syndromes and gave them insight into the severity of symptoms (Welsh, 2003).

The nursing field has also embraced the use of film in teaching advanced practice mental health. In a study of master's students' perspectives on the use of film in an on-line course, Raingruber (2003) reports films promote reflection, arouse emotions and empathy for clients, and are a good way to present both mental health content and introduce ethical dilemmas.

Teaching about psychological disorders in a course entitled "Images of Madness," Fleming, Piedmont, & Hiam (1990) use feature length films preceded by lecture and followed up by class discussion. Student reports at the end of the course showed films realistically portrayed posttraumatic stress syndromes and substance abuse while doing a poorer job regarding eating disorders. Overall, students felt the use of films helped to increase their knowledge about psychological disorders and thinking about mental illness (Fleming, et al., 1990).

Marriage and family therapy counselor education programs use films to help counselors in training to develop skills related to the way they perceive clients, conceptualize problems and execute treatment plans (Higgins & Dermer, 2001). Gladding (1994) uses films as a form of evaluation in marriage and family courses by asking students to identify family patterns and possible problems in families featured in films.

Toman and Rak (2000) reviewed the use of film with counselors and found film instruction useful in teaching "diagnosis, counseling theories, interventions and ethics" (p. 1). The authors further report graduate students' follow up questionnaires describe high satisfaction in learning the material, increased engagement in the material and better understanding of counseling field (Toman & Rak, 2000).

Despite positive reviews for using film in various curricula, caution should be used in implementation. Bhugra (2003) calls for careful use of film as many films may give a socially stereotypical portrayal of different cultures. This is substantiated by nursing students' suggestions that particular attention be paid to distinguishing a film's dramatic portrayal verses real-life portrayal of people's experiences (Raingruber, 2003). The importance of teacher-led discussions and reflection prior to and/or after viewing popular films is noted in the literature (Nugent & Shaunessy, 2003).

Feature films should be used to complement lecture and other forms of literary information and not as the sole basis for informing students. For example, students or trainees may over generalize the portrayals of mentally ill characters in films. Identifying the symptoms while recognizing them in the context of entertainment film is important (Byrne, 2003).

Logistical obstacles should also be addressed by teachers using films. Nursing students reported inconvenience in that films are time consuming to watch or may contain uncomfortable information. Raingruber (2003) suggests giving students a variety of film options from which to choose. Students should be allowed to make educated decisions on the different perspectives certain films might take on a topic and levels of violence/sexual content that fit their comfort levels (Raingruber, 2003).

THE USE OF CONTEMPORARY FILM IN SOCIAL WORK EDUCATION

While the literature about the use of film in related fields is extensive, the social work literature is less voluminous. However, there is evidence that the profession is recognizing the value of film in teaching certain course content, such as adolescent development and social context (Downey, Jackson, Puig, & Furman, 2003), therapeutic interventions (Vinton & Harrington, 1994), and social problems (Dressel, 1990).

An exploratory study by Downey, Jackson, Puig, and Furman (2003) confirms the findings of other professions' studies, as students reported positive responses upon viewing two motion pictures depicting mental illness and racism. The authors report over 90% of students agreed that the film enhanced their learning experience, complemented lecture information, and addressed learning objectives of the course. Visual learners and traditionally aged students in particular found the use of film the most helpful in illustrating concepts and theories of human behaviors and social problems (Downey, et al. 2003).

Moreover, using contemporary films in human service education allows instructors to make linkages between the relatively predictable world of the classroom and the more disorderly realities of the practice world (Downey, Jackson, & Furman, 2002). The authors suggest five characteristics of contemporary film that may account for their relevance in the classroom: films are concrete, providing a physical reality while

documenting a narrative; films present human and cultural diversity; films invite praxis, combining social and political theory with practice; the complexity of a film's storyline leads students to grapple with the reality of multiple approaches to assessment and intervention; and films encourage more active student engagement in the educational process. The authors urge instructors to make certain that each of these five areas is actively attended to by the classroom instructor in order to maximize the educational use of a film. All too often, films are used in a more random manner and are not utilized optimally.

Typically, films are used as case studies in the classroom, allowing students to develop an empathic connection to characters that may not occur with traditional case studies (Grodal, 1997). Since films are multi-sensory they can stimulate thinking and affect in a more holistic manner than written case-studies. For courses focused on individual and/or family diagnosis and treatment, then, films can be beneficial in introducing students to the complexity of family life in contexts that are different from their own (Pescosolido, 1990).

Given that films have been shown to help students gain skills in conceptualizing problems, diagnosing illnesses, and heightening cultural sensitivity in working with individuals and families, it makes sense that instructors might also use films to help students conceptualize social (as opposed to individual) problems, assess environmental factors, and identify strategies to address these issues. It is arguably more difficult, however, to locate contemporary films that cover macro-level content, including administration, community organization, and social welfare policy. Indeed, a national social work educators' listserv frequently posts questions by faculty members inquiring about film suggestions for macro courses. What is missing from these inquiries, however, are discussions about the knowledge and skills students should gain from viewing the film and the assignments and exercises that can be used to evaluate students' learning. The following section presents three films and accompanying assignments used by the authors to teach students policy concepts and skills.

FILMS IN SOCIAL WELFARE POLICY COURSES

Preparation for Viewing a Film:

Contemporary films that address social problems and/or social policies often include themes that are controversial; indeed, many contain graphic language and/or imagery that can be offensive to some students. Instructors should not only assess their students' readiness for viewing such films, but need to prepare them by discussing the purpose of the film and establishing parameters for the experience. In other words, students should be directed to focus on the substantive content of the film and its relevance to social welfare policy rather than a particular actor or actress in the film. Students should be introduced to the subject matter prior to viewing the film. This can be done through lectures and class discussions – discussing the pros and cons of eligibility rules, for example, prior to viewing a film about poverty. Additionally, having students complete value inventories about social problems prior to viewing the film

can help them mentally prepare to focus on the policy content.

Viewing Films about Social Welfare Policy:

Most films that include policy content also include content about administration, community development, and community organization. Therefore, the films identified below could be used with equal success in other macro courses. Ultimately, it is up to the instructor to determine how the film helps fulfill the course objectives.

Table 1. Description of Three films with sample discussion questions and areas for assessment

Film Title	Description	Sample Questions	Student Assessment
Scout's Honor	Documentary depicting a Boy Scout seeking to change policy restricting gays from joining or holding leadership positions in the Boy Scout organization.	What were the values that influenced Steven, his family, and others to take a stand about the ban on gays in the Boy Scouts? How did Steven want eligibility for membership determined? How did the Boy Scouts want eligibility determined? What groundwork occurred before advocacy began? What lobbying methods did he use? Assess the effectiveness of each. How was Steven changed by this experience? How was the national organization changed by this challenge?	Knowledge: Discrimination Gay rights legislation Ecological perspective Role of judiciary Social justice Policy analysis framework Skills: Advocacy Lobbying Campaign organization Petition drives Public speaking Policy analysis

Film Title	Description	Sample Questions	Student Assessment
Losing Isaiah	A middle class Caucasian family fosters and then adopts an African American baby. Three years later, the baby's bio-mother (recovering from drug addiction) seeks reinstatement of her parental rights. The last half of the film takes place primarily in the courtroom.	If social work values include "commitment[s] to human welfare, social justice, and individual dignity (Reamer, 1987, p. 801), does the social worker fulfill those values or violate ethical practice by fostering and adopting her client? Compare the adequacy, equity, and effectiveness of punishment vs treatment for drug addicted mothers. Should there be a state of limitations on one's ability to seek reinstatement of parental rights? Is it cultural genocide to permit cross-racial adoption? What is the appropriate role of the judiciary in adoption decisions?	Knowledge: Linkages among social problems, including drug abuse, poverty, substandard housing, child abandonment, and institutional racism Link between values, ethics, and professional actions Child welfare policy and practice Relationship between poor inner-city neighborhoods and prevalence of drug abuse and crime U. S. drug policies and social welfare Trans-cultural foster care and adoption Skills: Cultural competency Problem analysis skills Policy analysis skills Identification of strategies to address complex social problems

Film Title	Description	Sample Questions	Student Assessment
And the Band Played On	Fact-based film describing the evolution of HIV and AIDs with respect to the U.S. Center for Disease Control's role in the diagnosis and treatment of the disease, as well as the influence of the Reagan Administration's public policy about AIDS research and treatment.	The social problem of HIV/AIDS was framed differently by the physicians, politicians, victims, etc. Choosing one group's perspective, analyze the problem of HIV/AIDS. Apply the following evaluation criteria to contrast the advantages and disadvantages of giving cash versus in-kind benefits to HIV/AIDS victims: consumer sovereignty, target efficiency, cost-effectiveness, and trade-offs. What value conflicts were evident among disease sufferers, researchers, and administrators? How did these differences in values and ideology influence entitlement and eligibility decisions? Accessibility refers to the extent to which obstacles block entry to the service delivery network. List 3 examples of obstacles and identify a solution for each. Give 2 examples of how funding availability and/or constraints influenced service delivery. The purpose of policy analysis is to take action based on your assessment of the policy. First, take a position about the problem of HIV/AIDS and write a policy statement. Then, identify 2 strategies or tactics you would use to advocate for this policy.	Knowledge: Policy formulation, implementation, and evaluation processes Impact of power and wealth on policy and practice Role of media in policy process Role of the U.S. government in policy Skills: Cultural competency Social action Lobbying Public Speaking Community organizing

Described above are three films that are recommended for use in social welfare policy courses. We provide sample questions that can be used to facilitate class discussion or as individual assignments completed by each student and graded by the instructor. We also identify the knowledge and skills students should be able to demonstrate upon viewing the film and answering the discussion questions (assuming they have also read relevant text material and attended lectures). Please note that the questions and assignments are samples and intended to serve as guides only.

DISCUSSION

The research conducted by Downey and colleagues (2003) suggests that films ought to address five areas if they are to be meet course objectives. First, they should engage students in the course content and educational process. Second, they should document a narrative concretely to help students grasp course concepts. Third, they should depict human and cultural diversity without over-generalizing or presenting a socially stereotypical portrayal. Fourth, they should capture the complexity of problems so that students realize that multiple approaches could be implemented. Finally, they should demonstrate praxis by enabling students to link theoretical concepts to practice. This section examines how each of these five areas is addressed by the three selected films.

The beauty of using film to teach social welfare policy is that, for the many social work students uninterested in or wary about social welfare policy courses, films can interest and even engage them in policy content if the films portray an individual or family suffering from a social problem. Integrating the human component, then, is critical to the successful use of contemporary film. Each of the three films presented here does this. For example, the birth mother in "Losing Isaiah" is depicted as loving her son, but suffering from addiction problems that hamper her ability to care for him, while the foster/adoptive family is shown as compassionate and caring, yet flawed as they neglect one another in their quest to keep Isaiah.

In contrast, Steven Cozza in "Scout's Honor" tends to come across as a superhero in his advocacy efforts. To humanize him, the film-makers show him playing soccer, doing chores, and arguing with his mother – in short, acting like a "normal" adolescent boy. This could empower students to consider ways in which they, too, might take action on policy issues, thus reducing some of their feelings of helplessness and/or hopelessness.

Although "And the Band Played On" is more focused on organizational and national policies, it, too, introduces the human component by following one researcher as he struggles to identify and make sense of an unidentified and potentially deadly virus. Additionally, by flashing the pictures of celebrities who have died of AIDS, this film helps students connect the disease with actors, musicians, authors, and others with whom they may be familiar. In sum, by including the human element, students engage quickly with the social problem and are able to understand how individual problems often are also social problems.

Second, films concretize social problems in a way that lecture, discussions, and even guest speakers can not. Viewing discrimination in "Scout's Honor," for example, enables the student to see the effects of discrimination on friendships, within neighborhoods, and within the larger community. In a particularly moving example, Steven Cozza's life is threatened because he refuses to back down in his quest. In a graphic and arguably more powerful presentation, "Losing Isaiah" portrays the links between drug abuse, poverty, and substandard housing when Isaiah's mother refuses to leave her baby in her public housing tenement while she searches for drugs. Finally, "And the Band Played On" shows people slowly dying from AIDS, suffering from weight loss, open sores, and dementia. While such portrayals can be difficult for students to watch,

they convey the devastating and real effects that social problems have on individuals, families, organizations, and communities.

As an added bonus, these films provide an opportunity for instructors to introduce the ecological perspective and systems theory into the social welfare policy course, thus enabling students to understand how the ecological and systems models can be applied to macro practice, concepts that can be difficult for beginning social work students to grasp.

Third, although as discussed earlier, instructors should not rely solely on films to teach diversity content, films can be extremely useful in sensitizing students to human and cultural diversity. Of the three films presented here, "Scout's Honor" and "And the Band Played on" address issues of sexual orientation and discrimination and the subsequent impact on policy implementation. "And the Band Played On" also addresses racial, gender, and lifestyle diversity among HIV and AIDS patients, so that students become aware of the extent of the disease's reach.

"Losing Isaiah" also addresses racial diversity as the primary social problem in the film is whether or not cross-racial adoptions are acceptable. Because the film portrays both the biological mother (who is African American) and the adoptive mother (Caucasian) as loving but flawed, our experience is that students do not stereotype but rather come to appreciate the perspectives of both. Gaining the ability to understand and appreciate multiple perspectives is an important social work skill, particularly in policy analysis, and this film helps students develop that awareness.

Next, films increase students' awareness of the multiple and complex factors that contribute to social problems; the conflicting perspectives about the impact of each contribution; and the multiple approaches that are often used to ameliorate social problems. As a result, students gain an appreciation for opposing viewpoints and power differentials that influence policy-making. In "Scout's Honor" for example, many of Steven Cozza's friends, along with the national Boy Scouts organization oppose his efforts to change the eligibility policy. Ultimately, they witness the influence of the U.S. Supreme Court as it upholds the national Boy Scouts' policy restricting gays from membership.

Equally controversial, "Losing Isaiah" displays the opposing viewpoints inherent in cross-racial adoptions. At the heart of this issue is the tension between meeting the cultural identity needs of the child and the child's need for a permanent home. Despite research which suggests that African American children do not adversely suffer from growing up in white families, many social workers believe that children ought to be placed in families that are the same as their birth culture (Hogan & Siu, 1988). As a result, this film provides an excellent starting point for students to debate the issue of cultural genocide by comparing the Indian Child Welfare Act of 1978, for example, with research about cross-racial adoptions of African American children.

As a final example, "And the Band Played On" powerfully exposed the polarization that resulted between the Center for Disease Control researchers and their administrator as the former sought to research and treat the disease while the latter was constrained by the Reagan Administration in providing adequate funding. Not lost on the

students is the assumption in the early 1980s that HIV and AIDS occurred primarily in gay communities and that this may have led to the lack of federal funding. In sum, by being exposed to these types of ethical and practical dilemmas, students grapple with determining the most acceptable solution for a social problem while also realizing that every policy intervention is accompanied by unintended consequences.

Fifth and finally, films should demonstrate the concept of praxis – and the three discussed here do that as they enable students to not only gain knowledge about policy concepts, but each film also depicts some type of social action – the ultimate purpose of policy analysis (Chambers, 1993). For example, in Scout's Honor, the young protagonist Steven Cozza solicits signatures on petitions, marches in the San Francisco Gay Rights Parade, and appears in public venues to speak about the problem. The biological mother in "Losing Isaiah" finds a social worker who advocates for her by helping her find a job, a home, and an attorney so that she can work to get her son back. The film "And the Band Played On" displays advocacy efforts that include organizing gay men, petitioning city officials, and lobbying the U.S. Congress – each film illustrating a range of policy actions and strategies. By viewing these various approaches, students are exposed to important policy practice skills, which – when provided concrete examples – empower rather than intimidate them.

CONCLUSION

The use of films in social work education is an important pedagogical practice. Much of the literature on the use of films concentrates on their use in the areas of diversity, mental health issues, and family dynamics. Social welfare policy has historically been a course that generates less enthusiasm among students, largely because they fail to see the relationship of policy to their desire to practice micro-level social work. The goal of this paper has been to show that the use of films can inject this enthusiasm into the study of social welfare policy by drawing students into a storyline that allows empathy and the understanding of very complex social problems. Films can illustrate the nature of the relationship between micro- and macro-level social work, and they have the potential to bring abstract policy concepts into a more grounded and focused format. Combined with other typical pedagogical techniques, the use of films to teach social welfare policy can result in extensive exploration and even original research. Three films have been discussed in this paper. Suggestions for their use and possible discussion questions relative to social welfare policy have been presented. In addition, the necessities of careful selection of the films and preparation of the class for the film's use have been identified. In addition to those criteria, the following issues must be considered in the selection process: length of the film (to fit the class period); intensity of subject material (as a preparation issue); storyline (appropriate content); era of the film (timelessness or dated); "the hook" (might be actors, situations, provocative focal point, life experiences/identification, or cultural issue); and the type of film (documentary, reality-based, animated, etc.). The result of using films to teach social welfare policy can be an engaging and stimulating classroom experience with long term benefits for students undertaking social work education.

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COMMUNITY ALTERNATIVES FOR LOVE AND LIMITS (CALL): A COMMUNITY-BASED FAMILY STRENGTHENING MULTI-FAMILY INTERVENTION PROGRAM TO RESPOND TO ADOLESCENTS AT RISK

David Wilkerson
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Abstract: *Family strengthening has become a source of growing interest, research, and program design in the fields of prevention and treatment for problems of youth delinquency, school failure, alcohol, tobacco and other drug abuse (ATOD). Despite many studies that illustrate positive outcomes of family strengthening programs and family-focused interventions, their use in communities has not advanced commensurate with their promise. This article offers a rationale for why programming efforts should continue to be directed towards family strengthening efforts as opposed to youth-focused only interventions. In addition, a community-based, family-strengthening alternative is described that addresses issues of youth delinquency while reducing barriers associated with availability, accessibility, and cost.*

Key Words: *empowerment, multi-family intervention, family strengthening, adolescents at risk.*

For problems of youth delinquency, school failure, alcohol, tobacco and other drug abuse (ATOD) family strengthening programs have become a source of growing interest, research, and program design in the fields of prevention and treatment. Who is going to love and care enough to make the long-term efforts needed for change? Family strengthening interventions offer important answers based on their demonstrated success in years of outcome studies (Kumpfer and Alvarado, 1998). But while family focused interventions such as family strengthening approaches have shown much promise, they are not as prevalent as the use of youth only focused interventions when working with at-risk youth with ATOD (Muck, Zempolich, Titus, and Fishman, 2001). There are several reasons for the limited use of family strengthening approaches including cost and accessibility of these services.

This article offers a rationale for why programming efforts should continue to be directed towards family strengthening efforts as opposed to youth-focused only interventions when dealing with serious problems of youth delinquency and problems of ATOD. What follows will describe the design of one community-based, family-strengthening program that addresses issues of youth delinquency and ATOD while reducing barriers associated with availability, accessibility, and cost.

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FAMILY-FOCUSED VS. YOUTH-FOCUSED INTERVENTIONS

There is a substantial body of literature demonstrating family-focused interventions to be the most powerful and enduring interventions for adolescent presenting problems of alcohol, tobacco, and other drug use (ATOD) and youth delinquency (Dishion, & Kavanaugh, 2003, Kumpfer 1999). Family-focused interventions include those that are family strengthening. They build on the family influences that protect youth while mediating family influences, which place youth at risk. Years of studies have demonstrated decreases in child and adolescent problem behaviors when interventions aim at strengthening family protective factors such as positive parent-child attachment, and effective behavior management and reinforcement (Spoth, Kavanaugh, & Dishion, 2002). Studies have demonstrated adolescent presenting problems of ATOD and delinquent behavior decrease when interventions focus on strengthening parent nurturing behaviors and behavior management skills. (Spoth, Redmond, & Shin, 2001). Research has identified positive child outcomes from activities that focus on positive parental mental health, household routines, shared parent-child activities (Marsh, 2003). Effective family management by parents when the adolescent was 15 was found to lower the probability of youth violence at 18 years to 17% whereas the probability of violence increased to 41% when effective management was absent (Herrenkohl, Hill, Chung, Guo, Abbott, & Hawkins, 2003).

Family-focused intervention programs are increasingly studied because the youth-focused treatment approaches and programs that have been developed and implemented have been demonstrated to be ineffective for problems of youth delinquency and ATOD. These include intensive casework, remedial reading programs, training for employment, teaching social skills, participating in outdoor activities, individual psychotherapy, group psychotherapy, probation, institutionalization and residential treatment programs (Wilson & Herrnstein, 1985). A widely used youth only focused intervention, the Drug Abuse Resistance Education program (DARE), used by as many as half of the United States public and private schools, was demonstrated to be ineffective (Zickler, 2003).

Youth-focused interventions have also shown to be damaging to adolescents at high risk for delinquency and ATOD. For example, interventions in groups which aggregate youth with high risk for delinquency were harmful and increased both ATOD behaviors and delinquency (Dishion, Poulin, & Burraston, B., 2001). Placement in a group home setting as opposed to a therapeutic foster home setting increased opportunity for delinquent behavior and resulted in more arrests (Chamberlain, Fisher, & Moore, 2002). The Cambridge-Somerville Youth Study examined the effects of massive social work interventions for delinquency prior to World War II for adolescents after thirty years. This study found that negative life outcomes were 10:1 for adolescents who were aggregated in a summer camp for two successive summers compared to the matched control group (Dishion, McCord, & Poulin, 1999).

Despite ineffectiveness and iatrogenic results, youth-focused only programs continue to be financially supported. For example, in one Mid-West community, the first author recently attended three different county's local drug free coordinating council

meetings, which included discussion of funding objectives for the prevention and/or reduction of ATOD problems with youth. In each county, all projects associated with prevention or intervention activities for children and teens were youth-focused only programs and interventions.

Various reasons have been cited for the continued predominance of youth-focused interventions despite their ineffectiveness. In a literature review on family strengthening research, Kumpfer (1999 p.5) notes, "Historically, earlier approaches to rehabilitation and therapy assumed that it was the youth who had the problem, not the family. Additionally, working with children and youth is also much easier than working with parents and other family members. Children and adolescents are generally more accessible through schools and community groups for participation in delinquency prevention activities than are entire families."

Barriers to the implementation of family-focused interventions including availability and accessibility of intervention services for families are seen to result from multiple factors. In the mental health field, the previous decade has seen the dominance of insurance companies and managed care directing nature and delivery of treatment services. The result has favored bio-psychiatric treatments with family-focused approaches being utilized in a limited fashion and only as an adjunctive treatment to medications. Pharmaceutical companies, with their exhaustive marketing and selling of psychiatric medication based on a bio-psychiatric ontology of mental disorder, have further eroded demand for family-focused intervention programs (Duncan and Miller, 2000). What has been observed from personal experience in working with families is that parents who can afford treatment services believe solutions to youth difficulties are only available through chemical treatments. With this perspective, parents, and practitioners tend to ignore the family's own expertise and abilities as an essential resource in finding solutions with youth experiencing serious behavioral difficulties.

DESIGNS FOR FAMILY-BASED INTERVENTION MODELS

During the past thirty years, many family-based models of intervention have been extensively developed to address the issue of troubled adolescents and their families (Minuchin, 1974; Haley, 1980; Fishman, 1988; Madanes, 1991; Selekman, 1993). Not all family strengthening programs and models of intervention, however, are designed or implemented in the same fashion. Each focuses on a particular aspect of family functioning when designing or implementing intervention strategies. Each also delivers help-giving practices, which utilize methods that range from a continuum of expert-based methods with only the professional determining what is needed, to empowerment-based methods where the client or family determines what is needed.

A conceptual cornerstone of most family-based intervention models is family systems theory (Nichols & Schwartz, 1998). Essentially, a family systems view of a problem youth is its focus on the manner in which the young person's functioning is related to parental, sibling, and extended-family functioning as well as to patterns of communication and interaction within and between various family members (Ozechowski & Liddle, 2000). More recently, family-based models of intervention that address severe problems of youth have expanded the boundaries of clinical intervention beyond the

family unit and include the family's social and ecological context as an important part of the overall process of intervention (Liddle, 1995; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998).

One consequence of thinking ecologically has been its influence on present-day changes in the children's mental health field. For example, considerable efforts have been made in recent years to develop responsive community-based systems of care that emphasize individualized and culturally competent services developed in close partnerships with families and human service practitioners alike (Coe & Poe, 1993; Stroul & Friedman, 1996). This concept has captured the attention of national experts, advocates, and policy makers. The results led to human service practices that focus on the importance of establishing strong collaborative working relationships with those closest to the child needing service (Skrtic, Sailor, Gee, 1996). In addition to influencing the creation of strong client-professional partnerships, ecological perspectives have contributed to a greater appreciation for the concept of client empowerment (Rappaport, 1984; Wallerstein, 1992). Empowerment strongly suggests the need for a change in the way human needs and concerns are viewed, addressed, and operationalized. Not only is empowerment viewed as an important characteristic of a well developed system of care serving the needs of children, empowering families provides parents with the necessary social supports needed as they negotiate the vast network of social systems that often become involved in their children's lives as a result of their emotional and/or behavioral difficulties.

Despite the considerable efforts made at the policy level to influence a change in the delivery of mental health services to children, there have been modest gains in the area of developing effective service delivery systems for children with serious emotional disturbances and their families (Duchnowski, & Friedman, 1990; Knitzer, 1993). Significant impediment to gains in this area lies in the fact that interagency system development for children's mental health is considered a very difficult concept to operationalize at the community level for poorly funded community mental health service delivery systems, most especially in a funding environment that favors deficit-based, youth-focused only models of intervention. In addition, the system of care model largely depends on proactive and highly trained mental health professionals and administrators for its successful implementation. The concept assumes that at the operational level, professionals of different clinical backgrounds and orientation can effectively collaborate with one another for the sake of the family. In today's current funding environment and discipline-focused, this kind of inter-disciplinary and interagency collaboration is largely impossible.

Few family-focused models of intervention specifically guide the social work practitioner through the maze of multiple social systems that are typically involved when serious behavioral problems arise with at-risk youth. In an attempt to provide a clear roadmap for practitioners, Sells (1998) developed a 15-step, family-based intervention model that shows the promise of providing answers to the unique plight of the teenager presenting difficult behavioral challenges. The model recommends a highly structured process to effectively engage and collaborate with larger systems as well as getting the adolescent's behavior under control. This model has recently been adapted to a parent-

ing program that focuses on engaging parents towards reestablishing authority and nurturance (Sells, 2001). As with other family-focused models, the program requires the use of multiple, highly trained, group facilitators and utilizes both a youth-focused and family-focused training format. The program is practitioner driven and directed, and requires that close collaborative partnerships be developed with significant others for its effectiveness.

Although the research associated with family-based models show much promise, most family-based models of intervention contain generalized principles as its guide for implementation. Intervention and program manuals are a rarity. Those that do exist require that one follow a rigidly defined intervention protocol requiring the skills of highly trained mental health professionals. Because of their complexity and emphasis on generalized principles, practitioners utilizing existing family-focused intervention models are left up to their own devices to implement the general guidelines of a specific model intervention. In this context, family-based intervention services become a mystical process behind closed doors, are costly to implement, and not readily available to most families.

In an article on the effectiveness of family intervention, Pinsof and Wynne (1995) concluded, "in almost all of the family therapy research, it is impossible to know what actually occurred in family therapy" [p. 606]. Without the specification of key concepts, one does not even know whether or not the family practitioner treating the case is actually following the steps of an intervention model.

MOVING TOWARDS A COMMUNITY-BASED, FAMILY-FOCUSED ALTERNATIVE

For family strengthening programs to be successful, they must be readily available, accessible, and affordable to all families at different socio-economic levels and they must be designed to optimize the existing expertise of parents and families. For change to be durable and sustaining, family-focused interventions used in a family-strengthening program must provide a clear message that parents are ultimately the most important resource. Fogatch and Patterson (1989, p. 264) challenged the helping professions by stating, "It is only the parents who can produce long term changes in children". Consequently, efforts should be directed towards strengthening the family's existing resource, enhance community support systems to work with the family, and address motivational factors that promote change in the way we understand and deal with youth presenting serious behavioral challenges.

For help-giving to optimize the expertise and abilities of the family it must be empowerment based rather than professionally based. This suggests the role of the professional will also need to change if family-focused intervention programs are designed to highlight the importance of parents and families as a crucial and under-utilized resource for dealing with youth delinquency. A parent driven, problem solving format in this kind of program will ensure that solutions that evolve from the group are culturally and regionally significant, family-centered, and are realistically applicable (Dunst, & Trivette (1994). The literature provides several examples of how these important variables can be operationalized.

Availability, accessibility and cost were looked at with several studies which could be characterized as using family strengthening, empowerment models; they promoted active involvement by parents for the purposes of deciding about and learning new skills to reduce parenting stress and increase effectiveness. The new skills, which were developed, were family strengthening. That is these were skills which included effective limit setting and reinforcement that have been shown to provide protective factors for youth (Spoth, et. al. 2002). The studies compared community and school-based group parenting skills training programs with clinic-based individual parent training. One study found logistical barriers to attendance were reduced and utilization was increased when parents attended community and school-based group parenting skills training programs (Cunningham, Bremner, & Secord-Gilbert, 1993). A second study by the primary authors looked at parent behavioral skills training with preschoolers at risk for disruptive behavior disorders. They compared community-based treatment using parent behavioral skills training groups delivered by a facilitator to parent skills training delivered by a professional through individual family sessions in a clinic. Parents were less likely to enroll and participate in the clinic setting citing their child was not a problem (Cunningham, Bremner, & Boyle, 1995). Additionally, factors including cultural, linguistic, economic, educational and family barriers such as poorer family functioning were not found to predict either attendance or outcome for the group-based behavioral skills training program delivered in a community setting as opposed to a clinic setting with individual family sessions. Parents attending the community-based groups reported greater improvements in behavior problems at home and better maintenance of their gains at 6-month follow-up.

The studies also looked at cost, a factor that limits availability and accessibility. For the study of parent skills training for children with disruptive behavior disorders which was delivered in a large scale group, the group training was six times more cost effective than clinic-based individual family treatment (Cunningham, et al., 1995).

Several studies provide insight into the issue of family strengthening through empowerment by optimizing the existing expertise and abilities of families. The importance of this empowerment approach for increasing parent self-efficacy was noted in a study of three help-giving approaches for parents of preschool children. The help giving approaches included an expert based and professionally centered approach which was compared to a direct guidance approach where the client assists in delivering an expert determined intervention and an empowerment approach where skill acquisition was the central intervention to empower parents to solve their problems (Dunst, Trivette, Boyd & Brookfield, 1994). Empowerment approaches were found to produce significant increases in parent self-efficacy and effectiveness ratings of the help-givers.

Changing the role of the professional so that help-giving encourages families to take on a more significant role in the decision-making process rather than a professionally-centered approach where major decisions about treatment are determined by the professional, is supported in the professional literature. For example, the literature finds extensive validation for the effectiveness of nonprofessional psychological therapies (Christensen & Jacobson, (1994). In the specific area of children and adolescent treatment a meta-analysis of 108 studies failed to find superior outcomes for professional

therapists when compared to graduate students and paraprofessionals (Weisz, Weiss, Alicke, & Klotz 1987. The empirical support for the use of nonprofessionals was also found in a study of a parent-training group for children with disruptive behavioral disorders who were in residential treatment (Cunningham, C. E., David, J.R., Bremner, R., Rzasa, T., and Dunn, K., 1993). Parents were placed in leadership roles where they took on the role of experts, only viewing video excerpts of parenting errors from which they formulated their own solutions while a second group of parents only viewed video excerpts of corrected parenting methods in an information only and didactic delivery of program objectives. Parents who formulated their own solutions attended more sessions, arrived late significantly less often, were less likely to complain the program didn't work, were more likely to complete homework, and had higher satisfaction ratings than parents who only participated as an audience for the delivery of didactic information in the program.

THE BASICS OF THE COMMUNITY ALTERNATIVES FOR LOVE AND LIMITS (CALL) PROGRAM

Parents of challenging teens are often frustrated and confused. Stressful interactions between them and their teen have increased over time. Many parents have responded to this dilemma by reducing their involvement, management, and monitoring to minimal levels. One alternative to youth-focused only intervention is the Community Alternatives for Love and Limits (CALL) program.

The CALL program was developed to demonstrate the effectiveness of a community-based family strengthening multi-family intervention program to respond to adolescents at risk. CALL uses behavioral skills training to facilitate parental empowerment while supporting parental leadership as a primary resource for change. It intervenes with multiple families in a group format in order to develop a supportive network for parents. The program's strategies for empowering parents as well as its strategies for increasing accessibility, availability, and affordability, were modeled from numerous factors cited in the literature.

Epistemology: The program's epistemological underpinnings regarding the nature of at risk youth behaviors are based on the work of the Oregon Social Learning Center. A review of over 20 years of research by Patterson and his colleagues conducted through the Oregon Social Learning Center (OSLC) on antisocial youth cites the strong association between irritable and ineffective parenting methods and antisocial behavior in children (Patterson, Reid, & Eddy, 2002).

The OSLC had centered much of their effort on the development of their Coercion Model to explain how within the context of family influence antisocial behavior is reinforced and maintained. The trajectory of this influence is an unfolding series of developmental stages, which move from factors such as hard to take child temperament, maternal depression and family stress to a coercive process in the parent-child relationship whereby the parent's and child's use of aggression, intimidation and noncompliant behaviors are mutually negatively reinforced. When the child is negatively reinforced for the use of these behaviors in school with peers and teachers this coercive

process is strengthened, as are poor outcomes such as school failure and peer failure. The combination of school and peer failure progresses to the child's association with deviant peer groups, and in combination with coercive family interactions, reduced parental monitoring and supervision. ATOD and delinquency are seen to be later outcomes to this coercive process.

Target Population: The CALL program is designed for implementation with a middle school population of adolescents and their families. This is a crucial time for parental decision-making regarding the protective family influence of monitoring and supervision. The chronological age of the youth falls between twelve and fifteen. The adolescents represent an at-risk population, and decision makers within the community including school officials, other involved community agencies and parent groups determine selection criteria.

Accessibility, availability and affordability: The CALL program is delivered in a community-based setting rather than a clinic or hospital. Neighborhood schools are chosen because they are obviously familiar to families and easier to locate and attend as opposed to a clinic. Also, school-based programs do not have the stigma that is attached to mental health settings. Offering childcare further enhances availability. Evening programs are also seen to be a necessary ingredient so working parents can more readily attend. The program design allows for as many as 15 families to participate with only one group facilitator. In comparison to the limited professional resources and waiting lists associated with clinic-based services, significant savings can accrue.

Curriculum: CALL includes seven two-hour sessions. Each session introduces a theme, which is acted upon through behavioral family or parenting skill interventions. These behavioral skill building interventions enhance or develop parent leadership while building protective family factors. The program focuses on four protective factors found important by research: supportive parent-child relationships, positive discipline methods, monitoring and supervision, and communication to problem solve and negotiate conflict (Kumpfer, & Alvarado, 1998).

Description of group activities: The programs activities start by motivating parents to consider regaining family leadership to increase their involvement, management and monitoring. The stumbling blocks for motivation, e.g. issues of resistance, negative emotion, frustration, and giving up are managed in this program by helping parents find hope through an experience of empowerment. In this program, empowerment starts with the development of a belief by each parent that working with other parents can enhance their own abilities to become leaders for family change. This belief and the sense of empowerment that may result are seen to be important factors for gaining group participant's commitment to make the effort to change.

To experience empowerment, parents must begin to form supportive alliances with one another. A sense of empowerment is then enhanced through help-giving activities, which are family-centered. These empowering help-giving strategies start with the manner in which group activities are structured. The group is divided into several teams of four to five parents or three to four parents and their adolescents. Adolescents

do not participate in all group meetings and when they do participate they are paired either their own parent or another parent in the group. The teams then work together to decide upon, problem solve, model and practice the use of behavioral skills which are crucial for developing the protective factors of families.

Parent teams increase motivation, hope and empower leadership while developing support. An initial strategy calls for each of the parent teams to view videotape sequences, which depict parenting errors and then troubleshoot alternative skills or strategies, which they believe may lead to better outcomes. Each team elects its own leader who records and summarizes team solutions, makes sure their team stays on task, and makes sure all members get a chance to participate. For example, parents view a typical conflict where a parent sets a limit and conflict escalates with the result being several common negative outcomes, e.g. parent blows up or parent gives up. Following both large group and team group discussion, parents' ideas evolve about the consequences for continued use of ineffective behavioral practices. Discussion may consider the long term consequences for each of the protective factors like limit setting, attachment, monitoring and communicating or only one particular factor. Ideas about more effective skills or strategies needed to solve the problems depicted in the videotape are then explored along with their anticipated effect on the protective factors if used over time.

This type of structuring of problem solving activity offers parents an opportunity to become the expert. It creates an atmosphere for parent networking and enhances parental support. Parents get to know one another and learn to appreciate mutual strengths.

Problem-solving activities are linked with other empowerment strategies, which help parents, and families begin to decide about and practice the use of behavioral strategies in their own home. One such strategy is for the parents to decide about situations, which they would like to see the facilitator model using their teams preferred strategies. It is important to identify that the facilitator does not determine the situations or the strategies to be modeled. In some sessions a video example of a professionally "corrected" or expert-determined use of strategies may also be shown as a follow-up so that parents can compare their model result with that of the experts. When working with a large group of parents, the group's solutions will invariably look very much like the experts solutions. An empowering consequence is the enhancement of parent self-efficacy.

Parents also work together in teams or dyads to practice with one another a specific skill and implementation of the skill in their own home. Groups, which teens attend, allow for other variations on this method. Attitude change is enhanced when parents identify and discuss ineffective strategies, create better strategies and practice with the group the skills they have decided will make a difference for their family. The natural resistance, which is endemic to expert-based delivery of help giving, is eliminated.

In sum, the CALL program is designed as a family focused, family-driven, community-school based, and affordable alternative to current service delivery for delinquency and ATOD which is predominately youth-focused in delivery. Family strengthening

activities are employed to increase the protective factors of families. This is accomplished through behavioral skills training which employs group process to empower parents as leaders and a primary resource for family change.

DIRECTIONS FOR FUTURE RESEARCH

Family strengthening is an area of family-focused treatment that has been shown to be increasingly promising compared to youth focused only programs for decreasing negative outcomes associated with delinquency and ATOD. Help-giving practices in family strengthening programs whose intervention methods utilize empowering and client-centered strategies have been demonstrated to be effective for increasing parent self-efficacy. More investigation is needed, however, on the delivery of strategies that empower families and to what extent do these strategies contribute to the protective factors of family influence on social health problems of adolescent delinquency and ATOD. Other questions for investigation include whether the effectiveness of empowerment strategies is delimited by the age of the adolescent, the degree of risk the adolescent is experiencing and by parent factors such as mental health, substance abuse, and other family stressors. Does a community based setting facilitate the delivery of an empowerment-based family-strengthening program? Does the fact that the program is promoted and conducted from an empowerment base rather than a deficit base facilitate recruitment? What impact does empowerment strategies have on the integration of skills needed for family strengthening. Are empowerment strategies more effective for the integration of specific skills for family strengthening?

CONCLUSIONS

If in fact empowerment based models for family strengthening intervention have better effects for social health problems of adolescent delinquency and ATOD than deficit based help giving intervention strategies the traditions of social work practice would be enhanced. Greater efforts to develop strategies in partnership with families and community stakeholders would be needed. The current preeminence of bio-psychiatric methods in the mental health field approach to these problems would also demand greater scrutiny, questioning, and action.

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GROUP WORK WITH PARENTS OF ADOLESCENT SEX OFFENDERS: INTERVENTION GUIDELINES

Robert B. Bennett
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Abstract: *Interest and attention to adolescent sex offenders has increased greatly over the past twenty years. Allegations of adolescent sexual improprieties are known to have profound and disruptive repercussions on the entire family, especially the parents of the offending adolescent. Adolescent criminal acts, in general, result in a myriad of disconcerting emotions experienced by the parent(s). Although a great deal of attention is currently being focused upon treatment of adolescent sex offenders, little is being written about intervention with parents of these adolescents. This paper reviews the clinical and research literature pertaining to the family dimensions of male adolescent sexual offending behavior and offers a set of guidelines for use in group practice with parents of these adolescents.*

Key Words: *parents of adolescent sex offenders; male adolescent sex offenders; intervention guidelines*

INTRODUCTION

The problem of adolescents who commit sex offenses is commanding increased attention in recent years. This group of offenders has been defined by the National Adolescent Perpetrator Network as comprising "youth ranging from puberty to the age of legal majority who commit any sexual interaction with a person of any age against the victim's will, without consent, or in an aggressive, exploitive, or threatening manner (Lakey, 1994, p. 755)." It has been estimated that adolescents may be committing 34% to 60% of all sexual offenses (Cashwell & Caruso, 1997); and Snyder & Sickmund (1999) report that they are responsible for 20% or more of reported forcible rapes and child molestations in the United States. The Uniform Data Collection System of the National Adolescent Perpetrator Network indicates that the majority of adolescent sex offenders were found to be first time offenders with an average of seven victims (Bischof & Stith, 1995). Estimates regarding the number of youths committing sexual assaults involving force range from 195, 000 to 450,000 yearly (Weinrott, Riggan, & Frothingham, 1997). This figure does not take into account child molestation which is the most common sexual offense committed by juveniles. Also, it is important to bear in mind that many incidents of adolescent sex offending go unreported. This may be due to the offense being dismissed as mere experimentation or curiosity or general reluctance to report an adolescent due to fear of labeling them as a sex offender. Cashwell & Caruso (1997) have suggested that, due to unreported cases, there may be as many as 70% of adolescents committing sex offenses who receive neither services nor

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incarceration for their offense. It is of little surprise that programs designed to treat adolescent sex offenders have emerged in growing numbers. The mounting concern for this significant social problem has heightened as a result of information that indicates that most adult sex offenders committed their first sexual offense when they were adolescents (Barbaree & Cortoni, 1993; Becker & Hunter, 1997). In 1982, Knopp identified only 22 programs in the United States specifically designed to treat adolescent offenders. (Knopp, Freeman-Longo, & Lane, 1997). However, by 2000 there were 391 specialized offender treatment programs serving this population along with 66 programs treating pre-adolescent children (Burton & Smith-Darden, 2001). Over time the field has witnessed a wide variety of treatment approaches serving sexually offending youth. As Chaffin (2001) observed, these programs have included, "general and non-specific mental health treatment (e.g. individual psychotherapy, family therapy, inpatient milieu therapy), delinquency focused treatments (e.g. standard Multi-Systemic Therapy, boot camps, juvenile group homes) as well as programs designed specifically for, and limited to, adolescent sex offenders (e.g. cognitive behavior sex offender group therapy, relapse prevention, and arousal reprogramming techniques" (p. 91). Many of the services available to adolescents consist of sex offender-specific programs combining core treatment modules, case-specific treatment components, and parent components (Chaffin, 2001). It is believed that parental involvement in treatment can serve to: a) enhance the support and guidance available in behalf of behavior change, b) help assure necessary supervision and monitoring of the adolescent, and c) make possible early recognition of re-offending risks (Chaffin, 2001). While most professionals working in the field would probably acknowledge the importance of parental involvement in sex offender treatment, there is a scarcity of literature pertaining to practice with them. In speaking to this dilemma, this article: 1) reviews the clinical and research literature pertaining to the family dimensions of adolescent offending behavior, and 2) presents a set of practice guidelines applicable to treatment of parents in a group context.

RESEARCH ON FAMILIES OF ADOLESCENT SEX OFFENDERS

Research indicates that adolescent sex offenders come from all socioeconomic classes, ethnicities, and racial groups (Becker & Hunter, 1997; Moody, Brissie, Kim, 1994; Oliver, Nagayama-Hall, & Neuhaus, 1993). In a meta-analysis of empirical data concerning the demographic information and parental characteristics of adolescent sex offenders, Graves, Openshaw, Ascione, and Erickson (1996) found that 59% of the offenders were of low socioeconomic status, while 44% were of middle class origins.

Comparing the family environments of adolescent sex offenders, violent, and non-violent delinquents with a normative sample of adolescents, Bischof & Stith (1995) found no significant differences between the groups relative to parents' employment level or occupation. Several characteristics have been associated with families of adolescent sex offenders. In general, these families have tended to exhibit low warmth and cohesion (Bishof, Stith, & Wilson, 1992; Blaske, Borduin, Henggeler, & Mann, 1989) and high rates of parental difficulties characterized by frequent family violence, physical abuse, substance abuse, and family disorganization and instability (Awad,

Saunders, & Levene, 1984; Ford & Linney, 1995; Ryan & Lane, 1997; Smith & Israel, 1987). A study by Fagan and Wexler (1988) found that spousal abuse, child abuse, and child sexual molestation were more characteristic of adolescent sex offender's families when compared to the families of violent delinquents. In their meta-analysis, Graves, et al. (1996) reported that the families of adolescent sex offenders were usually dysfunctional and that those classified as pedophilic offenders and sexual assault offenders tended to come from chaotic/rigid as well as disengaged/enmeshed families. Bishof & Stith (1995) found that families of adolescent sex offenders tended to exhibit less cohesion, less expressiveness, and have lower levels of independence than families of non-delinquent adolescents. In another study by Bishof, et al. (1992), adolescent sex offenders perceived their families as having low emotional bonding, closed internal boundaries, rigid generational boundaries, and a general sense of separateness. Studying the families of adolescent sibling incest offenders, Worling (1995) found high levels of marital discord, parental rejection, physical discipline, and overall family dissatisfaction. Comparing the families of both sex offenders and violent nonsexual offenders, Blaske, et al. (1989) found both to have little positive communication and considerably more negative communication.

Some research has centered exclusively on examining the parental characteristics of juvenile sex offenders. Kaplan, Becker, & Martinez (1990) compared mothers of adolescent incest offenders with parents of non-incest sexual offenders and found that the majority of the incest perpetrators had mothers not living with adult partners. In addition, significantly more mothers of incest perpetrators reported having been physically and sexually abused themselves. A study by Kobayaski, Sales, Becker, Figueredo, & Kaplan (1995) discovered that bonding to the mother tended to decrease the level of sexual aggression in juvenile males. This study also found that sexual aggressiveness increased as a result of the adolescent being physically abused by his father and sexually abused by a male. In their study of parents of juvenile offenders, Graves, et al. (1996) found that mothers of pedophilic youth and mixed sexual assaulters were themselves often physically abused as children.

In general, to date most of the research pertaining to the family dimensions of adolescent sex offenders is descriptive, and much remains unknown concerning the causal role that family variables play in the development of adolescent sex offending behavior. In his comprehensive review of the research, Weinrott (1996) suggests that there is good evidence for the notion that lack of attachment and family instability are associated with more intrusive forms of adolescent sexual aggression. Commenting on the families of sexually abuse youth, Ryan and Lane (1997) suggest that "circumstances, experiences, and parental models in the early life environment may allow or support the development of sexual deviance or fail to develop the empathy and inhibitions that prevent exploitative behavior" (p. 137). They further observe that a cluster of family factors may play a defining role in this process: emotional impoverishment, lack of appropriate affect, family secrets, distorted attachments, and a history of disruptions in care (Ryan & Lane, 1997).

CURRENT TREATMENT PROGRAMS

While much remains to be learned about the role of family factors in the etiology of sexual offending behavior, few professionals in the field would dispute the importance of parental involvement in the assessment and treatment of this population. In some therapeutic regimes, parents are considered an integral, if not the central part of this process.

In multi-systemic therapy (Swenson, Henggeler, Schoenwald, Kaufman & Randall, 1998) emphasis is placed on "empowering parents or primary caregivers to be the change agent for their children" (p. 333). Parents or caregivers participate in individual sessions with the therapist, conjoint sessions with the offender and therapist, family sessions, and all contacts with external systems. Treatment interventions are oriented toward the modification of family and parental behaviors that contribute to and/or sustain the offender's behavior. These interventions draw heavily from strategic family therapy (Haley, 1976), structural family therapy (Minuchin, 1974), behavioral parent training (Munger, 1993), and cognitive-behavioral therapies (Kendall & Braswell, 1993). Given that adolescent sex offenders and their parents are often socially isolated, interventions also focus on developing their social skills and problem-solving capacities.

Thomas (1997) describes a comprehensive, family oriented intervention program that combines individual family therapy, multi-family therapy groups, a psycho-education group, weekend retreats, and a family informational packet/manual. This model proceeds through the following five-stages: 1) the crisis of disclosure, 2) family assessment, 3) family therapy interventions, 4) reconstruction and reunification of the family, and 5) termination and aftercare. Comprehensive strategies and interventions are identified for each of the respective stages.

A psycho-education program identified by Pithers, Becker, Kofka, Morenz, Schlank, & Leombruno (1995) treats children with sexual behavior problems by utilizing a model in which the children and their parents meet concurrently in separate groups for one hour and then come together for a half-hour session. Treatment is oriented to helping parents: establish safety rules; promote accountability for behavior; recognize, manage, and express emotions; promote healthy sexual development; recognize cognitive distortions; develop victim empathy; work through personal victimization issues; and prevent relapse (Pithers, et al., 1995).

Though groups for parents of offenders have been used in some programs, the literature discussing their use is limited despite their potential treatment value. As Kahn (1997) points out, groups provide a context in which parents receive support for what they are going through as well as education with regard to how they may aid in the treatment of their adolescent. Placing parents in groups with other parents who are experiencing many of the same emotions offers a safe forum for expression and discussion of these feelings. The mutual aid process operating in such group can give parents the feeling that they are not alone and offer needed support for their efforts to help their sons. In addition, the group becomes a valuable problem-solving resource as parents exchange ideas on how to cope with the challenges confronting them. While the case

for use of parent groups in offender treatment can easily be made, there is no literature providing guidance on how to maximize their use. Informed by the literature and their own practice experience with this population, the authors attempt to respond to this dilemma by setting forth a set of therapeutic guidelines for the implementation in treatment groups serving parents of adolescent sex offenders.

INTERVENTION GUIDELINES

The practice guidelines that follow are set out as a set of therapeutic tasks to be addressed by practitioners working with parents in a group context.

Guideline #1: Assess the potential role of family and parent factors in the adolescent's behavior

While much remains to be learned concerning the role of family and parent factors in the behavior of adolescents who offend, research and clinical literature would suggest that assessments should seek to understand the potential ways that the family's structure and functioning may give rise to or inadvertently serve to maintain the adolescents offending behavior (Shaw, 1999; Worling, 1995). In this regard, the following are among some of the potentially important areas to assess: 1) nature and degree of parental denial and/or minimization of the offense; 2) nature and extent to which parents hold the adolescent accountable for his behavior; 3) quality of harmony within the family (i.e. degree of cooperation, level of caring and affirmation, etc.); 4) provision for social/emotional needs of family members; 5) appropriateness of boundaries established in the family; and 6) firmness and fairness in setting and consistently upholding age-appropriate limits. Table 1 presents a checklist for assessing family constraints and resources along dimensions that the research suggests may represent potential risk factors for re-offending.

Guideline #2: Provide support as parents struggle with the emotional trauma surrounding the offending behavior.

For most parents, learning that their son has committed a sexual offense signals a period of emotional upheaval that can reverberate throughout the family system. This experience can be emotionally and psychologically catastrophic in proportion, not unlike that seen in traumatic stress responses. Common emotional reactions include shame, anger, disbelief, and confusion (Kahn, 1997). In addition, many of the following may also be present:

- Denial and/or minimization of the offense or specific aspects of it
- Guilt around not having been able to prevent the offense along with fears concerning the potential social repercussions
- A sense of social stigma that the offense occurred within one's family
- Sadness that such a problem could have befallen one's family
- Depression with accompanying sense of helplessness

Questions about how best to help and support the adolescent.

As parents confront their own distress around the offense(s), their emotional and psychological state can further threaten the stability of the family system. It is essential, therefore, that the clinician provides supports necessary to enable the parents to cope effectively in their efforts to respond to the total family unit in a constructive and helpful manner. The emotional turmoil experienced by parents provides a unique opportunity for them to benefit from the emotional support available in a group for parents. In the process of helping parents around the emotional dimensions of their struggle, clinicians should: 1) acknowledge and normalize the emotional impact of the experience; 2) allow for appropriate ventilation of feelings surrounding it; and 3) give space and time for parents to adequately come to terms with their emotions.

Table 1. Family Assessment Checklist

Communication	Do parents talk in clear and straight forward language? Are messages communicated in direct vs indirect ways? Do parents listen well and communicate their understanding?
Relational	Is there harmony between family members? Is caring/affection appropriately shown? Do parents spend time with their son? Is there evidence of cooperation between family members?
Boundaries	Do parents establish/reinforce age-appropriate boundaries with their son? Do parents establish/maintain appropriate boundaries between children? Are there indicators/signs of over-enmeshment between parents and children? Are there indicators/signs of disengagement between family members?
Leadership	Do parents set clear, age-appropriate expectations and limits? Do parents initiate appropriate consequences for misbehavior? Is discipline around infractions firm and fair? Are appropriate punishments/consequences consistently applied?
Problem-solving	Do parents confront problems needing attention in direct and timely ways? Do parents appropriately address relationship problems between family members? Do parent enable dialogue around problems oriented to solutions? Do parents allow negotiation around problem solutions when reasonable/appropriate?

Guideline #3: Provide parents the type of information that will help them respond and cope more effectively with the sexual offense

If parents are to be supportive allies on behalf of their son's treatment, they will need information that helps them understand the nature and dynamics of offending behavior as well as effective ways of coping with the problem. In this regard, it would make sense that the education dimensions of parent group treatment have some direct relationship to the core modules comprising the adolescent's treatment. The literature would suggest that some consideration be given to integration of the following kinds of information modules: 1) laws bearing on sexual behavior, 2) investigation process relative to sexual offending behavior, 3) effects of abusive behavior; 4) victim empathy; 5) personal risk-factors; 6) sexual attitudes and beliefs; 7) social skills; 8) human sexuality to include information pertaining to sexual myths/facts, physiology of sex, contraception, STD's, and HIV/AIDS; 9) anger management; and 10) relapse prevention (Becker & Hunter, 1997; Chaffin, 2001; Hunter & Figueredo, 2000; NAPN, 1993). While there is no one best way to assure that parents become informed on matters of importance, many resources are available to assist with the design and implementation of the education and instructional component of treatment including: select reading references, informational handouts, publications/brochures written especially for parents, written exercises, videotapes, group discussion, and joint adolescent-parent sessions (Gray & Pithers, 1993; Kahn, 1997).

Guideline #4: Address constraining influences in the family's functioning.

A comprehensive family assessment at the outset of treatment should provide basic information concerning those family issues of greatest clinical significance relative to the offending behavior under treatment (Cashwell & Caruso, 1997). Therapists should be particularly attuned to those family dynamics likely to heighten risk for re-offending and constrain the parents/family from effectively coping with all that follows from the offense. The literature suggests that the following are among the more common areas in which family functioning is apt to be compromised: 1) communication, 2) parent-adolescent relationship, 3) family boundaries, 4) leadership/discipline, 5) problem-solving and conflict-resolution. Each is briefly discussed below.

Communication: The importance of communication cannot be overly stressed. How parents and adolescents interact with each other can either heighten conflict and lead to impasse or can open doors to constructively talking about and working through some of the issues needing to be confronted (Cashwell & Caruso, 1997; Friedrich, 1990). The normal strains in communication between parents and adolescents are typically heightened as the parents struggle to address the issues around their son's offending behavior. Structured communication training processes can be integrated to bolster parent competence in such areas as active listening; expressing self in direct, open, and honest ways; checking out communication for understanding; providing constructive feedback; and making requests of one another in direct and constructive ways (Patterson & Forgatch, 1987; Robin & Foster, 1989). Beyond any efforts at sys-

tematic training in communication, therapists can provide ongoing coaching aimed at helping parents communicate in clear and direct ways and listen effectively to assure they accurately understand the needs of their son. Confronting and addressing indicators of poor communication when they present and using role-playing to help them find alternatives to communication breakdown have all proven to be instructive.

Parent-adolescent relationship: The relationship between offenders and their parents is typically a strained and conflicted one at the very least (Awad, Saunders, & Levene, 1984; Ryan & Lane, 1997). Normal struggles around separation, coupled with problems surrounding the offense often exacerbate conflict and compromise any bonding that may have existed prior to the offense. Signs of relationship disruption can be seen in many ways from lack of affirmation and caring to minimal interaction and lack of mutually shared activities (Marshall, Hudson, Hodkinson, 1993; Weinrott, 1996). Therapists should reinforce and build upon positive threads in the relationship, looking for opportunities to strengthen and nurture the relationship by recognizing and affirming positive behaviors. During this process, it is especially important that parents find ways to more effectively reduce conflict, show affection in appropriate ways, encourage greater cooperation among family members, and make time for constructive interactions with their sons. Therapy groups can provide a useful context in which parents look more closely at the quality of relationship they have with their son and explore ways to strengthen it.

Boundaries: Families of offending youth often exhibit significant deficits relative to their ability to establish and maintain appropriate boundaries. They may not understand or value the importance of respecting the boundaries and personal space of others, or they may lack the ability to consistently define and model appropriate interpersonal norms (Smith & Israel, 1987; Straus, 1994). Family norms should be clear relative to such matters as entering bedroom/ bathrooms without knocking, dressing in front of others, and sharing information of a sexual nature. Parents should be encouraged and supported in their efforts to promote a family climate that supports and respects the boundaries between all family members and consistently invokes appropriate consequences when these are violated.

Leadership: The parents of many delinquents often lack the ability to provide appropriate guidance and leadership within the family system (Graves, et al., 1996). An adolescent's sexual offenses may, in part, be symptomatic of dysfunction in this area. Major therapeutic initiatives should extend to helping parents: a) set clear, age-appropriate expectations and limits, b) initiate appropriate consequences in the face of serious misbehavior, c) be firm but fair in the application of discipline, and d) apply consistent consequences appropriate to any violations of expected behaviors. Parents should be supported in their efforts to promote and model personally and socially responsible behavior. Adolescents should be held accountable for assuming an appropriate share of responsibility for household tasks. They should attend school regularly and on-time and maintain grades appropriate to their level of educational functioning. Curfew limits should be clear, reasonable, and consistently upheld. Consequences for violations of significant expectations and family ground rules should be firm and

consistently applied. Occasions of blatant disrespect of family members should be confronted.

Guideline #5: Emphasize strengths and positives residing in the family context and build upon these in promoting change.

Ryan & Lane (1997) have called attention to the strengths that may be found in families of juvenile sex offenders such as intense family loyalty; parents' own survivorship of their traumas in life; and their genuine parental concern for their child. Some of the newer therapeutic models underscore and build upon the strengths and resources residing in clients (Cowger, 1994; deShazer, 1985; Miller, Hubble, & Duncan, 1996; Saleebey, 1997; Walter & Peller, 1992). Based on the overriding assumption that clients have within them the strengths and resources to address and resolve the problems confronting them, strengths-oriented models direct clients toward imaging possibilities for change, getting in touch with and applying coping resources that worked for them in the past, and taking small steps centered on improving their situation. For example, if the focus of intervention is on facilitating better communication between parents and sons, the therapist's inquiry might center on the following kinds of questions: "Think back to a time when communication was better than it is currently, what was it like then?" Or, "What is one thing each you could do that would improve communication?" Similarly, if discussion centers on building cohesion and strengthening emotional bonds within the family, the therapist might ask: "As you look back in the past, what was one of the happiest times you can remember and what made it so?" Or, "What is one thing the family might do together that everyone is apt to enjoy?" Given that parents of offenders typically come to treatment demoralized and overwhelmed, solutions-oriented strategies constitute a useful therapeutic strategy for bolstering morale and hope by affirming and respecting the parents' strengths and immediately focusing on ways they can draw upon some of their own resources to more effectively address the struggles encountered with their sons.

Guideline #6: Maintain a present-oriented and problem-focused approach to the stressors confronted by parents

Given that most parents of adolescent offenders need help in the way they go about addressing problems and relationship conflicts (Bischoff & Stith, 1995), some treatment initiatives should be oriented to enhancing parental competence in the areas of problem-solving and conflict resolution. Parents should be assisted and supported in their efforts to effectively: a) confront individual and family problems needing attention in direct and timely ways, b) enable dialogue around those problems that is solution oriented, and c) establish a climate conducive to appropriate negotiation around these solutions. Family psycho-education models have demonstrated the potential residing in teaching parents rational and planful ways of addressing the problems about which they are concerned (Barkley, Edwards, & Robin, 1999; Robin & Foster, 1989). Parents and larger family units can learn through didactic/experiential processes how to select and clearly define problems to be resolved. By approaching some problems in more

planful, rational ways, parents can be helped to move beyond emotional reactivity in ways that can enable them to more clearly see potential coping solutions for themselves. Group psycho-educational strategies also represent a valuable problem-solving resource. They provide a context within which parents can be helped to identify problems and systematically develop the strategies necessary to resolve them. This cognitive process also helps parents develop a number of corollary skills, including how to: brainstorm around possible solutions; weigh the pros and cons of alternative courses of action; select preferred solutions or courses of action; and identify steps to follow in implementing them.

The parent group represents a resource-of-choice in helping parents deal with problems of greatest concern. A brief check-in at the beginning of each session allows parents to identify those issues around which they would like the group's assistance. Through the exchange that unfolds about problems and solutions, parents can develop a greater sense of personal agency. The process of being understood often serves to heighten parental openness to addressing important issues around parenting especially some of those centered on communication, conflict resolution, anger management, negotiation, and discipline.

Guideline #7: Structure treatment in ways that require the completion of weekly tasks and homework assignments

A major issue confronting all modes of intervention centers on the nature and extent to which learning from the therapeutic experience transfers or generalizes to important contexts outside of treatment. If parents are to develop greater competence and sense of self-efficacy, it is important that they be supported in their efforts to transfer insights and learning from the group to their day-to-day interactions with their son and other family members. To promote this kind of transfer, parents will need to be encouraged through weekly tasks and homework assignments designed to promote constructive action in behalf of those issues about which they are concerned (Robin &_Foster, 1989). For example, where school performance is an issue, they will need to provide structure to assure that homework gets done. If the focus is on promoting more positive connections between family members, attention may be on scheduling and carrying-out a designated activity shared by all family members. In the face of school problems, parents may be supported in taking initiative to schedule a conference with key school personnel. A treatment process that promotes activity beyond the treatment session through relevant homework tasks/assignments can bolster the development of confidence and competence in acting on behalf of their own concerns and general well being.

Guideline #8: Integrate procedures for evaluation of individual progress and program successes and constraints

If treatment accountability and effectiveness are to be enhanced, it is incumbent on practitioners to structure for evaluation of the treatment experience. Evaluation activ-

ity on the part of the therapist should be oriented to both process and outcome and the group work literature provides a rich resource for informing the design and implementation of both (Corey & Corey, 1997; Gazda, Ginter, & Horne, 2001; Rose, 2001; Zastrow, 1997). Process assessments center on determining those aspects of the therapy that are perceived most and least beneficial/helpful relative to methods/techniques used, materials provided, group incidents or events. Such assessments should point to strengths and shortcomings in the on-going process of the group and also surface member suggestions for making the experience more beneficial. Formats for assessing process can range widely to include: tracking attendance and promptness, informal/formal discussion that elicits member feedback around their experience, post-session questionnaires/reaction forms, facilitator session critiques, and client satisfaction surveys and inventories The use of brief written group reaction forms is but one example of a process-oriented method that allows for monitoring member satisfaction levels, pinpoints emerging trouble-spots in the group process, and informs session planning. Outcome-oriented evaluative activity centers on determining the nature and extent of individual change and progress relative to goals established for the treatment group. Evaluation data of this sort can come from therapist direct observation, self-report questionnaires, client satisfaction surveys, and follow-up interviews/group sessions. As an example, informal requests for feedback prior to the group's ending can reflect individual perceptions of session benefits and surface actual or potential constraints, e.g. dislikes, aversive experiences, etc.

SUMMARY

While there has been general acknowledgement of the importance of parent involvement in treatment programs for adolescent sex offenders, the literature on how best to go about this is sparse. Responding to this deficit, this article has put forth a set of practice guidelines to orient therapeutic work with parents in a group context. These guidelines are based upon the literature addressing some of the characteristics commonly seen in the parents and families of adolescent sex offenders. In order to help parents achieve a better understanding of the issues involved in the sex offense(s) committed by their son and to aid in reducing the risk of re-offending, practitioners are encouraged to utilize these guidelines in their work with parents. It is important that future developments in the treatment of adolescent sex offenders continue to expand the clinical and research literature oriented to intervention with parents and families of the offenders.

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THE SPIRITUAL COMPETENCE SCALE: VALIDATING A POPULATION-SPECIFIC MEASURE OF CULTURAL COMPETENCE WITH A FAITH-BASED SAMPLE

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Abstract: *Cultural competence, including more focused forms of cultural competence such as spiritual competence, has been a topic of increasing professional attention over the past decade. Yet, while cultural competence is increasingly viewed as essential to effective service provision, few measures of cultural competence exist. To address the gap, the present study validates a new population-specific measure of spiritual competence with a random national sample of faith-based graduate students. Analysis suggests the eight item scale is a valid and reliable measure of spiritual competence. The instrument is designed to assess levels of competence in educational programs, but with modification it can be used in agency settings, or for individual self-assessment.*

Key words: *Cultural competence; Spirituality; Religion; Cultural sensitivity; Spiritual competence*

Due to changes in immigration policies in the mid-1960s, the United States has become an increasingly diverse society (Melton, 1999). The numbers of Muslims (Smith, 1999), Hindus (Williams, 1997) and many other cultural groups has grown significantly over the past forty years. U.S Census Bureau (2000) projections suggest the trend toward increasing diversity will continue for at least the next few decades.

The changing national mosaic has helped to focus professional attention on the issue of cultural competence (Dunn, 2002). Cultural competence has been conceptualized in a variety of ways. Among the more influential, is the conceptual framework of Sue, Arredondo and McDavis (1992). These observers view cultural competence as an ongoing process characterized by the following three traits: 1) awareness of one's own assumptions, beliefs, biases, limitations, etc. 2) empathetic comprehension of a culturally different worldview, and 3) development of skill sets and intervention strategies that are relevant and sensitive to a culturally different worldview.

Regardless of how cultural competence is defined, its importance is increasingly recognized. Effective service provision is understood to be predicated upon the development of cultural competence (Dunn, 2002). In order to provide services to a growing collage of cultural groups, social workers must develop an attitude of acceptance, respect, and sensitivity toward worldviews that differ from their own. Without developing cultural competence, Dunn (2002) suggests that social workers will be unable to fulfill their ethical mission of providing services to all people groups.

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The growing professional interest in cultural competence is reflected in a number of social work forums, including the academic literature, the code of ethics, educational standards, and professional organizations. In their 1995 review of the social work literature, Schlesinger and Devore (1995) noted that content devoted to cultural competence had increased substantially over the course of the previous decade. They noted the emergence of a distinct literature devoted to adapting prevailing practice modalities for work with diverse groups.

In 1996, Congress (2002) notes that the National Association of Social Workers (NASW) Code of Ethics (1999) was revised to incorporate standards that specifically address cultural competency. Standard 1.05 in the current code of ethics, for example, stipulates that social workers must deliver culturally competent services that are sensitive to differences among people and cultural groups.

These changes are reflected in the most recent version of the Council on Social Work Education's (CSWE) (2001) Educational Policy and Accreditation Standards (EPAS) (Congress, 2002). Social work programs are required to provide content that educates students about diversity within and between groups. Curriculum content should be designed so that students are equipped to deliver services that meet the needs of various groups and are culturally relevant to the groups involved (EPAS, 2001: IV, B).

In 2001, NASW issued the NASW Standards for Cultural Competence in Social Work Practice (2001). NASW referred to this document as "the first attempt by the profession to delineate standards for cultural competent social work practice" (NASW Standards for Cultural Competence in Social Work Practice, 2001, p. 2).

Concurrent with increased interest in cultural competence, there has been a resurgence of professional interest in spirituality and religion (Canda & Furman, 1999). Although various conceptualizations of spirituality and religion exist, they are generally defined as overlapping entities, with spirituality commonly understood as the broader construct (Canda & Furman, 1999; Carroll, 1998). For many people, spirituality provides an interpretive framework for understanding reality that informs them of who they are and how they should live (Maslow, 1968). As is increasingly recognized, a particular spiritual orientation can foster a distinctive culture (Richards & Bergin, 2000; Van Hook, Hugen & Aguilar, 2001). As the NASW Standards for Cultural Competence in Social Work Practice (2001) state, spirituality and religion often form a nexus from which culture flows.

As is the case with cultural competence, the developing interest in spirituality and religion is manifested in a number of venues. Canda and Furman (1999) observed that the previous ten years had seen a rapid increase in publications addressing spirituality and religion. The new ethical standards that address cultural competence explicitly mention religion (NASW Code of Ethics, 1999, p. 1.05c), as do the NASW Standards for Cultural Competence in Social Work Practice (2001). In other words, spiritual competence is recognized as a more focused form of cultural competence.

The number of social work programs offering courses in spirituality and religion has roughly tripled from 1995 to 2001 (Miller, 2001) and the extant data indicate that the vast majority of social work students are interested in taking a course on spirituality

and religion (Sheridan & Amato-von Hemert, 1999). The CSWE's (2001) Educational Policy and Accreditation Standards (EPAS) address spirituality and religion and, CSWE recently added a specialized symposium on spirituality at their Annual Program Meeting (APM).

In keeping with the profound effect spirituality often has in shaping clients' worldviews, social workers and other helping professionals are increasingly being asked to conduct spiritual assessments (Plante & Sharma, 2001). For instance, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 2001), a major healthcare accrediting agency in the United States, now recommends that social workers conduct a spiritual assessment to ascertain how the client's spiritual and religious beliefs intersect the treatment process.

As might be expected given the recent interest in the topic, the measurement of cultural competence is still in its infancy (Boyle & Springer, 2001). Although widespread acknowledgment exists regarding the importance of cultural competence, only a few measures have been developed. Reviews of the more prominent instruments indicate the existence of some problems (Boyle & Springer, 2001; Kocarek, Talbot, Batka & Anderson, 2001; Ponterotto, Rieger, Barrett & Sparks, 1994). In keeping with the work of Sue and associates (1992), cultural competency is commonly operationalized as an interrelated set of beliefs, knowledge and skills (Manoleas, 1994; Weaver, 1999). Clear three-factor structures have failed to emerge, however, leading observers to wonder about the exact nature of the construct being measured in some of the existing instruments.

Reliability has also been a problem in at least some instances. For example, the Multicultural Awareness-Knowledge-and-Skills Survey (MAKASS) has been used with social work students (Ben-David & Amit, 1999). With a sample of 334 Israeli social work students, a Cronbach's alpha of just .55 was obtained with the awareness subscale. This is similar to coefficient obtained by other researchers using non-social work samples (Kocarek, et al., 2001).

Based upon their review of cultural competence measures, Boyle and Springer (2001) made two recommendations: 1) that researchers should develop and validate new measures for use in social work settings (e.g., social work education), and 2) that the new instruments should be population specific. In other words, rather than develop global measures that attempt to assess cultural competence among all cultural groups, researchers should develop focused measures that tap cultural competence with a single group.

In light of the growing interest in cultural competence, the interest in spiritually based expressions of cultural diversity, and the need for new measures of cultural competence, the spiritual competence scale was created (see Table 1). This eight item instrument is designed to tap values essential for culturally competent practice with clients for whom spirituality and religion are salient life-dimensions. More specifically, the scale taps such values as openness, acceptance, respect, and sensitivity in tandem with a desire to understand, and assign a value to different spiritually-based cultures, perspectives, worldviews, beliefs, and narratives.

Scores are obtained by adding a constant and averaging the items together so that values range from 1 to 11 with higher numbers indicating higher levels of spiritual competence. Given the overlapping nature of spirituality and religion, both terms are used to provide a broader, more inclusive measure. Scale wording can be changed to assess levels of spiritual competence in specific classes, social work agencies, and other settings of interest to social workers (e.g., change wording "your social work program" to "your class on human diversity" or "your social work agency"). The scale can also be adapted for self-assessment, although focusing the items at the program level helps minimize social desirability bias while yielding information that may be just as useful in assessing levels of spiritual competence.

Table 1. Spiritual competence scale

1.	**To what degree does your social work program foster respect for religious and spiritual cultures?**										
	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
	Fosters extreme Disrespect										Fosters extreme Respect
2.	**How acceptable is it in your social work program to share religious or spiritual views?**										
	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
	Completely Unacceptable										Completely Acceptable
3.	**To what extent does your social work program foster sensitivity toward religious and spiritual beliefs?**										
	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
	Fosters extreme Insensitivity										Fosters extreme Sensitivity
4.	**To what extent does the atmosphere in your social work program foster respect for religious and spiritual perspectives?**										
	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
	Fosters extreme Disrespect										Fosters extreme Respect
5.	**To what degree are religious or spiritual believers free to be themselves in your social work program?**										
	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
	Must always censor or guard themselves										Totally free to be themselves
6.	**If religious or spiritual perspectives are shared in your social work program, to what extent are they valued?**										
	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
	Totally Disrespected										Totally Valued
7.	**To what extent does your social work program foster an empathetic understanding of religious and spiritual worldviews?**										
	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
	Fosters complete Misunderstanding										Fosters complete Understanding
8.	**When it comes to learning about the religious and spiritual worldviews that clients commonly affirm, how much openness does your program demonstrate?**										
	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
	Completely Closed										Completely Open

The spiritual competence scale was developed and validated in two stages. A stratified random sample of NASW affiliated graduate students was used for both development (N = 136) and validation (N = 303) of the instrument. Good psychometric properties were reported in the development and validation study (Hodge, in press).. All eight items loaded strongly on a single factor and the reliability coefficient was high (Cronbach's alpha of .921).

Proper validation, however, requires a series of studies, preferably using different samples (Jeffreys & Smodlaka, 1998). Although the NASW is the largest professional organization in social work, most graduate students do not belong to this organization (T. Lennon, Director of Information Services, CSWE, personal email communication, February 4, 2004). Further, given the nature of the construct of spiritual competence, it may be particularly important to validate the instrument with a sample of students who are more self-consciously engaged in spiritual issues.

Consequently, the purpose of this article is to validate the spiritual competence scale using a national sample of social work students who are unaffiliated with the NASW. If reliability and validity can be established with different populations, particularly those that are faith-based, then confidence that the instrument actually measures what it purports to measure is enhanced. Directly below, the method used to validate the scale is discussed.

METHOD

The sampling frame for this study consisted of graduate students affiliated with the National Association of Christians in Social Work (NACSW). NACSW affiliated students were chosen for a number of reasons. The NACSW is the largest faith-based professional organization in the United States, an important consideration when validating a measure of spiritual competence. It has a national membership suggesting the results will not be unduly biased by regional characteristics. Its student membership is also likely to differ substantially from the NASW student membership, at least in terms of religious and spiritual demographics.

A telephone survey methodology was used in conjunction with systematic sampling design. Relative to mail surveys, telephone surveys tend to foster more accurate responses and a higher response rate (Babbie, 1998). The response rate was a particular concern given the low rate of return some researchers have obtained using mailed surveys in tandem with professional memberships (Canda & Furman, 1999; Gartner, Harmatz, Hohmann, Larson & Gartner, 1990; Ressler & Hodge, 1999).

To ensure that as many students as possible had completed at least one semester of social work education, calls were placed in the spring semester. The survey was conducted earlier in the semester to minimize the inconvenience to students. To maximize the response rate, up to eight calls were placed to reach potential respondents.

Eight-eight graduate students in nonfaith-based social work programs agreed to complete the survey, 7 individuals declined to participate and, in a further 30 instances, no one was reached at the listed number. Thus, it is possible to calculate at

least two response rates. If it is assumed the instances where no was reached represent potential respondents, then the response rate is 70% (88/125). Conversely, if it is assumed that the instances where no was reached do not represent potential respondents (e.g., student moved, wrong number, etc.), then the response rate is 93% (88/95). Both rates, however, are well above the 50% rate widely accepted as adequate for analysis and generalization to the wider population (Babbie, 1998).

Given the expected communalities and factor loadings, the sample size of 88 was judged to be sufficient for factor analysis. Based upon the development and validation of the spiritual competence scale with other national samples, it was possible to make projections about the psychometric properties of the scale. As MacCallum, Widament, Zhang and Hong (1999) illustrated, sample sizes of well below 100 are appropriate for factor analysis if the communalities are consistently high (greater than .60), especially with simple models consisting of few factors and more indicators (e.g., 7 indicators per factor as opposed to three).

Guadagnoli and Velicer's (1988) work highlights the importance of strong factor loadings in determining adequate sample size. These researchers argue that as long as a factor has four or more items that load at .60 or greater, then the factor solutions are reliable regardless of sample size. With expected high communality levels, and expected factor loading above .60, the present sample size should produce reliable solutions.

The demographics for the sample are reported in Table 2. The sample is largely Protestant with a diverse number of theologically liberal, mainline and evangelical Christians. The average respondent had spent close to five years in the social work profession and, counting the current semester as one, had had just over four semesters of social work education. This depth of experience would suggest that the respondents were well qualified to address issues of spiritual competence in their educational settings.

Analysis was conducted to explore the extent to which the NACSW sample differed from the NASW sample used in the original validation study (Hodge, in press). No significant differences emerged between the two samples in age, gender, marital status, race, number of semesters in social work education, or length of time in the social work profession.

Table 2. Sample Characteristics (N=88)

Characteristic	N	Missing	%	Mean	SD	Median	Min	Max
Age	85	3		33.36	9.50	30.0	22	58
# of semesters of SW education	88	0		4.04	1.90	4.0	1	12
# of years of SW education	88	0		4.84	5.31	3.0	0	30
Gender	88							
Male	73			83.0				
Female	15			17.0				
Marital Status	87							
Single	37			42.5				
Married	39			44.8				
Widowed	1			1.2				
Separated	2			2.3				
Divorced	8			9.2				
Race	87							
White	68			78.2				
Black	4			4.6				
Hispanic	4			4.6				
Asian	6			6.9				
Native American	2			2.3				
Other	3			3.4				
Faith	86							
Protestant	79			91.9				
Liberal	7			9.0				
Mainline	17			21.8				
Evangelical	53			67.9				
Other	1			1.3				
Catholic	5			5.8				
Liberal	0			0.0				
Moderate	1			1.1				
Traditional	4			4.5				
Jewish	1			1.2				
Reform	0			0.0				
Conservative	0			0.0				
Orthodox	0			0.0				
Other	1			100.0				
Other type of faith	1			1.2				

Significant differences did emerge, however, on a number of religious and spiritual demographics. The NACSW sample was significantly more Protestant than the NASW sample (92% vs. 35%; $\chi^2 = 86.36$, $df = 4$, $p < .001$). Among those who self-identified as Protestants, the NACSW sample was comprised of significantly more evangelical Christians (60% vs. 8%, $\chi^2 = 39.86$, $df = 4$, $p < .001$). Among self-identified Christians of all strips, the NACSW sample was significantly more likely to report orthodox beliefs (96% vs. 50%; $\chi^2 = 54.50$, $df = 1$, $p < .001$). Based upon Hoge and Carroll (1978) measure of intrinsic motivation, the NACSW reported significantly higher levels of spiritual motivation ($M = 6.61$ vs. $M = 4.68$; $t = -18.38$, $df = 389$, $p < .001$).

Given the importance of validating new measures with different populations, the difference in spiritual demographics between the NACSW and NASW samples highlights the utility of the NACSW sample to validate a measure of spiritual competence. Particularly important is the fact that the majority of NACSW members are evangelical Christians. This population is the largest spiritual minority in the United States (Green, Guth, Smidt & Kellstedt, 1996), is disproportionately drawn from disenfranchised groups (Davis & Robinson, 1997), has developed its own subculture (Talbot, 2000), and is significantly underrepresented in social work circles (Sheridan, Wilmer & Atcheson, 1994). Given that social workers will likely encounter significant numbers of these Christians in their practice, it is critical to validate a measure of spiritual competence with these believers.

In addition to demographic items and the eight item spiritual competence scale, a number of questions were included to test concurrent and divergent validity. Cultural competence is widely viewed as existing along a continuum (Sue, et al., 1992; Manoleas, 1994). For instance, Maneleas (1994) posits a continuum ranging from culturally destructive to culturally proficient practice. Particular beliefs and attitudes are thought to be associated with each end of the continuum.

To test concurrent validity, a number of items from the code of ethics were used. As implied above, the NASW Code of Ethics (1999) lists four standards that explicitly mention religion (1.05c, 2.01b, 4.02 and 6.04d) and at least two standards that implicitly mention religion (1.05a, 1.05b) as a protected category toward which social workers should exhibit sensitivity. Compliance with the profession's ethical standards are widely held to represent attitudes and practices that fall on the culturally proficient end of a cultural competence continuum.

Individuals were read each ethical standard and asked to indicate their response on an 11-point response key, which ranged from complete violation of the ethical standard (-5) to complete compliance with the ethical standard (+5). A constant was added to each item so that the values ranged from 1 to 11 and the items were averaged to form a scale with higher values indicating higher levels of ethical compliance. The alpha coefficient for this six-item measure was .921. As implied above, it was hypothesized that perceptions of spiritual competence would be positively correlated with perceptions of compliance with the code of ethics' standards that address religion.

To test divergent validity, a measure of religious discrimination was included. Discrimination falls at the culturally destructive end of Maneleas' (1994) continuum and

is widely seen as representing a construct incompatible with cultural competence. Individuals were asked, "To what extent, if any, is religious discrimination a problem in your social work program." Individuals indicated their response on an 11-point response key ranging from "not a problem at all" to "religious discrimination permeates every aspect of the program." It was hypothesized that perceptions of religious discrimination would be negatively associated with perceptions of spiritual competence.

Four cases had missing data. Three cases had one missing value while one case had two missing values. The EM algorithm procedure was used to impute missing data. All variables were transformed so that the skewness and kurtosis values fell within a range of – 1 to + 1, values that approximate a normal distribution (Schumacker & Lomax, 1996). After imputation and transformation process, analysis was conducted, the results of which are reported next.

RESULTS

Analysis proceeded by computing a correlation matrix and examining the interitem correlations. As can be seen in Table 3, the interitem correlations ranged from .542 to .790. These values all fall into a range that implies the items are all unique, as evidenced by the lack of correlations above .80, and appropriate for measuring the construct of spiritual competence, as evidenced by the fact that all the items exhibit strong correlations above .50 (Kline, 1998).

However, to confirm the suitability of these items for factor analysis, tests were conducted to explore that a) a substantive relationship exists among the variables and b) the variables were not so highly correlated as to be redundant). To ensure that a relationship existed, Barlett's test of Sphericity was computed. Consistent with the high interitem correlations, the test was highly significant ($\chi^2 = 553.16$, $df = 28$, $p > .0001$), indicating a substantive relationship exists among the variables in the matrix. To test for multicollinearity, the value of the determinant for the correlation matrix was computed. A value of .0013 was obtained. Since this value exceeds .00001, multicollinearity was judged not to be a problem (Field, 2000).

Given the sample size of 88, the Kaiser-Meyer-Olkin (KMO) statistic was computed to test the sampling adequacy. Values range between 0 and 1. Values closer to 0 indicate that the patterns of correlations are diffused while values closer to 1 indicate that the patterns of correlations are compact and therefore likely suitable for factor analysis. Values below .5 indicate that either more data should be gathered or different variables should be used while values above .90 are excellent (Kaiser, 1974). In this case, the KMO statistic was .933, which suggests that the factor analysis should yield distinct and reliable factors (Field, 2000).

Table 3. Inter-item correlations for spiritual competence scale

	1	2	3	4	5	6	7
1							
2	.651						
3	.678	.643					
4	.691	.704	.768				
5	.623	.703	.595	.759			
6	.709	.718	.630	.790	.765		
7	.721	.665	.629	.736	.736	.774	
8	.542	.551	.558	.617	.592	.590	.625

An anti-image correlation matrix was also computed and the KMO statistic was examined for each variable. All values exceeded .90, indicating that none should be excluded from the analysis (Kaiser, 1974). In short, initial analysis of the data confirmed its suitability for factor analysis.

A Principle Components factor analysis was conducted using Varimax rotation followed by Promax rotation (Tinsley & Tinsley, 1987). Both methods of rotation produced virtually identical results. The communalities ranged from .553 to .813, although six items had values in the .600/.700 range. This set of communalities suggests that the factor solution is reliable with an N of 88 (MacCallum, et al., 1999).

To determine the number of factors, Kaiser's criterion was used in addition to an examination of the scree plot. Both methods indicated the existence of a single factor. An eigenvalue of 5.71 was obtained which accounted for 71.34 percent of the variance.

The factor loadings are reported in Table 4. As can be seen all items load strongly, with values ranging from .743 to .902. Thus, Guadagnoli and Velicer's (1988) criteria of at least four items loading in excess of .60 or greater was satisfied, indicating that the present sample size produces stable factor solutions. Although the results with Varimax are reported, the loadings with Promax rotation were identical.

Table 4. Principle Components factor loadings with Varimax rotation

Item	Loading
1	.832
2	.835
3	.813
4	.902
5	.858
6	.889
7	.874
8	.743

Reliability analysis indicated the eight item scale was highly reliable. A Cronbach's alpha coefficient of .943 was obtained, marginally better than the .923 obtained with

the NASW sample.

The measures of convergent and divergent validity performed as hypothesized. As posited, the spiritual competence scale was positively correlated with the ethics scale ($r = .513$, $p < .001$). Likewise, the spiritual competence scale was inversely associated with perceptions of religious discrimination. As hypothesized, the spiritual competence scale was negatively correlated with perceptions of religious discrimination ($r = -.682$, $p < .001$.) These two findings further enhance the validity of the scale by revealing that the construct of spiritual competence is related to other constructs in a manner that is consistent with theory.

DISCUSSION

This study validated an eight item measure of spiritual competence with a nationally representative sample of NACSW affiliated graduate students. The results suggest that the newly developed measure is a valid and reliable measure of spiritual competence. All items loaded strongly on a single factor, evidence of convergent and divergent validity was provided, and a Cronbach's alpha of .943 was obtained with the eight items.

The importance of developing and validating instruments that assess various forms of cultural competence is implied by the CSWE and NASW standards. The CSWE's (2001) EPAS indicate that social work programs should develop plans to evaluate program outcomes (Standard 8: 8.0, 8.1). Similarly, standard 10 of the NASW Standards for Cultural Competence in Social Work Practice (2001) state that the profession must develop measures to assess cultural competence.

The measurement of spiritual competence is an issue of critical concern to many clients. Social workers regularly interact with clients of faith. Further, in many instances, social workers are call upon to directly address spiritual issues. As mentioned in the introduction, JCAHO (2001), which accredits most hospitals as well as many other healthcare organizations in the United States, now recommends conducting spiritual assessments. If social workers are not well versed in spiritual competence, then harm may be perpetrated upon clients (Reddy & Hanna, 1998; Richards & Bergin, 2000).

The extant data on client perceptions suggest that the measurement of spiritual competence in educational and agency settings should be a priority. Among a Midwestern sample (N = 76) of evangelical Christians, 83% felt that social workers did not understand their religious beliefs and values, with the percentage rising to 94% for respondents that had received counseling (Furman, Perry & Goldale, 1996). Likewise, among a sample of evangelical church attendees (N = 145) in Wisconsin, Oklahoma and Nevada, only 26% agreed that "if I had to go to a social worker, I believe the person could be trusted" (Pellebon, 2000).

Similar concerns have appeared among observers of other faith traditions. Commentators have suggested that a number of Muslims (Altareb, 1996; Daneshpour, 1998; Kelly, Aridi & Bakhtiar, 1996), Hindus (Fenton, 1988; Goodwin & Cramer, 1998) and many other people of faith (Richards & Bergin, 2000) may be troubled about the level of sensitivity mental health professionals exhibit toward their cultural

norms and values.

These concerns among people of faith highlight the need to ensure that social work educational and agency settings are characterized by spiritual competence. Spiritual competence should not be assumed to exist in social work settings but rather, as implied by the CSWE and NASW standards, it should be measured and tracked over time. The spiritual competence scale provides a means for assessing fundamental values that are essential to culturally competent service provision.

In addition to discussing the strengths, it is also pertinent to note the limitations. It is important to emphasize that the scale measures perceptions of competence rather than actual competence. There is no guarantee that perceived levels of competence at the program, agency, or self-assessment level necessarily translates into actual competence in practice situations. Caution is further warranted by the fact that the scale only taps the values dimension of Sue and associates tri-dimensional conceptualization of cultural competence. Consequently, while a high score on the scale may indicated the presence of the values necessary for spiritually competent practice, it does not necessarily indicate the presence of the skills or knowledge necessary for spiritually competent practice.

Another set of limitations related to generalizability also exists. Approximately 12% of the NACSW students did not have a listed phone number. Although there is no reason to assume that individuals without phones differ in their perceptions from those with phones, it is not possible to assert that the sample is representative of the NACSW graduate student membership. Similarly, the respondents cannot be considered representative of other faith groups. Indeed, while the spiritual competence scale is designed as an ecumenical measure, the reliability and validity of the scale would be further enhanced by studies with other samples of social work students drawn from other groups, such as Muslims, Hindus and other people of faith.

In addition to further work in educational settings, subsequent research might explore the level of spiritual competence in social work agencies. As mentioned in the introduction, the wording can easily be adapted to address perceptions in agency settings. Longitudinal research might explore the relationship between perceptions of spiritual competence and client outcomes.

As society becomes increasingly diverse, social work must ensure that it provides services that are sensitive, relevant and respectful of clients' cultures. Exploring the perceptions of students, social workers, and clients provides valuable insight into the extent to which the profession is conforming to its stated ethical and educational standards. As Boyle and Springer (2001) indicated, researchers must develop population specific measures for use in social work settings. The spiritual competence scale represents the first attempt develop such a measure.

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