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Advances in Social Work is committed to enhancing the linkage among social work practice, research, and education. Accordingly, the journal addresses current issues, challenges, and responses facing social work practice and education. The journal invites discussion and development of innovations in social work practice and their implications for social work research and education. *Advances in Social Work* seeks to publish empirical, conceptual, and theoretical articles that make substantial contributions to the field in all areas of social work including clinical practice, community organization, social administration, social policy, planning, and program evaluation.

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Editorial

James G. Daley

I am humbled and energized as I take the reins as editor of this wonderful journal. *Advances in Social Work*, now in its third year of publication, has firmly created its place as a source of scholarly excellence in the growing volume of professional journals. Our mission is straightforward. We strive to be both conduit and standards setter. There are many superb scholars who conduct groundbreaking and vital theoretical and empirical studies. We hope to be an inviting way to get their work showcased to the world. We work hard to get manuscripts reviewed as quickly as possible and get them into print. Our review process is rigorous, with some of the finest scholars serving as our reviewers. We invite you to consider us for that manuscript that deserves to be shared with the world.

Besides serving as a conduit, the journal seeks to produce issues that coalesce state-of-the-art research and theory in a manner that pushes the field of social work to a more in-depth consideration of important topics. In the future, we will be developing special issues that will explore a topic in more depth and capability than any one article could provide. We hope to offer a thoughtful, useful issue that will serve as a valuable resource for the social workers and other professionals in urgent need of the latest knowledge.

The profession of social work exists in an information overloading and complex environment in which social workers must gather knowledge, analyze the best technologies, and create useful intervention strategies that produce empirically verified outcomes that benefit our clients. We are accountable to everyone and our very survival stems from justifying our actions. Other professions are rapidly developing best practice protocols, eroding profession-specific boundaries, and asserting claims that they, rather than social workers, are more capable, evidence-based, and resourceful. Fortunately, social work has a proud heritage of capability and has itself launched a myriad of best practice initiatives. Our mission, blending client-focused skills and effective societal advocacy, continues to be desperately needed and invaluable as a contribution to improving our world.

This journal is an important part of that social work mission. As editor, I accept a leadership role in supporting that mission. This issue exemplifies that commitment to excellence. The six articles provide you with a rich variety of thoughtful, useful information. The topics range from training social workers to using spirituality in practice, online social work practice, contrasting rural and urban differences in clients, issues of professional liability and risk, poetry therapy as a useful technique, and a more in-depth examination of substance abuse and suicidal behavior in young adult women. This issue should offer stimulating reading and education. It continues our effort to give the reader a depth and breadth of information that strengthens your skills.

I hope you enjoy the issue. I look forward to the vibrant path that this journal is taking. Stick around and watch what happens. It will be exciting!

Equipping Social Workers to Address Spirituality in Practice Settings: A Model Curriculum

David R. Hodge

Abstract: *While there is growing interest in incorporating clients' spiritual beliefs and values into social work practice, several studies have shown that social workers lack the necessary training to address spiritual issues in a culturally competent manner. This paper addresses this need by providing an annotated spirituality training course for use in various settings. Topics or domains covered in the curriculum include ethics and values, research and theory on spirituality, the nation's spiritual demographics, the cultures of major spiritual traditions, value conflicts, spiritual interventions, assessment approaches, and the rights of spiritual believers. A number of potential assignments are offered, which are designed to promote practitioner self-awareness, respect for spiritual diversity, and an enhanced ability to assess and operationalize spiritual strengths to ameliorate problems in practice settings.*

Keywords: Spirituality, course curriculum, training, education, religion

There is growing realization that for many clients spirituality is fundamental to their existence. Spiritual belief systems often function as an interpretive framework for understanding reality, informing individuals of who they are and how they should live (Maslow, 1968). As Rey (1997) has observed, these spiritually informed worldviews can affect numerous attitudes and practices of significance to social workers. For instance, bereavement, childcare, diet, intergenerational relationships, marriage relations, medical care, military participation, recreation practices, and schooling are all areas in which clients' spirituality can affect beliefs and actions.

Evidence is also building that spirituality is a significant personal strength for many clients. Several hundred studies on spirituality and religion have been conducted during the past few decades (Koenig, McCullough & Larson, 2001). Reviews have consistently found a generally positive association between spirituality and a wide number of salutary characteristics (Ellison & Levin, 1998; Gartner, 1996; Koenig et al., 2001; Pargament, 1997). For example, various dimensions of spirituality

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have been associated with empowerment (Calhoun-Brown, 1998; Maton & Salem, 1995), female leadership (Robinson, 1996), healing (Maton & Wells, 1995; McRae, Thompson & Cooper, 1999) and recovery from addiction (Turner, O'Dell & Weaver, 1999), depression (Propst, 1996), divorce (Nathanson, 1995), homelessness (Lindsey, Kurtz, Jarvis, Williams & Nackerud, 2000; Montgomery, 1994), serious mental illness (Sullivan, 1997), and sexual assault (Kennedy, Davis & Talyor, 1998).

Research also indicates that many clients wish to incorporate their spiritual strengths into practice settings (Privette, Quackenbos & Bundrick, 1994). According to Gallup data reported by Bart (1998), 66% of the public would prefer to see a professional counselor with spiritual values and beliefs and 81% wanted to have their own values and beliefs integrated into the counseling process. Approximately 60% of the public believe that their faith can be marshaled to address most of the problems they encounter (Gallup & Castelli, 1989). Furthermore, the salience of spirituality frequently becomes more prominent during times of personal hardship (Ferraro & Kelley-Moore, 2000; Pargament, 1997), times when social workers may be more likely to encounter clients.

As the NASW Code of Ethics (National Association of Social Workers, 1999) standard 1.05 stipulates, it is important for social workers to increase their understanding regarding the unique characteristics of spiritually-based cultures to be able to provide culturally competent services to clients. Several surveys have shown, however, that most social workers have received no training in spirituality during their graduate education (Bullis, 1996; Canda & Furman, 1999; Derezotes, 1995; Furman & Chandy, 1994; Furman, Benson, Grimwood & Franz, unpublished manuscript; Sheridan & Amato-von Hemert, 1999). For instance, Canda and Furman's (1999) stratified random sample of the National Association of Social Work (NASW) members (N=2,069) found that 73% received no content on spirituality during their social work education and only 17% agreed that social workers possessed the knowledge to address spiritual issues. While most social workers recognize the importance of spirituality, the data suggest that many social workers are not adequately equipped to address spirituality in practice settings (Canda & Furman, 1999).

The lack of education implies that widespread training is required in this area. Accordingly, this paper addresses the need by presenting a spirituality-training curriculum. The aim of the curriculum is to develop an understanding of spiritual diversity and lay a foundation for acquiring the necessary skills and knowledge to utilize spirituality in various practice settings in the areas of assessment, planning, and intervention. Toward this end, the three-fold objective is to develop a deeper understanding of the empirical and theoretical knowledge base, acquire a greater understanding of the various spiritual traditions practitioners are likely to encounter in practice settings, and develop the skills necessary to utilize spirituality in practice settings to ameliorate problems in a manner consistent with the profession's ethical mandates.

The curriculum can be adapted to a number of different settings, including agency-based workshops, short-term seminars, graduate level courses, small groups, or even self-study. This is accomplished by adjusting the amount of material addressed in various contexts, such as classroom settings, small groups outside of class, and homework assignments. Since curriculum material consists of a number of articles/

book chapters designed to address specific topics, contextual alterations can be made to tailor the material by incorporating additional pertinent readings. While compiling the material is more work than merely assigning textbooks, the reading packet serves as a type of textbook itself and can be continually updated by adding new articles as the knowledge base grows over time (Patterson, Hayworth, Turner Christie & Raskin, 2000).

As implied above, this paper provides an annotated overview of the curriculum material. There are 10 major domains or topics that might be considered in designing a spirituality curriculum: *1) ethics and values, 2) a review of the empirical research on spirituality, 3) theoretical explanations for spiritual strengths, 4) spiritual demographics of the nation, 5) an overview of the nation's major spiritual traditions, 6) value conflicts, 7) spiritually-based interventions, 8) assessment and operationalization of spiritual strengths, 9) rights of spiritual believers, and 10) assignment suggestions*. The material below is presented in a manner that highlights connections between readings and emphasizes pertinent themes that can be amplified upon in discussion or through personal reflection. The major topics are reviewed in the sequence in which they would be presented in a seminar, workshop, or course. Small-scale mini-assignments to enhance learning, which might take the form of class discussion topics or reflective take-home papers, are suggested for most domains. In a section at the end of the paper, suggestions for major assignments that help to integrate the material are provided.

The material presented below is also designed to be consistent with the Foundation Curriculum Content requirements specified in the Educational Policy and Accreditation Standards (EPAS) issued by the Council on Social Work Education (CSWE) (2001: IV). More specifically, the suggested domains and assignments have been created to foster learning in the content areas listed in the EPAS as they intersect spirituality; namely, values and ethics, research, human behavior and the social environment, diversity, populations-at-risk and social and economic justice, social work practice, and to a lesser extent, social welfare policy and services.

ETHICS AND VALUES

An appropriate place to begin a presentation on spirituality is with the profession's code of ethics (National Association of Social Workers, 1999). As the EPAS standards IV and A (Council on Social Work Education, 2001) state, education should provide students with the opportunity to integrate the NASW Code of Ethics into their practice with, and service to, clients. Three areas of particular significance are the standards related to client self-determination, religion, and professional competence. It is important to note that social workers are to respect the spiritual autonomy of clients (1.02). Practitioners must be careful not to impose or otherwise coerce clients into accepting their values. Richards, Rector, and Tjeltveit (1999) provide a concise overview of the intersect between values and spirituality in the clinical setting, along with helpful suggestions for safeguarding clients' rights in the area of autonomy. As supplemental reading to raise awareness concerning value differences, Jafari (1993) offers an Islamic view that helps to illustrate how the values associated with the Enlightenment-based Western counseling project may differ from the values associated with some faith-based perspectives.

The NASW Code of Ethics (National Association of Social Workers, 1999) lists four standards that explicitly address religion (1.05c, 2.01b, 4.02, and 6.04d), the vehicle through which most, although not all, clients express their spirituality (Gallup & Lindsay, 1999; Pargament, 1999). Furthermore, since religious believers comprise distinct cultural groups based on the norms of their faith traditions (Fellin, 2000; Talbot, 2000), there are at least two standards that implicitly address religion (1.05a, 1.05b). These standards can be reviewed and their implications regarding how social workers should interact with religious peoples examined.

Social workers are also mandated to offer services only within their area of professional competency (1.04). Practitioners do not function in the role of a pastor or spiritual director/mentor (O'Rourke, 1997). While it is generally appropriate for social workers to attempt to tap into clients' spiritual strengths to assist them in solving their problems, it is essentially outside practitioners' area of competence to address issues related to clients' spiritual well-being. Put simply, social workers should focus on helping clients overcome the obstacles they face rather than offering advice on clients' spiritual state, beliefs, practices, or behaviors. Social workers who envision themselves as working with spiritual issues on a regular basis should consider forming collaborations with local clergy drawn from the most prominent local faith traditions (Weaver, Koenig & Larson, 1997).

To help assimilate this material, course participants might consider what type of practitioner responses would engender a practice atmosphere that promotes creating a safe place in which spirituality can be explored in a non-judgmental manner. At some point in the curriculum, ethical dilemmas could be analyzed in light of the ethical standards discussed above (Council on Social Work Education, 2001: IV, A). For instance, given that Islam affirms sexuality within the context of heterosexual marriage (Halstead & Lewicka, 1998; Islamic Society of North America, 1999), the challenges that a gay therapist might face with a Muslim client wrestling with her sexual orientation might be explored.

REVIEW OF THE EMPIRICAL RESEARCH

As implied above, research on spirituality is increasing at a dramatic rate, with hundreds of studies on the topic now in existence (Koenig et al., 2001). The results of these studies have been remarkably consistent across populations regardless of age, ethnicity, gender, national origin, race, religious affiliation, and study design (Ellison & Levin, 1998; McFadden & Levin, 1996). Reviews consistently report a generally positive association between devout faith and a wide number of salutary characteristics (Ellison & Levin, 1998; Gartner, 1996; Koenig et al., 2001; Pargament, 1997).

The following articles provide a window on this growing body of empirical knowledge. After reading these five articles, students may be surprised at the breadth of available research. Interested individuals should be informed that research exists on most populations and issues of interest to social workers.

Green, Fullilove, and Fullilove (1998) offer a good entry point into the research with their qualitative study that describes stories of spiritual awakenings among participants of 12-step programs. The narrative format affords students the oppor-

tunity to encounter an experiential, phenomenological element that often gets lost in research. Worthington, Kurusu, McCullough, and Sandage (1996) present a thorough 10-year review of research that relates to practice concerns, such as studies on the relationship between spirituality and mental health, the role of values in therapy, and effective interventions. In Maton and Wells' (1995) review, the potential of religion to foster well-being through the pathways of prevention, healing, and empowerment is examined.

This content area also includes two studies that highlight the salience of spirituality with specific populations of interest to social workers. Donahue and Benson's (1995) study illustrates the significance of religion as a protective factor with adolescents, with religion often exhibiting a stronger influence than gender, single parent status, and other variables widely thought to be significant predictors of attitudes and behaviors. Kennedy, Davis, and Talyor's (1998) study documents the role of spirituality in facilitating recovery from sexual assault among a sample comprised largely of inner city minority women.

Since this section is oriented towards empiricism, it may be difficult to provide an assignment to help foster learning in this topic area. Accordingly, this may be an appropriate time to integrate into the course one of the major assignments discussed later in this paper. Alternatively, when the course is being taught in a CSWE-accredited educational institution and/or students have an understanding of research methodology, students might critique some of the existing research, explore, and summarize the existing research in a given area (e.g., the relationship between spirituality and depression), relying on good reviews such as Koenig, McCullough, and Larson's (Koenig et al., 2001), or conduct a literature search to explore the intersection between spirituality and a given population, such as African-Americans or the elderly.

THEORETICAL EXPLANATIONS

As the CSWE's educational standards (Council on Social Work Education, 2001: IV, D) imply, it is important for students to be exposed to empirically-based theories that explain the relationships between humans and their environments with an emphasis on the relationships that maintain and promote health and well-being. As interest in researching the effects of spirituality has grown, a number of theories have been proposed to explain the underlying mechanisms. While the preceding domain helps students understand the nature of spiritual assets, theory can assist course participants in their comprehension of the pathways involved. In other words, theory provides an explanation for how spirituality fosters positive outcomes.

Ellison and Levin (1998) provide a smooth transition from overviewing the research to discussing theoretical explanations for the association between religion and health. Seven possible explanatory mechanisms are reviewed, which may account for salutary outcomes, including the provision of social resources, promotion of positive self-perceptions, and provision of specific coping resources. Jacobs (1992) explores the underlying mechanisms between mental health and ritual, a key spiritual practice inherent in essentially all faith traditions. Finally, borrowing from attachment theory, Kirkpatrick (1995) suggests that God functions as

an attachment figure. Since attachment is theorized to be a malleable construct that can change over time, the negative effects of insecure childhood attachment can be compensated for by developing a secure attachment with a divine other.

For enhanced learning, students can reflect upon the various theoretical mechanisms as they intersect their own lives, or the lives of other significant individuals they know. Which theoretical explanations best explain the spiritual strengths they observe in their own lives? The lives of others? Do other theoretical pathways exist that provide a better theoretical explanation for the operation of spiritual strengths? If students had to construct their own theoretical model to describe the relationship between spirituality and well-being, what might it look like?

DEMOGRAPHICS AND OVERVIEW OF MAJOR SPIRITUAL TRADITIONS IN THE NATION

While diversity is a fundamental tenet of social work education (Council on Social Work Education, 2001: IV, B), in practice, individuals tend to form social networks based upon shared norms and values (Scheepers & Van Der Slik, 1998). Because people tend to enter into relationships, watch media, and read news reports that validate their own understanding of reality, individuals may not have an accurate understanding of the nation's spiritual demographics. Alternatively, individuals may only be dimly aware of other faith traditions and their own unique worldviews.

To counter misperceptions, it is important to provide students with a description of the most numerically prominent faith traditions in the United States. Since clients are most likely to come from these traditions, it is critical that social workers have some comprehension of the nation's largest faith groups and their animating value systems. Since, to some extent, most of the research and theory is based upon these populations, it helps to have some level of understanding of the nation's spiritual demographics in order to integrate the former content areas.

Gallup and Castelli's (1989) text, especially chapter 4, provides a comprehensive overview of the major denominations and faith-based groups in the country, including Evangelicals, Catholics, Mormons, Jews, and "nones." Also examined are the distinctive profiles of African Americans, Hispanics, teenagers, and Baby Boomers. While the material is somewhat dated, religious demographics remain relatively stable over time (Gallup & Castelli, 1989) as more recent data confirm (Hutchison, 1999).

For further reflection, individuals may wish to delineate the major faith groups in the nation, then map out the number of close friends in each group, paying attention to their level of orthodoxy or commitment to the historic mainstream tenets of their faith tradition. Of particular note is the degree of homogeneity vs. the degree of diversity. If one's social network is largely comprised of, for example, members of liberal denominations, nominal adherents, and "nones," it is important to reflect upon how this may affect interaction with groups, such as Evangelicals, who tend to have a different value system. Similarly, if one's social network primarily consists of devout Mormons, reflection upon the possible difficulties involved with working with more liberal groups is called for.

OVERVIEW OF MAJOR SPIRITUAL TRADITIONS

As an extension of the above material, this content area provides more specific information about major spiritual traditions that social workers are likely to encounter. Articles in this domain can introduce readers to the unique beliefs, practices, values, and assets associated with the specific spiritual tradition under discussion. By providing students with a basic understanding of the value system that guides adherents, social workers are better equipped to provide services that are culturally competent as stipulated by the code of ethics (1.05).

The following is a core list of common spiritual traditions that cover the majority of clients with whom social workers are likely to encounter in practice settings (Gallup & Castelli, 1989; Hutchison, 1999). Depending on such factors as time restraints and, perhaps, more importantly, the spiritual demographics of the area in which the course is taught, it may be appropriate to add material that addresses such traditions as Mormonism (Ulrich, Richards & Bergin, 2000), Islam (Daneshpour, 1998), Judaism (Zedek, 1998), Pentecostalism (Dobbins, 2000), Hinduism (Juthani, 1998), Buddhism (Scotton, 1998), Native American spirituality (Trujillo, 2000), and/or other traditions. In short, the content in this domain should be tailored to equip course participants with understanding the faith-based cultures they are most likely to encounter in practice settings.

Evangelical Christians are the nation's largest spiritual minority (Hutchison, 1999). DiBlasio (1988) provides an introduction to this population and discusses some of the implications of an Evangelical worldview for therapy. Catholics comprise the second largest spiritual tradition and the nation's largest denomination. Shafranske (2000) provides an overview of this tradition, highlighting issues of importance to practitioners. McCullough, Weaver, Larson, and Aay (2000) provide a review of mainline Protestants, which includes an overview of their history, fundamental beliefs and practices, views on social and moral issues, and suggestions for practice. A brief introduction to Eastern faiths is offered by Ryan (1993), who reviews Hinduism, Buddhism, Confucianism, and Taoism in the context of death and dying work.

As mentioned above, this list should be adapted to reflect the client populations which course participants are likely to encounter in practice settings. It is critical, however, that the writings in this domain reflect an unbiased, empathetic tone that communicates respect for the culture in question. Authors whose value systems are derived from the dominant secular culture, or whose value systems are otherwise incongruent with the group being discussed, can misrepresent faith-based cultures when value conflicts occur between the writer's value system and the population the author is addressing (Ginsberg, 1999; Wambach & Van Soest, 1997). When writers encounter values that differ from their own, they may attempt to counter the group's beliefs or depict them as deficits, problems, or concerns instead of conveying a strengths-based depiction that genders an empathetic understanding.

For instance, one article on the Pentecostal experience seems to suggest that beliefs central to this faith group, such as believing that Jesus performed miracles or believing in the necessity of a spiritual re-birth, are either incorrect or problems (Belcher & Cascio, 2001). While Enlightenment-based secular discourse commonly

discounts the reality of the supernatural realm, applying this framework as an interpretive lens to minority faith groups facilitates misunderstanding in the same manner that applying a white lens facilitates misunderstanding of, for example, African-Americans. In short, the articles selected for this content area should reflect the same sensitivity to faith-based groups that is extended to other groups commonly discussed in social work forums.

To enhance learning, course participants might select one of the commonly encountered faith groups whose value system differs substantially from their own and attempt to envision life through that particular worldview. As part of this process, individuals might visit a house of worship and/or obtain and read a variety of literature from a spiritual tradition that differs from their own, noting their personal reactions to these experiences.

The aim is to move toward spiritual competency by 1) developing an empathic understanding of a spiritually different worldview and 2) developing an awareness of one's personal spiritual worldview and associated biases (Sue, Arredondo & McDavis, 1992). More specifically, using Evangelical Christians as a possible client population whose worldview differs from the students' own, one might reflect upon the lens or worldview through which Evangelicals are viewed, attempt to discern how the biases associated with their worldview affects their understanding of Evangelicals, consider how to set aside their worldview and associated biases and see reality through the worldview used by Evangelicals, and finally, come to the point of appreciating reality as seen through an Evangelical worldview (Wambach & Van Soest, 1997).

VALUE CONFLICTS

Content on spiritual diversity flows naturally into a discussion on value conflicts that arise between subordinate and dominant spiritual worldviews. As implied above, conflict often occurs between the value system advocated by the dominant secular culture and the value systems of spiritual believers. As the CSWE educational standards (CSWE, 2001: IV, C) suggests, it is important for curriculum content to address issues of social justice and oppression. In order to work effectively with people of faith, it necessary to understand the bias they encounter in the dominant secular culture.

One of the more influential models for understanding value conflicts is Hunter's (1991) epistemological theory. This model posits that contemporary society is characterized by impulses towards two worldviews referred to by Hunter as orthodox and progressive. Orthodox believers derive their value system from transcendent authority, such as the Bible, the Koran, or the Dharma, while progressives individually construct their own value systems within the parameters proscribed by the current Enlightenment derived, secular ethos.

Two sections from Hunter's 1991 text provide a succinct introduction to this framework, the prologue "Stories from the front" (pp. 3-29) and "New lines of conflict: The argument in brief" (pp. 42-51). As implied above, the secular Enlightenment-based worldview referred to by Hunter as progressive dominates the centers of social power, particularly the reality defining the knowledge sector (e.g., media, academia, government bureaucracy, helping professions, etc.).

As mentioned above, it is important to develop an empathetic understanding of the bias that the difference in worldviews between people of faith and progressives often engenders toward orthodox believers (Roberts, 1999). It may be helpful to recognize that the dominant progressive worldview often marginalizes or otherwise de-legitimizes devout faith in such influential knowledge sector forms as television (Skill & Robinson, 1994; Skill, Robinson, Lyons & Larson, 1994), popular periodicals (Perkins, 1984), high school (Sewall, 1995; Vitz, 1986; 1998) and college level textbooks (Glenn, 1997; Lehr & Spilka, 1989), including social work texts (Cnaan, 1999; Hodge, Baughman & Cummings, 2002). Stockton (1994) illustrates how the clash in value systems can lead to Muslims being depicted in an unfavorable light in media, a forum that shapes general perceptions about populations (Hunter & Schaecher, 1995; Tower, 2000).

As one of the professions that comprise the knowledge sector, Hunter (1991) observes that a progressive worldview also pervades social work. One illustration of the salience of the progressive worldview in the profession is provided by the fact that some 60% to 70% of social workers reject the notion of a personal God in favor of non-theistic understandings of transcendent reality (Sheridan, Bullis, Adcock, Berlin & Miller, 1992; Sheridan, Wilmer & Atcheson, 1994). In contrast, at least 66% of the general population believe in a personal God (Canda & Furman, 1999; Gallup & Castelli, 1989). Furman, Perry, and Goldale's (1996) study demonstrates the effects that the difference in value systems can have on the willingness of some theistic clients to receive services from social workers who hold substantially different worldviews in tandem with little knowledge of spiritual diversity.

To enhance understanding in this area, course participants might consider which worldview they orient towards (i.e., orthodox or progressive) and how that particular orientation might affect their ability to work with clients from the alternative worldview in a culturally competent manner. A feminist, for example, might consider how her affirmation of the egalitarian gender roles might effect her ability to provider services to a Hindu couple that affirms complementary gender roles. Or to cite another example, an Evangelical Christian might reflect upon how her worldview might effect her ability to provide services to a sexually active gay man wrestling with the intersection between his spirituality and sexual behavior.

Material from the NASW Code of Ethics (NASW, 1999) might also be incorporated into assignments. Given that the Code of Ethics indicates that social workers should actively work to prevent and eliminate religious discrimination (standard 6.04d), individuals might deliberate upon the experiences of spiritual believers who encounter life in a culture that often ignores, devalues, and even ridicules their most cherished beliefs and values. Individuals might consider what actions they might take, both personally and systemically, on behalf of Evangelical Christians, traditional Catholics, Muslims, and people of faith from other traditions who often encounter bias in the dominant secular culture.

SPIRITUALLY-BASED INTERVENTIONS

Spiritually competent practice is predicated upon acquiring the ability to develop intervention strategies that are appropriate, relevant, and sensitive to the client's spiritual worldview (Sue et al., 1992). As the CSWE educational standards (Council

on Social Work Education, 2001: IV, F) imply, practice should focus on the clients' spiritual strengths, capabilities, and resources.

Although it is important to consider interventions within the context of the specific spiritual tradition of the client, there are some interventions that have been empirically validated with a number of traditions. Perhaps the most widely used spiritual intervention is prayer. McCullough and Larson (1999) provide a helpful overview of prayer, including information about its frequency, various manifestations, associations with well-being, and its function as a resource for practitioners.

Incorporating spiritual beliefs into traditional cognitive/behavioral modalities is also a widely used intervention. Studies suggest that a spiritually modified form of cognitive/behavioral therapy is at least as effective as traditional forms of therapy in a number of areas, including depression among Christians (Hawkins, Tan & Turk, 1999; Johnson, Devries, Ridley, Pettorini & Peterson, 1994; Johnson & Ridley, 1992; Propst, 1996), perfectionism among Mormons (Richards, Owen & Stein, 1993), and anxiety disorders (Azhar, Varma & Dharap, 1994), bereavement (Azhar & Varma, 1995a), and depression (Azhar & Varma, 1995b) among Muslims. Propst (1996) provides a good introduction to this approach.

A significant body of research also testifies to the importance of spirituality as a mechanism for coping (Pargament, 1997). Pargament, individually (Pargament, 1996) and in association with Brant (Pargament & Brant, 1998), overviews some of the more salient features of spiritual coping. Options for reframing difficulties as opportunities for spiritual growth are presented along with spiritual beliefs that may facilitate healthy spiritual coping.

Spiritual resources can also be tapped into to facilitate forgiveness, which is a major component of most major faith traditions (McCullough, Paragament & Thoresen, 2000). DiBlasio (1998) gives a helpful account of the use of decision-based forgiveness in therapeutic contexts.

To promote further assimilation of the above material, individuals might consider selecting one or more interventions and one or more of the spiritual traditions listed above. Course participants could reflect upon how the intervention(s) could be tailored to assist a client from a particular tradition. In other words, how might the intervention be customized to achieve therapeutic goals by tapping into a client's spiritual value system? To use Muslims as an example, students might consider the tenets that might be drawn from the Koran and those integrated into traditional cognitive interventions to assist a client who is wrestling with depression.

ASSESSING AND OPERATIONALIZING SPIRITUAL STRENGTHS

A number of frameworks have been developed to assess and operationalize clients' spiritual strengths. One of the more common approaches is taking a spiritual history (Boyd, 1998; Bullis, 1996; Canda & Furman, 1999; Dombeck & Karl, 1987; O'Rourke, 1997; Peck, 1993; Rizzuto, 1996; Tan, 1996). This process is analogous to taking a family history except the format is tailored to elicit the significant spiritual events that have occurred over the course of a client's life. For further specificity, Boyd's (1998) model might be presented.

While spiritual histories offer a verbal format for spiritual assessment, Hodge's (2002) spiritual life map provides a pictorial delineation of a client's spiritual journey. In their most basic form, clients use drawing pencils to map out their spiritual life history on a large piece of paper. Significant events, in the form of pictures, words, symbols, or other entities that resonate with the client's experiences are depicted on a path, a roadway, or a single line that represents the client's spiritual sojourn, typically from birth to the afterlife.

Spiritual genograms offer another method for accessing the spiritual dimension of existence (Bullis, 1990; Dunn & Dawes, 1999; Frame, 2000; Hodge, 2001; Rey, 1997; Roberts, 1999). As is the case with traditional genograms, spiritual genograms focus on the intergenerational aspects of spirituality. Hodge (2001) provides a good example of this assessment method while highlighting interventions that may be particularly suited to this approach.

While spiritual genograms highlight spiritual strengths over time, spiritual ecomaps emphasize spiritual strengths in space (Hodge, 2000). Put differently, while spiritual genograms focus on intergenerational strengths, spiritual ecomaps accent strengths that exist in the current environment. Hodge (2000) provides an introduction to this diagrammatic instrument.

These assessment approaches provide social workers with a set of tools that emphasize different aspects of clients' spirituality and, correspondingly, lend themselves to the operationalization of different spiritual strengths. Assessments conducted with spiritual genograms, for instance, may reveal spiritual assets in a client's family system that other methods might fail to uncover.

To promote a better understanding of these assessment approaches, course participants might list the strengths and limitations of each method. Areas to consider include ease of client involvement, client preference, ability to tap particular strengths, and smoothness of transition to particular interventions. For example, spiritual genograms may be particularly appropriate with clients where the extended family plays a significant role in clients' lives, while spiritual eco-maps may be better suited to clients who wish to focus on their immediate presenting problem. Similarly, spiritual histories may be ideal for verbally oriented clients, while more artistic or less verbal clients may find lifemaps a better choice.

RIGHTS OF SPIRITUAL BELIEVERS

When addressing spirituality, issues related to the free expression of religion arise with some degree of frequency. To use Hunter's (1991) terminology, orthodox believers may encounter discrimination in forums in which progressives dominate. For instance, school social workers may have to address situations in which students are sanctioned for wearing spiritually-based attire or sharing their spiritual beliefs in class settings. Consequently, it is important for social workers to have some knowledge of the rights that spiritual believers possess in public forums.

The updated version of former President Clinton's (1995) memorandum on religious expression in the public schools provides a helpful summary of the free expression rights of believers (Riley, 1998). Also helpful is Esbeck's (1998) review of Supreme Court decisions bearing on First Amendment freedoms. In addition to

the First Amendment of the United States Constitution, the United Nations (1948/1998) Universal Declaration of Human Rights is also an original source that contains material that directly relates to individuals' religious rights.

To promote further understanding of this material, students might summarize the rights that spiritual believers have. Alternatively, course participants could take a scenario of relevance to social work, such as a student in school or an employee at work, and list the rights that people of faith enjoy in these settings. Students might explore how a social worker might advocate for a client who has been denied religious rights or is facing some type of religious discrimination. For example, individuals might examine the steps that a school social worker might take on behalf of a devout Muslim student whose paper on Islam is rejected out-of-hand solely due to its spiritual content.

In addition, in keeping with the CSWE educational standards (CSWE, 2001: IV, E), students might analyze social welfare policy and services in light of the religious rights believers possess. For instance, individuals might explore ways in which public policy conflicts with the rights of spiritual believers. The Unlevel Playing Field (White House, 2001), an examination of faith-based barriers that exist in federal social service programs, might be used as a starting point.

ASSIGNMENT SUGGESTIONS

In addition to the domain-related mini-assignments discussed above, a number of major assignments can also be incorporated into the curriculum. These projects provide opportunities for course participants to develop a deeper, more personal understanding of many of the themes presented above in a manner that is congruent with CSWE educational standards (Council on Social Work Education, 2001: IV). Although any number of assignments could be proposed, the three discussed below may be particularly helpful.

Spiritual Autobiography

Spiritual autobiographies can be helpful tools for fostering student awareness of their own unique spiritual history. Writing a spiritual autobiography can assist individuals to understand their spiritual values and how these values have informed their lives. Individuals can chronicle their own relationship with the transcendent, including parental influences, spiritual awakenings, key turning points, specific spiritual strengths, how their spirituality has helped them to cope with trials, and how their spirituality has functioned as a protective factor in their lives.

Since this exercise is designed to foster increased self-awareness regarding one's personal spiritual journey, it may be particularly advisable to undertake this project early in the course. Spirituality can be defined in a broad manner so that all individuals can discuss how their views regarding transcendent reality have informed their lives (Canda & Furman, 1999). For individuals interested in a model, the *Confessions* by African spirituality writer Augustine (354-430/1991), widely considered to be the first autobiographical work in recorded human history (Clark, 1993), can be used.

Religious Countertransference

As course participants develop awareness of their own spiritual values, it is important to consider how those values may interact with the spiritual values of clients. In some situations, value systems may interact in a manner that inhibits the provision of client-centered services. The effectiveness of service provision may be particularly imperiled when individuals hold negative sentiment toward other spiritual traditions (Genia, 2000; Larson, Sherrill & Lyons, 1994).

Approximately one-third of social workers report ambivalent-to-negative feelings towards their religious background, which is primarily Christianity (Canda & Furman, 1999; Furman, Canda & Benson, 2001; Sheridan et al., 1992). For instance, 44% of Virginia-based clinical practitioners (N=108) no longer participate in their childhood religious tradition, with the shift occurring primarily away from Christianity to none or "other" (Sheridan et al., 1992).

As Genia (2000) observes, individuals who have failed to work through these negative feelings may encounter religious countertransference biases when working with individuals from their former spiritual traditions. Internal pressures from unresolved personal needs can drive interactions with devout clients from the Christian faith tradition and perhaps other traditions that affirm similar values (Black, Jeffreys & Hartley, 1993). Interactions with committed Christians may result in social workers acting out their unresolved negative feelings toward their past traditions with their present clients (Gartner, Harmatz, Hohmann, Larson & Gartner, 1990).

Accordingly, course participants might write a paper exploring their ability to work with clients from other spiritual traditions. Particular attention should focus on examining negative sentiments towards one's former childhood spiritual tradition and how unresolved issues might affect service provision. Thought could also go into deciding what emotional signals might indicate the necessity of a referral to another practitioner.

This paper might be written later in the course, perhaps as a useful complement to the "values conflicts" content area. Since this domain directly addresses the issue of conflicting worldviews, course participants are already thinking about macro level, epistemologically-based conflicts. As a supplemental assignment, this paper can assist individuals explore micro-level conflicts that may affect their ability to work with clients from differing spiritual traditions.

Spiritual Assessment Reflection Papers

Course participants might also benefit from writing a number of reflection papers on the spiritual assessment process. In conjunction with the "Assessing and Operationalizing Spiritual Strengths" topic area, course participants might form dyads and take turns conducting spiritual assessments. One individual could present with a particular problem, while the other conducts an assessment with the aim of eliciting spiritual strengths that might be operationalized to help ameliorate the presenting problem. After completion, the roles could be reversed.

Depending on time constraints, this process could be undertaken for each of the four assessment approaches profiled above. In other words, each course partici-

pant would play the part of a practitioner conducting four assessments, using a spiritual history, a spiritual lifemap, a spiritual genogram, and a spiritual ecomap. Concurrently, each individual would also serve as a client, experiencing each assessment approach from the vantage point of a social service consumer.

After completing an assessment, each person in the dyad might write a paper reflecting on his or her experiences. Attention should be directed towards regarding the extent to which spiritual strengths were identified and harnessed to address the presenting problem and how both members of the dyad experienced the process. Particular attention should focus on practices that promote or hinder a spirit of openness and acceptance in the clinical dialogue and alternative practices that might better achieve these goals.

After completing the reflection papers, the dyad members might exchange papers and discuss ways in which the individual who role-played the clinician might improve his or her ability to conduct a spiritual assessment. Points of congruence, in which both participants shared similar perceptions, should be noted as well as areas in which perceptions differed. The individual who functioned as the client should note the strengths of the person conducting the assessment and offer suggestions for building upon those strengths to improve his or her ability as a clinician. Finally, as is the case with all group exercises, issues of student privacy, comfort level, and group dynamics should be considered before engaging in the above exercise.

CONCLUSIONS

Most social workers seem interested in learning more about spirituality (Derezotes, 1995). Given that the majority of social workers appear to address spirituality in practice settings without proper training (Canda & Furman, 1999; Furman et al., unpublished manuscript), it is critical that resources be developed that can be used to equip practitioners to work with spirituality in an ethically consistent manner. While individuals interested in engaging spiritual issues on a regular basis should be encouraged to develop an extensive knowledge base concerning the major spiritual traditions they are likely to encounter in practice settings, the curriculum content presented in this paper provides a basic foundation on which to build. In short, the material presented in this paper lays the groundwork for spiritually competent practice.

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Online Social Work Practice: Issues and Guidelines for the Profession

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Abstract: *There has been growth in the utilization of information and communication (ICT) tools in the field of social work in recent years. While most of the work has revolved around community practice, some social workers have moved into the realm of online, web-based therapeutic practice. This paper discusses important issues emerging from this new form of social work practice and concludes with suggested guidelines for the use of ICTs in social work practice.*

Keywords: Web-based counseling, online therapy, technology-enhanced practice

The profession of social work has witnessed a growth in the creative use of technology in various areas of professional work for many decades (Finn & Lavitt, 1994; Finn, 1995; Shyne, 1954). Ranging from telephone support groups (Kennard & Shilman, 1979; Meier, Galinsky & Rounds, 1995; Roffman, Beadnell, Ryan & Downey, 1995; Rounds, Galinsky & Stevens, 1991; Wiener, Spencer, Davidson & Fair, 1993) to the more recent exploration of computer-based applications in human services (Finn, 1995; Finn & Lavitt, 1994; Smyth & Harris, 1993; Weinberg, Uken, Schmale & Adamek, 1995; Stofle, 1997), professional practice with individuals, families, and groups has seen the influence of emerging information and communication technologies (ICT). ICTs have also influenced the field of community practice in positive ways (Downing, Fasano, Friedland, McCullough, Mizrahi & Shapiro, 1991; McNutt, 2000), especially in the area of electronic advocacy (Bennett & Fielding, 1999; Boland, 1998; Buck, 1996; Fitzgerald & McNutt, 1999; McNutt & Boland, 1988; 1999; Menon, 2002; 2000c).

While most of the utilization of technology falls into the area of helping groups and communities, social work is beginning to see a growing interest in the provision of online counseling and therapeutic services for individuals (Cutter, 1996; Grohol, 1997; Levenson, 1997; Sampson, Kolodinsky & Greeno, 1997). Some of these professionals offer such services alone or as part of a group of practitioners[1]. As students and practitioners become more familiar with technology-based appli-

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cations (either on their own or through education), it is probable that the use of ICT for counseling will become more prevalent.

Professional organizations in fields similar to social work have begun to address the issue of online counseling. For example, the American Psychological Association (APA) and the medical field, particularly psychiatry, has begun to address ethical issues associated with the delivery of services online (see APA, 1997; American Medical Informatics Association, 1998). The National Board of Certified Counselors (NBCC) purports to "… create standard definitions of technology-assisted distance counseling that can be easily updated in response to evolutions in technology and practice" (NBCC, 2001) and the American Counseling Association (ACA) approved ethical standards for Internet and on-line counseling in 1999 (ACA, 1999). Internet Healthcare Coalition (IHC), an organization that attempts to set high standards for the distribution of health information via the Internet, has developed a set of ethical guidelines relevant to our profession (IHC, 2000). Finally, the International Society for Mental Health Online (ISMHO) has also developed guidelines for the practice of online counseling, though these are not specific to social work (ISMHO, 2000).

Despite this continued and expanded use of ICT in the field of social work, the profession currently has no established guidelines for the practice of social work online. Many individuals and organizations have begun to address issues related to the online practice of social work, citing possible advantages and disadvantages of such practice and occasionally providing some general guidelines for online practice (Coleman, 2000; Levenson, 1997; Stofle, 1997). Stofle (2001), a social worker, has written a book about choosing an online therapist; yet, this book is geared towards potential consumers, not practitioners. Finally, it was noted by Powell (1998) that while the NASW Insurance Trust mentions that social workers who practice online are covered for malpractice, they express concern about the issue of online practice.

Some social work organizations, such as the Clinical Social Work Federation (CSWF), have also argued strongly against the use of online counseling:

> "So much human suffering has been caused by disconnection—disconnection between individuals, between thought and feeling, between body and mind—and e-therapy offers yet another form. Clients seek our services in order to improve the quality of their lives, the quality of their relationships. Alienation from others and the self will not be healed through a virtual connection in cyberspace, a 'connection' that is fraught with risks and hazards for both clients and clinicians." (CSWF, 2001)

Despite CSWF's position, social workers currently provide online services and are likely to continue doing so. It is the contention of the authors of this paper that simple warnings about the dangers of online therapy or broad ethical discussions of this new modality of practice are not enough to protect our clients and practitioners, alike. There is clearly a need for the profession to step up and lead a debate culminating in specific guidelines for practice that helps to regulate the profession in virtual therapeutic and supportive environments.

The current practice of online counseling has heightened the need for the social work profession to seriously examine this avenue of service delivery. To expand this endeavor, this paper explores and highlights the important issues related to this area of social work practice. It will conclude by providing suggested guidelines for the practice of online social work.

DEFINING ONLINE THERAPY

Computer-mediated communication (CMC) is frequently thought of in terms of technology only, thus, many often assume that CMC is simply about receiving and exchanging information (December, 1997). However, it has been argued that CMC is "a process of human communication via computers, involving people, situated in particular contexts, engaging in processes to shape media for a variety of purposes" (December, 1997).[2] We know that social work communication in face-to-face settings involves the use of communication to bring about change. Online therapy is just one form of CMC, one that obviously involves more than simple information exchange.

Bloom (1998) defines webcounseling™ as "the practice of professional counseling that occurs when client and counselor are in separate or remote locations and utilize electronic means to communicate with each other" (p. 21). Obviously, this definition is fairly basic, including only the "context" of practice in the definition. Perhaps a definition adopted by King and Moreggi (1998) would be more inclusive and holistic. They define "behavioral tele-health" as "… all forms of synchronous and asynchronous Internet mental health efforts, where the stated goal is the establishment of some form of therapeutic contact" (p. 93). CMC can also be referred to as the creation and dissemination of meaning; through various mechanisms (e-mail, chat, web sites), the perception of meaning, and the participation in "forums for communication that begin to exhibit characteristics of community—including a shared sense of purpose, norms for behavior, and traditions" (December, 1997).

Distinguishing between the simple provision of information versus the communication and perception of meaning is particularly salient for social work. There are a wide range of services being provided online, ranging from the provision of information to the actual provision of social work services. Often, the terms used to describe these services are used interchangeably and, thus, provoke a misunderstanding as to the nature of services provided. For example, sometimes, online counseling services are simply informational services. At such websites the client has an opportunity to request information or ask a question related to a specific problem area. This is analogous to the many "help" columns seen in popular newspapers and magazines. Sometimes, the individual pays for the e-mail response that he or she receives for the question posed.

Another type of service is what is commonly known as "online therapy." The goal of online therapy is to provide a long-term therapeutic relationship. Such a service involves individual-therapist communication using electronic mail, chat rooms, instant messaging, and other tools over a protracted period of time. Such services aim to build rapport and provide for an ongoing therapeutic relationship. This paper largely focuses on the second kind of service, online therapy. For pur-

poses of this paper, we will define on-line therapy as *the provision of therapeutic services utilizing Internet applications, both text-based and audio/video, which enable clients to receive services without real face-to-face contacts with the provider* (Menon & Miller-Cribbs, 2001).

There are major issues related to providing online therapy that must be addressed by the field of social work (Menon, 1998a/b; 2000a/b; 2001; Menon & Miller-Cribbs, 2001). The following is a discussion of important issues related to providing online therapy by social workers: the issue of face-to-face contacts, anonymity, technical aspects of the provision of the service, legal issues, licensing and cross border practice, and evaluation of online therapy.

Face-to-Face: Is It Better? Is It Necessary?

The inability of a social worker to assess non-verbal cues online is an area that concerns many in the profession (Coleman, 2000). Thus, social workers are pressed to think about why face-to-face contact is preferable and highlight ways in which therapy can be conducted without non-verbal cues. Can warmth, caring, and compassion be conveyed via text? How should social workers account for the absence of non-verbal communication?

Therapy essentially involves an ongoing therapeutic relationship between two people who meet face-to-face. The therapist establishes trust and rapport with clients through this relationship. Often, non-verbal communication is as important as verbal communication. Online, it may be more difficult to establish trust and rapport since face-to-face contact is unavailable and the subsequent utilization of non-verbal cues becomes impossible.

However, others have argued that face-to-face communication is not necessarily the most ideal type of therapy for all clients and their problems. Walther (1996) argues that when a therapist has freedom from the social responsibilities of "looking interested," then, he or she is able to take the time to thoughtfully respond in terms of selecting the right words and message. Furthermore, the time delay between messages forces individuals to think about what they send prior to communicating their feelings.

There are also some possibilities for mimicking non-verbal cues using the keyboard. For example, Internet-based communication is filled with the usage of acronyms and emoticons (emotional icons, such as :) happy face ;(crying sadly, etc.).[3] One possibility is to develop a set of standardized emoticons and acronyms to capture the feelings of the client at any given point in time. These could be tailored into the software utilized for online practice. Alternatively, an online therapist could provide clients with a sheet of "emoticons," so that the client could incorporate these during sessions with the therapist.

Some of the issues listed above may be addressed once social workers have faster access to the Internet through broadband Internet-video technology. Broadband, either through DSL connections or by cable TV providers, may allow practitioners to have computer-based video conferencing options. This will enable social work practitioners to have adequate visual access to clients. However, until then, one must expect poor quality video/audio streams when

using telephone lines. Currently, the majority of the population who have Internet access utilize modems to dial-up in speeds ranging from 28.8K to 56K using regular analog phone lines. In some sectors of the country, we are also seeing an increase in DSL linkups. DSL, which stands for Digital Subscriber Line, provides high-speed Internet Access using regular telephone lines. It has the ability to move data over the phone lines at speeds up to 6Mb/s (six million bits per second) or 140 times quicker than the fastest analog modems available today (56,000 bits per second). In addition to its high speed, DSL has many benefits over analog connections. Unlike dial-up connections that require analog modems to "dial-in" to the Internet Service Provider every time the user wants to retrieve e-mail or obtain access to the Internet, DSL connections are always on. That means no more logging on and off, no more busy signals, and no more waiting for the connection to happen. Another benefit is the ability to use the telephone while accessing the Internet and not having to choose between the two.

The Cloak of Anonymity—A Good or Bad Thing?

There is a growing body of literature that attempts to disentangle the concerns around intimacy and nonverbal communication (Burgoon, Buller & Woodall, 1989; Cherny, 1995; Guerrero, DeVito & Hecht, 1999; Patterson, 1983; 1990). Furthermore, there are greater philosophical conversations conducted regarding the meaning of intimacy and self-disclosure (Walther, 1996). In fact, Lerner's (1990) definition of intimacy reveals little about the necessity for face-to-face contact in establishing intimacy as she notes:

> For starters, intimacy means that we can be who we are in a relationship, and allow the other person to do the same. "Being who we are" requires that we can talk openly about things that are important to us, that we take a clear position on where we stand on important emotional issues, and that we clarify the limits of what is acceptable and tolerable to us in a relationship. "Allowing the other person to do the same" means that we can stay emotionally connected to that other party who thinks, feels, and believes differently, without needing to change, convince, or fix the other. An intimate relationship is one in which neither party silences, sacrifices, or betrays the self and each party expresses strength and vulnerability, weakness and competence in a balanced way." (p. 3)

Others have argued that the lack of face-to-face contact can be a positive feature when working with certain clients. In some cases, the anonymity that faceless interaction provides could have certain advantages, such as higher levels of self-disclosure, more intimacy, heightened self-expression, and stigma management (Cohen & Kerr, 1998). People who are reluctant to seek out counseling in a traditional setting may be more willing to seek out an online counselor.

Thus, online counseling may be a viable method of service delivery for certain client groups and problems. The telephone, for example, has been a long established and accepted mode for delivering crisis intervention services. As Cohen & Kerr (1998) note, "While clients with strong needs for emotional support may find the reduced cues environment a poor substitute for face-to-face interaction, computer-mediated counseling may be a viable option for more independent

people dealing with specific problems or those interested in personal growth" (p. 24). Stofle (2001) addresses the issue of the appropriateness of online counseling in his conceptualization of "Levels of Care and Online Therapy" continuum. He refers to varying levels of intensity of treatment that need to match the intensity of the client's problem. He places online therapy on the lower intensity side of the level of care continuum and, so, it is best used for issues/problems that are low intensity, as well. Such a conceptualization is helpful in determining the uses and possibilities of online therapy by social workers. The profession of social work should carefully consider what kinds of problems and issues are best suited for online delivery and establish guidelines for the delivery of such services.

The provision of anonymity is both a strength and weakness of online social work practice. Often, particularly in small communities, people know where the therapists live or practice, so by simply parking a car in a certain place, an individual risks being "found out." These risks are not as apparent with online counseling. This could be especially beneficial for those individuals who seek help but are too embarrassed to go to a social worker's office.

Online practice also has the potential to limit or eliminate biases that can corrupt treatment and slow the rapport-building process. In this way, the Internet can be seen as a social leveler (Levenson, 1997). Age, gender, ethnicity, race, national origin, and other demographic features that provoke bias are absent. The client is a "faceless" individual and, thus, therapist and client bias are held in check. Some authors have stated that the "faceless" nature of counseling might, in fact, improve the chances of certain reluctant individuals seeking treatment (Cohen & Kerr, 1998). Under the cloak of supposed anonymity, certain people might actively take part in therapy sessions. It might allow some to be more open about the problems they face and not be embarrassed to talk about them.

Technical Aspects: Hardware, Software, and Skills for Social Workers and Clients

The utilization of technology for counseling has its inherent technological problems. Typically, web-based therapies are conducted through the client-side computer, the therapist-side computer, and the servers that connect the two. Furthermore, depending on the nature of the counseling session, somewhere between two and six software programs are used (see Table 1). Adding hardware and software into the practice repertoire creates some noteworthy salient issues. Social workers who practice online are ultimately responsible for protecting data (Levenson, 1997) as well as ensuring that they have the technical skills that are requisite for practicing online (Stofle, 1997).

Keeping Data Secure

The most important is data security. The "real world" is replete with reports of data and identity theft either through the improper, unauthorized access to a person's personal computer or through the malicious hacking of server or network traffic. In a review of websites conducted by the authors, it was disheartening to note that many of the mental health professionals who conduct web-based therapy often utilize unsecured servers and almost never use encryption software.

Table 1: *Software That May Be Utilized During Sessions*
For detailed information on any of the terms used here, search http://www.google.com.

Client/Therapist Side	Server Side
• Modem Dial-up (AOL, MSN, etc.)	• Encryption software
• Browser (MS Internet Explorer/ Netscape)	• HTML server software
	• FTP server software
• Instant Messenger clients (MSN, Yahoo, ICQ, etc.)	• Java Applets
	• Credit card processing
• Video Link (MSN, NetMeeting)	• Firewall
• Java programs for applets	
• Real Media (for videos/audios)l	
• MS Word/WordPerfect for documents	

With the growth of software that "snoops," it is also becoming much easier for anyone with malicious intent to load certain software into an unsuspecting client or therapist's computer (see Walker, 8/21/2000). The software, thus, is programmed to "capture" activities on a regular basis. Such an individual is then able to read confidential material and access client files and records.

Protecting health information is a critical social work issue, even beyond the online arena. There are numerous cases regarding the violation of health care information security[4] that are critical for social workers to be aware of while embarking in virtual practice. For the most part, social workers are unaware of who ultimately has access to their data, particularly electronic data such as e-mail.

Text Residue

A grave matter in the area of web-based counseling is the issue of reporting and taking down case-related notes. In an online, text-based environment, entire transcripts are recorded which include files that are seemingly "deleted" by the user. In fact, text residue is left behind even if records are deleted from the therapist or client computer. This residue can be resuscitated through the use of widely available data scavenging software. Current convention on recording case notes emphasizes that the social worker record only what is truly important in the case. In a web-based environment, this is not possible. As previously mentioned, protective measures such as encryption can be taken, but it is impossible to remove all the residual effects of communication (unless the hard drive is reformatted). This has legal implications for social workers, as these text-based communications, including electronic mail and other forms of data stored on the computers and servers, could be subpoenaed in court cases. As such, case notes would include the content of entire sessions and the social worker has less control over how the notes are to be interpreted.

For example, if a social worker were conducting a group session using an online chat session, each group member would have a transcript of the group session that could be printed, copied, and distributed to other individuals. Of course, this risk also exists in "live" group sessions, but individual group members do not have access to a printed record. However, the danger of the "printed" record should not be ignored. Clients in violent relationships who receive counseling

online might become more vulnerable if their text residue, e-mail, or chat information is intercepted.

Of course, there are risks associated with any kind of therapy (on-line or offline) as a result of negligence on the part of the social worker or malicious intent by an individual. However, most can be eliminated by proper use of secured sites and/or encryption software. Encryption[5] allows the sender and the receiver to scramble and unscramble messages sent through the network. This prevents the data from falling into the wrong hands. Currently, no one is required to utilize such software when they practice online, but such a requirement may be a useful guideline.

Licensing and Cross Border Practice: Who Is Responsible For Whom?

The "global" nature of online therapy makes the issue of licensing quite complicated. Obviously, ensuring accountability in social work practice is an important aspect of social work. Almost all states have some form of exam and/or the mandatory upgrading of skills through the accumulation of continuing education units. In an online environment, verification of such qualifications becomes more difficult. However, requirements for social work licenses vary from state to state. The licensing boards in each state are free to set their own standards and require practitioners to abide by them. Furthermore, most licenses have limited portability. State differences in licensing and portability issues make agreement on national standards for online counseling difficult. Social workers providing services to individuals in countries other than the U.S. is also an issue that needs to be addressed. Stofle (1997) remarks that online therapists should practice only in states where they are licensed and that a "national certification for online therapists" should be instituted. He further argues that only "experienced therapists" should practice online counseling.

Currently, several online sites provide a service that provides a "credentials check" of therapists. Consumers can go to such sites and retrieve information regarding the education, degree(s), and licensees of registered online therapists. It may be feasible to require that social workers register with such services and for the profession to develop some kind of national certification program for those interested in online therapy. To date, no national or state social work organizations have attempted such a service.

Evaluating Online Social Work Practice

The efficacy of online therapy has not been well studied. Most of the evidence, thus far, has been anecdotal with a few exceptions (Barak, 1999; Barak & Wander-Schwartz, 2002; King & Moreggi, 1998; Murphy & Mitchell, 1998). There is an obvious need to conduct empirical studies in order for the social work profession to proceed in this area of practice. The same standards utilized to evaluate face-to-face therapy should be applied to online therapy. There are many approaches one could try in order to understand the nature of semantic conversations. Apart from using standardized measures that are typically used in real-life settings, transcripts of online sessions could give way to the potential for rich qualitative and content analysis. It would also be interesting to see what types of theoretical frameworks work best in an online setting.

CONCLUSIONS

There is enormous potential for the delivery of online social work practice. ICT can provide services to hard-to-reach clients, as it is geographically accessible and can reach clients in remote areas. Online counseling can be conducted from home, thus, bringing services to homebound individuals or those with limited mobility. ICT can be convenient, perhaps helping busy individuals carve time from their lives to talk to a social worker. From a physical standpoint, online services are a safe way to deliver services. Some people may enjoy the anonymity it provides either because of the issue they would like to discuss or because the community in which they live is small, which compromises their privacy. It may be the best, most cost-effective way to deliver services such as follow-up, referrals, support for relapse prevention, group services, informational services, and case management.

Not much is known regarding the effectiveness of online therapy. In addition, there are a host of possible legal and ethical issues that must be considered. Social work must begin to seriously consider the impact of online therapy on the profession. As previously noted, many social workers are already using these new forms of electronic service delivery without having a set of specific social work guidelines in place. Professional organizations in other fields have begun to take online counseling seriously, to the point of amending the language in their Code of Ethics to reflect on-line therapies. Social work must also develop guidelines for the online practice of social work.

It is suggested that social work consider the following as suggestions for incorporating standards for online therapy into the social work profession:

1. Revise the Code of Ethics to reflect technological innovations, including such issues as:
    a. Confidentiality of clients.
    b. Providing services via secured and non-secured websites.
    c. Transferring information electronically.
    d. Securing client records.
    e. Identifying best use or a mandatory list of software, particularly encryption.
    f. Identifying the scope and boundaries of online practice.
    g. Establishing guidelines regarding the types of clients and issues for which online therapy is appropriate.
    h. Establishing availability of therapists.
    i. Providing limits of confidentiality (as in face-to-face therapy) but also including a discussion of the pros/cons and limits of online counseling.
    j. Addressing issues related to professional identification online, perhaps by mandating participation in “credentials check” services or establishing a “National Social Work Credential Check.”
    k. Addressing issues related to developing social work websites that advertise therapy services.

2. NASW tasks
   a. Reflect issues of web-based counseling in the NASW practice standards.
   b. Create a task force to examine the practice of and effectiveness of online therapies.
   c. Offer specific technology-based CEUs to online therapists.
   d. Limit cross-state/national borders counseling until liability guide lines are laid out.
3. Other tasks
   a. Mandate an intense empirical evaluation of any type of web-based therapy.
   b. Generate a list of accredited social work programs and licensed social workers available to potential clients on the web, with a link placed at the bottom of online social workers' web pages.
   c. Establish constant credibility/content checks of websites by NASW, CSWE, and other professional bodies.

The Social Work profession must keep pace with the new and emergent tools of practice. Traditional counseling will not "disappear" as these new approaches are adopted; however, poor practice of social work may occur if clear guidelines are not created for those social workers practicing online. Like it or not, social work practice will occur online, and it is up to the profession to ensure that such practice is conducted thoughtfully and ethically. As Stofle (1997) notes, "If the ethical therapist is not online, who is?"

Endnotes

[1] Metanonia.org provides a list of individuals who provide online counseling. There are several social workers listed on this site.

[2] For a discussion of scholarly debate on the definitions of Computer-Medicated Communications, refer to *CMC Magazine*, Volume 4, No. 1, 1997 at: http://www.december.com/cmc/mag/1997/jan/december.html.

[3] For information regarding emoticons, refer to: http://wombat.doc.ic.ac.uk/foldoc/foldoc.cgi?query=emoticon.

[4] For a list of news articles and resources related to healthcare information security, refer to: http://www.unh.edu/social-work/SW810/Ethicis.htm.

[5] For details about encryption, refer to NetAction's page: http://www.netaction.org/encrypt/.

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Social Work Practice Behaviors and Beliefs: Rural-Urban Differences?

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Abstract: *There is continuing debate within the social work profession on whether there are significant differences in the practice behaviors and beliefs between rural and urban clinical social workers and whether different standards should be applied in defining ethical practices. This study measures those differences with regard to five practice behaviors: bartering, maintaining confidentiality, competent practice, dual relationships, and social relationships. Differences were found in beliefs regarding the appropriateness of professional behavior though such differences did not translate into practice behaviors. More significantly, the research suggests considerable confusion about the meanings of ethical standards and the utilization of intervention techniques without formal training across both urban and rural social workers.*

Keywords: Social workers, ethics, urban-rural, standards of practice, practice behaviors-beliefs

Sociologists continue to debate whether urban/rural dichotomies are any longer of great significance (Castle, 1995; Johnson & Wang, 1997; Nelson & Smith, 1999). A similar debate goes on in nearly all professions (Erickson, 2001; Lyckholm, Hackney & Smith, 2001; Roberts, Battaglia, Smithpeter & Epstein, 1999), including social work (Carlton-LaNey, Edwards & Reid, 1999; Davenport & Davenport, 1995; Ginsberg, 1998a; Martinez-Brawley, 1999). What is clearly evident in these debates is the dearth of empirical evidence on the differences, if any, in the practice behaviors and professional beliefs of rural and urban social workers in the context of ethics. Questions such as whether community dynamics influence the ethical standards by which social workers practice, or whether there are differences between rural and urban social workers with regard to their ethical beliefs are largely answered with anecdotes or personal opinions (Jerrell & Knight, 1985; Mazer, 1976; Miller, 1994). This study is a beginning effort toward answering these questions with empirical data in the context of clinical practice.

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URBAN/RURAL DIFFERENCES IN SOCIAL WORK PRACTICE

Mermelstein and Sundet (1995) ask, "Are things so basically different about urban and rural contexts that we can justify a specialty, a title, a journal, a special alcove in the halls of social work? Increasingly the answer is 'NO'" (p. 5). In a study related specifically to professional practice roles and perceptions of client problems, York, Denton and Moran (1989) found no differences between rural and urban social workers. This research corroborates the study by Whitaker (1986), which found few differences between rural and urban social workers with regard to practice roles. There may also be few differences in the service needs and desires of urban and rural clients and the ways in which social services are delivered (Austin, Mahoney & Seidl, 1978; Young & Martin, 1989). Whether there are differences between rural and urban social workers within the realm of ethics is unknown.

Despite the lack of supporting empirical evidence, many who practice or identify with the helping professionals in rural communities continue to assert the doctrine of difference. Doelker and Bedics (1983), Ginsberg (1998a), Green and Webster (1976), and Martinez-Brawley (1993; 1999), for example, maintain that the unique features of rural social work practice require a special curricular focus in social work education, if not a specialty in rural practice. In addition, there is growing textbook literature on the special aspects of rural practice, all pointing to differences between rural and urban social work practice (Farley, Griffiths, Skidmore & Thackeray, 1982; Ginsberg, 1998a; Gumpert & Saltman, 1998; Johnson, 1980; Jones, 1993; Jones & Zlotnick, 1998; Weitz, 1992).

Waltman (1986) maintains that the differences between urban and rural social work practice are so significant as to warrant special attention from the profession. Sobel (1992) argues that in rural communities, "Psychotherapists, to be successful, must create systems within their own community and they must be willing to make compromises in professional standards and ethical guidelines to effectively establish themselves as members of the health professionals within the community where their practices are located" (p. 62). Sobel concludes that, "It is important to remember when practicing in small towns, strict adherence to ethical codes cannot always be made" (p. 69). Sterling (1992) states that, "Therapists in small communities have to create their own rules and guidelines and develop their own means of managing (boundary and confidentiality) issues" (p. 113). Within the context of bartering for professional services, Reamer (2001) notes that, "Many believe that barter is appropriate in limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community (p. 24). Ginsberg (1998a) also asserts that social workers in rural areas find they must adapt and modify traditional approaches to social work practice as taught in social work education.

Throughout this literature, academics and practitioners argue that practice and ethical standards adopted by professions are derived from an urban perspective and experience and do not take account of the rural environment. In essence, the call is for a "locality rule" as defined by local custom, which would hold rural practitioners to the professional standards of care, including ethical standards practiced in their community. In recognition of the difference between rural and urban professional norms, such a doctrine would, among other behaviors, allow greater

flexibility for rural practitioners when interpreting the meaning of various provisions of the social work code of ethics. While such assertions may make intuitive sense, there is little empirical evidence that can be cited to support it.

In recognition of the continuing debate on rural/urban differences within the context of professional ethics, the research reported here identifies five professional behaviors where differences between rural and urban social workers in direct practice have been asserted: 1) Bartering; 2) Maintaining confidentiality; 3) Competency; 4) Entering into dual or multiple relationships with clients; and 5) Forming social relationships with clients. These behaviors and professional beliefs about their appropriateness are the primary foci of this study.

BARTERING: THE EXCHANGE OF GOODS AND SERVICES AS PAYMENT FOR TREATMENT

Gutheil and Gabbard (1993), Kagle and Giebelhausen (1994), Pope (1991), and Simon and Williams (1999) argue that bartering is so fraught with potential conflicts in the professional relationship that it should always be avoided. Yet, bartering is viewed by some as part of the traditional cultural landscape in rural communities (Miller, 1994). Jennings (1992) maintains "that there are some special circumstances which emerge in rural settings in which bartering is justified and even desirable" (p. 101). *The Clinical Social Work Federation Code of Ethics* (1997) permits bartering arrangements, but "only in rare occasions" and "only (when the arrangements) involve the provisions of goods, as opposed to services, in exchange for treatment" (CSWF, Principle V.d).

Despite recognizing the dangers inherent in bartering, the National Association of Social Workers (NASW) Code of Ethics Revision Committee did not recommend a categorical prohibition of bartering and opted for a "last resort" rule, but only in the context of community custom; that is, bartering is accepted among professionals in the local community (Reamer, 1998). The current NASW Code of Ethics (1996) warns of the dangers of accepting goods and services as payment for professional services, but permits bartering "if it can be demonstrated that such arrangements are accepted practice among professionals in the local community, considered to be essential to the provision of services, negotiated without coercion and entered into on the client's initiative and with the client's informed consent" (NASW, 1996, Sec. 1.13).

This would appear to be an adoption of a "locality rule" within the context of ethics. However, in allowing bartering under limited circumstances, the Code also attaches a caveat warning to the social worker that he or she has the "full burden of demonstrating that this (bartering) arrangement will not be detrimental to the client or the professional relationship" (NASW, 1996, Sec. 1.13). Miller (1994) laments that this caveat may be seen by social workers as placing them in a too precarious or ethically risky position; hence, arrangements otherwise beneficial to the rural client and community will be lost.

Despite the debate on bartering and the current stance of various codes of ethics (American Psychological Association, 1992; CSWF, 1997; NASW, 1996), very little is known about the extent of bartering as a common professional practice in rural

communities. While Borys and Pope (1989) found a significant difference of opinion in the ethics of bartering among both social workers and psychologists, they also found its use as a method of payment for professional services to be relatively rare in practice. However, the extent to which rural social work practitioners actually enter into bartering arrangements and what they believe about the appropriateness of such behavior is otherwise largely unknown.

CONFIDENTIALITY

Nearly all commentators on professional practice in rural communities write about the lack of professional and individual privacy and the strains on principles of confidentiality (Cook, Hoas & Joyner, 2001; Ginsberg, 1998b; Schank, 1998; Schank & Skovholt, 1997). For example, Simon and Williams (1999) observe that family and community members may mount considerable pressure on the therapist for information about the client. Spiegel (1990) notes that, "The maintenance of confidentiality in psychotherapy in a small-town rural setting is constantly threatened because social, hospital, industrial, and educational counseling services overlap, and people know each other well" (p. 637). Waltman (1986) states that preserving confidentiality is of utmost importance in the therapeutic relationship with a rural client. However, confidentiality is a sacred professional principle whatever the context of practice (Jaffee v. Redmond, 1996; NASW, 1996). Except in limited contexts such as "duty to warn," child and elder abuse, or responding to the suicidal patient, there is little debate on the sanctity of confidentiality in all social work-client communications (NASW, 1996; Reamer, 1999).

There also seems to be little doubt that the knowledge of a therapist/client relationship is more widespread in a small or rural community and that there is easier access to the therapist by interested others in a rural environment. In most cases, entry into professional offices by known townspeople is clearly observable. However, does this mean that the principle of confidentiality takes on new meanings or presents different dilemmas in a rural environment? Again, most of the conclusions in answer to this question are based on anecdotal evidence and generalizations, perhaps even myths, about the current realities of the rural community.

COMPETENCY

Much of the social work literature on rural practice defines the role of the social worker within the context of a "generalist practice" (Davenport & Davenport, 1995; Ginsberg, 1998b; Martinez-Brawley, 1999). Under the generalist model of practice, the social worker must be competent to work with different systems such as families, groups, organizations, and communities (Tolson, Reid & Garvin, 1994).

Hargrove (1986) states, "In rural practice, the generalist model of practice prevails because of the lack of available resources and professionals. As a consequence, the rural psychologist is likely to be called upon to respond to a broad range of problems and people" (p. 374). Hence, without referral resources, the therapist finds herself in situations where the choice is either to provide treatment despite her limitations, or to provide no treatment at all (Welfel, 1998). In addressing this dilemma, Hargrove notes, "The most appropriate response to this ethically murky situation is not at all clear" (p. 374). Within the context of clinical practice,

Sobel (1992) asserts, "Small town practitioners may be called upon to treat situations with which they may not feel totally competent, but realizing alternative services are a great distance away, may choose to do so in order to keep the patient functioning in the community with support and other health and mental health professionals" (p. 62). Roberts, Battaglia, & Epstein (1999) also note that rural practitioners commonly perform professional work with broadened responsibilities, more independence, and a heightened need for specialist support, but with less training and supervision and fewer resources than their urban counterparts. Despite these assertions, the authors lack empirical data that indicates the extent to which practitioners employ intervention techniques for which they have had no training or whether there are, in fact, differences between rural and urban practitioners regarding levels of success with clients.

MULTIPLE AND DUAL RELATIONSHIPS

According to Rinella and Gerstein (1994), allegations of ethical misconduct based in dual relationships are becoming increasingly common. Younggren and Skorka (1992) define dual relationships as "any relationship that runs concurrently with the therapeutic relationship" (p. 32), giving examples as friends, lovers, and business associates. Other examples would include therapeutic relationships with relatives, neighbors, political, or committee associates (Pope, 1991; Reamer, 1994).

The NASW Code of Ethics (1996) responds to concerns over the meaning of dual relationships in the professional context by stating, "The social worker should not condone or engage in any dual relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client" (NASW Code, Sec. 1.06(c)). Since former clients often return for help when new problems arise (Hartlaub, Martin & Rhine 1986; Mattison, Jayaratne & Croxton, 2002; Robison & Reeser, 2000; Silbertrust, 1993), one might argue that the potential harm of intervening relationships is always present. The Code does not provide a definition of risk in this instance, thereby, placing the burden on the practitioner.

Despite the provision in the NASW Code of Ethics with regard to dual relationships, there is very little in the professional literature to guide social work practitioners in more specific terms (Ramsdell & Ramsdell, 1993; Rinella & Gerstein, 1994). Thompson (1990), for example, asserts that dual relationships introduce competing interests and pose a "major threat" to the therapeutic process, that "friendships, for example, are reciprocal and, thus, would require the focus of therapy to shift from one party to the other, from one set of interests to the other, and back again" (p. 56). Kagle and Giebelhausen (1994) insist that any "dual relationships are potentially exploitive, crossing boundaries of ethical practice, satisfying practitioner needs and impairing his or her judgment" (p. 213). In his seminal treatise on boundaries, Epstein (1994) asserts that "monitoring boundaries is as essential to psychotherapy as maintaining aseptic technique in surgery" (p. 33).

Other writers suggest the dual relationships are inevitable especially in rural communities (Bader, 1994; Jennings, 1992; Stockman, 1990) and that absolutist positions are unrealistic and unnecessarily restrictive. Such authors state that the emphasis should be not on avoidance but on risk management (Gottlieb, 1993). Ginsberg (1998), for example, states that, "For rural workers, many relationships

are multiple. One's friends, fellow church members, grocers, auto dealers and organizational colleagues may also be clients or may be related to clients" (p. 13). Simon and Williams (1999) write of the necessity to treat friends or relatives in certain situations and conclude, "The treatment of acquaintances that would be a boundary violation in larger cities may only require boundary adjustment in small or rural communities" (p. 1443). However, as Jerrell and Knight (1985) note:

> Many commonly held beliefs about rural practice have been derived from the anecdotal reports of practitioners, but little systematic information exists by which to compare these findings on a larger scale. Nor is it possible to make generalizations about rural mental health practitioners from the literature available. (p. 331)

SOCIAL RELATIONS WITH CLIENTS

Intuitively, there would seem to be little doubt that professional boundary issues arise more frequently in the rural context. As Sterling (1992) notes, "Small community therapists sometimes accept referrals to treat people with whom they have had a social relationship and treat people who have close relations with each other" (p.116). Fenby (1978) writes of catching a ride to work with a neighbor who happens to be a client. Brownlee (1996) relates the experience of treating a client who happens to be the teacher of the therapist's daughter. Backlar (1996) writes of befriending a client and suggests that the therapist must sometimes exercise judgment and not always follow rules. Gates and Speare (1990) assert and Mazer (1976) agrees that overlapping relationships are built into the fabric of rural communities and see the positive aspects of observing clients in other contexts. As Catalano (1997) states, "In small communities, the therapist may have common social and professional contacts with and may know significant people in the other's life" (p. 25). Despite such conclusions, we know little of the extent to which rural social workers maintain such relationships nor what they believe about the ethics of these behaviors.

METHODOLOGY

The study population consists of members of the National Association of Social Workers (NASW) who possess an M.S.W. and have identified themselves as being in "direct practice." This resulted in a sampling frame of 58,056 NASW members. A simple random sample of 1,200 was drawn from this population. After various exclusions (e.g., retirees, undeliverable addresses, etc.), the sample size was reduced to 1,143. Excluding those drawn in this random sample, additional random samples of 478 each were drawn from the following groups: African-American, Asian-American, and Hispanic/Latina. In addition, a discrete random sample of 485 social workers in private practice was also drawn. This resulted in a total sample of 3,062 social workers in direct practice.

Based on cases presented before the Michigan Committee on Inquiry, a pre-test with professional practitioners in the State of Michigan and an extensive review of the literature, a 10-page questionnaire was developed to study the previously mentioned practice domains. The questionnaire was sent to each respondent along

with a cover letter, a commitment postcard, and return envelope. If we did not receive the commitment postcard within three weeks, a second questionnaire, cover letter, and return envelope were mailed to the non-respondent. This procedure resulted in a return of 1,684 useable questionnaires for an overall response rate of 55%.

For the purpose of this exploratory paper, we identified practitioners in rural and urban settings by their responses to the following question: "Are the clients seen in your agency mostly (70% or more) from…." Those respondents who indicated "rural or farm communities (25,000 or less)" were identified as rural practitioners, and those respondents who indicated "a large city (500,000 or more)" were identified as urban practitioners. This procedure resulted in 126 respondents in the rural category and 441 respondents in the urban category.

RESULTS AND DISCUSSION

Tables 1 and 2 present specific items used to measure the dimensions of bartering, competency, confidentiality, multiple and dual relationships, and social relationships. The data in Table 1 present the respondents' beliefs about the appropriateness of the given behaviors in the larger professional context. In contrast, Table 2 presents information on the reported behaviors in question by the respondents.

BARTERING

Despite the debate over the use of bartering or the exchange of goods and services as payment for professional services, our data indicate that bartering in practice is a rare event with no significant differences between rural and urban practitioners. In fact, the responses are surprisingly similar given assertions that bartering for professional services is commonplace in the rural community. With regard to professional beliefs about the appropriateness of bartering, rural social workers are significantly different from urban practitioners in that they are more likely to approve of such behavior. These findings are similar to those reported by Horst (1989), Percival and Striefel (1994), and Pope, Tabachnick and Keith-Spiegel (1987). However, the data clearly indicate that beliefs about the appropriateness of bartering do not result in actual practice behaviors (see Table 2).

As Sonne (1994) notes, an exchange of services for treatment puts the client in the role of employee, a relationship placing the social worker in a potentially conflictual situation that may have implications for both ethics and social work licensing grievances. A compromise solution, one adopted by the Clinical Social Work Federation (1997), permits the exchange of goods but not services as payment. Such a compromise is at least partially responsive to those who have raised questions regarding whether the ethics of bartering arrangements may be worth further discussion. However, given the rarity of bartering in practice, one can only conclude that "necessity is *not* the mother of invention," and the advice of Gutheil and Gabbard (1993) is well taken: "The clinician should take a case at a reasonable fee or make a decision to see a patient for a low fee (e.g., one dollar) or none. Bartering is confusing and probably ill advised today" (p. 193).

Table 1: *Distribution and t-tests on Scales and Scale Items Regarding the Appropriateness of Practice Behaviors—Urban vs. Rural*

	Appropriate	Uncertain	Inappropriate	t-value	Sig
Bartering					
Accept goods or services from client instead of money				-2.745	.01
Urban	45(10.3%)	84(19.2%)	309(70.5%)		
Rural	22(17.1%)	31(24.0%)	76(58.9%)		
Competency				-1.044	ns
Use treatment techniques for which you received no formal training					
Urban	26(5.9%)	59(13.4%)	356(80.7%)		
Rural	12(9.3%)	17(13.2%)	100(77.5%)		
Maintain Confidentiality and Privacy (α=.60)				-1.065	ns
Share confidential information about client with relatives without client's consent when you thought it was in the client's best interest?					
Urban	47(10.6%)	44(9.9%)	353(79.5%)		
Rural	17(13.7%)	15(12.1%)	92(74.2%)		
Share confidential information about client with others (not family relatives) without client's consent when you thought it was in the client's best interest?					
Urban	54(12.2%)	52(11.7%)	338(76.1%)		
Rural	24(18.9%)	10(7.9%)	93(73.2%)		
Engage in Multiple or Dual Relationships (α=.75)				-4.593	.0001
Accept business associates or co-workers as clients					
Urban	32(7.0%)	52(11.4%)	371(81.6%)		
Rural	16(12.4%)	27(20.9%)	86(66.7%)		
Have clients with whom you have another relationship					
Urban	30(6.7%)	81(18.1%)	337(75.2%)		
Rural	22(17.1%)	38(29.5%)	69(53.4%)		
Accept relatives or friends as clients					
Urban	21(4.7%)	26(5.8%)	400(89.5%)		
Rural	11(8.7%)	14(11.0%)	102(80.3%)		

	Appropriate	Uncertain	Inappropriate	t-value	Sig
Engage in Social Relationships (α=.70)				-2.324	.05
Accept a client's invitation to a party or special event (e.g., wedding?)					
Urban	80(17.7%)	149(32.9%)	305(49.4%)		
Rural	28(21.9%)	47(36.7%)	53(42.3%)		
Participate in recreational or social activities with your clients?					
Urban	68(15.5%)	60(13.7%)	305(70.8%)		
Rural	29(22.8%)	19(15.0%)	79(62.2%)		
Ask favors from a client (e.g., a ride home)?					
Urban	10(2.2%)	17(3.8%)	422(94.0%		
Rural	6(4.6%)	9(6.9%)	115(89.5%)		
Invite a client to your home for a social event?					
Urban	13(2.9%)	16(3.5%)	422(93.6%)		
Rural	5(3.9%)	10(7.8%)	114(88.3%)		
Look after a client's belongings (house, pets, etc.) for a while?					
Urban	9(2.0%)	8(4.0%)	423(96.0%)		
Rural	6(4.7%)	8(6.2%)	115(89.1%)		

COMPETENCY

With regard to competency, we asked two simple questions. The first question inquired: *How often have you used treatment techniques for which you have had no formal training?* There was no statistical difference in the responses of urban and rural social workers to this question; in fact, the responses from both sets of social workers were remarkably similar. This does not mean, however, that the data does not have significance in the larger context of social work practice. Across both groups, more than 20% of our respondents acknowledged that they had used treatment techniques without formal training at least once, with 8% acknowledging that they had done so three or more times. Such behavior is surprising on several levels and certainly has insurance and malpractice implications. Within the realm of ethics, these behaviors could put those social workers in apparent violation of the NASW Code of Ethics (1996), which states that:

> Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study training, consultation, and supervision from people who are competent in those interventions and techniques.(Sec. 1.04)

Table 2: *Distribution and Chi-square Analyses on Conduct of Practice Behaviors—Urban vs. Rural*

	Never	1-2 Times	3> Times	X^2	Sig
Bartering					
Accept goods or services from client instead of money					
Urban	401(90.7%)	34(7.7%)	7(1.6%)	2.390	ns
Rural	111(86.7%)	15(11.8%)	2(1.5%)		
Competency					
Use treatment techniques for which you received no formal training					
Urban	353(78.8%)	59(13.2%)	36(8.0%)	0.077	ns
Rural	101(78.9%)	16(12.5%)	11(8.6%)		
Maintain Confidentiality and Privacy					
Share confidential information about client with relatives without client's consent when you thought it was in the client's best interest?					
Urban	324(72.0%)	96(21.3%)	30(6.7%)	5.777	ns
Rural	81(65.9%)	16(25.2%)	11(8.9%)		
Share confidential information about client with others (not family relatives) without client's consent when you thought it was in the client's best interest?					
Urban	336(75.2%)	61(13.6%)	50(11.2%)	1.569	ns
Rural	89(70.6%)	20(15.9%)	17(13.5%)		
Engage in Multiple or Dual Relationships					
Accept business associates or co-workers as clients					
Urban	393(86.6%)	41(9.0%)	20(4.4%)	9.692	.01
Rural	99(76.2%)	16(12.3%)	15(11.5%)		
Have clients with whom you have another relationship					
Urban	392(87.1%)	41(9.1%)	17(3.8%)	25.265	.0001
Rural	89(69.0%)	19(14.8%)	21(16.2%)		
Accept relatives or friends as clients					
Urban	408(90.9%)	21(4.7%)	20(4.4%)	2.278	ns
Rural	111(86.7%)	10(7.8%)	7(5.5%)		

	Never	1-2 Times	3> Times	X^2	Sig
Engage in Social Relationships					
Accept a client's invitation to a party or special event (e.g., wedding?)					
Urban	261(57.6%)	146(32.3%)	46(10.1%)	1.676	ns
Rural	81(62.3%)	40(30.7%)	9(10.0%)		
Participate in recreational or social activities with your clients?					
Urban	310(69.8%)	86(19.4%)	48(10.8%)	3.193	3.193
Rural	82(64.1%)	23(18.0%)	23(17.9%)		
Ask for favors from a client (e.g., a ride home)?					
Urban	417(92.5%)	31(6.9%)	3(0.6%)	1.479	ns
Rural	119(90.8%)	11(8.4%)	1(0.8%)		
Invite a client to your home for a social event?					
Urban	431(94.9%)	18(4.0%)	3(1.1%)	0.595	ns
Rural	122(93.8%)	7(5.4%)	1(0.8%)		
Look after a client's belongings (house, pets, etc.) for a while?					
Urban	445(98.0%)	8(1.7%)	1(0.3%)	3.418	ns
Rural	126(96.2%)	5(0.8%)	0(0.0%)		

The second question inquired: *How successful would you say you were with your most recently terminated client?* Interestingly, 14.1% of the rural social workers compared to 5.0% of the urban social workers reported they were unsuccessful (X^2=7.451, p<.01). We can only speculate why nearly three times as many rural practitioners report lack of success compared to their urban counterparts. It is possible, for example, that the rural social workers have less collegial or supervisory support, fewer options available for clients, or are simply faced with more difficult problems.

CONFIDENTIALITY

To measure the importance of confidentiality, we asked two questions (see Tables 1 and 2). As these data indicate, there are no significant differences between the rural and urban social workers with respect to behaviors and beliefs surrounding confidentiality. Most respondents attended to the importance of confidentiality in the professional relationship with equal concern and rigor. This does not discount nor minimize the difficulty in preserving confidentiality in the rural community, where pressure to reveal or maintain confidences may, indeed, be greater. Nor do the responses attend to assertions regarding common community knowledge of professional relationships. Our data only indicate that professional beliefs about confidentiality and maintaining confidentiality are not dependent on community

size. That is, regardless of practice location, social workers place high value on the principle of confidentiality.

MULTIPLE OR DUAL RELATIONSHIPS

Our data indicate that there are significant differences between urban and rural social workers in both practice behaviors and beliefs with regard to multiple or dual relationships. However, it should be noted that these differences may be partially explained by the responses to an ambiguous question, that is, *Do you have clients with whom you have another relationship?* What is clear, however, is that almost 70% of rural social workers, compared to 85% of rural social workers, report not having another relationship with clients, thus, contradicting those who maintain such contacts are inevitable. Yet, three times as many (17.1%) rural social workers compared to urban social workers (6.7%) consider such relationships appropriate. In addition, nearly a third (29.5%) of rural social workers compared to urban practitioners (18.1%) report uncertainty about the appropriateness of this behavior.

It is also noteworthy that accepting business associates and co-workers as clients is more common among rural practitioners, with 23.8% having done this at least once compared to 13.4% of urban practitioners. In addition, rural workers are also far more likely (33.3%) compared to urban workers (18.4%) to consider such behavior appropriate. In contrast, accepting relatives and friends as clients is a relatively rare occurrence, with little difference between rural and urban practitioners. Taken as a whole, these data indicate a substantial difference between rural and urban practitioners in both practice behaviors and beliefs. Without additional interpretation and guidance, code provisions related to dual and multiple relationships may pose significant dangers for rural practitioners.

SOCIAL RELATIONSHIPS

Despite what the literature suggests as the inevitability of engaging in social relations with clients in rural environments, we found no statistical difference between urban and rural social workers in the behaviors considered in this study. In fact, the responses are again remarkably similar. With regard to accepting a client's invitation to a special occasion or participating in recreational or social events with clients, nearly one-third of both urban and rural practitioners had done so once or twice. With regard to invitations for social contact initiated by the social worker, 90% of our respondents had never extended such invitations irrespective of community size. It is noteworthy, however, that with regard to client-initiated requests, our respondents indicated a good deal of uncertainty about the appropriateness of the behaviors mentioned, especially what to do when a client invites the worker to a party or special event, for example, a wedding.

IMPLICATIONS AND LIMITATIONS

On one hand, the research presented here within the context of ethics suggests that the teaching of social work values and ethics at the graduate level is strong enough to withstand environmental pressures, and that despite concerns raised in the literature, there is a broad acceptance of the professional code of ethics across both urban and rural practitioners. On the other hand, the level of uncertainty

about the appropriateness of specific behavioral responses, especially among those who practice in rural settings, suggests that schools of social work and the profession should give more attention to the ethical dilemmas faced by rural social workers.

It should be noted that the data presented here is confined to those in direct practice and excludes social workers who utilize other professional intervention methods such as community practice and administration. In addition, the data do not present a picture of any urban/rural differences as reflected in cases actually brought before the professional Committee on Inquiry. Neither do we know whether the same results would be obtained in a survey of social workers employed at the Bachelor of Social Work level. Indeed, whether the current NASW Code of Ethics is efficacious for those practicing other than clinical social work is a matter for continuing debate and research.

CONCLUSIONS

Based on the behaviors explored in this study, there appears to be a remarkable congruence between the practice behaviors and beliefs of rural and urban social workers. Except for differences in beliefs regarding the appropriateness of bartering and entering into multiple or dual relationships with clients, urban and rural social workers appear to have similar practice beliefs and professional behaviors. Given the rarity of bartering in practice in both urban and rural communities and in recognition of the potential conflicts of interest involved, perhaps the exchange of goods and services for social work intervention should be categorically prohibited. With regard to multiple or dual relationships with clients, differences between rural and urban practitioners, and the level of uncertainty about appropriateness among *all* respondents suggest that further clarification and more specific guidelines are needed. In the broadest sense, rural practitioners are more likely to consider all behaviors identified in this study as appropriate (albeit in small percentages). At the same time, rural social workers are also more likely to express greater uncertainty about the appropriateness of the behaviors in question. Thus, the rural practitioner appears to be enmeshed in a series of ethical dilemmas that demand additional attention within the curricula of professional education and resolution by social worker ethicists. More disturbing for the profession as a whole is the reported use by both urban and rural social workers of intervention techniques without the benefit of formal training.

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Correlates of MSW Students' Perceptions of Preparedness to Manage Risk and Personal Liability

Michael N. Kane

Abstract: *Few studies in the discipline of social work have identified correlates of preparedness to manage risk and personal liability among practitioners or students. This study investigated predictors of MSW students' perceptions of managing personal risk and liability (*N*=116). Four correlates were identified from the standard regression model that accounts for 43% of the adjusted variance. These predictor variables included: (a) concern and worry about lawsuits (Beta=-.458,* p*=.00), (b) understanding the fit between client advocacy and managed care (Beta=.328,* p*=.00), (c) understanding agency documentation requirements (Beta=-.164,* p*=.05), and (d) perceptions of field preparation for documentation (Beta=.162,* p*=.05). Implications are discussed.*

Keywords: Risk management, documentation, career preparedness

Throughout the United States and the world, managed care and other types of service delivery continue to change (Frazee, 1997). Much of this change is a result of evolving models of managed care and privatization (Berkman, 1996; Corcoran & Vandiver, 1996; Davis & Meier, 2000; Fletcher, 1999; Kane, Hamlin & Hawkins, 2000; Motenko et al., 1995; Oss, 1996; Perloff, 1998; Rose, 1996; Rosenberg, 1998; Vernon, 1998). These models were conceived to provide effective intervention while controlling costs (Corcoran & Vandiver, 1996; Davis & Meier, 2000). While these restrictive models of service delivery have infiltrated most health, mental health, and social service venues and have been a source of financial success, they have also been perceived as a political and cultural failure (Robinson, 2001). Attitudes toward managed care among consumers as well as practitioners of many disciplines are generally negative (Berger & Ai, 2000; Robinson, 2001; Yedidia, Gillespie & Moore, 2000).

It appears that these models of service delivery have focused primarily on the cost of services. No doubt the cost of services is an important consideration for practitioners, payers, clients, and organizations (Davis & Meier, 2000), especially in an age of scarce resources. While practitioners may hold negative attitudes toward these models, many practitioners work in managed care and

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privatized venues. Consumers may also hold negative attitudes toward managed care and privatization. However, consumers have more options. When consumers perceive that they have received service that does not meet the standard of care, they may increasingly opt for litigation. Practitioners are acutely aware that they face the brunt of exposure to litigation and are increasingly urged to seek legal counsel to ensure that they meet professional standards of care (Bernstein & Hartsell, 2000; Houston-Vega, Nuehring, with Daguio, 1997; Madden, 1998; Reamer, 1998; 2001). Also, professional schools are adding content to address the management of personal risk and liability. This exploratory study sought to investigate MSW students' perceptions of managing personal risk and liability. It also attempted to identify those variables that may be predictive for managing personal risk and liability among MSW students.

HEALTH CARE CURRICULA, SOCIAL WORK CURRICULA, PRIVATIZATION, AND MANAGED CARE

As a result of the pervasiveness of managed care and privatization, professional education for most health and allied health disciplines has been altered (Berger & Ali, 2000; Coggan, 1997; Fletcher, 1999). Medical schools have developed specific curricula that will responsibly prepare practitioners for current and future service demands in managed care and privatized environments (Coggan, 1997; Fletcher, 1999; Nordgren, 1996; Yedidia et al., 2000) as have schools of nursing (Jacobson, 1998; Sherer, 1993). While perspectives may be discipline specific, content includes clinical and ethical issues associated with managed care and privatized environments, best-practices and clinical pathways, practice evaluation methods, and risk management strategies (Coggan, 1997; Jacobson, 1998; Sherer, 1993).

Social workers function in these same managed care and privatized environments. Many social workers have contributed to a growing body of literature dealing specifically with these areas of concern. Some of this literature has investigated managed care operations and preferred practice models (Corcoran & Vandiver, 1996; Kadushin, 1996; Mitchell, 1998; Poole, 1996) as well as reconciling the profession's code of ethics and managed care's preferred methods of service delivery (Madden, 1998; Reamer, 1998; 2001). Practitioners have contributed to the profession's knowledge base in the areas of client advocacy (Houston-Vega et al., 1997; Sessions, 1998), appealing decisions of utilization reviewers (Callahan, 1998; Corcoran & Vandiver, 1996; Frager, 2000), confidentiality in current service delivery environments (Bernstein & Hartsell, 2000; Reamer, 1998; 2001; Rock & Congress, 1999), the fiduciary relationship (Bernstein & Hartsell, 2000; Houston-Vega et al., 1997; Madden, 1998; Reamer, 1998), methods of client referrals (Frager, 2000; Houston-Vega et al., 1997; Munson, 1998; Rock & Congress, 1999), documentation requirements in current environments (Bernstein & Hartsell, 2000; Davidson & Davidson, 1998; Kane, Houston-Vega & Nuehring, 2002), and evaluating relationships with reimbursement sources (Corcoran & Vandiver, 1996; Frager, 2000; Madden, 1998; Reamer, 1998; Watt & Kallmann, 1998).

There is also a growing body of social work education literature that focuses on the skills and knowledge necessary in current service environments (Berger & Ali, 2000; Kadushin, 1997; Kane, in press; Kane, Hamlin & Green, 2001; Kane, Hamlin & Hawkins, 2000; Kane, Houston-Vega & Nuehring, 2002; Rosenberg, 1998; Shera, 1996; Strom-Gottfried, 1997; Volland, Berkman, Stein & Vaghy, 1999). These authors generally suggest that practitioners must possess the knowledge and skills specific to managed care and privatized environments to competently provide service.

RISK MANAGEMENT AND PERSONAL LIABILITY

A common theme throughout most of this literature is the need for practitioners to provide appropriate service that meets the standard of care. This literature seeks to inform practitioners not only about the standard of care, but also about substandard service delivery that may result in charges of malpractice or negligence. There are several specific areas in the literature in which risk management and personal liability are referenced, including practitioner education, over-diagnosis, agency protocols, documentation, reimbursement, and client advocacy (Bernstein & Hartsell, 2000; Houston-Vega et al., 1997; Madden, 1998; Reamer, 1998).

It appears that organizations and reimbursement sources continue to shift the bulk of responsibility for service decisions onto practitioners as they seek to reduce organizational and payer risk and liability. Practitioners are required to have a keen understanding of their fiduciary responsibilities in order to provide appropriate service and manage risk and reduce personal liability (Callahan, 1998; Davidson & Davidson, 1998; Davis & Meier, 2000; Frager, 2000; Houston-Vega et al., 1997; Kane et al., 2002; Kapp, 1999; Madden, 1998; Moline, Williams & Austin, 1998; Reamer, 1998; 2001). Awareness of professional responsibility and competent practice strategies may be important for reducing concern and worry over potential liability and law suits (Houston-Vega et al., 1997; Kapp, 1999; Madden, 1998; Moline et al., 1998; Reamer, 1998).

Professional social workers are formed through a specific educational program that includes both classroom and field components. Both components provide the essential knowledge and skill development necessary to prepare future practitioners for competent and independent functioning. Of critical importance in both classroom and field portions is the knowledge and skills associated with documentation in practice (Kane, 2002).

As a method of risk management, documentation provides a record of the encounter between client and provider. It serves as a protection to both clients and providers (Houston-Vega et al., 1997; Kane et al., 2002; Madden, 1998; Moline et al., 1998; Reamer, 1998; 2001). Professional organizations and state licensing bodies require practitioners to document. Kapp (1999) suggests that documentation should be (1) accurate and truthful, (2) thorough and complete, (3) legible, (4) timely, and (5) without editorializing comments. Documentation may support practitioners in allegations of substandard service delivery and provide detailed information regarding how clients were best served.

Agencies and providers may depend on documentation for reimbursement from third-party payers and other funding sources. These agencies and providers

may have their own agendas regarding documentation and require specific information to ensure organizational reimbursement. These agendas, which may center on reimbursement, have the potential to become ethical and/or value conflicts for professional social workers. In these cases, some practitioners may feel pressured to "chart-to-the-negative," over-diagnose, or mis-diagnose to ensure that clients receive necessary services and/or the agency gets reimbursed (Houston-Vega et al., 1997; Kane et al., 2002; Madden, 1998; Moline et al., 1998; Reamer, 1998; 2001). These pressures may be particularly powerful as practitioners interact with utilization reviewers and other funding sources.

Social work practitioners are aware that they have a primary responsibility to their clients' welfare as informed by the profession's Code of Ethics (Houston-Vega et al., 1997; NASW, 1996; Reamer, 1998). This requires that they clearly understand their responsibility to clients and develop ethical skills to advocate for clients in current service delivery environments. Without this awareness, practitioners are rendered vulnerable from a risk management perspective and clients may receive inadequate service.

As noted previously, future practitioners may hold various attitudes toward managed care and other restrictive models of service delivery. These attitudes may influence their ability and willingness to navigate in these environments. Future social workers will face clinical and ethical conundrums as they try to obtain appropriate services for clients while managing risk and personal liability (Berger & Ai, 2000; Kane, 2002; Reamer, 2001; Strom-Gottfried, 1997). The social work literature reveals that educators and practitioners have investigated how best to prepare practitioners for the demands of current and future social work practice along with the necessary skills and knowledge critical to these environments. Yet, there is little empirical information that directly focuses on the predictors of managing risk and personal liability among future practitioners, especially in managed care and privatized environments.

This study investigated predictors of MSW students' perceived ability to manage personal risk and liability. Through a literature review, several variables appeared as potential factors that may predict an individual's ability to manage risk and personal liability. These variables include: professional experience in managed care and privatized environments, occupational responsibilities, type of agency at which the professional is employed, understanding agencies' financial agendas, understanding agency documentation guidelines, awareness of ethical and value conflicts such as over-diagnosis/mis-diagnosis, educational preparation for documentation, the skills of advocacy in current environments, preoccupation with lawsuits, understanding gatekeeping and utilization review processes, and field preparation for employment. These exploratory findings may offer educators and curriculum planners information about students' perceived preparedness for future employment opportunities and practice competency. This important information may assist students, employers, and educators in providing services to clients that meet the standard of care and allow organizations and practitioners to effectively manage risk and personal liability. Finally, this information may provide valuable content for curriculum development.

METHODOLOGY

Participants. A sample of students (n=116) was obtained from two Florida MSW programs. Students currently enrolled in or who had completed at least one field practicum and were enrolled in clinical practice, advanced research, or field seminar classes were asked to anonymously volunteer to complete an instrument. Access to these students was based on instructor willingness to dedicate class time to completing this instrument.

The typical respondent in this survey was female (84%), Anglo (49%), and had some social work experience. Because of the diverse population of Florida, respondents self-identified as Hispanic/Latino (19%), African-American (10%), and West Indian/Caribbean (15%). The mean age of respondents was 31.86 years, with ages ranging from 22 to 51. Field sites were identified as public (41%), private for-profit (17%), or private not-for-profit agencies (40%). Approximately 53% of the sample indicated that they had two to five years of social work experience, while 28% of the sample indicated that they had less than two years of experience.

Instrument. Kane, Houston-Vega, Tan and Hawkins (in press) developed an instrument that contained nine variables that measured student preparedness for managed care environments. The "Understanding agency financial agendas" variable used six items to measure respondents' understanding of how organizations use clients' benefit packages for reimbursement. Specific items in this scale investigated agencies' concern for service reimbursement, service termination if benefits are exhausted, and their preferences for serving clients who can pay for services. The variable of "managing personal risk and liability" used six items to determine whether respondents perceived that they had adequate knowledge and skill to prevent a lawsuit. Specifically, items investigated respondents' beliefs about having the necessary skills to protect themselves from being sued and avoid potential liability. "Understanding agency documentation requirements" is a variable that uses four items to evaluate whether respondents are aware of specific documentation guidelines that are in place at agencies to shape professional behavior. "Awareness of ethical conflicts surrounding over-diagnosis or misdiagnosis" measured the tension that may exist in practice that would encourage a practitioner to "stretch the truth" to ensure agency reimbursement or service authorization for clients. The variable "classroom preparation for documentation" used several items to measure perceptions about the level of preparedness that respondents may feel as a result of their classroom education. "Understanding the fit between client advocacy and managed care" was a variable that evaluated respondents' perceptions about their ability to navigate and advocate for their clients in complicated and restrictive service environments. An item in this variable is, "I believe I am capable of advocating for my clients in managed care environments" (Kane, Houston-Vega, Tan & Hawkins, in press). The variables of "worry and concern over lawsuits," and "knowledge of utilization review and gatekeeping" assess a respondent's perceptions in these specific areas. The variable of "field preparation for documentation" assesses respondents' perceptions of how well the field site prepares them to manage risk and personal liability through documentation strategies. One item used in this variable is "Documentation of my clinical work is a skill I learned mostly in my field place-

ment" (Kane, Houston-Vega, Tan & Hawkins, in press). Respondents receive a score for each variable scale. Values assigned by respondents for each variable item are added together to obtain a variable score. There is no overall instrument score. The variable of managing risk and personal liability was designated as the study's dependent variable for the purposes of multivariate analysis.

Reliability alpha coefficients were computed for each variable, including agency financial agendas (α=.88), personal risk and liability (α=.84), agency documentation requirements (α=.79), ethical conflicts (α=.81), classroom preparation for documentation (α=.80), advocacy skills (α=.80), concern over lawsuits (α=.76), knowledge of utilization review and gatekeeping (α=.58), and field preparation for documentation (α=.49). Normally, alpha scores above 0.7 are preferred. Because of the exploratory nature of this research, two variables with lower alpha scores were retained. Finally, Kane, Houston-Vega, Tan & Hawkins (in press) reported face validity for this instrument.

To this instrument, demographic variables were added such as gender, age, ethnicity, social work experience, field experience, agency type, and future employment plans. The instrument was administered to all participants and took less than 20 minutes to complete. Prior to participant completion, the instrument was piloted using practitioners and field supervisors.

Analysis: Univariate analysis included mean, standard deviation, minimum, and maximum scores for each variable scale. To determine the strength of the relationship between each independent variable and the dependent variable, correlation coefficients were computed. Finally, standard multiple regression was used for model building to identify those variables that were most predictive in understanding the dependent variable.

FINDINGS

Descriptive Analysis of the Variables

Overall, respondents indicated that they perceived themselves to be moderately well prepared to manage risk and personal liability (Table 1). Most respondents reported feeling moderately well equipped to understand agency financial agendas, understanding managed care gatekeeping and service authorization requirements, and advocating for clients in managed care environments. Most respondents also believed that they had been moderately well prepared in the classroom for documentation, moderately aware of ethical conflicts regarding over-diagnosis, and had a moderate concern and worry about lawsuits. Most MSW student respondents strongly indicated that the field had prepared them to document and that they understood agency documentation requirements. Table 1 provides specific information regarding these variables.

Bivariate Analysis

Correlation coefficients (Table 2) were computed for the dependent variable (managing risk and personal liability) and gender, age, MSW status (concentration or foundation year), ethnicity, field placement site, and career goal. None of these coefficients were significant. Correlation coefficients were also computed for the dependent variable and (a) understanding agency financial agendas, (b)

understanding agency documentation requirements, (c) awareness of ethical conflicts/over-diagnosis, (d) classroom preparation for documentation, (e) understanding advocacy for clients in managed care environments, (f) concern and worry over law suits, (g) understanding managed care gatekeeping and service authorization, and (h) field preparation for documentation. Three of these variables were significantly correlated with the dependent variable: classroom preparation for documentation, understanding advocacy for clients in managed care environments, and concern and worry about lawsuits. Two other variables approached significance (awareness of ethical conflicts/over-diagnosis and field preparation for documentation). Finally, several variables, including concern and worry about lawsuits, were negatively correlated with the dependent variable. This finding suggests that the concern and worry about lawsuits variable is reduced through managing risk and liability.

Multiple Regression Analysis

Standard regression analysis was initially performed using (a) understanding agency financial agendas, (b) understanding agency documentation requirements, (c) awareness of ethical conflict/over-diagnosis, (d) classroom preparation for documentation, (e) understanding advocacy for clients in managed care environments, (f) concern and worry over law suits, (g) understanding managed care gatekeeping and service authorization, (h) field preparation for documentation, (i) age, and (j) field placement site. The initial solution yielded a model (R=.688, Adjusted R^2=.419, F=8.718, *p*=.000) with few significant predictive variables.

In further exploratory analysis, all items that were not significant in the initial regression analysis were excluded from further model development. A final model was selected which accounted for 43.1% of the adjusted variance (F=21.994, *p*=.000) using four independent variables. These variables included (a) concern and worry about lawsuits (Beta=-.458, *p*=.00), (b) understanding the fit between client advocacy and managed care (Beta=.328, *p*=.00), (c) understanding agency documentation requirements (Beta=-.164, *p*=.05), and (d) perceptions of field preparation for documentation (Beta=.162, *p*=.05). Table 3 contains further information.

Table 1: *Variable Descriptives*

Variable	Mean	SD	Min.	Max.
Managing personal risk and liability	16.04	3.93	8	25
Understanding agency financial agendas	17.57	6.07	6	30
Understanding agency documentation requirements	15.52	3.63	4	20
Awareness of ethical conflicts/over-diagnosis	9.40	3.89	4	18
Classroom preparation for documentation	7.44	3.07	3	15
Understanding advocacy for clients in managed care environments	12.85	3.39	6	20
Concern and worry about lawsuits	8.82	2.74	3	15
Understanding managed care gatekeeping and service authorization	9.58	2.41	5	15
Field preparation for documentation	7.33	2.00	2	10

Table 2: *Bivariate Analysis: Correlations to Perceptions of Managing Personal Risk and Liability*

Variable	Correlation	Significance
Gender	.033	.735
Age	.070	.482
MSW status	.108	.262
Ethnicity	.006	.952
Field placement site	-.030	.753
Career goal	-.094	.330
Understanding agency financial agendas	-.084	.378
Understanding agency documentation requirements	-.061	.525
Awareness of ethical conflicts/over-diagnosis	-.166	.080
Classroom preparation for documentation	.357	.000
Understanding advocacy for clients in managed care environments	.454	.000
Concern and worry about lawsuits	-.577	.000
Understanding managed care gatekeeping and service authorization	-.050	.598
Field preparation for documentation	.172	.070

Table 3: *Final Regression Summary*

	B	Beta	t	Sig.
Understanding agency documentation requirements	-.176	-.164	-1.926	.05
Understanding the fit between client advocacy and managed care	.381	.328	4.166	.00
Concern and worry about lawsuits	-.658	-.458	-5.983	.00
Field preparation for documentation	.317	.162	1.995	.05

DISCUSSION AND IMPLICATIONS

Four variables made significant contributions to a regression model and attempted to explain social work students' perceptions of managing risk and personal liability. These variables included (a) concern and worry about lawsuits, (b) understanding the fit between client advocacy and managed care, (c) understanding agency documentation requirements, and (d) perceptions of field preparation for documentation. It appears that respondents' perceived that concern or worry about potential lawsuits would be reduced by managing risk and personal liability. In some sense, this worry or concern over the potential for litigation may foster an increased sensitivity among practitioners to provide services that meet or exceed the recommended standard of care. While not the primary motivation for the provision of appropriate service, awareness of personal liability may still be a powerful incentive.

The traditional social work role of client advocate was viewed by respondents as being an important method of managing risk and personal liability. In managed care and privatized environments, clients are frequently in need of scarce services. Social workers have been trained to navigate these complicated systems for their clients and to advocate for scarce resources. This suggests that by ensuring the primacy of clients' needs, practitioners are aware that they are most appropriately upholding the standard of care. A practitioner's best strategy from a risk management perspective is to meet or exceed the standard of care (Houston-Vega et al., 1997; Kapp, 1999; Madden, 1998; Moline et al., 1998; Reamer, 2001). In addition, it seems reasonable to assume that clients who are cognizant that their practitioner is also their advocate realize that their best interests are being upheld by practitioners. Clients who feel that they have someone working on their behalf are generally those who are less likely to choose litigation.

Respondents indicated that understanding agency documentation requirements was critical to managing risk and personal liability. This information is typically provided in both the classroom and field components of social work education. As noted previously, documentation critical to protecting both client and practitioner has repeatedly been cited in the literature, as it provides an accounting of client-practitioner interaction and evidences whether the standard of care was met (Corcoran & Vandiver, 1996; Houston-Vega et al., 1997; Kane, in press; Kane et al., 2002; Madden, 1998; Moline et al., 1998; Reamer, 1998; 2001).

Finally, respondents perceived that the field component is critically important for career preparation. This critical area in social work education assists students to develop expertise and competence in many areas, especially in developing an awareness of risk management strategies. These strategies may be learned from the field supervisor who informs students about personal liability or through the risk management strategies of the organization. Of critical importance in these settings is the use of documentation. It appears that the experiential learning that occurs in field education prepares students for documentation in compliance with agency agendas.

While these contributing variables are important to understanding students' perceived preparedness to manage risk and personal liability, the variables that did not significantly contribute to the model are of equal interest. The following variables were not significant predictors for the final model: gender, age, MSW status, ethnicity, field placement site (private-for-profit, private-not-for-profit, public), career goal (private practice, agency work, combination), or experience in managed care and privatized environments. Of particular interest is the fact that field placement site and experience (private for-profit, private not-for-profit, public) were not contributors. It seemed logical to assume that experience and field site might affect perceptions and suggests that future investigation is necessary to verify these findings. Consistent with other literature, particularly among medical educators and students, perceptions of knowledge and skill development were not significantly influenced by either managed care or non-managed care settings (Yedidia et al., 2000).

While negative attitudes toward service delivery models accomplish little, so does excessive worry regarding potential litigation. While practitioners must

ensure that they provide the best service possible, they must also develop an awareness of potential risks and seek to avoid them. It is important for students to develop not only the necessary knowledge and skills to protect themselves and their clients in these environments, but also to develop attitudes that will ensure that they capably advocate for vulnerable populations and options that will enhance service delivery.

Developing curriculum to adequately prepare students for current service environments continues to be a great challenge for professional educators (Berger & Ai, 2000). Client advocacy, liability concerns, documentation requirements, and field experience may be pivotal in preparing students to manage risk and personal liability.

LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

This study used a purposive sample of 116 MSW respondents from two educational programs. While small samples from one educational program have been used to investigate levels of student preparedness and satisfaction, in order to assert generalizability and statistical power, larger and more representative samples of students from geographically diverse locations are necessary.

While this study relied on social work student respondents, further investigation is necessary. Curriculum development and knowledge generation will require other information sources such as managed care organizations, service environments, supervisors, educators, administrators, risk managers, and practitioners.

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Poetry Therapy as a Tool for Strengths-Based Practice

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Abstract: *This article explores the congruence between poetry therapy and the strengths perspective of social work. It demonstrates the ways in which poetry therapy is consistent with the strengths perspective and discusses methods for its utilization in direct practice settings. Case examples are provided to help the practitioner learn how to utilize poetry therapy with clients from diverse backgrounds. As a tool in strengths-based practice, poetry and poetry therapy can help empower clients and help to focus practitioners on clients' capacities and resilencies. This article seeks to expand upon the growing literature of strengths-based social work, addressing how the theory can be applied to clinical practice situations.*

Keywords: Poetry therapy, strengths perspective, social work practice

Currently, the strengths perspective is rising to the forefront as one of the most important and influential guides to practice for social workers (Chapin, 1995; Lewis, 1996; Logan, 1996; Perkins & Tice, 1994; Saleebey, 2002; Van Wormer, 1999). While many of the values and principles of the strengths perspective are not new (Maluccio, 1981; Robinson, 1949; Smalley, 1967; Taft, 1939), its development and conceptualization as a separate perspective dates back only slightly more than a decade (Graybeal, 2001; Weick, Rapp, Sullivan, & Kishardt, 1989). While the underlying assumptions, values, and precepts have been well articulated (Early, 2000; Saleebey, 2002), intervention techniques and practice methods related to the perspective need further development and articulation (De Jong & Miller, 1995). There are techniques that readily lend themselves to possible inclusion under the rubric of the strengths perspective. One such approach is poetry therapy, the structured and therapeutic use of reading and writing poems that seeks to draw out the innate resources and healing power that lie within each individual. As such, it is highly congruent with the basic assumptions of a strengths-based approach to clinical practice. This article demonstrates the ways in which poetry therapy is consistent with the strengths perspective and discusses methods for its utilization in clinical settings.

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Several issues will be explored. First, a discussion of the healing and growth inducing aspects of poetry and poetry therapy are presented. Second, the nature of the strengths perspective as complimentary with poetry therapy are discussed. Third, the congruence between poetry therapy and the strengths perspective are explored by discussing key elements of the strengths perspective and how these elements can be actualized through the use of poetry and poetry therapy. Fourth, case studies that demonstrate the integration of theory and practice vis-a-vis poetry therapy and the strengths perspective are explored.

THE CURATIVE NATURE OF THE POEM AND POETRY THERAPY

As tools, poetry and poetry therapy have been successful in drawing out the inner capacities of individuals from many different populations, including the chronically mentally ill (Goldstein, 1987), the elderly (Edwards & Lyman, 1989), troubled children and adolescents (Alexander, 1990; Langosch, 1987; Mazza, 1987, 1996; Mazza, Magaz & Scaturro, 1987), veterans (Geer, 1983), the terminally ill (McLoughlin, 2000), substance abusers (Bump, 1990; Leedy, 1987), and families (Gladding, 1995). Practitioners working in diverse settings including women's shelters (Hynes, 1987), nursing homes (Edwards, 1990; Kazemek & Rigg, 1987), and elementary schools (Gladding, 1987) have made use of poetry and poetry therapy. In addition, poetry has even been incorporated into family work (Mazza, 1996), diversity work (Holman, 1996), community work consciousness raising (Kissman, 1989), and research (Poindexter, 1998).

Poets and philosophers have been aware of the curative and healing nature of poetry for millennia. Long before there were social workers or other helping professionals, poets and storytellers helped people deal with their deepest fears by echoing the struggles of humanity in their poems, myths, and stories (Harrower, 1972). In hearing these works, people have learned that they are not alone with their pains; they are part of a greater struggle. The Aristotelian concept of psychagogia (Lerner, 1981), "the leading out of the soul through the power of art" (p. 8) predates Freud's notion of sublimation by more than a thousand years. Aristotle discovered that through the process of creating poetry, people were able to transform their problems into power and their sadness into strength.

Many poets have discovered the liberational power of the poem in helping them maximize their own emotional and spiritual resources. For example, American counter-culture poet Charles Bukowski (1991) saw poetry as the "ultimate psychiatrist." While poetry has been therapeutic to many "professional" poets, poetry can be therapeutic and used therapeutically with many different groups of people.

As a discipline, poetry therapy falls into the broader classification of bibliotherapy, the intentional use of poetry and other forms of literature for healing and personal growth (Reiter, 1997). While many types of therapy are poetic in nature, poetry therapy is a separate entity (Rothenberg, 1987), with several professional organizations and journals devoted to its development (NAPT, 2001). Those who identify themselves as poetry therapists include psychiatrists, psychologists, counselors, substance abuse specialists, and social workers. Table 1 shows some useful resources for exploring poetry therapy.

Lerner (1981) defines poetry therapy as the structured use of reading and writing poetry and similar literary genres to facilitate therapeutic goals. He draws a dis-

Table 1: *Useful Resources for Poetry Therapy*

Name	Address	Website
National Association for Poetry Therapy	5505 Connecticut Ave., North West, #280, Washington, DC 20015; Telephone: (202) 966-2536	www.poetrytherapy.org
The Center of Journal Therapy	12477 W. Cedar Dr., #102, Lakewood, CO 80228	www.journaltherapy.com
Journal of Poetry Therapy	Editor; Nicholas Mazza, Ph.D., Florida State University, School of Social Work, Tallahassee, FL 32306	
The Arts in Psychotherapy	Editor; Irma Dosamantes-Beaurdy, Ph.D., World Arts and Cultures Department, Box 951608, Los Angeles, CA 90095-1608	

tinction between a poetry therapy group and a poetry workshop in that the former uses poetry as a means to accomplish treatment goals, whereas, poetry therapy uses poetry as a means to an end. Gladding & Heape (1987) note that popular music such as rap can be used to make the medium more accessible.

THE STRENGTHS PERSPECTIVE AND IMPLICATIONS FOR THERAPY

To many, the construct of therapy represents an activity of practice that necessitates hierarchical patterns of practice that perpetuate or even accentuate social inequities. Many models of therapy are associated with the medical model of practice where the professional therapist seeks to help the patient "fix" some deficit or problem that lies within them. In many ways, the strengths perspective has been developed as a reaction against such approaches that pathologize instead of empower. Unfortunately, therapy itself is now often identified with practice that disempowers and blames. This is unfortunate because therapy does not have to be conceptualized as a relationship between unequals that blames a client's problems on personal deficits. Finding a new means of reframing the process of therapy is essential, as this is one of the most common tasks that social workers undertake in their practice (Gibelman, 2000). Fook (1993) has explored therapy and casework as a means of overcoming oppression and altering social and personal inequities. Creative uses of therapy and therapeutic arrangements can assist clients explore the social causes of their struggles and find the means to overcome their structurally created bonds, thus, freeing energy for personal and social growth and transformation (Fook, 1993; Lee & Pithers, 1980; Mullally, 1993.)

One principle of the strengths perspective is that the social worker is encouraged to work in collaboration and dialogue with the client. Therapy need not be something that is done "to" people (Saleebey, 2000) but can be conducted as a collaborative experience guided and driven by clients as a means of helping them maximize their internal and external resources and achieve their dreams. Based upon the literature of resiliency, the strengths perspective challenges social workers to

help people utilize their skills and competencies in overcoming life's problems. The strengths perspective does not deny the existence of problems, but asserts that maximizing the strengths and resources of individuals and groups is the best means of helping them overcome life's challenges. Saleebey (2002) describes the strengths perspective in the following way:

> Practicing from a strengths orientation means that everything you do as a social worker (or therapist) will be predicated, in some way, on helping to discover and embellish, explore, and exploit clients' strengths and resources in the service of assisting them to achieve their goals, realize their dreams, and shed the irons of their own inhibitions and misgivings. (p. 3)

THE STRENGTHS PERSPECTIVE AND IMPLICATIONS FOR THERAPY

The strengths perspective rests upon a number of assumptions including empowerment, dialogue, and collaboration between social worker and client, membership, resilience, healing, and wholeness (Saleebey, 2002). These assumptions are also consistent with the use and application of poetry in therapy and poetry therapy.

The very engagement in the creative process can tap into inner strengths that are not always apparent and can draw out well-hidden resiliencies (Makin, 1998). In his expansion of Maslow's hierarchy of needs, Gil (1990) postulates that creative expression is an essential human drive. It has been argued that when the drive is expressed, humans are freer to solve their problems, think creatively, and maximize their potential. If creative expression is difficult for clients with multi-stressors and overwhelming responsibilities, engaging clients in creative processes such as creating poetry can help liberate energy that can be utilized for growth and healing (Wade, 1997).

Talerico (1986) notes that engagement in the creative process encourages the development of many skills that social workers attempt to instill in their clients, such as expressing feelings, confidence through risk-taking, developing new insights, problem solving, conflict resolution, and reducing anxiety. Other skills and resources can be maximized to develop writing and verbal abilities essential to successful participation in most social institutions.

Johnson (1983) asserts that the process of creation unleashes the healing potential within each person. As a key precept in strengths-based practice, this idea can find its roots in social work practice with the early functionalist scholars and practitioners. Poetry therapy is not something done "to" people; it is a means of engaging them in the process of maximizing their strengths and helping them achieve their hopes and desires.

The strengths-based approach is entwined with constructivist practice insights and ideas. In both theories, one can view the lives of people as stories that are constantly evolving and changing. As authors of the stories of their own lives, people can reposition themselves and other characters and change the script to better reflect their visions and dreams. In therapy and other helping experiences, the social worker, thus, helps the client develop new ways of envisioning their future.

The metaphors that lie at the heart of client stories and the narratives that guide how we see people are extremely powerful in shaping our behavior (Mazza, 1999).

Cowger and Snively (2002) discuss the powers of how certain metaphors of disease have greatly shaped social work practice.

> Deficit, disease and dysfunction metaphors have become deeply rooted in the helping professions, shaping contemporary social work practice through the emphasis on diagnosis and treatment of abnormal and pathological conditions within individuals. (p. 106)

One effective way of helping clients re-author their lives is through helping them develop alternative metaphors for their lives. Metaphor and metaphoric language are key therapeutic elements to poetry and poetry therapy. The metaphor, the symbolic use of language where an object or event represents another object or event, is a core means of organizing the human experience. People hold core metaphors that represent their images of themselves, their lives, and their futures. When disability or hopelessness characterizes the metaphors that clients hold for their lives, they see little hope in changing their lives. It is important to note that the use of metaphor is not appropriate to all client populations. For example, people with chronic and persistent mental illnesses such as thought disorders might find metaphoric language confusing and frustrating. In such cases, poetry that is concrete is far more acceptable and useful.

Often, metaphors are how clients talk about their lives. By speaking in metaphoric language, clients are able to safely discuss issues that are often too painful to address directly. An example from the practice of the first author illustrates this point clearly. One male client with a history of addiction and depression envisioned himself as a bird that was locked in an iron cage. As he pounded his head against the bars day after day, year after year, he imagined that somehow this desperate act would free him from the agony of his enslavement. Metaphorically, he was able to discuss how he used his teenage drug habit to escape his memories of molestation. By constructing such a metaphor, he was allowed to explore events that he was not ready to face directly. Poetic explorations such as these enable clients to test their ability to deal with painful events and feelings slowly and safely. By helping clients discuss their prevailing metaphors and stories and affirming their creativity and courage in sharing, social workers can help them learn to see themselves as having strengths and the ability to conquer their pasts (Rothenberg, 1987; Zahner-Roloff, 1987).

GUIDELINES FOR THE USE OF POETRY THERAPY IN PRACTICE

Some guidelines for social work practitioners who want to integrate a few of the techniques of poetry therapy into their strengths-based practice are discussed here. In regards to structure, Lerner (1981) suggests that no table be placed between group members in order to avoid artificially distancing members. Typically, the first author organizes the setting for poetry therapy groups using the same principles that guide more traditional groups, making sure that there is also comfortable space for people to write when asked to do individual work. A few desks or a table should be provided, as not everyone is comfortable writing in their laps.

As previously discussed, the very idea of writing poetry can be anxiety producing for some clients. Houlding and Holland (1988) have designed several creative methods for reducing client anxiety. In the first group session, they pass out poems with certain phrases blocked out. Clients are asked to fill in the blanks with their

own words. The authors had found that this exercise eliminates the anxiety created by the forebodingness of a piece of blank paper. In early sessions, the authors utilized poems characterized by concreteness and neutrality, progressing to more metaphorical and emotionally laden work as members became more comfortable with each other and with the processes of poetry therapy.

Collaborative poems are useful in creating group cohesiveness (Mazza, 1985), maximizing communication abilities and interpersonal skills and establishing a culture of productivity. One activity that is useful to groups is for the therapist to ask group members to identify feelings they want to handle better and resolve. Members are broken off into pairs based upon the feelings that they chose. Each subgroup is then given a poem that relates to the theme they had chosen, which they read and discuss together. The pairs are then instructed to write a poem together, exploring what the poem meant to them. This process encourages empathy, as members who want to gain acceptance from their peers usually try to include the ideas of others. Participants also learn that they can learn to work with each other and that other group members can facilitate their healing and recovery. This helps to reinforce healthy patterns of mutual interdependence, an important concept in strengths-based practice.

In one group session with veterans attending group therapy in an inpatient substance abuse treatment center, a group of three men choose to work on fear. This triad read a poem about the topic, then wrote an 11-line poem with each line starting with "Fear is… ." As they completed each line, they provided feeling and insight with that line. Some of the lines were, "Fear is getting old, not knowing who I am," "Fear is dying young, not knowing my children," "Fear is failure on life's own terms," "Fear is the future we don't know," "Fear is the past we know too well."

After writing this poem, the triad shared its work with the larger group. They discussed the poem's content and the process of working together. Group members were encouraged to explore and were helped to identify their own style of communication, the areas of relating that are difficult to them, and the behaviors of others that trigger difficult feelings or behaviors. The poem elicited a discussion on ways of coping with fears, a particularly difficult issue for veterans who suffer from Post Traumatic Stress Disorder triggered by combat experiences. The first author, as the therapist in this group, helped the group focus on acceptance of this fear as a natural and normal consequence of having witnessed such horrors and on recognizing the enormous strength that it takes to live with such memories.

Creating a collective poem is a collaborative exercise that usually centers on a theme discussed previously in the group. Each member writes a line to a poem in process (first lines can be created by the therapist, a group member, or can be taken from an existing poem). An interesting extension of this exercise involves each group member writing a first line, then passing the poems around so that each member adds a line. This often results in useful feedback for the creator of the first line.

APPLICATIONS OF POETRY THERAPY AND CASE EXAM

Geer (1983) helped a Vietnam veteran redefine his self-concept by using poetry therapy techniques to reconstruct his core life metaphor. During the intake, the

client described himself as a "Marine/machine" who was only able to experience his emotions violently as a Marine or repress them as a machine. He saw himself as powerless over his feelings and clearly saw how limiting these two options were. The more he tried to control his feelings, the more his feelings controlled him. As a machine, he saw himself predetermined to act in a mechanistic, rote manner. The therapist encouraged him to search for a new metaphor for himself, a metaphor of the person he was capable of being and wanted to be. The therapist helped the client explore other possible ways of viewing himself, encouraging him to find a more flexible and expansive metaphor. In time, the client began to call himself the "poet of the rocks," referring to his newfound discovery of his creative, feeling self and his growing love of nature. With this as his new guiding metaphor, he was able to explore new behaviors that were more congruent with this new self-concept. He learned to maximize existing strengths and worked to create new ones.

Hynes (1987) utilized poetry therapy in her work with battered women. In strengths-based practice, it is important for the social worker to help normalize a client's feelings. While the ultimate aim of strengths-based practice is to help clients discover and develop strengths and resiliencies in the service of meeting their goals, it in no way implies denying current feelings. Therefore, before stories can be re-authored, they must be explored and constructed. Sometimes this is difficult for clients. Poems that approximate their experiences or that can be used as jumping off points for dialogue about their personal stories are valuable in helping clients begin the process of growth and healing. To this end, Hynes reads a poem to help battered women feel less isolated in their experiences. The poem has very intense images such as, "The emptiness of my future cuts me like a knife," "I am begging to understand the joke life played on me," and "The absence of my anger, the silence of my screams."

After the poem was read allowed, each member was asked to identify what was significant to them about the poem or to identify an issue that needed to be discussed. The process allowed the women to express similar feelings in a safe manner.

In further expanding on Hynes' work from a strengths perspective, several other questions and experiences can be presented to such a group. Members can be asked to discuss how the person who wrote a poem might transform their experiences. What inner capacities and strengths has each group member learned from their oppressive and even abusive histories? How can they use the experiences to become more fully human and complete? Each group member can also be asked to write a follow-up poem of transcendence or reframing. For instance, how might the poem sound if one focused on positive, compensatory behaviors developed in the process of coping with abuse? How might the poem sound different if it were written one year later after more healing had taken place?

The feelings of helplessness and powerlessness associated with oppression, such as racism and institutionalization, may lie at the heart of many emotional difficulties (Fanon, 1963; Gil, 1990; Van Wormer, 1997). Helping people become conscious of the roots of such oppression can lead to powerful emotional and behavioral changes (Freire, 1970). Again, poetry can be utilized to help people re-author their lives. Poems can be used to help explicate what people have learned about themselves from their history, then challenge these messages.

Poetry, often seen as being written for and by society's intelligencia, can be used as a powerful tool in empowerment oriented practices. Feminist and minority writers have used poetry in therapy to build community empowerment (Kissman, 1989). Through using poetry techniques, clients can learn to understand their struggles in the context of institutionalized oppression, which can mark the first step away from self-rapprochement and towards empowerment. When the mystique of poetry is deconstructed for clients and they learn not only to understand it, but also create it, an amazing sense of accomplishment and empowerment is achieved. Clients begin to realize that they can accomplish many of the things that that their internalized oppression has taught them they could not. Even clients who cannot read or write, who need to recite their words for others to write down, can begin to acquire an increased sense of mastery and accomplishment.

The first author has used poetry therapy techniques with former patients of the state psychiatric hospital system, patients who lived in community residences and attended a partial hospital program. Having suffered through years of institutionalization, most of these clients learned entrenched patterns of helplessness and experienced feelings of worthlessness and expendability. These feelings clouded their perceptions and led them to attribute their marginalized socialization solely to their mental illnesses and not to the affects of years of isolation and loneliness of institutional life. By helping them understand the etiology of their feelings, these clients started to blame themselves less and make real changes.

The group consisted of eight mental health consumers, age 25 to 60. Each was a member of a half-day partial hospitalization program that they attended anywhere from three to five days a week. No one in the group had any previous experience with writing poetry and all reported a significant history of academic failures. The members also ranged in functional ability from one who planned to return to college, to another who could not remember how to read or write. They met once a week for one and a-half hours for three months.

Each session consisted of three phases. The first phase consisted of a simple didactic discussion on the elements of language and poetry. Topics, such as the use of adjectives, nouns, metaphors, and sentence structure, were explored to help each member improve the technical aspects of their writing and to help improve their sense of mastery.

During the second phase of each session, poetry was read aloud. Readings tended to be thematic, chosen by the therapist in consultation with the clients to reflect themes of therapeutic value to the clients or they were selected by the participants as they expressed the need. Themes included friendship and support verses isolation, love versus hate, prejudice verses acceptance, and apathy verses overcoming adversity. Trips to the local library and university libraries led to the selection of many poems by the group members. This, alone, was empowering, as many group members did not know how to use a library. Learning to navigate the library helped several members feel a sense of efficacy. One member realized that if he could negotiate a library, he could perhaps return to work one day.

Group members were given much control over their group. The structure was only meant to provide order and a sense of safety. During a session one member asked the group to read a poem on helplessness. He had started to realize that dur-

ing his 15 years of confinement at the state hospital that he learned to rely on the staff to meet all of his needs. He started to realize that many of the decisions and choices he continued to make emanated from the core belief that he was helpless. During the discussion of a poem by a paraplegic, several group members said they felt similarly trapped and confined by their limitations. In time, they recognized that these limitations were not, in fact, truth, but stories they learned about themselves that were open to analysis.

During this particular group session, members began to write about the themes of institutionalization and helplessness. Each member who was now comfortable and capable of working independently would work on a poem that reflected his/her response to the previous discussion or his/her reaction to the work. Members not capable of writing on their own dictated their thoughts to the therapist or worked with another member of the group. Both flexibility of structure and acceptance of where each member is at during each session are crucial factors in order for poetry groups to be safe and therapeutic environments.

After sufficient time had elapsed in order for all members to feel finished (with the previously established understanding that creative work often requires many revisions, if the author so desires), the members were encouraged to share their work with others. By this time, the eighth session, group members had progressed to the point where each either read their works or had others read them aloud. A poem written by a member was read to the group. The theme focused on being medicated and the poem was vivid. As the member read the poem, the words included the statement, "I can't move my hands, but they work O.K.," "I was not that bad before their rooms, and their drugs, and their thugs," and "It will cost quite a lot to get back all that I lost."

The author of this poem began to cry after reading this aloud. He said that it was one of the first times that he had gotten in touch with the effects being medicated had upon him. The members of the group shared in his pain and they encouraged each other to explore how they could change some of those effects. The idea that they were changing many of their learned patterns of helplessness was both liberating and frightening, as many of those patterns had become simultaneously comfortable and depressing. Subsequent group sessions focused on group members finding or creating poems that focused on their transforming themselves.

ADDITIONAL CONSIDERATIONS

Several additional implications and limitations of poetry therapy need to be addressed. First, claims of efficacy in this article are based upon unsystematic, clinical observations of individual cases and not on systematic research. While many contributors to the field of poetry therapy have noted the effectiveness of the approach with various client populations, little generalizable, empirical research exists. For those who utilize poetry therapy, Mazza (1999) has noted the importance of conducting evaluations of their practice. He calls for the use of various methodologies, including single-system design, ethnographic, and conventional experimental designs to improve upon the knowledge base. The research that exists tends to focus on process issues, such as group cohesion and positive interactions and not on client outcomes (Mazza, 1999; Rossiter & Brown, 1988).

Similarly, little research exists on the efficacy of the strengths perspective in direct social work practice. Future research should also seek to validate the concepts and suppositions of the perspective.

Poetry and poetry therapy can also be valuable tools in social work education. Using poetry in classroom settings can lend variety to teaching methods. Teachers are encouraged to explore literature and poetry that has value to them and think of creative ways of using this material. When poetry that has an emotional connection is used, students are more likely to find value in it. The first author of this article has used poetry to help students understand various client situations. Poetry is especially helpful in teaching Human Behavior in the Social Environment, as poetry can help to convey various psychosocial issues from the perspective of those experiencing them. Writing poetry can also help students to understand various issues on a personal level, thus, improving their "professional use of self."

CONCLUSION

Using poetry therapy allows clients, in conjunction with their social worker, to create a sense of freedom, accomplishment, insight, and connection with others. Clients who are dealing with issues that are difficult or painful to discuss in treatment can use poetry as a vehicle toward developing new capacities and resiliencies.

This article explores the connections and congruence between poetry therapy and strengths-based practice. The ability to use poetry therapy to help empower individuals to master their emotions and experiences can aid the strength-based practitioner with assisting his or her clients toward growth and wellness. Similarly, the poetry therapist can work from a strength-based framework by guiding clients' creative expression toward future achievements, desired outcomes, and help them maximize their internal resources.

The social work field and other helping professions can benefit from integrating poetry therapy and the strength-based approach, two effective and complementary methods that can be linked in creative ways to help social workers better meet the needs of clients.

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Substance Abuse and Suicidal Behavior in Women Ages 30 to 39 Years

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Abstract: *A growing number of young women abuse substances and engage in suicidal behavior. Combinations of these problems are under-researched. Research that exists includes women of all ages in the samples. This study adds information to the current state of knowledge on these problem behaviors by limiting the sample to women ages 30 to 39 years. A group of 113 women, part of a larger study of 364 women who had received inpatient psychiatric treatment, was included in this study. Findings revealed that most of the women had made at least one suicide attempt and nearly one-quarter were in the hospital for a current attempt. Almost 60% had engaged in substance abuse at some point in their lives. The combination of continued substance abuse and suicidal behavior could result in an early death for some women. Implications for treatment and future research are discussed.*

Keywords: Women, substance abuse, suicidal behavior

This study examined the prevalence of substance abuse and suicidal behavior among women in late young adulthood. To date, this population of women has received limited attention (van Wormer, 1999). According to the 1994 report on the treatment of women who abuse alcohol and other drugs, little is known about women who abuse substances because resources for substance abuse research and treatment focus more on men (Center for Substance Abuse Treatment, 1994; Uziel-Miller, Lyons, Kissiel & Love, 1998). There is a need to expand the focus of substance abuse to include women due to the increased acceptance of alcohol and other drug use and/or abuse in young women, plus a lack of accurate diagnosis and reporting of substance abuse in this group (Uziel-Miller et al., 1998). Substance abuse has been linked to suicidal behavior in young women. The actual incidence is hard to identify because many attempts go unreported and many women do not seek treatment for an attempt (Crosby, Cheltenham & Sacks, 1999). Compared to males, females attempt suicide and report suicide ideation more often (Canetto & Sakinofsky, 1998) and, according to the 1990 National Institute on Alcoholism, female alcoholics complete suicide more frequently than male alcoholics (van Wormer, 1999).

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Previous studies on substance abuse and suicidal behaviors have included women of all ages (12 years to 80+ years) in the samples (Osgood & Manetta, 1998; Substance Abuse and Mental Health Services Administration, 1999). Some researchers believe that women undergo changes as they age, and there is a difference in life experiences in the 20s, 30s, 40s, and beyond (Bee, 2000). The current study adds to this knowledge base by providing information on women in a distinct age group—30 to 39 years.

ALCOHOL, DRUG ABUSE, PSYCHIATRIC ILLNESS, AND SUICIDE

Substance abuse encompasses both alcohol and other drug abuse. An estimated 12 million women consume alcohol (Center for Substance Abuse Treatment, 1994). Reporting on the 1992 National Household Survey on Drug Abuse and the 1992 National Household Survey, the Center for Substance Abuse Treatment (1994) stated that 14.5% of women under age 35 consumed alcohol once a week compared with 10.9% of women over age 35. Alcohol abuse occurs more frequently than other drug abuse (Rogers, 1997). The 1992 National Household Survey on Drug Abuse found that 4.4 million women had used illegal drugs and 1.3 million women had used psychotherapeutic drugs for non-medical reasons in the one-month period prior to the study (Substance Abuse and Mental Health Services Administration, 1993). An astounding estimated 80% of young adults have tried at least one illegal drug (Rogers, 1997). Illicit drug use is highest in the late teens, peaks in the mid-20s, and declines thereafter (Kandel & Raveis, 1997).

Alcohol and drug abuse are factors in psychiatric illness. Some women who seek substance abuse and mental health services often receive dual diagnosis. Approximately three out of 10, or 30% of women with a psychiatric illness, have been treated at some point in their lives for a substance abuse problem (Center for Substance Abuse Treatment, 1994). Depression is often masked by substance abuse (Jarvis & Copeland, 1997). An estimated seven million women in the United States suffer from clinical depression (Norman & Lowery, 1995). Studies have shown that the frequencies of women with dual diagnoses of substance abuse and psychiatric problems range between 56% and 92% (Haver, 1997).

A link between substance abuse and suicidal behavior has been identified by other researchers (Brabant, Forsyth & LeBlanc, 1997; Haver, 1997; Jarvis & Copeland, 1997). In their study of 298 alcoholic patients, Roy, Lamparski, DeJong, Moore & Linnoila (1990) reported that 30% of the 85 alcoholic women studied had attempted suicide. There was no difference in the ages (young vs. old) of the women who attempted suicide. In addition, women who attempted suicide reported a greater daily average intake of alcohol than did non-attempters. Well over half (62%) of these women also met the criteria for a diagnosis of major depression.

Abusing substances is a way of numbing psychic pain; suicide is a way to relieve the pain forever. Many young women engage in both practices. Using alcohol before suicide or a suicide attempt is a common practice. According to the Harvard Mental Health Newsletter (1996), alcohol is involved in almost half of completed suicides. Nielsen, Stenager and Brake (1993) reported 44% of the women in their study had consumed alcohol either before or during a suicide

attempt. Women who attempt suicide are likely to make subsequent attempts and are at high risk for eventually killing themselves (Suokas & Lonnqvist, 1991).

Following the premise that substance abuse declines as women enter the latter part of young adulthood (Kandel & Raveis, 1997; Substance Abuse and Mental Health Services Administration, 1999) and suicide gradually increases across the lifespan (Canetto & Sakinofsky, 1998), we focused on women between the ages of 30 and 39 years. In this study, we report on chart review of 113 women discharged after inpatient psychiatric treatment. We followed a descriptive cross-sectional survey design by providing demographic information and information on the prevalence of alcohol and other drug abuse and suicidal behavior. The research questions addressed were:

(1) Is there a positive association between alcohol abuse and suicidal attempts in women 30 to 39 years of age who were treated on an inpatient basis for psychiatric problems?

(2) Is there a positive association between other drug abuse and suicidal attempts in women aged 30 to 39 years of age treated on an inpatient basis for psychiatric problems?

STUDY METHODOLOGY

Data for this study were gathered at one medical hospital and two state psychiatric facilities in Central Virginia. Criteria for inclusion in the study were (l) discharged patient, (2) female, (3) 30 years of age or older, and (4) admitting diagnosis of one of the depressive disorders, substance use disorder, or substance abuse disorder. Hospital staff used a computer to randomly generate 364 charts from their enumerated charts that met the above criteria during the period October 1994 to October 1996. The total sample included women 30 to 85 years of age (see Manetta, 1997 for a complete description of the sample). The findings reported here are based on a sub-sample of the 113 women who were aged 30 to 39 years.

The methodology consisted of a chart review by a trained research team. The team recorded information from patient charts on a standardized coding instrument. The team was instructed to record information only when it was specifically listed in the patient chart. Inter-rater reliability was 100%. This high rate of inter-rater reliability was attributed to the amount of training the team received (six hours to review 10 charts) and the specificity of the information to be recorded. Demographic information, information on past and current alcohol or other drug abuse, age at first use, and information on past and current suicidal behaviors was generated for each subject.

Current alcohol abuse was defined as being present when the attending physician recorded a primary or secondary DSM-IV diagnosis of alcohol abuse in the chart. Past alcohol abuse was determined by specific notes on the chart referring to a past diagnosis of alcohol abuse, alcohol abuse disorder, or specific notations in the chart of past “alcohol problems.” The variable, alcohol abuse, included any past or current alcohol abuse recorded in the chart.

Other drug abuse refers to any psychoactive drug (e.g., over the counter drugs, street drugs, and prescribed drugs). Current other drug abuse was determined to

be present when the attending physician recorded a primary or secondary DSM-IV diagnosis of substance use disorder or substance abuse disorder in the chart. Other past drug abuse was also determined by recording specific chart notations that listed other drug abuse. Other drug abuse was defined as any current or past DSM-IV diagnosis of substance disorder/abuse.

Current suicide and past suicide attempts were defined as any act or repetitive acts deliberately directed toward the self that resulted in physical harm or tissue damage and/or which were attempts to bring about a premature end of life. Suicide attempt(s) were recorded when the behavior was specifically identified in the patient's charts. The only missing data was for marital status. The available marital status data, however, was used to provide demographic information only and not for any of the other analysis.

The demographic data for the 113 women who had alcohol and/or other drug abuse and/or suicide attempt(s) showed the mean age of the sample was 34.6 years, with a range from 30 to 39 years. The women had an average of 12 years of education. The majority of women were separated or divorced (Table 1). A little more than half of the sample was Caucasian-American and slightly less than half were African-American. The majority of respondents (79.6%) did not list their religious preference. The preferences that respondents noted were Baptist (9.7%), Catholic (3.5%), and other (7.1%). Due to the sizable degree of missing information, religious preference was not analyzed as a variable.

Table 1: *Demographic Information on Women Aged 30 to 39 Years (N=113)*

Characteristic	***n***	**%**
Marital status[a]		
Married	24	22.0
Separated/divorced	49	45.0
Widowed	2	1.8
Single	34	31.2
Ethnicity		
Caucasian-American	61	54.0
African-American	52	46.0

NOTE: [a]contained four cases with missing data.

FINDINGS

To describe the prevalence of substance abuse and suicidal behavior we conducted frequency tests using the Statistical Program for the Social Sciences (SPSS).

Of the 113 women, 30.1% (n=34) currently abused alcohol and 44.2%(n=50) currently abused other drugs (Table 2). More than half (59.3%, n=67) abused alcohol and/or other drugs at some point in their lives. The average age that women reported first consuming alcohol was 18 years. Other drug abuse began slightly later, and the average age for first using other drugs was 20 years. The type of drug abused was listed for 31 women and the drug of choice these women identified

was cocaine (68%, n=21). Thirteen percent (n=4) identified abusing prescription drugs.

Suicide ideation was present in 56.6% (n=64) of the women at the time of their hospitalization. The ideation information was collapsed into one variable to show those who had never had any suicide ideation, those who experienced ideation at one point in time (either in the past or currently), and those who experienced ideation at two points in time (past and currently). Almost half of the women had experienced suicidal ideation at two points in time (44.2%, n=50).

Less than half of the women had attempted suicide at some point in their lives (46.9%, n=53) and 23.0% (n=26) were in the hospital for a current suicide attempt.

Table 2: *Suicidal Behavior and Substance Abuse of Women Aged 30 to 39 Years*

	Yes		No	
	N	**%**	***n***	**%**
Suicide Issues				
In Hospital for Current Attempt	26	23.0	87	77.0
Past Attempts	53	46.9	60	53.1
Current Ideation	64	56.6	49	43.4
Past Ideation	65	57.5	48	42.5
Combined Attempts and Ideation	79	69.9	34	30.1
Substance Abuse				
Current Alcohol Abuse	34	30.1	79	69.9
Past Alcohol Abuse	45	39.8	68	60.2
Current Drug Abuse	50	44.2	63	55.8
Past Other Drugs	50	44.2	63	55.8
Combined Alcohol and Drug Abuse	67	59.3	46	40.7

To answer our first question, "Is there a positive association between alcohol abuse and suicidal attempts in women 30 to 39 years of age who were treated on an inpatient basis for psychiatric problems?" we used a chi-square test of independence. The alpha level for the chi-square was set at .10. Table 3 shows a statistically significant association between current alcohol abuse and whether there was a current suicide attempt ($X^2(1)=3.5$, $p \leq .05$). However, contrary to our research question, the statistically significant association was in the opposite direction. More women who did not attempt suicide abused alcohol (34.5%) than those who attempted suicide (15.4%).

To answer our second question, "Is there a positive association between other drug abuse and suicidal attempts in women aged 30 to 39 years of age who were treated on an inpatient basis for psychiatric problems?" we used a chi-square test of independence. The alpha level for the chi-square was set at .10. We found that there was a statistically significant association for current other drug abuse and whether there was a current suicide attempt ($X^2(1)=2.5$, $p \leq .08$). The statistically significant association was in the opposite direction than we had suggested in our research question. The association showed there was not a positive association between current other drug abuse and current suicidal attempts. Abuse of other drugs was more frequent among women who did not attempt suicide (48.3%) than it was among women who did attempt suicide (30.8%) (Table 4).

Table 3: *Current Alcohol Abuse and Current Suicide Attempt for Women Ages 30 to 39 Years*

	Current Suicide Attempt		
Current Alcohol Abuse	**No (87)**	**Yes (26)**	**X^2**
No (*n*=79)	57 (65.5%)	22 (84.6%)	
Yes (*n*=34)	30 (34.5%)	4 (15.4%)	3.5*

*p<.05

Table 4: *Current Other Drug Abuse and Current Suicide Attempt for Women Ages 30 to 39 Years*

	Current Suicide Attempt		
Current Alcohol Abuse	**No (87)**	**Yes (26)**	**X^2**
No (*n*=63)	45 (51.7%)	18 (69.2%)	
Yes (*n*=50)	42 (48.3%)	8 (30.8%)	2.5*

*p<.08

DISCUSSION

Many factors contribute to suicidal behavior in young women. We have examined the frequency of substance abuse and suicidal behavior only. While the majority of the women who engaged in alcohol and other drug abuse were not currently in the hospital for a suicide attempt, many of them had attempted suicide in the past. Though the current risk of substance abuse and suicidal behavior may be small, the lifetime risk is much larger, and some of these women are a vulnerable population based on their continued abuse of substances and their combined past and current suicidal behaviors.

Unfortunately, it is not abnormal to find higher rates of substance abuse among women in this age group. Their exposure to risk could be explained by the cohort era. The women were born at a time of changing social values that contributed to the increase in substance abuse (Harrison, 1989). At the time when the average subject in the current study began using illegal drugs (roughly 1985), almost 40% of young Americans had used some type of illicit drug (Mathias, 1996). Although the frequency of illicit drug use was high in the 1980s, reports also indicate that most illicit drug abuse was declining at that time (Rogers, 1997). It appears that some of the women studied were part of that decline. Nearly 50% of the women in our sample began using illicit drugs before age 23, and the rate declined to 39% of those who continued to abuse drugs at the time of this study. These women had engaged in illicit drug use for 12 to 21 years. We were not able to determine why substance use continued because our sample was selected by a chart review of discharged psychiatric patients and lacked information that may have been available had it been selected from a substance abuse population.

Substances are often used to mask depression. Fortunately, patients with co-occurring psychiatric and substance abuse problems are likely to have their sub-

stance abuse problems treated (Depression Guideline Panel, 1993) in order to make an accurate psychiatric diagnosis (Weiss, Griffin & Mirin, 1992). The psychiatric diagnosis most often associated with suicidal behavior is depression (Cohen, Lavell, Rich & Bromet, 1994). Treating substance abuse, then making a psychiatric diagnosis would be helpful to the women in our study. Once their alcohol abuse is under control, their psychiatric problems can be addressed. However, as pointed out previously, women often abuse prescription medications and the alcohol abuse could be replaced by abuse of psychotropic medications. We can speculate that this may have occurred because, in our study, we found that over time, alcohol abuse had declined but other drug abuse had remained the same. Thus, we did not support the findings that alcohol abuse is more prevalent than other drug abuse that other researchers have reported (Rogers, 1997). The length of time substances were abused, however, was consistent with other studies that report current substance abuse in dually diagnosed patients of long duration (Dixon, McNary & Lehman, 1998). Others have reported that alcohol abuse/use is present in some women who engage in suicidal behaviors. Our findings were congruent with theirs (Haver, 1997; Jarvis & Copeland, 1997; Osgood & Manetta, 1998). In this study, we found that young women who abused alcohol and/or other drugs were less likely to attempt suicide compared to young women who did not abuse alcohol and/or other drugs. Based on the limited research available on this population, we were surprised at these findings. It is possible for young women to use alcohol and/or other drugs to self-medicate for depression and, therefore, they are less likely to engage in suicidal behaviors.

This was not a longitudinal study. It is possible that self-medicating with alcohol and/or other drugs is one way to combat depression in the younger years; however, as these women grown older, the alcohol and other drugs could actually become a contributing factor in later suicidal behavior. When we looked at older women from this sample, we found a positive relationship between abusing alcohol and suicidal behavior and abusing other drugs and suicidal behavior (Osgood & Manetta, 1998). Another possible explanation for the current findings is that some young women, in spite of their alcohol and drug abuse, do not turn to suicide because they have other internal or external factors that allow them to be resilient.

Treatment Implications

Treatment modalities for combined substance abuse problems and psychiatric problems, including suicidal behaviors, are scarce (Cornelius, Salloum, Lynch, Clark & Mann, 2001). Therefore, treatment should be based on the combined known indicators of each diagnosis. It is known that the intent to kill oneself rises with each suicide attempt and depression is often present before and after the attempt (Hamdi, Amin & Mattar, 1991). In addition, many women claim depression is a trigger for their drug abuse (Griffin, Weiss & Mirin, 1989). If a woman seeks treatment for depression and suicidal behavior and her substance abuse is not revealed, she may be given psychotherapeutic medications to treat the depression. When combined with alcohol or other illicit drugs, these medications can create a lethal cocktail. Also, many psychotherapeutic drugs are addictive

and, if the underlying causes are not treated, a cycle of drug abuse and suicidal behavior often occurs. It is essential that clinicians working with young women provide concurrent treatment for both substance abuse problems and psychiatric problems. Furthermore, a longer length of time is needed to treat dually diagnosed women than the short time used to treat women diagnosed with substance abuse only (Center for Substance Abuse Treatment, 1994). Thus, the current cost saving measures of brief therapy will not work as well with this population.

CONCLUSION

In this study, we have provided additional information to bolster the scant knowledge that exists on dually diagnosed women. Substance abuse is present in many suicidal attempts and completed suicides. People who eventually complete suicide have often made a previous suicide attempt. For women, the chance of completing suicide increases with age. In this research, we have identified the prevalence of substance abuse in women in the late part of young adulthood; and we have identified the fact that more than half of these women have engaged in suicidal behavior at some time in their lives. We have suggested treatment implications for professionals who provide services to the women.

This study has some limitations. First, data were gathered by chart review. Chart review is an acceptable data source and is often used when availability to subjects is limited (Carmen, Rieker & Mills, 1984). Second, information may have been missing from the charts. Nevertheless, the information in the charts was originally compiled for treatment purposes, thus, the researchers relied on the professionals at the psychiatric facilities to obtain a comprehensive history of the problems being treated. Third, most of the information was self-reported by patients and selective information may have been given. Providing selective information that portrays people as having desirable social qualities is a limitation in many survey research studies. The women in this study had been in a psychiatric facility; consequently, they were already outside of the norms of social behavior. Therefore, we believed the threat to internal validity of obtaining selective information was low. Finally, cross-sectional research focuses on what exists at one point in time and, thereby, limits the generalizability of the results. The reader needs to be aware that this research is only generalizable to the population studied. Nonetheless, only limited information on substance abuse and suicidal behavior in young women is currently available; and the available information tends to include both genders in the results. Thus, the exclusive focus on young women in this study adds valuable information to the knowledge base of professional helpers.

There is a need for future studies. A longitudinal study on women with suicidal behavior and substance abuse could describe the behaviors that occur as these women reach different ages. Other studies are needed to identify factors that underlie substance abuse and suicidal behaviors among women of various ages. Women undergo diverse life events, have dissimilar perspectives toward life, and have different coping skills at different ages. It is only by teasing out the differences in the factors that contribute to suicidal behavior and/or substance abuse that we can begin to understand and build the knowledge base necessary to

describe incremental age differences between substance abuse and suicidal behaviors of women. Therefore, future examinations of this age group could focus on particular resiliency factors that protect this vulnerable population of women from suicidal behavior.

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