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EDITORIAL – Social Work Values in *Perspectives on Social Work*

Social work is a broad field with social workers across the globe engaging diverse populations in a variety of settings. The scope of *Perspectives on Social Work* reflects this spectrum by accepting a variety of submissions covering a myriad of topics in social work. We ask only that submissions encompass social work values and ethical principles. As in the social work profession itself, the values of social work create a common thread for the papers we feature in our journal.

The Perspectives on Social Work Editorial Board was proud to host the second annual PhD student “Meet and Greet” during the November 2018 CSWE Annual Program Meeting in Orlando, Florida. Our signature networking event was held at Rix’s Sports Bar and open to our peer reviewer network. We were excited that our gathering doubled in size from its first year with doctoral students in attendance from Fordham University, Howard University, Norfolk State, The Catholic University of America, The Ohio State University, University of Toronto, and Virginia Commonwealth University. We look forward to hosting future events like this!

In this issue, the authors tackle complex challenges central to the core competencies identified by the CSWE. They touch on new and innovative topics that push us to think intentionally about both our educational approaches to training social workers as well our efforts to practice in ways that address the diverse issues present in contemporary culture. Christine Bishop and Sara Alamdari (2019) analyzed quantitative data from of the Children of Immigrants Longitudinal Study to closely look at an identified set of variables and its association with depression for Latino children of immigrants¹. Ami Goulden (2019) offers a review of the dominant epistemologies attached to models of disability by using an authentic case vignette from her social work practice². Rachael Richter (2019) uses the Grand Challenges for Social Work Initiative to develop and describe a creative graduate social work assignment designed to generate student enthusiasm for policy advocacy practice³. Josselyn Sheer (2019) interests is in recent literature specific to shame in adolescents and explored ways in which social work practitioners understand and treat shame during the “identity versus role confusion” stage of development⁴. Wenocour et al., (2019) concludes this journal issue by building a case for the recognition of the beneficial nature of the human-animal bond and support for clients who seek animal companionship.⁵ We are excited to present the work of PhD students who are well on their way to becoming scholars who will contribute greatly to the profession.

Kenya R. Minott
Editor in Chief

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The impact of paternal involvement and United States stay length on Latino youth's depressive symptoms

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Abstract

Latino youth in the United States are more at-risk for depression than youth of other ethnic backgrounds. This manuscript assesses the impacts of sex, age, United States stay length, and whether or not Latino children of immigrants' fathers live with them on the youth's depressive symptoms. For this purpose, data of the Children of Immigrants Longitudinal Study was used. Using multiple regression analysis, the relationships among the aforementioned factors were examined among 1305 immigrant youth who were born in Latin America and Caribbean countries. The results of the study indicated that being male, living with one's father and longer stay in the United States are significantly associated with less depression for Latino children of immigrants. The implications of the study can be applied to multiple settings including youth's homes, social service agencies, and personnel who work with depressed populations. Raising awareness among immigrant parents, training mental health and social service providers, and developing culturally sensitive interventions were recommended. Although this study is a significant and timely topic, using data that are more recent could be more beneficial.

Keywords: Adaptation, culturally-sensitive intervention, depression, immigrants, Latinos, mental health, paternal involvement.

Introduction

Latinos, persons “of Latin American origin or descent” (English Oxford Living Dictionaries, 2018), are reported to be the largest growing minority population in the United States (U.S.) (Prelow, Loukas & Jordan-Green, 2007; Terriquez, 2013). The literature surrounding this population collectively refers to these individuals as both “Hispanic” and “Latino”, and often does not clarify the differences between the two. The researchers refer to the participants of this study as “Latino”, due to ethnic origin being their main associative factor. In addition, since male and female people of Latin American origin or descent are referred to collectively in this work, the term of Latino is used throughout the paper.

Over 25% of the U.S. population is expected to consist of Latinos by 2060 (Umaña-Taylor & Updegraff, 2007). The average age of Latinos living in the U.S. is 27 years-old, and the population, as a whole, is younger than the African-Americans, Asians, and European-Americans living in the U.S. (Pew Hispanic Center, 2009). A high proportion of Latinos in the U.S. are school-aged youth (Zychinski & Polo, 2012). This indicates the importance of studies for Latino youth. These youth often experience difficulties with regard to transition that may affect their mental and physical well-being (Cobb, Xie, Meca, & Schwartz, 2017; Jagers & MacNeil, 2015). For example, facing exploitation, having limited income, and fearing deportation are some of the common difficulties that these immigrants experience (Cobb et al., 2017). Social work’s obligations in terms of service and social justice (National Association of Social Work, 2008) commit social workers to work toward Latino youth’s well-being through practice and research.

Literature Review

Adolescence and Depression

Aside from undergoing pressures from adapting, depression is common during adolescence, especially among Latinos (Ford-Paz, Reinhard, Kuebbeler, Contreras, & Sánchez, 2013; Kassis, Artz, & White, 2017; Santos et al., 2017). Part of the reason for the population’s experiences with depression is due to underutilization of mental health services (Ford-Paz et al., 2013; Santos et al., 2017). Differences in language, communication patterns, and the lack of insurance are some main reasons for this underutilization of services (Bledsoe, 2008). The stage of adolescence consists of many internal and external changes that youth must undergo (Zeiders, Umaña-Taylor, & Derlan, 2012). Due to the difficult transitions that often occur during adolescence, depressive symptoms can be heightened for youth during this stage (Cicchetti, Rogosch, & Toth, 1994; Mruk, 2006; Zeiders et al., 2012). According to the National Institutes of Health (NIH), in 2015, 12.5% of the U.S. adolescents aged 12 to 17 experienced at least one major depressive episode in the past 12 months (NIH, 2017). It is noteworthy that adolescent Latinos are at a higher risk for depression than adolescents from other ethnic groups (Ford-Paz et al., 2015).

Factors Influencing Depressive Symptoms

Many factors may contribute to why adolescent Latinos are at a higher risk of depression than youth from other ethnic groups. The factors may include lack of parental involvement, English language barriers, no access to health insurance, which is associated with lower access to mental health services (Carson, Stewart, Lin, & Alegria, 2011), a cultural stigma of seeking mental health care amongst the Latino community, and parents who are not able to recognize depressive symptoms (Ford-Paz et al., 2015; Potochnick, & Perreira, 2010). Further, there are some fundamental factors, which are not specific to any ethnic group, such as age, sex and length of stay in the new community (Miglietta, & Tartaglia, 2009; NIH, 2017). The researchers of this study decided to examine a few of these factors including age, sex, length of stay in the new country and paternal involvement in regard to depressive symptoms.

Sex. According to a 2015 national survey of adolescents, NIH reported greater prevalence of major depressive episodes among females (NIH, 2017). Similarly, in a study of Hispanic youth in the U.S., Lorenzo-Blanco, Unger, Baezconde-Garbanati, Ritt-Olson, and Soto (2012) found a higher rate of depression among girls. Therefore, this factor is critical to be examined.

Length of stay in the new country. The notion of needing to adapt to one's new environment and culture is associated with the process of immigration. Adapting to life after immigration is typically stressful (Jagers & MacNeil, 2015). For a Latino youth who has moved to a new country and/or continent, immigrating and adapting to a new language, school, community, etc. could inevitably be difficult transitions to be forced to withstand (Berry, Kim, Minde, & Mok, 1987). As the length of stay in a new country increases, newcomers get adapted to the host community, and therefore, their experienced stresses decrease (Miglietta & Tartaglia, 2009). In this case, looking at the length of stay in a host country can be an important factor to consider.

Paternal involvement. Parenting is a factor that can significantly affect a youth's depressive symptoms and later outcomes (Campos, 2008; Jeynes, 2003; Kassis et al., 2017; Martinez, DeGarmo, & Eddy, 2004). Parents can have a substantial impact on youth's mental health and well-being, and decrease children's level of risk (Kassis et al., 2017; Teel et al., 2016). It is reported that immigrant children's level of parental involvement can largely influence these children's future success (Behnke, Taylor, & Parra-Cardona, 2008). *Familismo* is a culturally-relevant term that refers to family being placed at the center of one's life (Glass & Owen, 2010). For Latinos, in particular, family is viewed with more significance, and family members are seen as more of a provider of guidance for Latino youth than youth of other ethnic backgrounds (Suárez, 1995). Positive, consistent parental involvement serves as an asset to youth's development, and their future life trajectories, especially for minority youth, who are low-income (Brent & Behnke, 2005; Jeynes, 2003; Martinez et al., 2004).

Unfortunately, the number of children who live in single-parent homes is an increasing trend (Goldscheider, Scott, Lilja, & Bronte-Tinkew, 2015; Teel et al., 2016). In 2010, the majority, around 85% of single parents were mothers (Goldscheider et al., 2015). This number made the researchers interested in studying children with no father present. Single-parenthood affects mothers in many ways, including higher rates of poverty and a lower perception of support from loved ones (Kramer, Myhra, Zuiker, & Bauer, 2016; Teel et al., 2016). Unsurprisingly, stress levels are often higher

among single mothers, which affect the children's well-being in a negative way (Daryanani, Hamilton, Abramson, & Alloy, 2016; Teel et al., 2016). Fathers' involvement, in particular, can improve youth's emotional and social-behavioral development (Allport et al., 2018; Teel et al., 2016). Fathers benefit from their involvement in their children's lives; in particular, less depression and substance abuse, as well as improved self-confidence are examples of these benefits (Allport et al., 2018).

Taking into account the value and importance of the concept of "family" in Latino households (Fischer, Harvey, & Driscoll, 2009), if Latino youth's fathers are not living in the home, it would likely be difficult for these youth to live up to their potential well-being (Crean, 2008). Typically, the parenting roles of White, American fathers are emphasized the most in relevant literature (Cabrera & Garcia-Coll, 2004). There is currently a gap in available literature regarding the impacts of parenting roles of Latino immigrant fathers on Latino youth living in the U.S., indicating a need to further examine this topic.

To address this gap, the purpose of the current study is to examine whether fathers living with Latino youth predicts the youth's depressive symptoms. Other factors (i.e., age, sex and length of stay in the U.S.) are also considered to achieve a better understanding of depression's predictors among this group. The hypothesis of the study is that being younger, being female, not living with one's father, and shorter length of stay in the U.S. will predict higher degrees of depressive symptoms among Latino youth.

Method

Data

The data for this study originates from the Children of Immigrants Longitudinal Study (CILS) (Portes & Rumbaut, 1991-2006). CILS was conducted to evaluate the adaptation process of children of immigrants. That is, children who were born in the U.S., but at least one of the parents is an immigrant, or the children who immigrated into the U.S. in early childhood (Portes & Rumbaut, 1991-2006) were included. This study was conducted at three separate points of time. The sample was recruited from students in public or private schools in Miami, Florida, Ft. Lauderdale, Florida, and San Diego, California. The parents of the respondents were from 77 different nationalities. The first survey was in 1992, and had 5,262 respondents recruited from grades 8 and 9. The survey was regarding baseline information about children of immigrants and their family, such as their grade level, their parents' arrival year to the U.S., the total number of members living in their households, academic-related test scores, and information regarding their mental health (Portes & Rumbaut, 1991-2006).

Three years later, the second survey (first follow-up) was conducted on the evolution of key adaptation outcomes, such as ethnic identity, self-esteem, and language. There were 4,288 participants overall. Nearly 1,000 respondents from the first survey were not available. Concurrently, 2,442 parents were surveyed through a parental survey regarding the characteristics of the immigrants' parents. This survey was translated to six languages (Portes & Rumbaut, 1991-2006). The final survey was implemented one decade after the first survey. In this final follow-up, 3,613 people participated. This survey focused on patterns of adaptation in early adulthood, including educational attainment, employment, occupational status, income, civil status, political

attitudes, and participation. Mailed questionnaires were the principal source of data in the third survey (Portes & Rumbaut, 1991-2006).

Sample and Selection

For the purpose of this study, the researchers used the first wave of the CILS. To choose the sample, one inclusion criterion was used. Participants who were born in Latin America and Caribbean countries were considered. The countries included were Mexico, El Salvador, Cuba, Dominican Republic, Belize, Costa Rica, Guatemala, Honduras, Nicaragua, Panama, Argentina, Bolivia, Columbia, Ecuador, Guyana, Peru, Uruguay, Venezuela, Puerto Rico, Chile and Brazil. Using this inclusion criterion, a total number of 1305 of respondents were examined. These countries are considered Latin America and Spanish is the primary language.

Independent Variables

Four variables including respondent's sex, age, length of stay in the U.S. and whether the family's father was living in the household were considered as independent variables. Age was measured using an open-ended question in an interval level. Sex was measured with one question with two options of male (code=0) or female (code=1). Length of stay in the US was measured with a question with four response choices. Responses were "all my life" (code=1), "ten years or more" (code=2), "five to nine years" (code=3), and "less than five years" (code=4). This variable was treated as a continuous form of measurement. Whether or not participants' fathers lived with them was a fourth independent variable in this study with a categorical form of measurement. This variable was recoded into a dichotomous variable. The initial response options for the variable consisted of three options of dead/unknown, no and yes. No and dead/unknown options were combined as code 0, meaning the respondent did not live with the father. The other option was coded 1, indicating the respondent lived with the father.

Dependent Variable

Four items were combined to create a "depressive symptoms" dependent variable. The items were: "felt sad past week", "could not get going past week", "did not feel like eating past week", and "I felt depressed past week". The CILS derived these four variables from the Center for Epidemiologic Studies Depression Scale (CES-D) to examine depressive symptoms among the target population (Portes & Rumbaut, 1991-2006). These are the only items used for this purpose in the CILS study. Although Portes and Rumbaut (1991-2006) did not use all the items of the CES-D, the researchers of the current study consulted with several colleagues, who are experts in the field of mental health, and confirmed face and content validity of these items. Cronbach alpha for these items were 0.74, which indicated strong internal consistency. Since these four items were all measured via the same type of four-point Likert scale (codes of 1 to 4), they could be combined together to create a new variable. Thus, the possible range for depressive symptoms variable was between 4 and 16, in which the greater numbers presented higher depressive symptoms.

Statistical Analysis

Multiple regression analysis was an appropriate statistical test for examining the effects of multiple independent variables on a dependent variable when the dependent variable is measured on a continuous level (Gravetter & Wallnau, 2016; Hinkle, Wiersma, & Jurs, 2003). To conduct this test, the assumptions for independence of observations, linearity, multicollinearity, and normality (Kurtosis= 1.22; Skewness=1.18) (Gravetter & Wallnau, 2016; Hinkle et al., 2003) were met. However, the scatterplot indicated the assumption of homoscedasticity (Gravetter & Wallnau,

2016) was not met. No statistical correction was performed to address this assumption, indicating the results need to be interpreted with caution.

Findings

The sample ($N=1305$) consisted of 48.4% males ($N=631$) and 51.6% females ($N=674$). The mean for respondents' age was 14.14 ($N=1305$, $SD=0.86$, $Max=17$, $Min=12$). On average, respondent's U.S. stay length was 2.52 ($N=1304$, $SD=0.70$). The mean of 2.52 indicates that the respondents' average length of stay was around 5 years or more. Among the 1294 who responded to the question regarding if their father lives with them, 34.2% ($N=443$) did not live with their father, whereas, 65.8% of respondents ($N=851$) reported that they lived with their father. The mean of the dependent variable, depressive symptoms was 6.67 ($N=1277$, $SD=2.60$). The descriptive statistics for the dependent and independent variables can be found in Table 1 below.

Table 1

<i>Descriptive Statistics for Dependent and Independent Variables</i>				
Variables		<i>N</i>	<i>M</i>	<i>SD</i>
Depressive symptoms		---	6.67	2.60
Gender	Male	631 (48.4%)	---	---
	Female	674 (51.6%)	---	---
Age		---	14.41	0.86
Length of stay		---	2.52	0.70
Father living with participant	No/dead/unknown	443 (34.2%)	—	—
	Yes	851 (65.8%)	—	—

The regression model was significant ($F=31.04$, $p=0.00$, $R^2=0.09$). R-squared indicated the regression model explains 9% of the variance in the dependent variable by the independent variables. Sex ($B=1.36$, $p=0.00$, $SE=0.14$), the length of stay in the U.S. ($B=0.28$, $p=0.01$, $SE=0.10$) and whether father is living with participant ($B=-0.60$, $p=0.00$, $SE=0.15$) were significant predictors of depressive symptoms. However, age ($B=0.15$, $p=0.07>0.05$, $SE=0.08$) was not a significant factor. Interpretation of significant factors is as follows. Males were less likely to be depressed than females. There was a 1.36 unit increase in depression for females, as compared to males. Participants whose fathers lived in the home were less likely to be depressed than participants whose fathers did not live in the home. There was 0.60 unit decrease in depression for participants whose fathers lived with them. Finally, as the time in the U.S. increased, there was 0.28 unit decrease in participant's depressive symptoms. The unstandardized and standardized coefficients and significance values can be found in Table 2 below.

Table 2

<i>Unstandardized and Standardized Coefficients and Significance Levels</i>				
Independent Variables	<i>B</i>	<i>SE B</i>	β	<i>P Value</i>
Sex	1.36	0.14	0.26	0.00
Age	0.15	0.08	0.05	0.07
Length of stay	0.28	0.10	0.07	0.01
Father living with participant	-0.60	0.15	-0.11	0.00

Discussion

This research was to examine potential predictors of depressive symptoms among Latino youth. The results showed that 9% of depressive symptoms is explained by respondents' sex, age, whether or not the respondents' fathers live with them, and length of stay in the US. The results indicated the significant impacts sex, length of stay in the U.S., and fathers living in the home with Latino youth can have on their depressive symptoms. These results were consistent with the existing literature. For example, being a girl was reported as a risk factor for depression in many studies (Hankin & Abramson, 2001; Lorenzo-Blanco et al., 2012; NIH, 2017). Examining the relationship between depression and acculturation among nearly 2,000 Hispanic youth living in Southern California, Lorenzo-Blanco et al. (2012) found stronger depression among girls than boys. In a national survey among adolescents, NIH (2017) reported greater prevalence of depression among females.

Likewise, time in the U.S. was reported as a critical predictor in immigrant youth's health status (Chilton et al., 2009; Potochnick & Perreira, 2010). Potochnick and Perreira (2010) studied about 300 first generation Latino youth in terms of anxiety and depression, and reported time in the U.S. as a protective factor. As the length of stay in the U.S. increased, Latino youth learned how to adapt to the new country, and therefore, their depressive symptoms declined (Potochnick & Perreira, 2010).

Further, consistent with our findings, some studies reported significant impact of family-related factors, such as family cohesion and conflict and single-parenthood on immigrant youth depressive symptoms (Beiser, Hou, Hyman, & Tousignant, 2002; Lorenzo-Blanco et al., 2012). Studying depression and acculturation among Hispanic adolescents in the U.S., Lorenzo-Blanco et al. (2012) recommended improving family functioning as a protective factor to youth's psychological well-being. As a particular family-related factor, father's involvement in Latino families was found as a positive factor not only in children's well-being, but also in their academic achievement (Campos, 2008; Jeynes, 2003; Martinez et al., 2004). Studying Mexican-American youth, Ramírez García, Manongdo, and Ozechowski (2014) indicated the significance of youth-reported paternal acceptance in depressive symptoms. These findings are consistent with our results, indicating the absence of a father in the family as a risk factor to depression.

This study's results could be useful for immigrants who are currently living in the U.S. Raising awareness and training immigrant parents about depressive symptoms and predictors is crucial (Yeh, 2003). These trainings can happen in different settings, including schools, mental health facilities, or social service agencies in order to improve parental empowerment and commitment (Jasis & Ordoñez-Jasis, 2012). Latino parents, especially single mothers, should be

trained about the fact that fathers' involvement with Latino youth can aid youth's depressive symptoms (Bacallo & Smokowski, 2007). This helps them be more cognizant of depressive symptoms youth might be exhibiting if their father does not live in the home, especially when the youth are female, and encourage fathers' involvement in an effort to mitigate the youth's depressive symptoms. By being aware of potential symptoms, single mothers could seek professional assistance for their child as a precautionary measure (Ortega, Rosenheck, Alegria, & Desai, 2000). In addition, by training fathers who do not live in the home with their Latino youth, they could become aware of the benefits of engagement, emotional support, and regular contact on their child's well-being (Marsiglia, Parsai, & Kulis, 2009).

Mental and behavioral health professionals who work for agencies that aim to aid Latino youth or families could use this study's findings to provide culturally-sensitive services (Garza & Watts, 2010). For example, if Latino fathers are not able or willing to be involved in their children's lives, the personnel of these agencies could help mothers with incorporating positive male role models and/or mentoring services into the youth's lives to serve as a buffer for the lack of paternal involvement (Saenz & Ponjuan, 2009). Further, social workers and professionals should be aware that females are more likely to experience depressive symptoms and place extra effort toward preventing or mitigating depressive symptoms for the Latino youth female population. Similarly, length of stay in the U.S. is a critical factor that mental health and social service agencies should consider during different phases of intervention (Kouyoumdjian, Zamboanga, & Hansen, 2003). For example, during initial assessment, service providers working with immigrant youth should include a question about the length of stay in the U.S. in their intake forms. In this scenario, if the length of stay is short, more preventive and maintenance attention is needed.

A limitation of this study is that the extent of the participants' relationships and the extent of contact with their fathers are not clear. For instance, some of the respondents' fathers could have not lived with them, but it is possible they still had regular contact with one another and/or saw each other regularly. In future studies, it is important to examine the extent of the relationships and contact with fathers. It is also notable that shifts in political, social and cultural context, since the time the data was gathered, limit the generalizability of the results. The dataset used in this study had data from three points of time. It could be beneficial to look at differences and changes across these three points, particularly if researchers take into account shifts in political and cultural contexts. This study is also limited because of examining only a few factors. For future studies, examining more potential factors, such as economic stress, coping strategies, and family, school and social support is recommended.

Conclusion

This study sought to examine the impact of sex, age, living with one's father, and time in the U.S. on depressive symptoms of Latino youth. Except age, other variables were found to be significant predictors of depression. Whether youth were living with their fathers was a factor insufficiently studied in the existing literature. Thus, the main contribution of this study was to examine this factor and provide implications in this case. Although this study is a significant and timely topic, using data that is more recent could be more beneficial. Similar studies can also be replicated for other immigrant youth groups with different regions of origin.

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The integration of self-determination theory: Supplementing preceding and future models of disability

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Abstract

Disability studies continues to grow as an emerging area of practice and theoretical research, branching out into sundry professions and frameworks. This expansion is leading to perpetual discussion of the more prominent individual (medical) and social models of disability as well as the development of more inconspicuous models. This paper reviews the dominant epistemologies attached to these models of disability with the support of an authentic case vignette from the author's social work practice. It is argued that the supplementation and immersion of self-determination theory in established and future models of disability will enhance the models' applicability to professional practice and better reflect the individual's self. The integration of self-determination theory to models of disability is presented in multiple diagrams.

Keywords: disability, epistemology, self-determination, social work, models of disability

Introduction

Disability studies has been an emerging area of research in Western European academia since the mid-1970s (Meekosha & Shuttleworth, 2009). Its dominant epistemologies and models originated from members of the disability community itself, highlighting its grassroots spirit. Disability scholars, who were often living with disabilities themselves, began to conceptualize and raise awareness of the lived experiences of persons living with disabilities (Ferguson & Nusbaum, 2012). Disability research raised predominant concerns within the disability community and naturally began to combine a common set of core ideas (Ferguson & Nusbaum, 2012). The existing focus of disability research appears to be weighted on opposite ends of a spectrum. On one end of the spectrum is medical research to "fix" bodily impairments, while on the other end is policy research to prompt greater accessibility to resources and services (Pfeiffer, 2001). These two spectrums are regularly defined as the individual (medical) model and the social model of disability (Oliver, 2004). Researchers often argue that the two models conflict with one another and as will be discussed, are conflictual in the research community. New models have been introduced in disability studies with partial success either to find a balance

between the two models or offer an alternative approach. Nonetheless, the adoption of alternate models has been sporadic and unpopular, until the introduction of Rosi Braidotti's (2013) critical posthumanism. Some disability scholars have suggested a link between disability and posthumanism, asserting disability as the quintessential example of the posthuman condition (Dolezal, 2017; Goodley, Lawthom, & Cole, 2014).

The goal of this paper is to further develop the discussion of alternate disability models between scholars and the disability community by considering the epistemological underpinnings for disability studies. I will do this by introducing a case vignette from social work practice that will inform discussion around the dominant individual (medical) and social models of disability from a historical perspective, new models that have appeared within the disability community, and self-determination as a complementary framework for all models. This paper is organized in five sections: (1) a case vignette, (2) a discussion of epistemological issues in disability research from a historical perspective, (3) the presentation of alternative perspectives in disability research, (4) the sharing of supplementary perspectives in disability studies, and (5) the coverage of future areas of research. The brief case vignette that is presented is from my own professional social work practice and is shared to assist in facilitating some examples within the paper.

Case Vignette

During my social work practice at a pediatric hospital, I worked with an individual named Jenn (age 13 years), whose name has been changed for anonymity purposes. Jenn and her mother were initially referred for social work support because Jenn wanted support regarding effective strategies for pain management and her mother desired help for coping with a conflictual divorce. I worked with Jenn and her mother for approximately two years and observed Jenn's needs growing over time. At our initial meeting, I learned about the strengths and complexities of this family. Over the two years that I worked with them Jenn dealt with several interdependent challenges in her familial environment and with her mental, biological, and social health. For example, her parents were in a conflictual divorce that required family court intervention. Jenn also disclosed a history of sexual abuse, which required further child welfare and police involvement. In addition, her bodily pain was intensifying. Jenn's illness went from a level of manageable pain with which she was still able to teach swimming lessons, to that of sporadic uncontrollable pain, where she required the use of a walker.

Jenn had approximately six medical specialists that she saw on a monthly to yearly basis, a multitude of allied health professionals, and her family physician. She also attended a yearly camp for children and youth with autoimmune conditions. The working diagnosis for her illness was fibromyalgia, but not all of her symptoms were consistent with that condition. After approximately one year, Jenn revealed to her mother that she was transgender (female to male), and wanted to be referred as Chris using the "he/him" pronoun. Although Chris' family and health professionals were supportive, his social health worsened. After being unable to continue going to his school, he ended up registering in a private school for children and youth with special needs. Even though this particular school was designed to welcome Chris regardless of present challenges, that is not always the case with educational institutions (Graham & Iannacci, 2013).

Chris' story is being shared because it highlights the complexity of people's needs. All Chris' needs were interdependent and connected—it was infeasible to separate them. The risk

with attempting to stratify them is the loss of some context and understanding of the whole picture. As I continue with this discussion, I will refer to Chris' case to ameliorate the connection between theory and practice.

Issues of Epistemology in Disability Research from a Historical Perspective

Individual (Medical) Model of Disability

McClimens (2003) asked, "how do we know anything about disability?" (p. 42). Perhaps we can take this question one step further and ask how we know disability exists? What we know and what we consider to be knowledge is always from a certain perspective and for a certain purpose (Fang Law & Ramos, 2017). Before something can be asserted about disability, we must abandon the notion that there is only one perspective and that it is not political. Can something be asserted about disability? From a positivist and postpositivist epistemology it can. Positivism was the dominant epistemological underpinning of disability research in Western Europe in the 1700s (Oliver, 2004). The positivist paradigm's ontological assumption is that there is one reality that can be observed and measured in an objective way (Chilsa, 2012). The positivist epistemology is referred to as both the individual and medical model of disability, and it replaced the moral/religious model in the Enlightenment Period (Bingham & Green, 2016). In both the moral and individual (medical) models, disability is associated with impairment or bodily difference (Bingham & Green, 2016). In the moral model, impairment was viewed as a moral failing or as the result of divine punishment for previous behaviour. The individual (medical) model shifted this perspective of impairment being a moral failing to a problem. This inspired medical professionals to diagnose and treat impairments in hopes of helping the individual to return or get as close to "normal" as possible. The individual (medical) model focuses on defining, grading, and categorizing conditions and impairments (Hughes, 2013).

In Chris' case, diagnosing and treating were the major focus of the medical work. As explained previously, his working diagnosis was fibromyalgia but that did not fit with all his symptoms. Regardless, there is currently no known cure for chronic pain conditions; however, medical professionals and his family were desperate to find a diagnosis, resulting in continued medical visits and tests. According to Oliver (2004), the medicalization of disability gives physicians power and leaves people with disabilities powerless. If individuals with disabilities are pathologized whereby the impairment is deemed to need fixing, the physician becomes regarded as an expert of the individual's body. This imbalance creates a dynamic between the physician and person with the disability that reflects power and powerless.

Social Model of Disability

In the early 1980s, Mike Oliver, a disability rights campaigner, individual, and scholar, introduced an alternate perspective to the individual (medical) model, which is currently referred to as the social model of disability. Oliver stated that the social model of disability is, "a switch away from focusing on the physical limitations of particular individuals to the way the physical and social environment impose limitations upon certain categories of people" (Oliver, 1981, p. 28). There are two key terms in the social model: (1) impairment, which is a long-term characteristic of an individual that affects their body, mind, or senses; and (2) disability, which is a result of exclusion because of the barriers society puts in the way (Hughes, 2013). For

example, the dominant discourse around being transgender was that it was a treatable disease, whereas now, there has been a shift through human rights initiatives to discredit that opinion and move toward embracing diversity and awareness (Robertson & Doyle-Jones, 2015). Nevertheless, transgender medical services still subscribe to the medical model. Medical professionals are persistent in wanting to identify, categorize, diagnose, and set eligibility criteria for sex reassignment surgery. In the past, some teens were psychiatrically hospitalized for treatment of gender identity disorder and made to wear dresses, even though wearing dresses is not necessarily a characteristic of being a woman (Pazos, 1999). This reflects how femaleness and femininity were constructed within that paradigm.

The social model of disability stems from a transformative paradigm, its purpose is to destroy myths and empower people to change society radically (Chilsa, 2012). Contrary to the positivist paradigm, an ontological assumption of the transformative paradigm is that multiple realities are shaped by human rights and disability values (Chilsa, 2012). The medical model is configured in such a way that it never fails. If the medical community does not have a remedy or solution for something, its logic is to invest more resources into researching and elucidating one. It does not reduce the value of medical intervention or treatment but instead strives to focus on developing or identifying solutions to the disadvantages or issues that many people experience (Hughes, 2013). Oliver's hope for the social model at the time of its introduction was that it would accurately reflect the experience of members of the disability community and inform political movements (Oliver, 1990). It was successful in that regard as the social model of disability was promoted in a range of training and organizations, played a role in the Disability Movement, and was adopted by the British Council of Organisations of Disabled People (BCODP) (Oliver, 2004).

Paradigm Shift in Disability Approaches

In 2006, the United Nations Human Rights Office of the High Commissioner adopted The Convention on the Rights of Persons with Disabilities to signal a paradigm shift from the traditional individual (medical) model approach to disability to one based on human rights (UNHR, 2018). The discourse began to focus on accessibility to education, employment, independent living, participation in community, and social justice (UNHR, 2018). Similarly, the World Health Organization's definition of limitation and disability are consistent with that in the social model as well, identifying disability as "a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives" (WHO, 2018, 1). The social work profession has also taken initiative to integrate disability within a critical and social justice lens. In 1993, The Canadian Association of Social Work Education (CASWE) founded the "Persons with Disabilities Caucus" to address the lack of social work education and research relating to persons with disabilities in Canadian social work programs (Carter, Hanes, & MacDonald, 2012). CASWE accreditation standards were eventually established from this initiative and disability was included as a guiding principle for accreditation of social work education programs within a diversity and social justice framework (CASWE, 2014).

These models of disability are applicable to Chris' situation. For example, he experienced inaccessibility to public education. He did not fit into the standardized education system and he required flexibility and accommodation. In addition, his classes were physically far apart, amplifying his pain when travelling to class, and he began failing his classes due to missed time because of medical appointments. Bullying was not an issue at his school and socialization at

school was a strength. However, due to the aforementioned barriers and constraints of the public-school system, his disability was reinforced. This example highlights how the setup of the structural system exacerbated Chris' disability, rather than his impairment.

Alternative Perspectives in Disability Research

Some scholars, along with Oliver, insist that diversity in disability models are strengthening and enriching (Levitt, 2017; Oliver, 1996; Smart & Smart, 2006). Multiple models can make a greater contribution to our understanding than a single perspective. Alternative models have been suggested but there appears to be apprehension in the literature regarding their adoption and application. Some of these models include the multifactorial perspective of disability (e.g., physiological, environment, social, cognitive, and emotional factors) (Johnston, 1997), the affirmative model (i.e. positive identity encompassing impairment) (Swain & French, 2000), the environmental model (Smart & Smart, 2006), and the Bolt model (i.e., the happiness-related model) (Bolt, 2015). One of the more recent suggestions is the active model, which focuses on the impact of the actions of disabled persons on disability itself (Levitt, 2017). These actions include both individual and collection actions.

There has been a lot of discussion about the social model and alternative models of disability (Oliver, 2013). Oliver published a commentary in 2013 titled "The Social Model of Disability: Thirty Years On" in *Disability & Society*, calling on researchers to either "reinvigorate the social model or replace it with something else" and pressed that the talking about them should stop (p. 1025). Most approaches to expand or reinvigorate the social model are theoretical and have not been translated into practice. Oliver explains in his commentary that initially the objective of the social model of disability was to emphasize impairment and disability in the social context to protect benefits and services. However, he states that due to the recent economic climate in the United Kingdom, policy is further dividing the population of people with disabilities into those who are severely impaired (deserving) and those who are not (Oliver, 2013, p. 1026). Individuals are being assessed and categorized into moderate, substantial, and critical categories, with most services being offered to those in the critical category. This is occurring similarly in Canada. For example, in Ontario there is a program in place to support new mothers with physical disabilities named the *Direct Funding Program*. This program finances the offering of self-directed attendant services to qualified mothers and supports the hiring, training, and paying of their attendants (Ocampo, 2001). The mother directs the attendant on what they would like them to do and describes how to care for the baby, acting like a surrogate for the mother. However, this is a restricted program—only those mothers with the most "severely physical" impairments have access to the funding.

Dichotomizing and categorizing individuals is problematic because it does not account for the individuals' needs as a whole. In terms of Chris' disability, he was at the point that he needed to use a walker but that is not considered a severe impairment in the context of the *Direct Funding Program*. Nevertheless, the complexities of his issues at the time were pronounced. Under the terms of the *Direct Funding Program*, a mother may have a full-time family member living with her or an older child who could help and thus does not require the service due to her particular circumstances. However, another woman may be a single parent with no support, and that program's support may make a difference between child welfare involvement or not. This is where multiple contingency thinking is relevant.

Posthumanism

Disability research appears to be moving in the direction of posthumanism. Posthumanism criticizes the humanist ideal of man as the universal representative of what a human being is (Brandotti, 2016). Brandotti uses the example of the Vitruvian Man as the ideal human. He is white, able-bodied, masculine, and European. When people deviate from this image, we begin to question if they are less than human. Prominent disability scholars like Dan Goodley agree that “human” may be an outdated phenomenon and contends that disability is a quintessential example of posthumanism (Goodley, 2014). This is because like posthumanism, disability breaches the traditional definition of human and is always in conflict with the idea of what the ideal human is (Goodley, 2014). Posthumanism decenters man as the measure of all things, acknowledging its interdependence on other humans, technology, and the environment (Dolezal, 2017). As a result, individuals have fluid and multiple identities (Brandotti, 2016). This is not far removed from disability whose members sometimes rely on others and assisted living technology for support.

Posthumanism is not in conflict with the social model of disability and has potential to tackle ableism. A women’s studies scholar, Dolezal, (2017) wrote about a posthumanist example that discussed athlete and model, Aimee Mullins. Mullins is Paralympic athlete, model, and actress in the United States. She was born with a medical condition that required both of her lower legs be amputated. Mullins later became famous for her 12 pairs of legs and presented a Technology, Entertainment, Design (TED) talk wherein she introduced her many legs. Her legs are various lengths depending on the heels she is wearing and she has different variations. Dolezal (2017) argues that Mullins represents posthuman embodiment, her body is full of possibility and enhanced capabilities. On the other hand, this example demonstrates the use of technology being used to bring Mullins nearer to the “normal” body. She argues that the ideal able-bodied person is still preferable in mainstream society (Dolezal, 2017).

Chris seemed to be very heartened when he found role models like himself. Each summer, Chris went to a week-long camp for children and youth with autoimmune diseases. After the first summer he recalled how shocked he was that the counsellors and other youth had been diagnosed with fibromyalgia and lived with chronic pain as well. Mullins plays a similar role in terms of representation within the disability community. It is unclear if individuals living with disabilities see her as an example.

Supplementary Perspectives to Disability Research

Self-Determination

In this section, I offer my own thoughts on how to best supplement the dominant disability models and the newer proposed models of disability. Something missing from the existing models, or which is not as prominent as what was previously described, is the questioning of dichotomous modes of thinking. An approach to this frame of questioning is to consider the individual’s self-determination and subjectivity. In disability studies, there is a dichotomy of disabled/not-disabled and the “disabled” get further categorized into subgroups. The individual (medical) model faults the problem as impairment and the social model faults the problem as society. The diversity and intersectionality of the group are missing from this discussion because as the context and subjectivity changes for the individual so can the category

criteria and whether the individual is even still in the “disabled” group. Chris’ relationship with his peers is an example of this.

During the years in which Chris’ health was declining he began to spend less time with his friends. His mother became concerned that he was becoming antisocial and blamed chronic pain as the culprit of his withdrawal; his physicians became concerned and worried that he was becoming depressed; and I became concerned that he was not getting enough opportunities to socialize. These are three alternative responses to Chris spending less time with his friends. Chris’ perspective was missing. After discussing it with him, he expressed that he was not upset or concerned about spending less time with friends. In terms of socialization, he was getting his needs met through family and the little time he was spending with his friends during his time at school. When youth begin withdrawing from friends and activities it is sometimes a sign of concern, but this is not the case for all youth. The barrier with overarching disability models and categorization of disability is that the individuals’ context can get lost. Normal is argued to be conceptualized and predisposed toward the needs and interests of the privileged (Sprague & Hayes, 2000); therefore, caution should be applied when implying what someone’s behavior should look like.

The two diagrams in Figure 1 are proposed as alternatives to the siloed models presented thus far in disability studies. There is agreement with Oliver that diversity among models is essential to understanding the full scope of needs in the disability community. However, there need to be precautions to ensure that some individuals are not assimilated into the experiences of the dominant group. Specifically, there must be freedom allowed for individuals to move fluidly throughout categories, reject categories, and adopt categories.

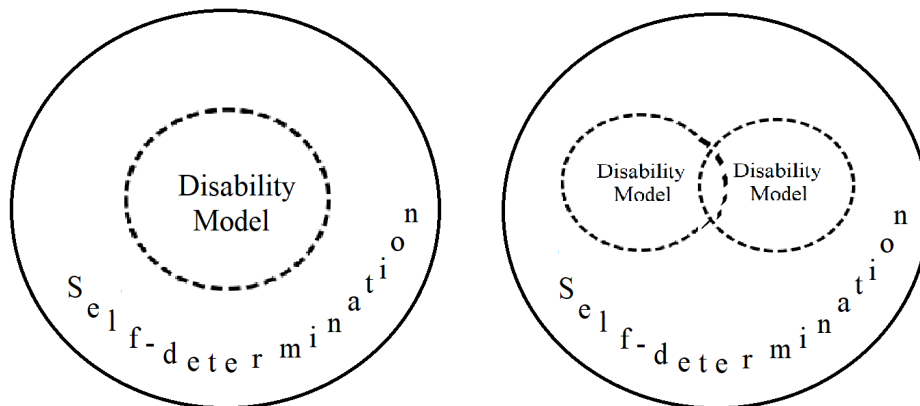


Figure 1 – There are two diagrams. The first, located on the left, is a perforated circle with “Disability Model” written in the middle. It is engrossed by a larger circle labelled “Self-determination.” The diagram on the right is identical except it has two perforated circles in the middle with “Disability Model” written in both of them. The two middle perforated circles overlap with one another.

The two diagrams in Figure 1 are similar, except the diagram on the right shows an ability to have more than one model of disability. The idea illustrated within the diagrams is that disability model(s) are located in the middle and then engrossed by the individual’s self-determination. The model(s)’ circles are broken to illustrate the freedom to move in and out and to reject the notion of rigid categories. It is

possible to use multiple disability models if appropriate in context; these two could even be the individual/medical and social models. Importantly, the individual's self-determination never gets lost in the perspective.

Self-determination theory posits two broad types of motivated behavior: those consciously chosen in the service of intrinsic or extrinsic needs and those that are not consciously chosen (Deci & Ryan, 2012). Self-determined behavior is constructed from the individual's and their environment's inputs and are selected based on the person's needs (Deci & Ryan, 2012). In contrast, mindless or automated behaviors are conditioned, and the behavior is automatic (Deci & Ryan, 2012). Examples could be playing with your hair or blowing bubbles with gum. These behaviors are functional and linked to specific needs (Deci & Ryan, 2012).

Discussion around self-determination does not appear to have a large presence in disabilities studies. It seems to be cited and applied more in the field of education pertaining to children and youth with learning and intellectual disabilities, often for the purpose of investigating whether self-determination skills should be taught in school (Marks, 2008; Russo Jameson, 2007; Zhang, 2001). One study by Stoner, Angell, House, and Goins (2006) investigated the perceptions of 12 adults living with a congenital physical disability (e.g., spina bifida, cerebral palsy). They used semi-structured interviews to ask participants how they defined self-determination, how it is important, and if the participants could identify any barriers. Their findings suggested that even though the participants received little to no formal instruction, they exhibited high levels of self-determination. Support from families, individuals, and support networks was an important theme that emerged from the stories regarding facilitators of self-determination. When identifying facilitators of self-determination, one participant stated that, "Self-determination to me is ... that it was laid out for me, it all started at home. I mean, with, there was a foundation that was laid for me. They've [participant's parents] allowed me to grow and to learn on my own (Stoner et al., 2006, p. 13).

Interestingly, when asked about barriers to self-determination, the participants named both impairment and societal factors as impediments. All participants named their physical impairments as a barrier to self-determination. For example, one participant expressed that it takes them several hours to brush their teeth and they will never be able to tie their shoes (p. 15).

The societal barriers that were mentioned included financial assistance, accessibility barriers, and discrimination. The negative attitudes of others were also perceived as a barrier to self-determination. The interviews illustrate differences in how individuals with disabilities experience self-determination and barriers, as well as how personal experiences can shape individual perspectives. Simultaneously, it is apparent that self-determination is affected by interpersonal and social-structural relationships, and that the "self" is socially constructed (Sprague & Hayes, 2000). The ongoing development of the self is another example why the proposed disability models are broken lines making up the circles in the middle of the diagrams, because the process is ongoing.

Areas for Further Research

In response to Oliver's (2013) commentary regarding the reinvigoration or replacement of the social model of disability, Levitt (2017) had further questions of his own. Levitt also wondered how the social model could be implemented, aside from it being used as a practical tool. He speculated what the primary goals of the social model should be. Before brainstorming ideas for how to use the social model

in multiple context, perhaps it is beneficial to apply it well in a practical way. Similar qualitative studies that Stoner et al. (2006) completed with persons living with physical disabilities may be beneficial in learning how individuals construct their own reality and their “self.” It would also be worthwhile to interview family members and service providers, as these groups also impact how the individual constructs their experience with disability. Collecting visual and textual data is another approach to explore how disability gets constructed. For example, reviewing material on the *Direct Funding Program* or another social service program would inform some of these questions.

Conclusion

The objectives of this paper were to (1) introduce the dominant models in disability studies and alternative models of disability and (2) to discuss ways to supplement current social work practice to better support the disability population. Positivism and the social model of disability from historical perspectives were reviewed to illustrate how the dominant individual (medical) and social models of disability emerged. Examples of alternate models that have been introduced in the literature but had sporadic support and minor acceptance were discussed. Oliver’s (2013) call for new ideas regarding the social model of disability in the *Journal of Disability and Society* appears to have ignited a discussion on how to improve the status quo with alternative models of disability (Bolt, 2015; Johnston, 1997; Levitt, 2017). Instead of retiring disability models, this paper proposed that they be supplemented with self-determination theory.

The combination of the steady increase in the number of persons living with disabilities and the continued difficulty regarding accessible social services programs are two key reasons for why facilitating and participating in discussions around models of disability is crucial to social work practice. Applying the disability models and self-determination theory to the case vignette illustrated how social work perceptions and the conceptualization of disability inform practice with persons living with disabilities. In addition, the respect and promotion of self-determination with clients is a social work ethical standard and responsibility in both the National Association of Social Workers (2008) and the Canadian Association of Social Workers (2005). Applying disability models in social work practice within the context of self-determination is consistent with the profession’s code of ethics and respectful of the clients and families social workers support. However, social workers often adopt the individual (medical) models of disability (Mackelprang, 2010), indicated that further work in this area is needed. There is optimism that the future of disability studies is heading toward a plethora of innovative ideas and strategies to better serve those individuals living with a disability, which can ultimately be applied to the social work profession.

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Engaging MSW students in policy advocacy practice: A sample assignment inspired by the Grand Challenges Initiative

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Abstract

Current workforce data reveals minimal social work engagement in policy practice. Similarly, a recent examination of social work education shows a continued emphasis toward micro/clinical practice despite ongoing mandates from professional social work organizations to promote social and economic justice. Existing literature suggests that assignments which raise students' awareness of intersectionality and structural inequalities and include experiential learning activities can inspire social action. This article describes a creative graduate social work assignment designed to generate student enthusiasm for policy advocacy practice. The assignment, which requires students to interact with policy experts and develop a digital infographic and position statement informed by this interaction, is anchored by the Grand Challenges for Social Work Initiative.

Keywords: Grand Challenges for Social Work, policy advocacy, social work education, infographics, social and economic justice

Introduction

According to a recent social work workforce profile only 2.8% of social workers were employed by civic, social, advocacy, or grant making organizations as reported on the 2015 U.S. Census (Salsberg, et al., 2017, Table 15, p. 21). Similarly, a survey of 2017 social work graduates revealed that policy and advocacy work are the primary focus for a mere .1% of all master's level survey participants (Salsberg, Quigley, Acquaviva, Wyche, & Sliwa, 2018, Table 53j, p. 48). Despite the social justice and advocacy mandates included in the Code of Ethics (National Association of Social Workers [NASW], 2017b), the Educational Policy and Accreditation Standards (Council on Social Work Education [CSWE], 2015) and the Global Standards for Social Work Education and Training (International Federation of Social Workers [IFSW], 2012), the practice emphasis in social work educational programs remains within direct/clinical practice for both bachelors and masters graduates surveyed (Salsberg, et al., 2018).

To encourage students to develop values, knowledge, and skills to achieve the mission of social work—to promote well-being for all—formal social work education at both the undergraduate and graduate levels must offer a curriculum that promotes an understanding of structural inequality,

intersectionality, and the role of oppressive and discriminatory policies and practices in the perpetuation of injustice. It is critical that this enhanced understanding be reinforced by classroom and field practicum experiences that allow students to engage in policy analysis and social change and advocacy efforts. The statistics referenced above suggest social work education has considerable room for improvement. The purpose of this article is to advance the conversation about dynamic policy education and to share an example of an experiential graduate level policy assignment created to stimulate students' interest in social action and further their understanding of barriers to advocacy and methods for dismantling these barriers through policy practice.

Conceptual Foundation

To provide some context, I present a rationale for reinvigorating macro practice education and examine some current pedagogical approaches. In addition, I suggest several components relevant to policy education: intersectionality, digital advocacy tools, and the American Academy of Social Work and Social Welfare (AASWSW) Grand Challenges for Social Work Initiative.

The Rationale for Macro Practice Education

It has been previously established that curricula which support macro practice, specifically social welfare policy content, have developed significantly over time yet there continues to be a shortage of programs that offer macro practice-oriented specializations and field placements (Richter, 2016). The recent National Social Work Workforce Study of 2017 graduates indicated that only 18% of participants who graduated with a Bachelor of Social Work degree (BSW) and 13.2% of participants who graduated with a Master of Social Work degree (MSW) described the practice focus of their education as community organizing, advocacy, or indirect practice (Salsberg, Quigley, Acquaviva, Wyche, & Sliwa, 2018, Table 37, p. 35). Policy advocacy was included in the definition of indirect practice and identified as their primary employment role by just 8.3% of BSWs and 3.7% of MSWs surveyed. (Salsberg, Quigley, Acquaviva, Wyche, & Sliwa, 2018, Table 3, p. 18).

In my experience, students often remark they are not interested in and do not need to study policy because they plan to practice in clinical social work settings. Unfortunately, nothing could be further from the truth. Michael Reisch, a prolific scholar and social work educator, argued convincingly for the need for macro practice knowledge and skills at all levels of practice:

All social work practice occurs in a community context, and virtually all social workers work in organizations that are affected by social policies. Understanding the dynamics of communities and organizations and the policy development process, therefore, is an essential component of effective practice with every population and problem with which the profession is involved. (2016, p. 261)

Similarly, NASW ethical principles "social workers challenge social injustice" and "dignity and worth of the person," (which includes respect for diversity) as well as "Ethical Standard 6: Social Workers' Ethical Responsibilities to the Broader Society," provide direction to all members of the profession regarding specific change efforts, including shaping policies and taking social and political action, that will positively impact opportunities for equality and justice (NASW, 2017b). The Global Definition of Social Work includes the importance of human rights, social change and social justice, and

respect for diversity (IFSW, 2014). The Global Standards for Social Work Education and Training, adopted in 2004 by the International Association of Schools of Social Work and the International Federation of Social Workers, also identify advocacy and social action against injustice on behalf of marginalized populations and the importance of human rights as central to the core purpose of social work. These standards recommend curricular content which includes social welfare policy and social change processes as well as methods of practice that challenge inequalities and injustices (IFSW, 2012). Finally, the CSWE Educational Policy and Accreditation Standards (EPAS) mandate macro policy content, "...social work is actualized through its quest for social and economic justice, the prevention of conditions that limit human rights, the elimination of poverty, and the enhancement of the quality of life for all persons, locally and globally" (CSWE, 2015, p. 5). In fact, all 2015 CSWE competency descriptions include at least one of the following terms: policy, oppression, justice, human rights, or diversity.

In terms of actual social work practice, a brief examination of current data on poverty and discrimination suggest that there is much work to do. Although it appears that the official poverty rate has decreased slightly, and household income increased for the first time since the 2008 recession, the latest report still showed 43.1 million people living in poverty in the United States (Proctor, Semega, & Kollar, 2016). Marginalized populations of color, such as African Americans, continued to experience poverty at a much higher rate than Whites. Women and children also had higher rates of poverty (Proctor, Semega, & Kollar, 2016). A 2013 publication from the Movement Advancement Project (MAP) reported that the lesbian, gay, bisexual, and transgender population (LGBT) experienced higher rates of poverty and job discrimination than heterosexual counterparts. The NASW report "Advancing the American Agenda" (2017a), issued to provide guidance to the Trump Administration, also detailed the negative impact of institutional racism, and reviewed how social workers can help create change by calling attention to hate crimes and racial profiling. Other suggested initiatives included immigration reform, reduction of child poverty, and equitable pay for women.

Clearly there is evidence to support that poverty, discrimination, and oppression continue to exist. In addition, there is agreement among the major professional social work organizations about the need for graduates to have policy advocacy knowledge and skills to achieve the mission of social work regardless of practice setting. However, it appears that some students may not share this perspective. As a result, social work educators are challenged to develop innovative strategies to facilitate engagement in policy practice.

Current Policy Pedagogy

A 2015 CSWE survey reported that only 4.2% of programs offered a policy practice specialization and just 1% of master's level students were enrolled in policy field placements (CSWE, 2016, Tables 35 & 36, p. 27). It appears that not much has changed since Ritter (2007) completed her study of licensed social workers and their involvement in political participation over a decade ago. Study results indicated that 48% of respondents thought they were not adequately prepared to engage in political activities (Ritter, 2007). More recently, Pritzker and Lane (2014) identified barriers to integration of policy practice within field practicums. The barriers included a lack of student interest and student fears about missing out on developing clinical experience. The authors also reported structural challenges such as geographical distances from macro placements and concern for adequate supervision in those

placements. Pritzker and Lane (2014) recommended infusing policy content throughout the social work curriculum as one way to generate student interest. CSWE recently partnered with several foundations to offer funding to schools of social work to encourage and support innovation in the integration of policy practice in field education. The summary report of the methods used by Policy Practice in Field Education Initiative grantees is now available as a resource (CSWE, 2018).

Other research details specific course assignments that raise students' awareness about structural inequalities, intersectionality, the dynamics and maintenance of oppression, and the impact these assignments have on all system levels as a method for changing attitudes and inspiring social action (Castillo & Becerra, 2012; Hancock, Kledaras, & Waites, 2012; Lane, et al., 2006; Snyder, May, & Peeler, 2008; Van Voorhis & Hostetter, 2006). Experiential learning events such as Legislative Advocacy Days are particularly effective (Lane, et al., 2006). Sundet and Kelly (2002) brought real world issues to life by requiring students to explore all sides of current legislative priorities through development of policy briefs which were ultimately used by legislative committees. Ritter (2013) approached her policy course from a practice perspective and taught students how to practice policy advocacy at the state legislature through a series of assignments which included written policy analysis briefs, fact sheets, and legislative testimony. Students then practiced delivery of oral testimony in mock committee sessions.

An informal review of a popular social work policy electronic mailing list confirmed that social work educators frequently use assignments that require students to write letters, emails, or opinion editorials advocating for specific policies. On this list, Klemm (2017, January 23) shared her unique plan to set aside time in her courses for students to contact their legislators by phone to share policy opinions and concerns. Her rationale for using this approach during class time included teaching students how to correctly identify who to contact and encouraging a routine practice. Finally, Bernklau Halvor (2016) studied how undergraduate students responded to policy education efforts and shared recommendations for how to improve students' policy practice skills. The assignment presented in this article is consistent with several of her suggestions including an emphasis on praxis, current events, and a variety of advocacy methods within a structure that allows for student self-direction.

Intersectionality

To teach effective policy practice, social work educators must be intentional in their efforts to help students develop awareness and understanding of how discrimination, oppression, power, and privilege are compounded by the intersection of multiple individual social identities. However, the full potential of this approach will not be realized without analysis of the systems of power that maintain such marginalization (Moradi & Grzanka, 2017). In addition, Crenshaw (1991) argued that a focus on identity politics alone disregards significant within-group differences. Content on intersectionality sometimes appears in diversity and cultural competence courses, although little has been written about the application of this framework in social work education according to Robinson, Cross-Denny, Lee, Rozas, and Yamada (2016). Bubar, Cespedes, and Bundy-Fazioli (2016) suggested teaching students about intersectionality should occur across the curriculum. The results of their examination of graduate students' papers demonstrated a lack of student awareness about the impact of intersectional identities and power differences within the professional-client relationship. The assignment proposed here requires students to consider the impact of social justice barriers of policies and practices created by existing systems of power.

The Importance of Digital Literacy Skills

Current guidance provided by professional social work organizations emphasizes the importance of digital literacy for practicing social workers. In 2017, NASW published “Standards for Technology in Social Work Practice,” a document developed in collaboration with CSWE, the Association of Social Work Boards (ASWB), and the Clinical Social Work Association (CSWA) (NASW, 2017c). The standards address providing information to the public, design and delivery of services (including advocacy), information management, and education and supervision. Also, the NASW Code of Ethics was revised to explicitly include technology practices in communication and the provision of social work services (NASW, 2017b). Lastly, technology is an official element of the EPAS, “Competency 1: Demonstrate Ethical and Professional Behavior” which includes the component behavior “Use technology ethically and appropriately to facilitate practice outcomes” (CSWE, 2015, p.7).

The use of social media for advocacy work has exploded in recent years. Gismondi and Osteen (2017) reviewed the role and power of technology in three actual case studies of student activism on campus. Current policy textbooks include web-based resources for policy research and present examples of how social media can be effectively used in advocacy practice (Jansson, 2018; Lewis, 2018). The University at Buffalo School of Social Work (2018) has created a helpful interactive infographic which provides detailed guidance about the use of social media by social workers.

I have observed that although many social work students are already using social media, most have not received specific training about how to do so ethically, nor are they familiar with how to create and use digital tools for advocacy purposes. Thus, one of the learning objectives for the assignment presented in this article is for students to design an infographic, one type of digital tool that can be used in policy advocacy.

The Grand Challenges Initiative

The purpose of the AASWSW Grand Challenges for Social Work Initiative is to generate research, collaboration, and social action around twelve equally important social problems. In creating this social agenda, the AASWSW desires to promote:

- Individual and family well-being,
- A stronger social fabric, and
- A just society that fights exclusion and marginalization, creates a sense of belonging, promotes trust, and offers pathways for social and economic progress. (2018, para. 4)

The Grand Challenges framework provides a helpful structure for students to develop an understanding of policy advocacy. The AASWSW website provides current research, policy briefs, and policy action statements for each of the identified challenges. These documents offer a starting point for further exploration and application of social work policy practice skills. Any of the Grand Challenges could be used for this proposed assignment. However, to keep the background reading and overall project manageable within the other course requirements, I identified the Grand Challenge “Achieve Equal Opportunity and Justice” as sufficiently broad for use in my policy course. Per the policy brief issued by AASWSW, “addressing racial and social injustices, deconstructing stereotypes, dismantling inequality, exposing unfair practices, and accepting the superdiversity of the population will advance this challenge” (AASWSW, 2016, para 1). The scope of this challenge allows students a wide range of policy topics to

choose from. The remainder of this article summarizes a sample experiential policy advocacy assignment that incorporates digital tools and is anchored by this Grand Challenge.

Sample Policy Advocacy Assignment

Course Description

Social Welfare Policy is a required core course in an online MSW program of a public university. The physical campus and most of the full-time faculty are in the southwestern United States. The course is designed to help students develop policy practice skills and conduct legislative advocacy at local, state, and national levels, and within organizations and communities. Course objectives include applied assessment of the impact of policies on social justice and human rights efforts with disenfranchised populations.

The Assignment: Social Issue Interview, Infographic and Position Statement

Overview. Students are asked to choose a social justice topic of personal or professional interest, conduct research about relevant policy efforts, identify current barriers to advocacy in four domains (social, environmental, political, and economic), and recommend policy actions. The assignment is divided into two parts: The Social Issue Interview and Infographic and the Position Statement. Related reading assignments include material about the Grand Challenge “Achieve Equal Opportunity and Justice” and the textbook for the course, *Becoming an Effective Policy Advocate* (8th edition) by Bruce Jansson, which provides a skills-oriented framework for policy practice and policy advocacy. Jansson defines policy practice as:

efforts to change policies in legislative, agency and community settings by establishing new policies, improving existing ones, or defeating the policy initiatives of other people” and policy advocacy as “policy practice that aims to help relatively powerless groups...improve their resources and opportunities. (2018, p. 2)

CSWE competencies and assignment learning objectives. The first two learning objectives for the assignment address components of “CSWE Competency 3: Advance human rights and social, economic, and environmental justice” and “CSWE Competency 5: Engage in policy practice” (CSWE, 2015, p. 8). The objectives are (a) students will demonstrate an understanding of barriers to advocacy and the advancement of social justice within social, environmental, political, and economic contexts; and (b) students will identify options to advocate for policies that advance human rights and social, economic, and environmental justice. Through their work on the assignment, students must identify and assess the impact of social policies on service access and delivery as well as think critically about policies that will advance justice. In the process they will expose unfair practices that prevent equal opportunity and justice and look for solutions. Successful achievement of the first two objectives will require students to “apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels” (CSWE, 2015, p. 8).

The third learning objective applies to digital literacy: Students will design a policy advocacy infographic. As previously discussed, this learning objective is timely and relevant as social media and other digital tools are frequently employed in current policy practice and advocacy efforts. To demonstrate achievement of this objective, students will design a one-page digital infographic

highlighting their selected social issue, related policy, barriers to social justice, and recommended policy actions. Infographics are primarily visual representations of information and data.

Part one: Social issue interview and infographic. For the first part of the assignment, students are asked to review the Grand Challenges information and select a social issue of interest to them which exemplifies a lack of equal opportunity or justice for a specific population. Next, they must identify a local politician/legislator or social work administrator in their community who has some knowledge about this issue and arrange for a face-to-face or phone interview. The purpose of the interview is to discuss the interviewee's position on the issue; learn about existing social, environmental, political, and economic barriers to justice and advocacy; and explore possible ways these barriers could be addressed through policy actions. To prepare for the interview, students are instructed to research background information about their topic including current legislation/policy, programming, funding, and barriers to advocacy. Students are provided with some sample interview questions such as: What about the social context related to this issue makes advocacy and social justice difficult to achieve? What policy actions could a social worker support or engage in to work toward equal opportunity and justice for individuals affected by this problem?

To complete Part One, students are instructed to design a one-page infographic to summarize the information gained in their research and the interview. Since developing an infographic is an unfamiliar skill for most students, suggested resources for free infographic software, internet tutorials, and sample infographics are provided. In addition, students are given detailed guidance about the required elements which include (a) the issue, (b) relevant background, (c) at least one current barrier to advocacy and social justice in each context and identified as such (social, environmental, political, and economic), (d) at least two specific policy actions to overcome barriers and achieve social justice, (e) the name, title and credentials of the individual interviewed, and (f) references.

Part two: Position statement. In the second part of the assignment, students are instructed to use the information collected during the Social Issue interview to prepare a succinct yet well-developed position statement of advocacy for social justice around their selected topic. Suggested length is one to two pages and content guidelines include a summary of the overall issue, a brief statement of their advocacy position, and a list of bullet points outlining at least three specific policy advocacy recommendations to support this position. Students are encouraged to review relevant NASW policy information and to evaluate their recommended policy and service actions for consistency with professional social work values and ethics.

Implications for Policy Social Work Education

Despite long-standing advocacy on the part of many macro-oriented social work practitioners and educators as well as the clear mandates of professional social work organizations, recent data confirm the continued emphasis toward micro and clinical education and practice. The proposed unique assignment is one way to actively engage students and generate excitement about macro practice. Graduate social work students are encouraged to select topics that are personally relevant and to be creative when designing an infographic and position statement. The assignment requires critical policy analysis and interaction with actual policymakers to identify social justice and policy advocacy barriers and actions yet provides a welcome change from writing a lengthy research paper.

Qualitative student feedback about the assignment has been positive; many students admitted they enjoyed learning how to use new digital tools and appreciated the opportunity to be creative. Students reported feeling energized about their topics and have articulated a new awareness of policy advocacy skills that can be used in all levels of social work practice. At the same time, some students have expressed frustration about the amount of time required to learn the infographic software and the challenges of arranging an interview.

This assignment can be used alone or as an addition to the standard “write your Senator” assignment. In fact, some students have even reported proudly sharing their infographics with legislators and agency administrators. As discussed here, The Grand Challenges Initiative provides a structured framework to anchor policy advocacy education and serves as a reminder of the ongoing work required to achieve well-being for all. The proposed MSW policy assignment is one educational tool which can aid in this vital effort.

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Future directions for psychotherapeutic treatment of shame: A scoping study

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Abstract

This study uses Arksey and O'Malley's (2005) framework for scoping studies and references Rubin and Bellamy's (2012) discussion on evidence-based practice to scope the current literature concerning the use of psychotherapy to treat shame in adolescents and to develop a research question. The author focused on shame in adolescents and explored ways in which social work practitioners understand and treat shame during the "identity versus role confusion" stage of development. While definitions of shame vary across the scholarly literature, many of them include similar elements. Morrison (2011) defines shame as "a negative feeling about the state of the whole self, a noxious conviction that the self is bad, defective, a failure" and emphasizes the pervasive sense of self-condemnation (p. 25). Recurring themes and therapeutic approaches for managing shame in the therapeutic context are reviewed and summarized. The findings of this scoping study suggest that while the preponderance of the literature points towards the importance of addressing shame and its associated psychopathologies within the therapeutic context, there are few scholarly works that address how to reduce shame in a psychotherapy context and none that present data from studies whose designs were experimental. This paper calls for developing an evidence-based body of research into how best to treat shame in psychotherapy settings. Implications for social work practice, education, and research are discussed.

Keywords: shame, strategies, psychotherapy, treatment, adolescents, study design.

Introduction

In the classic text *Social Diagnosis* (1917), Mary Richmond established the framework for a systemized social work methodology. Richmond believed that the social work profession ought to be guided by a standardized, pragmatic epistemology. In an effort to make social work principles operative, she famously asserted the need for developing a scientific knowledge base and pooled way of thinking amongst social workers. Richmond's view was that social work knowledge must be grounded in a pragmatic approach that utilizes research-generated evidence. While practice wisdom, experience, and expertise in the field provide a foundation for one's social work practice, Richmond notably constructed the foundations for the scientific methodology development and "the use of research-generated facts to guide the provision of direct clinical services as well as social reform efforts" (Rubin & Bellamy, 2012, p. 4).

In the "age of accountability" and evidence-based practice eras, research-based evidence allows for clinicians to generate practice decisions based on available scientific evidence available (Rubin & Bellamy, 2012, p. 5). The term *evidence-based practice* (EBP) is defined as "a process for making practice decisions in which practitioners integrate the best research evidence available with their practice expertise and with client attributes, values, preferences, and circumstances" (Rubin & Bellamy, 2012, p. 7). The hope is that the combination of practice wisdom and credible evidence-based research will result in the best possible practice decisions.

This combination is critical to practitioners who work with adolescents dealing with shame. A better understanding of the phenomenon of shame in adolescents can assist practitioners and researchers to develop appropriate approaches to treating shame in adolescents. While the currently available research both examines and acknowledges shame as a primary emotion that commonly arises in psychotherapy treatment and consistently points towards the importance of understanding and addressing shame in therapy, there are few studies that address how to do this.

Methodology

Stage 1: Identifying the Research Question

As noted above, *shame* has been defined as "a negative feeling about the state of the whole self, a noxious conviction that the self is bad, defective, a failure" (Morrison, 2011, p. 25). Both the first (1913) and second (1989) editions of the *Oxford English Dictionary* defined *shame* as:

[t]he painful emotion arising from the consciousness of something dishonouring, ridiculous, or indecorous in one's own conduct or circumstances (or in those of others whose honour or disgrace one regards as one's own), or of being in a situation which offends one's sense of modesty or decency (n.p.).

The earliest use of the word *shame* in a scientific context that this author found was by Charles Darwin (1872) in his book, *The expression of the emotions in man and animals*. Darwin (1872) considered the ways in which emotions were expressed in animals and found that blushing as a result of shame was uniquely linked to human beings.

Shame is considered to be a universal part of the human condition, (Brown, 2008; Heller, 2003). As such, it is imperative that social work practitioners and researchers understand the role it plays during the most formative years of a patient's life. To formulate the research question, the author first analyzed how shame is discussed in the extant literature on human development in order to properly situate the question within the current understanding of human development and the historical trajectory of the discussion of, and research into, shame.

Erikson (1959) posited that identity formation is a process that continues throughout one's life but noted that "the formation of a strong and coherent sense of identity represents the crucial developmental step associated with the transition from adolescence to adulthood" (Phoenix, 2001, p. 350). Erikson (1959) also noted that teenagers are tasked with resolving the crisis of "identity versus role confusion" (Erikson, 1959/1980, p. 94). While Erikson (1959) focused on the transition from adolescence to adulthood, it is elucidating to also explore how shame interacts with the process of identity formation during the transition from childhood to adolescence and even earlier.

According to Bennet, Sullivan, and Lewis (2005), shame is an experience that begins as early as toddlerhood at 3 ½ years of age and continues to develop well into adolescence. As adolescents undergo changes in their cognition, physical appearances, and sexuality, it is possible that experiences of shame may be particularly prominent during this stage of development (De France, Lanteigne, Glozman, & Hollenstein, 2017). Cognitively, adolescents are actively involved in developing a sense of identity and experience increased ability to self-evaluate and reflect on their actual self versus an ideal self (De France et al., 2017). As adolescents begin to experiment with their sense of self, they may be prone to greater self-consciousness, susceptibility to the influence of their peers, and experiences of shame (De France et al., 2017). Thus, it appears from that literature that adolescents seem susceptible for experiencing increased shame and self-criticism due to the likelihood that they are considering "others' interpretations of themselves to be trait-like, meaning that a negative evaluation implies flaws reflective of the self, rather than the behavior" (De France et al., 2017, p. 770). Adolescents are prone to becoming concerned about their outward appearances and body image as it pertains to specific cultural standards of attractiveness (De France et al., 2017). As maturation continues, adolescents may develop dissatisfaction with their physical attractiveness, generating feelings of shame regarding their entire self-identity. Lastly, sexual development and sexual behaviors that are common in adolescence begin to emerge as adolescents begin exploring and understanding their sexuality. Adolescents begin to reference and rely on their peers rather than on their parents or caregivers and aim to achieve their individual identities through a group identity (Berzoff, Flanagan, & Hertz, 2011).

As a whole, "adolescence may be a crucial time for the assessment and monitoring of shame experiences" (De France et al., 2017, p. 770). Given that adolescents are more likely to take part in self-evaluations, Reimer (1996) suggests that the shift toward experiencing shame occurs during adolescence as a result of the maturational shifts and the growing prominence of peer evaluation. Social workers must develop an understanding of the evolution of shame during this developmental stage and create strategies for treating shame and its related disorders (De France et al., 2017).

Research Question

The author would like to understand the nature and effectiveness of strategies that therapists have used to treat shame and its concomitant disorders. This author's research question is: What treatments currently exist to treat adolescents presenting with shame and its concomitant disorders? This research question includes elucidating which of these treatments are evidence-based and which of them have been shown to be effective.

Question Significance. This research question is important because it is a first step in the process to integrate, as noted previously, the best research evidence available with the treating professionals' "practice expertise" and their clients' "attributes, values, preferences, and circumstances" to develop a best-practices approach to treating shame (Rubin & Bellamy, 2012, p. 7).

Working within the framework of Reimer (1996), this author first examined the historical, foundational literature on shame with the goal of understanding the continuum techniques used to treat shame within the psychotherapeutic context. This examination revealed that there are only a few treatments that are specifically shame-focused. Tangney and Dearing (2011) note only four treatments that they describe as being shame-focused therapies: Gilbert's compassion focused therapy (CFT); Linehan's dialectical behavioral therapy (DBT); Brown's Shame Resilience Curriculum: Connections; and emotion-focused therapy (EFT). Tangney and Dearing (2011), however, note that the empirically validated research on shame-based treatment was in its early stages and opined that research grounded in randomized experimental designs could clarify the effectiveness of shame-based treatments in psychotherapy (Tangney & Dearing, 2011). To date, there is a dearth of such randomized, experimental designed studies.

Erik Erikson (1964) developed a psychosocial timeline that looked at the stages of development over the course of a person's life cycle (Berzoff, 2008). He posited that people are constantly changing over the course of their entire lives and suggested that there are identifiable stages of change within this continuum: the Epigenetic Stages include Infancy, Early Childhood, Play Stage, School Age, Adolescence, Young Adulthood, Adulthood, and Old Age (Berzoff et al., 2011). For the purposes of this study, the author will focus on what Erikson (1964) named the "adolescent" stage as there is a dearth of literature regarding the psychotherapeutic treatment of shame during this developmental stage.

Berzoff et al., (2011) defines adolescence as a period of hormonal, biological, and sexual changes and impulses taking place between the ages of eleven to eighteen. During Erikson's (1964) adolescent stage of development, there is a tension between identity and role confusion. From childhood to adulthood there is a continuum of development as individuals feel more independent, question their identity, struggle with social interactions, and grapple with moral issues (Berzoff et al., 2011). As individuals transition to being adolescents, they ask themselves who they are (Berzoff et al., 2011). Erikson (1964) suggests that adolescents must integrate a basic sense of trust, a strong sense of independence, competence, and control over their lives. During this stage, the most significant relationships are with peer groups. Individuals who receive reinforcement and validation during this stage will develop a strong sense of self. Erikson (1964) states that completing this stage leads to fidelity, which he described as "the ability to sustain loyalties freely pledged in spite of differences in values" (Berzoff et al., 2011, p. 112). Adolescents navigate physical, intellectual, social and emotional changes and, while some of these experiences are empowering and liberating, they can also result in confusion, pressure, and challenge (Berzoff et al., 2011).

An issue seen frequently by this author in her current psychotherapy practice is the feeling of shame among adolescent patients. It is common that adolescents referred to this author for psychotherapy have a combination of mood disorders such as anxiety and depression, however, a common issue seen by this author is the feeling of shame. Therefore, this author intends to investigate the clinical approaches that would enable a psychotherapist working with adolescents to help patients who present with similar issues.

Stage 2: Identifying Relevant Studies

This author chose to scope the social work, psychology, and sociology literature in the following six electronic databases: ProQuest Central, PsycInfo, PsycBOOKS, PsycARTICLES, MEDLINE, and the Academic Search Premier.

In the initial phase of the author's research, the author searched across the platform database by using the Basic Search option. The author searched under keywords and phrases, as well as under selected peer-reviewed articles. In the next phase, the author formulated a specific research question pertaining to the psychotherapeutic treatment of shame; this guided the search process as it provided a targeted and more detailed search. Each database offered the option to browse articles in specific publications and journals. In each phase, the search was limited to peer-reviewed articles only.

Keywords such as *shame* and *adolescence* were used initially to search for articles and the Advanced Search options were utilized to look for specific terms and fields. Key search questions were also generated that yielded more key words and terms and that catalyzed additional searches. For example, the question "What are the psychoanalytic roots of shame?" generated the search items 'psychoanalytic' and 'shame.' Word variations, synonyms, and alternate terminologies that were associated with the key search terms were used as well. For example, 'psychotherapeutic treatment' is synonymous with 'therapy.' The population parameter of adolescence was at times expanded to include terms such as 'children,' 'teenagers,' and 'young adults.' Boolean operators such as 'and,' 'or,' and 'not' were used between search items; this typically served to broaden the search results. Lastly, the author also found it helpful to read primary sources from seminal shame researchers. This process yielded articles that were then organized into three broad categories, the first two of which comprise the majority of the research reviewed in this paper.

The first category consists of articles that were found through ProQuest Central. This database provided the author access to full-text articles from thousands of scholarly journals. ProQuest Central presented the author with a wide range of focused topics within the broad subject areas of the social sciences, psychology, and social work. The basic search tool bar was used to explore literature across the available topics. The author used quotation marks when looking for an exact phrase.

The second category consists of the information obtained from the PsycInfo database including PsycBOOKS and PsycARTICLES. The search of the PsycInfo database yielded full-article access to a wealth of psychological literature and content; it contained high quality literature from an array of disciplines ranging from psychiatry, social work, and psychology. PsycInfo articles contained citations,

abstracts, cited references, and descriptive information such as the page count, ISBN, language, keywords, and publication type.

The third broad category consisted of the information gleaned from the database MEDLINE as well as a search of the Academic Search Premier database. MEDLINE provided the author with research studies published in journals such as the *Journal of Clinical Psychology*, *The International Journal of Psychology & Psychological Therapy*, and *The Journal of Evidence-Based Social Work*. The Academic Search Premier search yielded only one relevant article.

Stage 3: Study Selection

The author sought to read research articles that examined the therapeutic treatment of shame in adolescents. From among the more than 100 articles that the author's search criteria yielded, 44 peer-reviewed articles were selected for this study. In addition, the author read three seminal books: *The expression of the emotions in man and animals* by Darwin (1872), *Shame and guilt in neurosis* by Lewis (1971), and Tangney and Dearing's (2011) *Working with shame in the therapy hour: Summary and integration*. The list of research articles, theoretical articles, and books that this author chose for this study can be found in Table 2: Article by Category.

Of the 44 articles selected, ten were research articles and 34 were theoretical articles. Four of the ten research articles chosen for this study targeted the adolescent population while five of the research articles examined young adults or adults. Several common themes recurred across the ten research studies including one's susceptibility to shame, shame and psychopathology, the impact of shame on the therapeutic relationship, and assessments of shame using different scales. These ten research articles provided the author with important background information on shame and the diversity of the scales along which it is assessed. While these articles were informative, they did not provide the author with solutions to the question of how to treat patients presenting with shame. This author was particularly intrigued by more recent, theoretical works written, or co-authored, by Brown (2006; 2008; 2009; Brown, Hernandez, & Villarreal, 2011), and sought out all of her work.

In addition, the author was interested in learning which standardized measures of shame were most often used in the research studies. The author's research yielded information about 22 different shame scales; the scale most commonly referred to in the ten research studies selected for this study was the Test of Self-Conscious Affect for Adolescents (TOSCA-A) (De Rubeis & Hollenstein, 2009; Feiring & Taska, 2005; Schoenleber & Berenbaum, 2010; Tangney, Wagner, & Gramzow, 1992). Two other scales that were noted in these research studies as being commonly used were the Impact of Event Scale-Revised (IES-R) (Cunha, Matos, Faria, & Zagalo, 2012; Pinto Gouveia & Matos, 2011) and the Other as Shamer (OAS) (Cunha et al., 2012; Pinto Gouveia & Matos, 2011).

Six of the 44 articles did expound on treatment techniques: Van Vliet (2009), Feiring and Taska (2005), Gilbert and Procter (2006), Rizvi, Brown, Bohus, and Linehan, (2011), Brown (2006; 2009), and Yard's (2014) research. Both Van Vliet (2009) and Feiring and Taska (2005) recommended using cognitive behavioral approaches.

All 44 articles are categorized in Table 2: Article by Category according to whether they are research articles or theoretical articles and/or whether they set forth information regarding treatment

techniques. The ten articles were deemed by this author to be research articles because they examined shame in some capacity. Methodologies used in past studies were identified, which assisted the author in discovering where there were gaps in the research. These research studies are listed under the column in Table 2: Article by Category, labeled as “Research Articles.” The second column in Table 2: Article by Category, labeled “Theoretical Articles,” lists the 34 theoretical articles the author read. These articles explored the work of influential theorists who had written about shame and identified key questions about the topic. These articles enabled this author to learn about the ways in which shame research has developed over time and in discovering areas in need of further exploration. This author also read three seminal books; they are listed in the third column of Table 2: Article by Category labeled “Seminal Books.” These books acted as key resources for this author’s research. Lastly, the fourth column lists the six articles that consider psychotherapeutic treatment techniques of shame.

Stage 4: Charting the Data

In line with Arksey and O’Malley’s framework (2005), data were charted in Table 1: Research Articles, which highlights literature that met inclusion criteria for this study. The purpose of charting the data, as described by Arksey and O’Malley (2005), is to synthesize the data gathered in order to illuminate key themes that were presented in the various research articles. The chart includes general information about the study, including the author(s), year of publication, study location, the study population, the general aim of the study, the methodology, outcome measures, and important results concluded from the study.

Stage 5: Collating, Summarizing, and Reporting the Results

Of the 44 articles and three books included in this scoping study, sixteen examined shame within a psychotherapeutic setting, and eleven noted the importance of addressing shame within the therapeutic context. Seventeen of the articles reviewed did not highlight the importance of addressing shame within the therapeutic context.

The author identified three major themes from the ten research studies: (1) the importance of examining ways in which individuals resolve and recover from shame; (2) the connection between shame and psychopathology, and; (3) the connection between identity development and shame. Across the 34 theoretical articles, several articles that the author read outlined developmental stages (Berzoff et al., 2011; Curtis, 2015; Erikson, 1959; Erikson, 1980; Levin, 2015, Phoenix, 2001; Reimer, 1996), while others outlined important practices such as evidence-based studies (Creswell, 2013; McNeece & Thyer, 2004; Rubin & Bellamy, 2012) and scoping studies (Arksey & O’Malley, 2005). A frequent theme was the examination and relationship between adolescent identity development and shame (Bennett et al., 2005; Klimstra, Hale, William, Raaijmakers, Branje, & Meeus, 2010; Phoenix, 2001). Several theoretical articles examined shame in psychotherapeutic settings (Brown, 2008; Brown, 2009; Brown et al., 2011; Candea & Szentagotai, 2013; Gilbert & Irons, 2005; Gilbert & Procter, 2006; Gilbert, 2011; Greenberg, 2002; Hayes, Strosahl & Wilson, 1999; Morrison, 2011; Nathanson, 1987; Steiner, 2015; Urdang, 2010; Yard, 2014), while others simply note the importance of addressing shame within the therapeutic context but do not delineate specific ways to do so (Goldberg, 1990; Kaufman, 1992; Middleton-Moz, 1990; Reimer, 1996; Witkin, Lewis & Weil, 1968). Two articles used case examples and vignettes to demonstrate the presence of shame in the therapeutic relationship (Goldberg, 1990; Steiner, 2015). Specific therapeutic techniques for addressing shame were explored in six articles.

Among the three research articles that spoke to the issue of the importance of examining ways in which people resolve and recover from feelings of shame (Brown, 2006; Feiring & Taska, 2005; Van Vliet, 2009), Brown (2006) used Grounded Theory to generate a new theory entitled the Shame Resilience Theory (SLT), which is used to understand shame in women. Brown (2006) also explores practice implications for resolving shame. Feiring and Taska (2005) examine the long-lasting impact of feelings of shame on those who experience sexual abuse and raise the question of whether the emotional experiences of shame is a barrier to healing from sexual abuse. Van Vliet (2009) examines the ways in which individuals recover from shameful events.

A different set of three research articles explored the connection between shame and psychopathology (De Rubeis & Hollenstein, 2009; Schoenleber & Berenbaum, 2010; Tangney et al., 1992). Specifically, De Rubeis and Hollenstein (2009) examined shame-proneness and depressive symptoms; Schoenleber and Berenbaum (2010) examined the associations between shame and Cluster C personality disorders including avoidant, dependent, and obsessive-compulsive personality disorders; Tangney et al., (1992) assessed the links among shame, guilt, psychopathology, and whether those who experience shame have difficulties with interpersonal relationships.

A further two of the ten research articles spoke to the connection between identity development and shame (Cunha et al., 2012); Pinto-Gouveia & Matos, 2011). Cunha et al., (2012) examined adolescent identity development, the impact that shame has on adolescents memories, and common negative emotional states they may experience as a result of shame such as depression and anxiety. Pinto-Gouveia and Matos (2011) investigated whether shame memories become central components of a person's identity. Neither of the final two research articles contained themes that were reflected in the other nine articles. Black et al., (2013) examined the presence of shame within the therapeutic relationship. De France et al., (2017) utilized The Shame Code to examine when adolescents found situations to be stressful.

However, what is missing from the literature is a focused discussion of specific assessments scales and treatment techniques that have been shown to be effective in addressing shame in the therapeutic context. The author is left wondering (1) what specific clinical strategies would help in assessing the pervasiveness of a client's feelings of shame and (2) what specific techniques and strategies have been shown to be effective in helping clients who present with shame (Table 1: Research Articles).

Few articles addressed *how* to reduce shame in a psychotherapy context. Only six out of the ten research studies explicitly explored the treatment of shame in psychotherapy. Of the 34 theoretical articles, only four spoke specifically about treatment techniques (Gilbert & Procter, 2006; Rizvi et al., 2011; Brown, 2009, Yard, 2014) and only five noted the importance of addressing shame within the therapeutic relationship (Goldberg, 1990; Kaufman, 1992; Middleton-Moz, 1990; Reimer, 1996; Witkin et al., 1968).

Among the research articles, Van Vliet (2009), Feiring and Taska (2005), Gilbert and Procter (2006), Rizvi et al., (2011), Brown (2006; 2009), and Yard (2014) all pointed to different treatment modalities but failed to answer the research question of which tools and specific approaches within these modalities were effective in treating adolescents who present with shame. Van Vliet (2009), in a discussion of various approaches, mentions several modalities that other researchers have posited as being

useful in a therapeutic setting: CBT approaches, acceptance and commitment therapy (Hayes et al., 1999) and emotion-focused therapy (Greenberg, 2002). Feiring and Taska (2005) also recommend CBT as a modality of treating shame in children and adolescents. Techniques such as cognitive restructuring and the creation of a list or hierarchy of experiences that were shameful can be used to help children create a narrative around their shame-based experience(s) (Feiring & Taska, 2005). The therapist is instrumental in this process in helping the client confront their shame and fear.

Compassion focused therapy (CFT), which was initially developed for individuals with high levels of shame, focuses on acceptance and understanding which is a powerful and corrective experience for those who are shame-prone (Gilbert, 2011). There have been various nonexperimental evaluations of CFT that indicate positive results. Specifically, a study conducted in the UK included patients who had severe mental health diagnoses and were participating in a day treatment program; the study showed that participants who participated in compassion training experienced decreased shame, self-criticism, feelings of inferiority, depression, and anxiety (Gilbert & Procter, 2006). CFT is a relatively new treatment modality. Leaviss and Uttley (2015) conducted a study that measured the effectiveness of CFT that included fourteen studies and three randomized controlled studies. CFT was found to be an effective treatment for people who were high in shame and self-criticism.

While Linehan's (1993) dialectical behavioral therapy (DBT) is also noted as an effective treatment for individuals with borderline personality disorder (BPD), which is commonly related to chronic and intense feelings of shame, Rizvi et al., (2011) summarize a growing body of research that indicates an association between BPD and shame. Studies that seek to opine about the effectiveness of treatments for BPD and the associated shame must first wait until more research is conducted that explores the role that shame plays in BPD.

Although the majority of the research Brown (2006) conducted was qualitative, a formal evaluation of her curriculum was conducted in three residential substance abuse facilities in California. Brown et al., (2011), citing Hernandez's study (2010), noted that:

statistically significant differences were detected between pre and posttest measures for general health, depression, internalized shame, and self-conscious affect. Statistically significant differences were also detected for each of the elements of shame resilience, indicating that the women involved in this research experienced gains in recognizing and understanding shame; identifying the individual, familial, and societal expectations that fuel shame; understanding the importance of reaching out for social support; and speaking out about shameful feelings and what they needed to reach treatment goals and sustain recovery (p. 356-357).

Brown (2006) introduced Shame Resilience Theory (SRT) which was developed to address the impact that shame has on adult women's mental health. SRT provides a framework for understanding how individuals can cope with shame. Brown (2009) suggests that part of treating shame is understanding one's triggers and building an awareness of one's areas of vulnerability. Connections is a 12-session psychoeducational shame resilience curriculum developed by Brown (2009) in 2006. The curriculum notes that the most significant barrier to working with individuals with shame is fear. Brown (2009) refers to "three quick things about shame: (a) we all have shame, (b) we're all afraid to talk about it, and (c) the

less we talk about it, the more we have it” (p. 360). Brown (2009) focuses a great deal on understanding that shame is pervasive and must be overcome, as well as on the importance of sharing one’s shameful experience with someone you trust, acceptance of the experience, and understanding triggers. What Brown (2009) seems to suggest, though, is that shame must be eliminated from one’s life. This author was not able to find any studies that confirmed that Brown’s approach is effective.

Lastly, Yard (2014) makes two significant points about the treatment of shame. First, she emphasizes the importance of embracing three therapeutic skills in competently treating shame, containment, toleration, and empathy. To reduce worsening shame, Yard (2014) stresses the importance of curiosity, collaboration and sensitive timing in the pace and content of interpretations. Secondly, Yard (2014) emphasizes the importance of therapists recognizing their own experiences of shame, which can easily get in the way of being present and empathic. Shame has the ability to place clinicians in vulnerable positions, interrupting the treatment. Yard (2014) does not discuss ways for clinicians to manage their own shame within their practices, however.

Implications for Practice, Education, and Research

Implications for Practice

The literature on shame is spread across several academic disciplines and is, consequently, varied in its approach to the subject. The majority of the literature reviewed in this study points towards the importance of reducing shame through therapeutic intervention; it is clear that the impact of shame on mental health is extensive (Cunha et al., 2012; De Rubeis & Hollenstein, 2009; Schoenleber & Berenbaum, 2010; Tangney et al., 1992; Nathanson, 1987; Nathanson, 1992; Candea & Szentagotai, 2013). To date, there has been a dearth of well-designed and well-executed studies that could yield clear data about the effectiveness of any given treatment modality. As a consequence, current practitioners must rely on the limited scholarly literature on treatment options, literature that may present nothing more than anecdotal and self-reported “data” and may, however inadvertently, rely on post-hoc reasoning. Practitioners should be aware of the limitations of the extant research into the effectiveness of treatment modalities and the consequent lack of evidence-based treatment strategies that practitioners can deploy. In summary, future researchers and clinicians must be cautious with the treatment strategies that they employ with vulnerable patients given the insufficient data regarding the effectiveness of the currently available treatments.

Implications for Education

While many educational institutions offer practice sequences that teach clinical social work skills that are widely applicable to many practices, exploring concentrated skills for clinical social work, undergraduate and graduate students may not receive instruction on what shame is, how to identify it, and how to work with it. For example, Tangney and Dearing (2011), who have done extensive research on shame, have noted that client shame was never a focus of their clinical training. Similarly, Brown (2009) states that limited psychotherapy training merely mentions client shame.

The implications for education are deeply rooted in shame-focused evidence-based treatment research studies, which are scarce. In order for clinicians to effectively treat shame, experimental research designs that will yield reliable data are needed to evaluate effectiveness of shame-focused interventions.

The psychotherapeutic treatment of shame has been a long-overlooked clinical area in the field of social work. What is needed next are effective treatment modalities for addressing shame in therapy in which to ground appropriate curricula (Tangney & Dearing, 2011).

Implications for Research

In conducting this study, this author became aware that the scholarly research into shame and how to treat it is dominated by study designs that are non-experimental and cross-sectional. This study revealed that there is a lack of specific instruments available to measure shame that can yield data that is broadly applicable or that can reveal causation rather than simply correlation. While there are several shame scales that use scenario-based measures such as Self-Conscious Affect and Attribution Inventory (SCAAI), Test of Self Conscious Affect (TOSCA), and Attributional Style Questionnaire (ASQ), these measures lack internal consistency. The data that is derived from such situation-based measures has its own unique variance and cannot reliably be extrapolated to other non-identical scenarios. Other studies employ various methods of self-report data collection such as surveys and questionnaires including, but not limited to, the Experience of Shame Scale (ESS), Guilt and Shame Proneness Scale (GASP), Test of Self-Conscious Affect (TOSCA), and The Shame Inventory. While much is learned from these scales, they are unable to capture the experience of shame as it occurs and is observed by others.

Whether the lack of specific instruments or the complexity of shame is the cause of, or is independent of, the decisions made by researchers when formulating their research designs, this scoping study has elucidated the fact that there is a dearth of randomized, experimental designed research studies that examine the psychotherapeutic treatment of shame.

Given that causal inferences cannot be drawn from the data yielded by these types of studies, it is not possible to make an evidence-based assessment regarding the effectiveness of the interventions described in studies such as these. Van Vliet (2009) and Brown (2006), recognizing the problematic nature of such research, used grounded theory for their studies. As discussed by Creswell (2013), grounded theory research moves beyond narrative research, allowing the researcher to develop a theory that offers an explanation or framework for future research. Limitations of using grounded theory, however, include research bias, insufficient details within very large volumes of data, and questionable trustworthiness of the findings (Rubin & Bellamy, 2012, p. 252).

As a whole, researchers have found that shame is difficult to measure and evaluate. For researchers who opt to use scenario-based instruments to study shame, the usefulness of their results could be enhanced if the chosen scenarios were specifically targeted to the population being studied. It is critical that future researchers make attempts to study shame in a more systematic, evidence-based approach (Van Vliet, 2009).

Conclusion

Shame presents with many different faces, including feelings of inferiority, worthlessness, and a global sense of self-condemnation and is not infrequently seen in psychopathology such as depression, bipolar, schizophrenia, and narcissism (Morrison, 1989; Nathanson, 1987). The literature reviewed in Table 1: Research Articles reflects a great deal of shame research within the psychotherapeutic context, however, there is a dearth of randomized, experimental designed studies that specifically address and/or assess the effectiveness of shame-focused interventions in psychotherapeutic contexts involving

adolescents. While there are some, albeit few, studies that posit strategies for exploring shame within the psychotherapeutic context, more exploration is needed to elucidate how shame reduction can actually be achieved. Researchers must take steps to develop a deeper understanding of treating adolescent shame in psychotherapy. Future studies using scientifically informed, randomized experimental designs can clarify the effectiveness of shame-based treatments in psychotherapy (Tangney & Dearing, 2011).

Table 3: Research Articles

AUTHOR(S), PUBLICATION YEAR, STUDY LOCATION	STUDY POPULATION	AIM OF THE STUDY	METHODOLOGY	OUTCOME MEASURES	IMPORTANT RESULTS
Black, R.A., Curran, D., & Dyer, K. F. W. (2013). Primary care adult mental health service.	50 treatment-receiving adults ages 21-67 with an assortment of mental health diagnoses.	To examine the presence of shame and its associated coping styles within the therapeutic relationship and intimate relationships.	Questionnaire measures of shame states, shame coping styles, intimate relationship functioning, and the therapeutic alliance.	<i>Compass of Shame Scale, State Guilt and Shame Scale, The Working Alliance Inventory—Short Form, The Multidimensional Relationship Questionnaire (MRQ).</i>	Using withdrawal to cope with shame made individuals less likely to have a valuable therapeutic alliance and to have dissatisfying intimate relationships.
Brown, B. (2006). The University of Houston.	215 women with a mean age of 40 years old.	To generate a theory about women's experience of shame, and to understand strategies women use to resolve shame.	Conversational interviews via telephone or e-mail.	N/A.	Shame resilience theory (SRT) emerged from the data.
Cunha, M., Matos, M., Faria, D., & Zagalo, S. (2012). Public schools in the district of Coimbra, Portugal.	354 adolescents (157 boys and 197 girls) from 7 th -12 th grade.	To explore the relationship between shame, shame memories, and their impact on one's psychopathology in adolescence.	Adolescents were given a brief description on the purpose of the study. Adolescents completed the measures at the beginning of class at the same time and order as the rest of their classmates.	<i>Priming for the Shame Memory, Centrality of Event Scales (CES), Impact of Event Scale-Revised (IES-R), Other as Shamer (OAS), Internalized Shame Scale (ISS), Depression, Anxiety and Stress Scale (DASS-21).</i>	Shame traumatic memory and centrality of shame memory are connected to external and internal shame, depression and anxiety symptoms. Shame memories tend to exist as negative narratives tied closely to one's sense of self.

AUTHOR(S), PUBLICATION YEAR, STUDY LOCATION	STUDY POPULATION	AIM OF THE STUDY	METHODOLOGY	OUTCOME MEASURES	IMPORTANT RESULTS
De France, K., Lanteigne, D., Glozman, J., & Hollenstein, T. (2017). Southern Ontario.	149 youth between the ages of 12-17.	To assess the ability of the Shame Code to detect the amount of shame adolescents experienced during a socially stressful situation.	Filled out questionnaire on computer. Then, the experimenter asked the participants to provide a three-minute speech on any topic of their choice without preparation. Participants then completed a state-based self-report measure of the level of shame s/he experienced while participating in the speech task.	<i>The Shame Code.</i>	The Shame Code is a reliable coding scheme that is able to measure shame behaviors in real time.
De Rubeis, S., & Hollenstein, T. (2009). University of Toronto.	89 girls and 52 boys ages 11-16.	This study examined a mediation model of shame-proneness and depressive symptoms in adolescents, using avoidant coping as a mediating variable.	141 individuals filled out web-based questionnaires used to measure shame-proneness, depressive symptoms, and avoidant coping. 46 of those 141 did a one-year follow-up and filled out same questionnaire.	<i>Children's Depression Inventory (CDI), Test of Self-Conscious Affect for Adolescents (TOSCA-A), Children's Coping Strategies Checklist (CCSC).</i>	Shame proneness was a significant predictor of depressive symptoms, both concurrently and over the course of a year.
Feiring, C., & Taska, L. S. (2005). Urban and suburban populations in New Jersey.	118 sexually abused children ages 8-15.	To examine if shame is a long-lasting emotional consequence of sexual abuse.	Structured interviews.	<i>The Test of Self-Conscious Affect for Adolescents (TOSCA-A), The Children's Impact of Traumatic Events Scale-Revised, The Trauma Symptom Inventory (TSI), My Family and Friends (MFF).</i>	Children who experienced abuse-related shame were at high risk of maintaining high levels of shame throughout their lives. They were also prone to, experiencing more severe levels of PTSD symptoms.

AUTHOR(S), PUBLICATION YEAR, STUDY LOCATION	STUDY POPULATION	AIM OF THE STUDY	METHODOLOGY	OUTCOME MEASURES	IMPORTANT RESULTS
<p>Pinto-Gouveia, J. & Matos, M. (2011).</p> <p>University of Coimbra, Coimbra, Portugal</p>	<p>811 participants from general population, consisting of 481 undergraduate students and 330 subjects from normal population.</p>	<p>To explore the nature of shame as a central component to a person's identity.</p>	<p>Filled out self-report questionnaires that measured external shame, internal shame, traumatic memory characteristics and psychopathology.</p>	<p><i>Other As Shamer Scale (OAS), Experience of Shame Scale (ESS), Depression, Anxiety and Stress Scale (DASS-42), Centrality of event scale (CES), Impact of event scale-revised (IES-R).</i></p>	<p>Early shame experiences show centrality of memory characteristics.</p> <p>Individuals who recall significant shame memories from childhood and adolescence reveal more internal and external shame in adulthood.</p> <p>There is a high, positive correlation between recalled shame experiences and depression, anxiety, and traumatic stress reactions.</p>
<p>Schoenleber, M., & Berenbaum, H. (2010).</p> <p>University of Illinois at Urbana-Champaign.</p>	<p>237 undergraduate students, ages 18-27.</p>	<p>To examine connections between shame and Cluster C personality disorders.</p>	<p>The Positive Affect Negative Affect Schedule (PANAS) was administered and audiotaped by an investigator.</p> <p>The Test of Self-Conscious Affect-3 (TOSCA-3) presents 16 scenarios to a participant which they rate on a scale of 1-10.</p> <p>The Shame-Aversive Reactions Questionnaire (ShARQ) presents 14 statements with which they rate on a 7-point Likert scale.</p>	<p><i>The Positive Affect Negative Affect Schedule (PANAS), Test of Self-Conscious Affect-3 (TOSCA-3), Shame-Aversive Reactions Questionnaire (ShARQ).</i></p>	<p>There is a strong association with shame and Cluster C Personality Disorders.</p> <p>Cluster 3 PD's including avoidant, dependent, or obsessive-compulsive were prone to experience shame as aversive.</p> <p>Participants with Dependent personality disorder (DPD) correlated shame with pain.</p>

AUTHOR(S), PUBLICATION YEAR, STUDY LOCATION	STUDY POPULATION	AIM OF THE STUDY	METHODOLOGY	OUTCOME MEASURES	IMPORTANT RESULTS
<p>Tangney, J. P., Wagner, P., & Gramzow, R. (1992).</p> <p>George Mason University.</p>	<p>Study 1: 245 students ranging from ages 18-55; Study 2: 234 students ranging from ages 17-35.</p>	<p>To examine the links between shame, guilt and psychopathology.</p>	<p>Questionnaires.</p>	<p><i>The Self-Conscious Affect and Attribution Inventory (SCAAI), The Test of Self-Conscious Affect (TOSCA).</i></p>	<p>There is an association between shame- proneness and impaired empathy, an inclination to externalize blame and regulate periods of anger.</p> <p>Shame-prone individuals have difficulty in interpersonal relationships.</p>
<p>Van Vliet, K. J. (2009).</p> <p>University of Alberta, Edmonton, Alberta, Canada.</p>	<p>13 adults ranging from ages 24-70.</p>	<p>To examine how adults recover from experiences of shame</p>	<p>Face-to-face, semi- structured interviews.</p>	<p>N/A.</p>	<p>Participants recovered from experiences of shame by lessening the incongruities between their actual selves and their ideal selves, and embracing a more realistic self ideal.</p>

Table 2: Article by Category

<i>Articles by Category</i>
Research Articles (N=10)
Black, R.A., Curran, D., & Dyer, K. F. W. (2013); Brown, B. (2006) Cunha, M., Matos, M., Faria, D., & Zagalo, S. (2012) De France, K., Lanteigne, D., Glozman, J., & Hollenstein, T. (2017); De Rubeis, S., & Hollenstein, T. (2009); Feiring, C., & Taska, L. S. (2005); Pinto-Gouveia, J. & Matos, M. (2011); Schoenleber, M., & Berenbaum, H. (2010); Tangney, J. P., Wagner, P., & Gramzow, R. (1992); Van Vliet, K. J. (2009)
Theoretical Articles (N=34)
Bennett, D. S., Sullivan, M. W., & Lewis, M. (2005); Arksey, H., & O'malley, L. (2005); Berzoff, J., Melano Flanagan, L., and Hertz, P. (2008); Black, R. A., Curran, D., & Dyer, K. W. (2013); Brown, B. (2008); Brown, B. (2009); Brown, B., Hernandez, V. R., & Villarreal, Y. (2011); Candea, D.-M., & Szentagotai, A. (2013); Creswell, J.W. (2013); Curtis, A. C. (2015); Dickerson S. S., Gruenewald T. L., Kemeny M. E. (2004); Erikson, E. H. (1959/1980); Gilbert, P., & Irons, C. (2005); Gilbert, P., & Procter, S. (2006); Gilbert, P. (2011); Goldberg, C. (1990); Greenberg, L. (2002); Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999); Heller, A. (2003); Kaufman, G. (1992); Klimstra, T. A., Hale, William W., I.,II, Raaijmakers, Q. A. W., Branje, S. J. T., & Meeus, W. H. J. (2010); Levin, P. (2015); Mark, B. S., & Incorvaia, J. A. (1995); McNeece, C. A., & Thyer, B. A. (2004); Middleton-Moz, J. (1990); Morrison, A. P. (2011); Nathanson, D. (1987); Nathanson, D. (1992); Phoenix, T. L. (2001); Reimer, M. S. (1996); Rubin, A., & Bellamy, J. (2012); Steiner, J. (2015); Urdang, E. (2010); Witkin, H. A., H. B. Lewis and E. Weil. (1968); Yard, M. A. (2014)
Seminal Books (N=3)
Darwin, C. (1872); Lewis, H. B. (1971); Tangney J. P., & Dearing R. L. (2011)
Articles that Expounded on Treatment Techniques (N=6)
Brown, B. (2006; 2009); Feiring, C., & Taska, L. S. (2005); Gilbert, P., & Procter, S. (2006); Rizvi, S. L., Brown, M. Z., Bohus, M., & Linehan, M. M. (2011); Yard, M. A. (2014)

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Social work for all species: Dual consideration of social work ethics and the human-animal bond

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Abstract

The lives of social work clients can be greatly enhanced by relationships with non-human animals. This paper presents the viewpoint that recognition of the beneficial nature of the human-animal bond and support for clients who seek animal companionship is not only within the scope of ethical social work practice, but also an essential competency in contemporary social work practice. Using the six social work values of the *Code of Ethics* (service, social justice, importance of relationships, dignity and worth, integrity, and competence) to frame the discussion, the paper presents examples of each value in action as it applies to animal assisted interventions and to clients' relationships with their own pets. The authors introduce several real-world clinical examples supporting this viewpoint. Overall, the paper makes recommendations to social workers on how to practice ethically with regard to non-human animals and discusses steps to be taken within the field to promote these practices.

Keywords: Human-animal bond, social work ethics, companion animals, animal-assisted therapy

Introduction and Background

Social work practice continues to evolve in response to the needs of communities that social workers serve. Over the past several decades, pets have become a common part of family structure in the United States (American Veterinary Medical Association [AVMA], 2012). Moreover, social workers have incorporated therapy animals into their work in a variety of settings (Fine, 2015). The human-animal bond, a term that encompasses human relationships with non-human species as pets or in a therapeutic context, is credited with enhancing quality of life and decreasing a variety of physical and psychological symptoms for millions of Americans (Lem, Coe, Haley, Stone, & O'Grady, 2016; Ogechi, et al., 2016; Wood et al., 2017). This is particularly true for individuals who face social isolation or are otherwise marginalized. Because of the central importance that the human-animal bond plays in the lives and well-being of many individuals and families, social workers should be attuned to these relationships and

consider their potentially significant influence when working with clients. Furthermore, social workers should provide support for clients who seek to benefit from the companionship of non-human animals.

The social work *Code of Ethics*, originally published in 1960, has grown and changed over time to reflect the profession's evolution (National Association of Social Workers [NASW], 2017). While the *Code* does not currently reference relationships with non-human animals, the core values of service, social justice, importance of relationships, dignity and worth, integrity, and, competence can be interpreted to include the role of clients' companion animals and the benefits of social work interventions involving animals. Given the rising popularity of animal assisted interventions (AAI) and demographic trends in pet ownership, contemporary social workers may frequently come in contact with non-human animals in the course of their work (Evans & Gray, 2012). Dual consideration of social work ethics and the human-animal bond is therefore not only within the scope of social work practice but emerging as a timely and relevant competency in the field. Through case examples and discussion of relevant literature, this paper is meant to shed light on the potential applications of this dual consideration to clinical social work practice.

Key Terminology and Statistics

According to the AVMA (2012), about 85 million United States households have a pet, and sixty-percent of pet owners consider these animals to be family members. Further study suggests that up to ninety-seven percent of pet owners include these animals in descriptions of their families (Risley-Curtiss, 2010). The importance of pets in the family structure is highlighted in the synonymous term, "companion animal," which is often used in literature pertaining to the human-animal bond (American Society for Prevention of Cruelty to Animals, 2018). Pet ownership is associated with a range of physical health and psychosocial benefits. Among adults without chronic health conditions, cat or dog ownership is correlated with a decreased risk of cardiovascular disease (Ogechi et al., 2016). Street-homeless youth with dogs have lower rates of clinical depression than their peers without dogs (Lem et al., 2016). Pet-owning residents in high-density urban areas are more likely to know their neighbors, an indicator of social cohesion, than residents without animals (Wood et al., 2017). These benefits underscore the potential importance of companion animals as an integral part of holistic treatment planning.

While not all clients on a social worker's case load benefit from or even enjoy spending time with animals, many clients' lives are enhanced immeasurably by the human-animal bond. Non-human animals play a wide range of formal roles in social work settings. In Animal Assisted Therapy (AAT), social work clinicians incorporate trained and certified animals in the course of goal-directed interventions. Examples include involvement of animals in psychotherapy, or in medical settings to increase patient engagement in physical or occupational therapy exercises (Abrahamson, Richards, Cline & O'Haire, 2016; Bachi & Parish-Plass, 2017). Conversely, the term Animal Assisted Activities (AAA) refers to unstructured contact between clients and therapy animals. AAA are typically not directed by professionals and often are comprised of a volunteer handler bringing their certified therapy animal to visit hospital patients, or children in schools (Anderson & Olson, 2010; Ichitani & Cunha, 2016). AAI is an umbrella term that encompasses AAT and AAA, as well as interventions not fitting into either category, such as courthouse dog programs designed to provide emotional support to victims during testimony (Fine, 2015).

Methodology and Scope

This paper explores a dual consideration of ethical social work practice and the human-animal bond using the six core values of the *Code of Ethics* as a framework. Drawing from the existing literature on human animal interactions, the authors present relevant research findings and case studies from their own practice to illustrate ethical practice pertaining to clients' relationships with companion animals and the implementation of AAI. Throughout the paper, the *Code* is quoted and otherwise explicitly referenced. In some cases, the authors have re-worded phrases within the *Code* that use human-centered language. Most notably, the principle of *Importance of Human Relationships* has been presented as the principle of *Importance of Relationships*. While social workers' duty to ethically serve human clients is the primary focus, this paper discusses some principles of animal welfare. Consideration of human and animal well-being are not mutually exclusive in social work practice (Taylor, Fraser, Signal, & Prentice, 2016). In fact, practices that promote the welfare of clients' animals or therapy animals can benefit clients' overall well-being. A social worker can model appropriate self-care or relational norms and maximize the impact of the human-animal bond through promotion of interactions with healthy animals mutually able to benefit (Evans and Gray, 2012; Fine, 2015).

Social Work Value: Importance of Relationships

The *Code* recognizes that, "relationships between and among people are an important vehicle for change" and advises social workers to "engage people as partners in the helping process" (NASW, 2017). For many individuals, the relationship with an animal may stand in for or complement the benefits of human relationships. One of the authors (Karlovits) works as an in-home assessment clinician and once evaluated Anna¹, a four-year-old girl, to determine whether Anna would benefit from services addressing sensory integration issues and speech delays. Anna's mother Claire recently separated from her husband, and Claire and Anna moved to a town several hours away from friends and extended family. Claire became tearful while discussing the challenge of starting over and expressed guilt over the potential impact that these life changes might have on Anna. Just as the author was about to respond, Bella, the family mastiff, bounded into the room with Anna. Claire began to laugh and shared that spending time with Bella was, "like therapy" for her and Anna, and that spending time with Bella helped her to enjoy parenting and have optimism about the future.

Importance of Relationships and Clients' Companion Animals

The role that the family mastiff played in Anna's home life highlights the potential of human-animal relationships for facilitating human social support. Claire, for example, might make the acquaintance of other neighbors while walking Bella or taking Bella to the dog park; these acquaintances could develop into a social support network for her family. In fact, many individuals experiencing social isolation find that pets provide a feeling of connection that can positively impacts overall well-being (Bryant, 2008). For people coping with chronic and terminal illnesses, pets may also provide unconditional acceptance that their human companions, family, and friends may lack. In a study of men with AIDS, those who were closely attached to pets had significantly lower rates of depression than their counterparts without strong bonds to a companion animal; this increased adherence to medical directives which has potential implications for increased life expectancy (Siegel, Angulo, Detels, Wesch, & Mullen,

¹ Several case studies are discussed in this paper. All names and identifying information have been altered to preserve client confidentiality.

1999). For many individuals experiencing homelessness, pets provide comfort and emotional support, encourage responsibility, and can even facilitate interactions with others (Fine, 2015). A recent study on LGBT+ youth identified that many young adults *come out* as their identified sexual orientation or gender identity to their companion animals prior to their human family members (Jin, 2018). In each of these examples, the non-judgmental presence of trusted animal companions facilitated human social engagement and support.

Moreover, research on the physiological basis of the human-animal bond provides further support for the health benefits of spending time with companion animals. In a brief pre-test/post-test intervention study of play between dogs and owners, Odendaal and Meintjes (2003) found that the humans participants measured increased exogenous levels of the affiliative hormone oxytocin and the “feel good” hormone dopamine, and decreased levels of the stress hormone cortisol. These results are consistent with pet owners’ reports that animals provide, “self-esteem, calmness, soothing, and acceptance” (Brown, 2007, as cited in Walsh, 2009, p. 469). Odendaal and Meintjes’ (2003) study also found that the dogs measured increased levels of oxytocin and dopamine following playtime with their owners. This suggests there are mutually beneficial aspects of human-animal interactions. As stated previously, many pet owners consider their pets to be family members. Social workers might honor clients’ potential relationships with animals by asking about pets during a general intake questionnaire that would also ask about human family members (Risley-Curtiss, 2010).

Importance of Relationships and AAT/AAI

All models of AAI build upon the benefits of human-animal interactions discussed above. Similar physiological benefits have been measured in human participants in both canine and equine assisted therapy. Preliminary evidence suggests that animal assisted treatment for symptoms of post-traumatic stress disorder (PTSD), is associated with increased oxytocin levels, (Abrahamson et al., 2016). Higher levels of oxytocin, the neurotransmitter that modulates social behavior and physiological arousal, may facilitate decreased physiological PTSD symptoms including hypervigilance and heightened startle response (Yount, Ritchie, Laurent, Chumley & Olmert, 2013). The presence of an animal in therapy can also alleviate anxiety or physiological arousal associated with seeking help, allowing clients to feel safe and able to participate in an intervention (Hunt & Chizkov, 2014). If a client is reluctant to seek treatment and has positive relationships with animals, a social worker might consider referring the client to an appropriate AAI.

Social Work Value: Competence

Social workers are ethically bound to “develop and enhance their own areas of expertise” and advised to “practice within their areas of competence and consult and collaborate with professionals across disciplines as appropriate” (NASW, 2017). When social workers involve non-human animals in their work, they assume the ethical responsibility to understand the nuances of the intervention and ensure safety for both the client and animal (Fine, 2015). Equine assisted therapy has emerged as a promising modality for the primary or adjunctive treatment of behavioral health disorders (Hallberg, 2017). While some social workers may have competencies necessary to manage the equine components of the modality, some practitioners involve an equine professional to focus on the horse’s needs and behaviors during the intervention (Zilcha-Mano, Mikulincer, & Shaver, 2011). Irrespective of whether the social work involves an equine professional, the decision to make accommodations for both client and animal well-being communicates that the social worker is practicing with their areas of expertise.

Competence and AAT/AAI

The act of a social work clinician partnering with an equine professional to ensure high quality service could communicate that the clinician is committed to practicing within their areas of expertise and open to collaborating with other professionals to meet client needs. Social workers can develop competence in working directly with animals, or in implementing AAI through continuing education programs. At the time of this writing, two University-based schools of social work offer comprehensive certificate programs addressing the social work role in human-animal interactions. The Graduate School of Social Work at University of Denver houses the Institute for Human-Animal Connection (IHAC). Through IHAC, social workers and students can pursue certificates in Animal Assisted Social Work and Equine-Assisted Mental Health. IHAC also hosts professional conferences and IHAC faculty maintain active research agendas related to human-animal interactions (Institute for Human-Animal Connections, 2018).

Similarly, at the University of Tennessee-Knoxville, the Schools of Veterinary Medicine and Social Work host an interdisciplinary certificate program in Veterinary Social Work. Students can take courses towards this certificate during or after their MSW program, and develop competencies in AAI, the link between human and animal violence, animal-related grief and bereavement, and compassion fatigue (Veterinary Social Work, 2017). Both programs can be completed while one is a current MSW student or after graduation for continuing education credits. The online format of both programs' post-graduate options enhances the accessibility of high-quality social work education.

Social workers wishing to involve their own animals in practice settings must first identify the kind of work for which their animal might be best suited. Traditional notions of a 'therapy animal' might be a friendly visiting program in a hospital. Programs employing such animals exist in a wide range of medical settings and have been associated with decreased chronic physical pain and increased reported mood in patients (Coakley & Mahoney, 2009; Ichitani & Cunha, 2016; Kaminski, Pellino, & Wish, 2002). In order to participate in visiting programs in hospitals or other facilities, animals (most commonly dogs) typically require certification from one of the many accrediting bodies including Pet Partners, Therapy Dogs International, and a wide range of locally operated therapy animal organizations. Certification is achieved by examination; animals must pass obedience tests and demonstrate familiarity with scenarios that might be common in the line of therapy work (Pet Partners, 2014; Therapy Dogs International, 2018).

Non-hospital settings, such as schools, nursing homes, and libraries often also require certification, which can often be obtained from the same organizations that certify animals for hospital visiting programs (Anderson & Olson, 2010; Kirnan, Siminerio, & Wong, 2016). In a clinical practice setting, therapy animals play a different role and might be required to be more interactive with clients and respond to emotional cues (Chandler, 2005). Social workers must be aware of their animal's temperament and the settings in which the animal might best meet the needs of clients. For instance, animals suited for hospital visiting programs might not be appropriate in a library reading program. Here, part of the social worker's duty of competence is to determine an appropriate role for their animal based on the animal's temperament, strengths, and comfort level (Howie, 2015; Vanfleet & Faa-Thompson, 2017). Consultation with an animal behaviorist can be an important tool for social workers during the process of determining what role, if any, their animal might play in social work practice.

Competence and Clients' Companion Animals

Clients may ask social workers for advice regarding pet care and training, particularly if the social worker involves an animal in their practice. Social workers should be mindful of remaining within the bounds of their professional roles. While social workers might discuss the relationships that clients have with their pets, or even discuss the training approaches, social workers should refer questions in the scope of veterinary medicine or animal behaviorism to the appropriate professionals. The training programs referenced earlier emphasize the importance of establishing interdisciplinary connections between social work and animal serving professionals (Institute for Human-Animal Connections, 2018; Veterinary Social Work, 2017). To support clients while also remaining within the bounds of professional competencies, social workers might consider creating a list of local resources for distribution including free and low cost veterinary care, animal training, and animal rescue organizations.

Social Work Value: Service

To meet the needs of clients, social workers, “elevate service to others above [their own] self-interest” and to “draw on their knowledge, values, and skills to help people in need” (NASW, 2017). Client needs must take precedence in any social work intervention, including those involving animals. Self-disclosure about companion animals, for example, has the potential to enhance client outcomes, but should be used intentionally for this purpose. One of the authors (Cabral) works in a program that empowers aging out foster youth to develop job skills through internships and volunteer work at local animal shelters. Part of her role is to support participants in managing frustration and difficult emotions elicited by the tedious or unpleasant components of shelter work. She adopted her own dog from a shelter and often refers the ways that rescue organizations and their volunteers saved her dog’s life. This form of self-disclosure helps program participants to re-frame their own role in the larger context of animal rescue, ultimately supporting participants’ development of coping skills to manage stress and tolerate frustration in the workplace. Here, the author draws on personal experience and knowledge to benefit clients’ overall development and well-being.

Service and AAT/AAI

Social workers can ensure that animals are only involved in client work if involvement benefits the client. A social worker should not implement AAI out of self-interest, for example, if the social worker lacks pet care during a long shift and brings their animal into the work setting in place of paying a pet sitter. Successful implementation of AAI requires a clinician to be familiar with the benefits of the human-animal bond, and to have a strong understanding of how to integrate animals into the therapeutic setting (Bachi & Parish-Plass, 2017). The social worker should use this knowledge to ensure that the use of an animal in the intervention is appropriate for the client. Likewise, a social worker should not provide AAI to a client who would not benefit from or does not wish to participate in this form of intervention. During the intake process, the social worker should first determine whether AAI is appropriate for and desired by the client. A social worker might assess the importance of animals or pets in the life of the client and ask about for any past negative experiences with or allergies to animals which might preclude the client from safe participation in AAI (Kaminski, et al., 2002).

Furthermore, the social worker should ensure that the animals involved in the therapeutic setting are certified and screened by an organization that specializes in evaluating animals to safely participate in AAI (Coakley & Mahoney, 2009). Best practices for screening an animal for participation in AAI include

certification by an accrediting body and additional testing for animal temperament. When applicable, the social worker's ongoing communication with their coworkers is necessary to ensure that the AAI is not disruptive to other services being provided in proximity to the AAI (Abrahamson et al., 2016). For example, an outpatient social worker might notify coworkers of days that the therapy animal is scheduled to be present; this would allow other social workers to notify phobic or allergic clients to avoid scheduling appointments on those days.

Service and Clients' Companion Animals

The bond between humans and their companion animals is powerful and social workers can serve clients by acknowledging the importance of their pets and applying the same values and skills towards the relationship that they might employ when working with human members of a client's family (Risley-Curtiss, Holley, & Wolf, 2006). A social worker can fulfill the value of service through empowering clients to properly care for their pets. Programs exist that increase the likelihood of appropriate pet care for individuals with barriers to appropriate veterinary care. The shelter medicine program at The University of Pennsylvania School of Veterinary Medicine, for example, trains veterinary students to serve low-income communities surrounding the University through education about basic animal care and promotion of preventative veterinary medicine. The goal is to prevent relinquishment of pets to shelters in response to treatable behavioral and health issues (Penn Vet, 2018). While not explicitly a social work program, the shelter medicine program exemplifies the value of social work service as it assists vulnerable individuals in maintaining ownership of their pets and, therefore, continuing to reap the benefits of the human-animal bond.

Social Work Value: Social Justice

Social justice is at the heart of social work practice; social workers are beholden to "pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people" (NASW, 2017). There are many programs that tap into the human-animal bond to empower marginalized individuals progress towards independence. In the prison-based New Leash on Life program inmates learn dog training and handling skills and prepare the dogs to be adopted to new families or become service animals (New Leash on Life USA, 2018). The program is mutually beneficial. The dogs, who often were at risk of euthanasia, benefit from round-the-clock contact with a devoted caregiver who is becoming proficient in reading and responding to canine body language. Inmates develop skills in dog training that could be transferable to post-incarceration employment and forming emotionally beneficial relationships with dogs (Strimple, 2003).

Social Justice and AAT/AAI

The New Leash on Life program is a powerful example of an AAI that has short and long-term benefits for participants. It exemplifies the core value of social justice and has been successful in its approach to support inmates preparing for re-entry. Social workers may promote social justice by implementing AAI in work with clients who may be unable to have a pet due to socioeconomic status, disability or other form of disenfranchisement (Evans & Gray, 2012). AAI has been implemented in settings including psychiatric hospitals, juvenile justice centers, and domestic violence shelters (Chandler, 2005; Fine, 2015). This allows clients to benefit from the human-animal bond when pet ownership may not be possible or when an individual may be temporarily separated from their pet.

Additionally, social workers might also work to alleviate barriers to accessing AAI. As discussed previously, equine assisted therapy is a promising treatment for a wide range of physical and psychological health conditions (Hallberg, 2017). Because horses require specialized environments such as riding centers or farms, equine therapy programs tend to be located in rural areas, thus limiting access to clients in urban areas, and services may be costly and not covered by standard health insurance (Buck, Bean, & de Marco, 2017). To support marginalized client populations that might benefit from this modality, agency-based social workers could apply for grants to offer equine therapy as an adjunct to regular services, or advocate for program funders and donors to cover some of the costs associated with the modality, including those for transportation.

Social Justice and Clients' Companion Animals

Another importance component of social justice is, “promoting sensitivity to and knowledge about oppression and cultural and ethnic diversity” (NASW, 2017) With regards to clients' pets, social workers can express respect and appreciation for clients' differing cultural attitudes towards animals. While the human-animal bond is documented across cultures, clients might have strong and culturally-informed opinions about animal care and training, and the roles that animals are expected to play (Risley-Curtiss, Holley, & Wolf, 2006). These opinions may differ greatly from the social worker's. One of the authors (Wenocur) previously worked in a family homeless shelter and integrated trained therapy dogs into the work. Many families living in the shelter shared their experiences of having dogs for the purpose of protecting their family from harm and expressed surprise when the author shared that her dog was not in a position to provide any protection for her.

Just as social workers should honor the diversity of family structure in their clients, social workers should not presume clients' relationships with animals to mirror their own. An exploratory study found that there were differences based on race and ethnicity in people's attitudes toward the importance of spaying and neutering pets, providing regular veterinary care, and declawing cats (Risley-Curtiss, et al., 2006). Individual and cultural differences can be a delicate issue to address with clients. Social workers are encouraged to maintain a stance of curiosity and openness when learning about different cultures, but also to promote justice for vulnerable populations such as the animals that we encounter in the field. While some people maintain an attitude of dominance toward animals, social workers have an opportunity to open discussion with clients about the greater value of animals (Hyers, 2015).

Social Work Value: Dignity and Worth

Social workers must approach relationships with clients, “in a respectful fashion” and to be, “mindful of individual differences” that impact clients' behavior and overall functioning (NASW, 2017). This is particularly important when working with marginalized populations, including individuals who may be isolated. Early in her career, the one of the authors (Wenocur) was a case manager in a public nursing facility. Many of the residents had lived there for years, and lived with debilitating conditions including traumatic brain injury, late-stage Huntington's disease, and advanced dementia. Visitors were infrequent, and most residents lacked social connections to the outside world. There were, however, several facility cats that roamed the halls freely. Some residents found immense comfort in spending time with the cats and would describe the cats as their friends or loved ones. Some higher functioning residents assisted in the care of the cats and would proudly discuss their contributions to the cats' well-being.

Dignity and Worth and AAT/AAI

Interactions with the cats provided the nursing home residents with much needed social engagement, and evoked joy and a sense of purpose among the residents. This is a particularly impactful intervention for clients who may be socially isolated (Bryant, 2008). Through the introduction of the onsite cats, the nursing home facilitated recognition of individual clients' dignity and worth. Social workers are also called upon to remain, "cognizant of the dual responsibility to clients and the broader society," which may include taking steps to support programs that promote dignity and worth of the person (NASW, 2017). On a macro level, social workers might advocate for legislation that broadens the reach of these modalities through programmatic and research funding support. Inspired by the impact of therapy dogs on students healing from the trauma of the Sandy Hook Elementary School shooting, the state of Connecticut passed a bill that provided organizational structure and funding for therapy dogs to be deployed to areas impacted by large scale tragedy (An Act Concerning Animal Assisted Therapy, 2013). At the federal level, there has been at least one request for applications for funding exploratory demonstration projects on the efficacy of AAI (Department of Health and Human Services, 2016). In the long term, social workers can fulfill the dual responsibility to clients and broader society through promotion of such legislation, particularly if the legislation results in expansion of AAI and AAT to isolation or otherwise marginalized individuals.

Dignity and Worth and Clients' Companion Animals

Social workers might also express respect for the dignity and worth of the person through, "promoting clients' socially responsible self-determination" (NASW, 2017). Opportunities for social workers to promote the dignity and worth of clients in this manner may arise frequently, especially for clinicians who provide services in clients' homes and witness interactions between clients and their pets. As previously discussed, social workers should be mindful of cultural differences that might impact treatment of pets and should not provide advice outside the scope of social work expertise. However, social workers can support clients to make informed decisions about pet care through provision of reading materials and other resources. The cellphone application "Dog Decoder" (Breitner, 2015) costs only a few dollars and includes cartoons delineating the subtleties of dog body language. This resource enhances clients' abilities to respond to dog communication patterns and promotes mutual respect and enjoyment in the human-animal bond. Similarly, children's books such as, "Tails are Not for Pulling" by Elizabeth Verdick (2005) might assist families with children in setting limits around interactions with animals and empower children to recognize the impact that their behavior may have on their dog's well-being.

Social Work Value: Integrity

In social work practice, integrity is defined as the, "responsibility that social workers have to behave in a trustworthy manner" and includes "maintaining an awareness of profession's ethical standards and practices and promoting these [practices] within [professional] organizations" (NASW, 2017). A social worker might demonstrate integrity to clients through honest recognition of and response to an animal's expression of their needs. In turn, this communicates to clients that the social worker is capable of acknowledging and responding to client needs. One of the authors (Cabral) has a dog named Raina who is certified as a therapy dog. While volunteering at Children's Hospital of Philadelphia (CHOP), the author recognized that CHOP was not the best fit for Raina based on the dog's body language. Raina was far too playful and rambunctious around children, which was inconsistent with the hospital's expectation that therapy dogs remain calm and under the control of the handler. The author

knew that Raina was more relaxed around older adults and began to bring Raina to visit nursing homes and adult hospital populations. Raina quickly became a welcome, anticipated visitor in the nursing home, and displayed excited and joyful body language when visiting.

Integrity and AAT/AAI

Although the author had been excited to volunteer at CHOP, Raina's temperament was better suited for work with adult clients. Involving Raina, a dog who showed visible discomfort during her visit, would have been a disservice to the patients at CHOP. Conversely, bringing Raina to a nursing home set up the dog for success, and nursing home residents benefitted from the presence of a therapy dog that was appropriately suited for the work environment. Overall, social workers who bring their own animals into practice settings have a duty to act with integrity towards their clients, as well as towards their therapy animals (Howie, 2015). For example, one of the authors (Wenocur) informs clients that they are welcome to request evidence of her therapy dog's vaccination records. Clients are entitled to a clean and safe environment that fosters a trusting relationship with their social worker (NASW, 2017). Therapy animals are an extension of that environment and as such should remain up to date on preventative veterinary care and basic hygiene. Specific therapy animal certification programs have guidelines regarding animal hygiene and the management of allergens (Pet Partners, 2014; Therapy Dogs International, 2018).

Social workers that involve ill-prepared animals in social work interventions open themselves to legal liability for professional malpractice. Reamer (2003) cautions that social workers who present themselves as specialists in a particular area will legally be held to the standards of a specialist, even if their claims of specialization misrepresent their actual level of expertise. The training, supervision, and ongoing consultation required to successfully and ethically implement AAT renders a social worker a specialist in this area of practice (Bachi & Parish-Plass, 2017; Howie, 2015). Therefore, if a social worker violates ethical codes of conduct while falsely presenting themselves as an AAT practitioner, they risk professional censure and even legal recourse (Reamer, 2003).

Integrity and Clients' Companion Animals

Transparency and honest communication are important components of integrity in social work practice. Previous sections have discussed potential appropriate responses to concerns about the health and safety of clients' pets including the provision of resource materials. Social workers can also model open communication about human animal interactions and empower clients to consider and express their own needs. For example, one of the authors (Karlovits) has some allergies to hair and dander and, during the course of a home visit, began to have an allergic reaction to a client's cat. The author acknowledged the potential disruption to the assessment she was conducting and requested that the client and she find an outdoor area to continue their conversation. Social workers might also promote honest communication with clients who wish to adopt a pet. A social worker might explore with their clients' what kind of pet, if any, might fit with the client's lifestyle. A social worker might also support the client in determining whether pet ownership is appropriate. If the client does not adopt a pet, but still seeks the benefits of spending time with animals, the therapist might support the client in finding an appropriate venue. This might include volunteering at an animal shelter or benefiting from the presence of a therapy dog.

Conclusion

Not all clients will have pets or want to participate in AAI. In fact, some clients may be allergic to or have fears of the animals commonly involved in interventions. Similarly, not all social workers will choose to implement AAI. Some social workers may experience fears or allergies, or they may not want to take on the responsibilities associated with AAI. Social workers should, however, support clients who seek to benefit from human-animal relationships. It is an ethical imperative for social workers to remain within the bounds of their professional practice while supporting and empowering the populations they serve. As the benefits of human-animal relationships become more understood in the literature, social workers have a responsibility to acknowledge and support the roles animals play in the lives of their clients.

Non-human animals continue to shape and enhance the worlds of families and individuals. Social workers have a duty to honor these relationships in an ethically-informed manner. Applications of the ethical principles discussed in this article represent a small percentage of the potential manifestations of these principles. Within the social work field, ongoing collaboration between professionals well-versed in the human animal bond is required. The American Counseling Association has developed a Standard of Competencies for professional counselors implementing AAT (Stewart, Chang, Parker, & Grubbs, 2016). Because the social work scope of practice extends beyond therapy and counseling, it would benefit the profession, and all those served by the profession, to adopt a formal code of ethics that incorporates the human-animal bond. Such a document would provide clear guidance to social workers grappling with ethical issues related to non-human animals and enhance overall capacity to meet client needs.

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The logo features a large, stylized letter 'U' in a dark red color. The 'U' is composed of four rounded rectangular segments that meet at a central white circle. Inside this white circle, the text 'UNIVERSITY of HOUSTON' is displayed. 'UNIVERSITY of' is in a smaller, grey, sans-serif font, while 'HOUSTON' is in a larger, bold, red, sans-serif font. A thin horizontal line is positioned below 'HOUSTON'.

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