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Contemporary Rural Social Work

Volume 6 (2014)

Editor's Introduction

Our journal continues to flourish, attracting new ideas and new features, as well as continuing to expand the knowledge base of the profession on rural practice. The journal is an important resource for both practitioners and educators.

It gives me great pleasure to announce a new feature for *Contemporary Rural Social Work*, our Poetry Section. Ably edited by Dr. Danielle Beazer Dubrasky from Southern Utah University, this issue contains several evocative submissions as well as an eloquent introduction to the new Poetry Section by our new editor.

Article submissions continue to increase. Volume six contains a number of thought-provoking articles that explore important aspects of rural social work. Liz Blue and coauthors in *Ethical Guidelines for Social Work Supervisors in Rural Settings* fill a gap in the literature on ethics in rural practice. The authors interviewed supervisors in rural and small communities in two Midwestern states and used the interview data to develop guidelines for ethical supervisory practices in rural environments as they add to our knowledge base on ethical rural practice.

Trella and Hilton explore the seldom considered issue of rural homelessness in their article "*They Can Only Do So much: Use of Family While Coping with Rural Homelessness*" through an exploration of individual and family reliance on non-homeless family members in coping with homelessness in Michigan's Upper Peninsula. Findings include the fact that while almost all participants relied on non-homeless family members for assistance, there was variation in the amount of help sought and received depending on whether or not participants were childless and single or were homeless with children. Implications for policy and services are presented.

Ryan et al. compare the differences between children with fetal alcohol spectrum disorders and attention deficit hyperactivity disorders in their article *Differences between Children with Fetal Alcohol Spectrum Disorders and Attention Deficit Hyperactivity Disorders: Rural Social Work Implications for Prevention, Assessment, and Treatment*. They reviewed nine quantitative research studies published between 1992-2013 that compared children with Fetal Alcohol Spectrum Disorders (FASD) and Attention Deficit Hyperactivity Disorder (ADHD) to identify: (a) the differences between these children (e.g., intellectual, behavioral); and (b) the diagnostic tools that may be used to distinguish between them, thereby providing a differential diagnosis. Special focus was placed on rural treatment implications.

Mingun Lee and coauthors discuss an important aspect of rural practice in their article *Impact of Providers' Cultural Competence on Clients' Satisfaction and Hopefulness in Rural Family Services: A Pilot Study*. This article is especially important since there is limited work on cultural competence of rural social work providers. The study examined relationships between families' perceptions of cultural competence, therapeutic alliance, and practice outcomes in rural practice settings. Research participants were drawn from 45 youth and their parents who were receiving

intensive in-home family preservation services in Appalachian Ohio. Utilizing the results of their research, the authors provide suggestions for enhancing social work practitioners' cultural competence in rural settings.

Ida and Mark Mills in their article *Gun Control: College Student Attitudes and the Meaning for Appalachian Social Workers* share timely information on an important topic from their survey of rural Appalachian college students and explore an aspect of rural culture that is rarely examined in the literature. This study explored gun control attitudes in order to consider what makes compromise and consensus on the issue of gun control so difficult. The authors discuss the influence of culture on this issue and the implications for rural social workers.

Flanagan and coauthors in their article, *Black Gold and the Dark Underside of its Development on Human Service Delivery*, reflect the changing environment in rural North Dakota as a result of a boomtown economy stemming from oil production growth. This paper examines perceptions of human service workers regarding their employment experiences and adaptations in oil-impacted rural communities in the Upper Missouri Valley of North Dakota. This study is part of larger pilot project designed to better inform health and human service professionals and elected officials about the nature of human service delivery systems in boomtowns. Qualitative methodologies were employed to analyze information gathered by interviews conducted with 40 human service workers. Both individual interviews and focus groups were conducted. Study findings indicate that the impact of oil on the human service network is complicated. Human service workers in the study were burdened with new and more complex challenges than before the boom, and had fewer resources to address these additional challenges. Their burden was eloquently summarized by one worker who stated, "While somebody else benefits, we carry the burden of oil boom repercussions." Smaller scale local strategies appear to creatively meet many needs, and show signs of worker resilience in strategy adaptation.

Volume six also offers readers a provocative Practice Note. O'Neill et al. in their Practice Note, *Mental Health First Aid USA: The Implementation of a Mental Health First Aid Training Program, in a Rural Healthcare Setting*, provide readers with a description of the implementation of an evidence-based certification program designed to teach lay citizens to recognize certain symptoms of common mental illnesses, offer and provide first aid assistance, and guide a person toward appropriate services and other support. The program targets a broad audience, from teachers, police officers, clergy members, and healthcare professionals to the average citizen volunteer. This Note made me wonder how many other communities have programs like this that should be shared with other rural practitioners and educators. We look forward to more submissions like this one.

This issue has a number of interesting Notes that will be useful to those of us who teach. The Teaching Notes section of *Contemporary Rural Social Work* contains useful materials that are especially applicable to education in rural areas. Rice and Walsh in *Building University-Community Partnerships in Rural Settings through a Community-Based Learning Assignment* point out that universities located in or near rural settings are uniquely positioned to partner with their communities to offer important resources often lacking within rural social service agencies. This Teaching Note describes a community-based research assignment implemented within an MSW advanced research methods course. In their Teaching Note, *Iterative Ethical Discussion in Hybridized Practice Classes*, Blake and Davis present their experiences in conducting online

ethics discussions and provide suggestions for incorporating online scenarios that reflect practice dilemmas for students to consider critically before responding to posted questions. Praglin and Nebbe in their Note, *Introduction to Animal- and Nature-Assisted Therapies: A Service-Learning Model for Rural Social Work*, discuss the teaching philosophy and practices of a university service-learning course in nature- and animal-assisted therapies. The course took place at a wildlife rehabilitation center, and students engaged as counselors, put academic theories into action by facilitating an “animal camp” for 25 at-risk children.

The Book Review section continues to provide thoughtful reviews of books related to rural social practice. This issue of the journal features reviews of books dealing with rural mental health, immigrant experiences, rural social work and community capacity, and the organization called the Minutemen.

We hope you enjoy reading these works as much as we enjoyed reviewing them. Hopefully you will discover materials to use in your practice and share with your students as we continue to celebrate the richness that is rural social work practice.

Peggy Pittman-Munke, Editor-in-Chief

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Ethical Guidelines for Social Work Supervisors in Rural Settings

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Abstract. Little research literature exists integrating ethics, supervision, and rural/small community practice. This paper reports results of a study conducted by a joint student-faculty team. The study engaged supervisors in rural and small communities in two Midwestern states in semi-structured interviews. Interview data were then used to develop guidelines for BSW students about what constitutes ethical supervisory practice in rural environments.

Keywords: rural, supervision, ethics, boundaries

This study discusses the unique needs, roles and requirements of ethical social work supervision in rural and small community practice environments. It reports results of a joint student-faculty exploratory study conducted with 11 rural social work supervisors in northeastern Minnesota and northwestern Wisconsin. The study gathered information about the nature of rural and small community supervisory practice, roles supervisors play, common ethical and boundary dilemmas they encounter, and barriers to ethical professional supervision. Initial guidelines for teaching BSW students about the realities of ethical social work supervision in rural environments emerged from the findings.

This was an independent project undertaken by two graduating seniors under the supervision and direction of a social work professor during an eight week period in the summer of 2011. Going into the project, the authors knew that summer sample recruitment could be problematic because of vacations, field work, and the large geographic service area. In short, rural practitioners' time and energy would be stretched thin. The authors approached this as an exploratory study, hoping to begin a wider discussion of this topic and to promote thinking about the topic among other professionals and students. It was the authors' fond desire that the study would serve as a catalyst for other interested parties to study as well.

Often social work students from rural or small community environments describe unique cultures, demands and mores embedded in the smaller communities in which they intend to practice. Students question how to locate ethical, professionally-based supervision when working in these smaller communities. They describe wanting to remain true to professional ethics, as taught in school, but know they will encounter numerous ethical gray areas in practice. Students may be working in settings where there are few other social work practitioners; as a result, they may struggle to find ethically-based supervision and mentorship. Students from rural and small communities know ethical and boundary issues abound in these environments. They also know that social workers' relationships with clients and the community are multi-layered, intertwined, excruciatingly visible, and unbelievably complicated. Social workers in these settings are often professionally and personally isolated with limited, often unpalatable, options available to them when engaging in ethical decision-making. Professional decision-making, grounded in social work ethics, has potentially widespread ramifications for them as workers and their families.

The two student researchers held some of these apprehensions themselves. They were concerned that acquiring and identifying ethical supervision might be an immediate issue for them when they graduated. They recognized that supervision would play a critical role in their professional development. This motivated them to discover more about how rural-based supervisors approach the supervisory role and manage ethical dilemmas. They also wanted to be able to recognize what constitutes ethically grounded supervision. The two of them conceived the study from these reservations, joining forces with a faculty person, who was already researching ethical supervision in smaller community environments.

There is much available resource material on ethical decision-making (Congress, 1999; Dolgoff, Loewenberg, & Harrington, 2005; Reamer, 1990). A robust literature exists on ethics and rural practice (Daley & Hickman, 2011; Ginsberg, 2005; Lohmann & Lohmann, 2005; Martinez-Brawley, 2000). There is a strong literature base on supervision (Brashears, 1995; Dolgoff, 2004; Kadushin & Harkness, 2002; Levy, 1973; Weinbach, 2007) and on ethics and supervision (Cicak, 2011; Copeland, Dean, & Wladkowski, 2011; Dixon, 2010; Horn, 2011; Lerman, & Porter, 1990; Reamer, 1998). There is no literature, however, integrating ethics, rural practice and supervision.

Related social work literature focuses heavily on direct practice boundaries in rural communities (Boisen & Bosch, 2005; Daley & Doughty, 2006; Daley, & Hickman, 2011; Gumpert & Black, 2005; Lohmann & Lohmann, 2005; Martinez-Brawley, 2000). Much of the available literature comes from outside of the United States. There is little reference specifically to supervisory roles in the rural environment (Galambos, Watt, Anderson, & Danis, 2005; Cohen, 1987). Ethics literature related to rural practice focuses on differences and difficulties in rural service delivery. It does not address how to work through these quagmires with the aid of a supervisor (Ginsberg, 2005; Healy, 2003; Lohmann & Lohmann, 2005). In all of this literature, there are numerous cautions and guiding principles offered. Ethically appropriate supervisory strategies germane to rural situations were not offered. This study begins to address this gap, providing fresh community-based insights to use in working with BSW students in the classroom.

Method

Participants

Study participants were 11 individuals who at the time of the study or in the recent past had supervised human service workers and social workers in a rural environment. We sought participants engaged in social work supervision in rural northeastern Minnesota and northwestern Wisconsin since these areas were readily accessible. To develop the sample, professors and persons working in the two rural environments were asked to identify potential subjects. Participants were also identified using county government websites. Tribal governments and agencies were included in the sample given their prevalence in the study area. Additionally, once interviewed, respondents were asked to suggest other supervisors as potential participants. Forty-nine persons were approached to participate in the study. The final sample size was 11, which yielded a return rate of 22%.

This study used a non-probability criterion sampling method. Subjects were engaged in social work or social services supervision in rural areas. Rural has “generally [been] considered as having 2,500 residents or less” (Kirst-Ashman & Hull, 2012, p. 243). We considered the geographic areas in which we were collecting data, and created population definitions for these communities. These study definitions included: rural community (less than 1,000 residents), small town (1,000 to 5,000 residents), large town (greater than 5,000 residents), as well as an *other* category. One respondent commuted from an agency situated in a large community, which had a satellite agency in a rural community in the study area. That person was still considered a rural practitioner, serving an isolated rural community with limited services and resources. Because of the non-probability sampling method, the study results are not generalizable to anyone but the study participants.

Participant characteristics. There were 11 participants in the study. Table 1 presents demographic data on subjects’ gender, educational background, and ethnicity. The sample was predominately female and of European American descent. Respondents were not asked their specific ages.

Table 1

Gender, Ethnicity and Education of Participants

Ethnicity	Men				Women			
	BSW	MSW	Other BS/BA	Other Masters	BSW	MSW	Other BS/BA	Other Masters
European American	–	1	–	–	3	2	1	3
Asian American	–	1	–	–	–	–	–	–
Total	–	2	–	–	3	2	1	3

Note. Cells containing dashes had no respondents reporting the attribute.

Table 2 reflects participants’ experience as a social worker and as a supervisor. Nine of the 11 respondents (82%) had been in the field for 15 years or longer, all of whom at some time served as a supervisor. While there was a small subgroup of less experienced supervisors (three persons) among current supervisors, the majority of the group had depth of supervisory experience from which to share.

Table 3 identifies fields of practice in which the participants worked and agency auspices. All but one respondent worked for a public agency, including two who worked for tribal agencies. One of the persons who worked in mental health worked for a private for-profit agency. Table 4

looks at the location of agency in relation to distances traveled by clients for service and distances traveled by the social worker to come to work.

Table 2

Experience in Social Work and Supervision

Experience	Men		Women		All	
	Range	Mean	Range	Mean	Range	Mean
Years of Social Work ^a	16-38	27.0	10-36	19.1	10-38	20.7
Years as Supervisor ^b	10-14	12.0	2-25	8.3	2-25	9.0
# Now Supervising ^c	0-6	3.0	4-25	9.6	0-25	8.3
# in Past Supervising ^d	10-24	17.0	6-12	9.7	6-24	11.3

Note. ^a1 person (female) missing. ^b1 person (female) missing. ^c1 person (female) missing. ^d2 persons (female) missing; one a new supervisor.

Table 3

Fields of Practice and Agency Auspices by Gender

Field	Men		Women		Total In Field
	Public	Private	Public	Private	
Child Welfare	1	–	6	–	7
Mental Health	2	–	2	1	4
Adult Services	–	–	2	–	2
AODA	1	–	1	–	1
DD	–	–	1	–	1

Note: Cells containing dashes had no respondents reporting the attribute. Three of the participants practiced in multiple fields –two in three fields and one in two fields –all within the single agency in which each worked.

Table 4

Agency Location and Distances for Clients and Workers by Gender

Agency Location	Radius Agency Service Area in Miles			Miles Worker Lives from Workplace		
	N	Range	Mean	N	Range	Mean
Rural Community	1	40	40.0	1	4	4.0
Small Town	6	50-90	74.2	7	4-35	18.1
Larger Town	1	75	75.0	2	15-25	20.0
Tribal Community	1	15	15.0	1	3	3.0
All Communities	9	15-90	63.9	11	4-35	15.8

Data collection techniques

This study was an exploratory one-group cross sectional design with data collection carried out over eight weeks. We planned to collect data using a semi-structured interview process. Because the interviewers were students, interview training was conducted that included situational coaching and follow-up questioning strategies.

Three different semi-structured data collection methods using the same instrument were actually used: (a) two in-person interviews; (b) five phone interviews; and (c) four emailed/self-administered surveys. The initial study was to only use in-person interviews for consistency, but due to time constraints and an initially poor response, the study was expanded to include the other two collection methods. These additional methods then allowed us to collect as much data as possible in an efficient manner and in the time available. Many individuals we contacted indicated that they were interested and believed in the need for this study, but simply did not have the time to devote to it within the timeframe available. Although we began contacting individuals early in the process, reaching potential subjects by phone and/or gaining access to them was difficult. Often, contact had to be made through support staff who then acted as a liaison to the supervisor. Frequently, we were thrown into voice mail limbo and did not get responses even after numerous calls.

Each of the three data collection methods had its own strengths and limits. Both the in-person and phone interviews had the advantage of the presence of an interviewer to clarify possible misunderstandings the participants may have had. With telephone interviews, we, however, did not have non-verbal cues available to pursue. The self-administered survey, conducted through email, did not allow the participant to clarify any possible misunderstandings. The advantage of conducting a self-administered survey through email was that it allowed participants to complete it at their convenience. It also offered a level of privacy for the

participant that was not available in the other methods. In reality, it did little to improve the overall response rate.

Data analysis

The researchers evaluated the data collected in two ways. We entered the demographic questions and the closed-response questions into a statistical program for descriptive analyses. We ordered the open-ended qualitative data into themes. Each team member independently themed the data, after which we came together to discuss each theme and come to mutual agreement about the category under which responses fell. After the data were grouped by theme, we tallied the frequency of occurrence of the themes and identified exemplars of responses under the various themes.

Measurement issues

The two student researchers developed the survey instrument with input from their professor; first, we conducted a careful literature review which examined rural social work, ethics in rural social work, and supervisory best practices, seeking places in the literature where all these threads coalesced. From this work, survey items emerged. We used the literature to identify the common ethical issues in direct practice that were then matched with issues in supervision. As the first list of possible items was extensive; it required reduction and refinement. The list was scaled down during team discussions, as well as in consultation with other faculty members in the institution with which all three team members were affiliated.

Ethical, social justice, and human diversity issues

The University of Wisconsin-Superior Institutional Review Board approved this research study (#676) before data collection began, to ensure the rights of the participants, to ensure informed consent, and to protect subjects' confidentiality. We crafted an informed consent script that was used to enlist participants using telephone contacts to initially identify study participants and request participation. We sent the interview schedule and the informed consent to each potential participant to look over before calling to schedule the interview. If a participant indicated a willingness to proceed at the time of the call and had received the consent and schedule, they were considered to have given their consent.

Ethical supervisory practice in rural settings has not been well defined to date. This study aligns with the social justice issues of fairness and competence in the workplace, and also guiding the ethical practice of rural professionals. We reached out to many kinds of agencies in an attempt to recruit diverse participants, including tribal government, and local government and private agencies. We exercised care in creating a survey that was inclusive in its terminology and which might appeal to a diverse group of participants.

Results

Roles played by rural social work supervisors

The survey document included a checklist of common roles often played by social work supervisors; participants could also add additional roles they felt they played. The roles employed on this survey item were derived from a well-known, commonly used social work text by Kirst-Ashman and Hull & Hull (2012), using their definitions. The researchers included investigation of these roles to discover the degree and extent to which these rural social work supervisors wore multiple hats in the execution of their responsibilities.

There were thirteen roles about which respondents were queried: enabler, mediator, integrator/coordinator, manager, educator, analyst/evaluator, broker, facilitator, initiator, negotiator, mobilizer, advocate, and mentor. One role, in particular, raised questions among respondents. In this study, the term enabler meant being helpful and supportive in assisting someone to reach an end or goal. Five respondents who participated in the face-to-face and telephone interviews indicated they were reluctant to identify themselves as playing the role of enabler. For them, the term had quite another meaning, making excuses for people's inappropriate behavior or assisting others in avoiding the consequences of their behavior. Interviewers had to reframe this definition for those respondents. Respondents described themselves as playing from 6-11 roles simultaneously. Table 5 describes the roles each said he or she had taken on the job by gender and in total.

Table 5

Roles Played by Rural Social Work Supervisors by Gender

Role	Men	Women	All Respondents
Teacher	2	9	11
Manager	2	9	11
Mentor	2	8	10
Mediator	1	8	9
Facilitator	1	8	9
Negotiator	1	8	9
Initiator	1	8	9
Coordinator	1	7	8
Analyst	1	7	8
Advocate	1	7	8
Mobilizer	1	7	8
Enabler	1	5	6
Broker	1	5	6
Other ^a	–	2	2

Note: Cells containing dashes had no respondents reporting the attribute. ^aThe 2 responses in the “Other” category were a fiscal agent (1) and cheerleader (1).

Unique needs of ethical supervisory practice in a rural area

The respondents identified four primary and unique ethical challenges that rural social work supervisors face. Table 6 describes these issues. Most of these related directly to defining and managing relationships. As one respondent indicated, “I am keenly aware of potential conflicts because they are more frequent in rural social work.”

Table 6

Ethical Challenges Faced by Rural Social Work Supervisors

Ethical Challenge	Number
Managing worker and agency protection of client confidentiality	7
Managing dual relationships with workers and community members	4
Managing dual roles within the agency setting	4
Setting appropriate boundaries with supervisees and co-workers	4

The supervisor respondents in this study agreed that in the rural environment, confidentiality is not limited to only information shared between agencies, but also can include information shared within an agency. One supervisor remarked, “Confidentiality issues are big. Staffing clients can be tough, because we have to be careful about too much information that can’t be shared, even between staff members.”

Three of the supervisors described concerns about being professionally isolated, meaning they were often the only professional social worker in the agency and sometimes the community; they described ramifications occurring when making decisions based on professional ethics, that were not necessarily understood or recognized by others in the agency or community. One said, “I feel isolated from other supervisors, and it’s hard to find other supervisors to consult with who understand what you are dealing with.”

Another three discussed the difficulty in making appropriate decisions about how to handle informally acquired knowledge. One of the three described this well: “Because of my longevity in the community, I also may know some things about families that my workers do not know and have had to wonder if what I know is necessary for the worker to know in dealing with the family.”

One supervisor described the tension she experienced because of the difficulty in finding and acquiring resources for clients, and another talked about dealing with issues relating to social isolation in the larger community and within the agencies. Finally, a supervisor told the interviewer she thought that it was sometimes difficult to convince employees that professionalism extended to off-duty as well as on-duty behavior.

Barriers to providing ethical supervision

When asked to identify barriers to providing ethical social work supervision in their agencies, five supervisors divulged that being privy to informal knowledge and making decisions about what to address and what to let go was difficult. Five supervisors also described how difficult it was to avoid dual relationships in these smaller communities. Four respondents revealed that maintaining confidentiality could be incredibly difficult. One of them said, “Other county agencies assume an attitude of right-to-know in certain incidents. It is difficult to maintain relationships at the same time as setting privacy boundaries.” Another supervisor remarked regarding the prevalence of dual relationships, “You feel isolated in small communities. It’s not like other work situations where you can socialize and have fun, you always have to second-guess yourself.”

Other supervisors individually noted additional themes which created barriers to ethical supervision: dealing with limited resources in their small rural areas, experiencing social and professional isolation, small town politics, lack of equitable supervision, being uncomfortable that they may be practicing outside of their areas of expertise, and maintaining appropriate professionalism. One supervisor confided, “We also have community standard setters with long memories, so it is often difficult to procure services when providers have preconceived notions about individuals and families.” In carrying multiple roles as supervisors, they found themselves at times involved in areas about which their training and experience had not prepared them. As one said, “In a perfect world, you would know all of the areas you supervise. You are not specialized in one program. In the rural world, one supervisor supervises all areas.”

Guidelines employed to make ethical supervisory practice decisions

Guidelines that these rural social work supervisors cited using most often included: the NASW Code of Ethics (eight supervisors), their own agency policy and procedures guides (seven supervisors), and their personal common sense and experience (six supervisors). One person explained, “I use sound social work theory and practice with back-up by statute and department rule. I try to consult the Code of Ethics, but find it is difficult sometimes. I use the Code as my guide, as well as county policies and common sense.”

Two supervisors reported using government regulations, such as the State of Wisconsin Department of Regulations and Licensing Code, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Data Practices Manual. One noted using the Board of Psychology Code of Ethics. One supervisor tries “using a worst case scenario outlook, should things blow up. I also like to think about if this was elsewhere, would I see a problem.” Another participant stated, “I tend to overcompensate because of the rural environment,” indicating he is overly cautious, because he is in a more isolated setting with less opportunity to consult on ethics.

Strategies for delivering ethical rural social work supervision

Participants were asked what options or strategies they had developed for delivering social work supervision, given the limitations and uniqueness of the rural areas or the small communities in which they practiced. Ten supervisors identified each of these strategies:

working hard to encourage staff development, having themselves and employees cross train in order to understand and be able to stand in for one another if needed, and maintaining an open-door policy to allow supervisees adequate access to them and their time. One told us, “You must have a focus on staff development vs. program development, as often our only resource is our staff, not a new program.” Another stated, “As director, I understand the need to wear many hats and learned many roles that I would not normally have learned. For example, I became Rule 25 certified and a certified AODA prevention specialist so I could assist in areas with high work load.”

Five supervisors discussed each of these strategies: providing balance and flexibility by considering workers’ needs in order to develop and retain them, utilizing both formal and informal avenues of leadership, and reassigning cases if necessary. One supervisor stated that her “biggest strategy has been a focus on staff support and retention. If turnover is high, no one gets the attention they deserve. If retention is good, everyone gets the attention they need.”

Additional strategies identified were use of professional consultation to check out decisions that they (the supervisors) were making, finding the means necessary (i.e. additional training) to increase their own and workers’ areas of expertise, immediately and plainly addressing dual relationships, and setting clear boundaries and expectations. One disclosed, “I am following strict guidelines for myself in regard to my roles with my employees. I have no secondary relationships with them.”

Positive aspects of being engaged in rural social work supervision

Supervisors were then asked to provide examples of the positive aspects of rural social work supervision. Nine of them noted the value of having strong personal connections within the agency and community to assist them in being better able to understand the agency and community needs; nine also noted that they liked working in an arena where change is more readily and immediately apparent. One respondent described herself as liking to see “the changes in my small community. I get to watch small changes develop on a bigger scale and help families for generations.”

Five respondents noted that it was important to them that they could develop relationships within the community, make beneficial workforce connections, and have fairly immediate access to power brokers in the agency and community. They felt that this strong networking amongst community professionals allowed for creativity in problem solving approaches. To illustrate, one said, “I have great opportunities and an increased knowledge base. I have access to power brokers that I wouldn’t have in a large community. This makes it easier to get things done and start new programs.”

Another positive aspect noted by two respondents was being able to access knowledge in the community informally as well as formally which allowed them a more accurate read of the needs of the community; two liked their opportunity to develop a personal style, to model professionalism, to understand resources available for clients well, to provide staff development opportunities, and to encounter variety in practice activities. One enthused, “Working in a rural environment helps you see a common bond of humanity. What an honor that is and how precious that is! At the school or store; interdependence that you may not see in an urban environment.”

Differing supervisory approaches

Participants were asked if they used different supervisory approaches for employees with a social work education versus those without this background. Nine of the participants made comments indicating that they supervised at least some employees who did not have a social work education. Because of this, six said they often utilized staff development activities where they could add extra supervision and extra staffing for cases, as well as provide outside agency trainings. One supervisor noted, “I have learned to support their experiences and strengths and gently provide professional knowledge without judgment.”

Five described using a case-by-case evaluation according to the staff member’s needs. Two of them were careful to note that they did not treat these kinds of employees differently than employees with a social work background. One supervisor explained her approach with individuals without a social work education, saying, “It depends on who they serve. I have noticed that we have more discussions about person-in-environment issues. But, it has not been a big issue and I think it really depends on the individual.”

Advice for new social work supervisors

The supervisors were asked to pass along advice to potential new supervisors in rural social work fields. The piece of advice offered most often was that new supervisors find balance and flexibility by being a boss first, by using fairness in dealing with employees, and by maintaining professionalism (modeling appropriate professional behavior and boundaries). One respondent advised, “Flexibility- you cannot hang on to a rigid set of guidelines. You think outside the box, follow process, so you don’t break the law, but don’t let it rule; the outcome matters.”

The second-most offered advice was that a new supervisor develop a personal supervisory style; the third most frequent advice was that the new supervisor should focus on professional development activities. The fourth most frequently offered advice suggested that the new supervisor use professional consultation to sort out complex issues and also recommended setting clear and professional boundaries with supervisees. Other suggestions were: using one’s creativity, looking to policies and procedures for potential guidance, being aware of informal knowledge making the rounds in the community, utilizing staff development, and being mindful of dual roles. As one supervisor cautioned, “The issues in rural areas are complex and each small community has history, changes very slowly, and values their community and what is special about it.” One participant felt it was easier to “come in with high expectations and then loosen up”, while others said “to lead by example” and advised new supervisors to “remember the context in which you practice.”

Discussion of the Findings

Many themes ran through participant responses; for example, the issues of managing confidentiality and dual relationships came up frequently. Supervisors expressed concerns that agency employees did not understand ramifications of excessive internal sharing with other staff of case information within the agency. They described difficulties convincing supervisees that such unprofessional behavior damaged clients. Supervisors viewed dual relationships as

inevitable in smaller communities and felt a responsibility to manage power differentials that occurred occasionally with clients, coworkers, and other community members.

They also spoke often about professional and social isolation that social work supervisors experience in rural and smaller communities. They described consciously maintaining professional ethics at work. They recommended social support outside the professional environment and sometimes away from the community. They described feeling bothered that they sometimes avoided potential friendships with coworkers and supervisees, despite having a great deal in common with them, and they cited a lack of community alternatives.

Respondents felt it was important for supervisors to find balance, creativity and flexibility when working in a rural environment. They felt it necessary to find ingenious ways to create support for staff. They used open-door policies to create access for their supervisees, provided opportunities for modeling and discussion with supervisees, and trained staff to take on new duties and expand their abilities. They learned how to be understanding, but firm, and to think outside the box, while honoring rules and regulations. They found ways to become engaged in the community outside of their work roles.

Participants described very high levels of satisfaction with their jobs, in spite of having to manage ethical and other practice situations as a supervisor. They readily pointed to the uniquely positive aspects of practicing in the rural environment. They liked the variety the job offered and the closer connection to the community. They could see change occur, not just in the short run, but over time. They appreciated the easier access to power brokers not available in larger communities. They felt this made it easier to get things done and pursue new ideas.

Relationship of findings to literature review

Respondents identified four ethical areas that corresponded with concerns identified in the literature review. Widely reported in the rural ethics and practice literature, concerns included:

1. The issue of dual and multiple relationships, which is reported widely throughout the rural literature (Boisen & Bosch, 2005; Galambos, et al., 2005; Healy, 2003; Lohmann & Lohmann, 2005; Martinez-Brawley, 2000);
2. The issue of confidentiality (Galambos, et al., 2005; Healy, 2003; Lohmann & Lohmann, 2005);
3. The issue of use of client information gained informally (Gumpert & Black, 2005; Lohmann & Lohmann, 2005); and
4. Conflicts of interest (Ginsberg, 2005; Healy, 2003; Lohmann & Lohmann, 2005).

Usefulness of findings to BSW education

Future social workers should be exposed to the unique needs, roles, and requirements of ethical social work supervision in a rural/small community practice environment. This is true whether or not students think they will practice in a rural area. Many new social workers unexpectedly find themselves having to work in smaller communities when they had not necessarily intended to do so. Rural-based students are often already aware that they will have a need for reliable, ethical supervision. All students, however, can benefit from education about

ethics in rural situations, ought to be able to recognize ethically-grounded supervisory practices, and should know seek how to seek out adequate and ethical supervision. There are numerous gray areas for which students need additional ethical and practice guidance.

BSW students should be educated to seek supervision around the following rural practice issues:

- The implications and consequences of not setting good boundaries with clients and staff in an environment in which one is highly visible;
- The knowledge of when to use or not use informally acquired knowledge, which is a common occurrence in smaller communities;
- The development of expertise in locating supports and referral sources in an environment with scarce resources, as is the case with smaller communities;
- The necessity of seeking out consultation and advice from agency policies and procedures, the NASW Code of Ethics, and experienced and ethical mentors;
- Pursuit of professional and staff development opportunities whenever they arise;
- The importance of finding balance, both professionally and personally, in order to remain a viable social worker;
- The value of developing appropriate personal connections within the community, as these will offer vital support and information needed in serving rural clients well; and
- The significance of listening to the community to find solutions and resources.

Finally, BSW students should be taught to identify the character and quality of appropriate supervisory behavior, which is an especially critical aspect of rural practice. They should be taught to recognize the ideal supervisor as someone who: (a) regularly discusses ethics and boundaries, and their implications in rural practice; (b) actually uses the NASW Code of Ethics to build solutions with supervisees within the agency and in the larger rural community of practice; and (c) consistently models ethically appropriate personal and professional boundaries when working in a rural environment.

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"They Can Only Do So Much:" Use of Family While Coping with Rural Homelessness

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Abstract. This research explores individual and family reliance on non-homeless family members in coping with homelessness in a rural area. Drawing on 114 in-depth, semi-structured interviews with homeless adults and families in Michigan's Upper Peninsula, we found that almost all participants relied on non-homeless family members for assistance, but with variation in the amount of help sought and received. Some participants displayed high thresholds for help-seeking, only relying on family under extreme circumstances and generally asking for modest assistance. This was common among childless single homeless adults who often had different support. Other participants displayed low thresholds for help-seeking, frequently asking for and requiring much assistance from non-homeless family members. This was especially common among homeless persons with children. Implications for policy and services are presented.

Keywords: homelessness, rural, poverty, family assistance, coping behaviors

Coping with homelessness is difficult everywhere, but especially in a remote area like Michigan's Upper Peninsula (UP) where services are scarce and the climate unforgiving. Hilton and DeJong (2010) found that surviving while homeless in the UP often requires tremendous adaptability and the capacity to harness supports from multiple sources including family members, friends, service providers, and the larger community. This study focused on one potential support in coping with homelessness, relationships with non-homeless family members.

Considerable research in recent years has focused on homeless persons' relationships with non-homeless family members. The majority of this work found that the homeless tend to have little contact with non-homeless family members, and family help that was received proved insufficient to help recipients successfully manage, let alone escape homelessness (La Gory, Ritchey, & Fitzpatrick, 1991; Polgar, North, & Pollio, 2009; Toohey, Shinn, & Weitzman, 2004).

Several studies have suggested that being homeless makes it difficult to maintain positive relationships with non-homeless family and friends (Anderson & Koblinsky, 1995; Lindsey, 1998; Shinn, Knickman, & Weitzman, 1991; Toohey, et al., 2004). Liebow's (1995) qualitative study of homeless women in an urban shelter, for example, detailed difficulties associated with maintaining relationships with non-homeless family and friends, including pride, shame and guilt, and fear of judgment. This work also demonstrated issues related to past relationship histories; transportation difficulties; substance abuse and mental health related issues; and general stress associated with homelessness and extreme poverty.

Most studies on social networks of the homeless, and homelessness in general, have been based on urban or at least non-rural samples (Bassuk, Rubin, & Lauriat, 1986; Bassuk & Rosenberg, 1988; Goodman, 1991; Grisby, Baumann, Gregorich, & Roberts-Gray, 1990; Letiecq, Anderson, & Koblinsky, 1996; North & Smith, 1993; Rossi, Wright, Fisher, & Willis 1987; Wood, Valdez, Hayashi, & Shen, 1990). One reason researchers have focused less on rural than urban homelessness is that rural homelessness is less visible. The homeless in smaller

communities are typically harder to identify or count than their urban counterparts given the relative scarcity of shelters and other human services that serve the homeless (Henry & Sermons, 2010; Lawrence, 1995; Patton, 1988; Post, 2002; Strong, Del Grosso, Burwick, Jethwani, & Ponza, 2005). Many have suggested that homeless counts underestimate this rural problem since many rural homeless are hidden in campgrounds, cars, and other substandard housing, often avoiding or otherwise failing to engage homeless shelters and other programs (Fitchen, 1991; Hilton & DeJong, 2010; Hoover & Carter, 1991; Kusmin & Hertz, 2010; Post, 2002).

Several qualitative studies of rural homelessness found that the rural homeless cope differently than their urban counterparts, as they use various tactics to obtain short-term shelter, food, and other basic necessities. Moving between family and friends, or piecing together shelter arrangements through relying on social networks, obtaining help from social service agencies, and roughing it (e.g., camping, squatting in abandoned buildings, and living in cars) is common in rural areas (First, Rife, & Toomey, 1994; First, Toomey, & Rife 1990; Hilton & DeJong, 2010; Hoover & Carter, 1991; Nord & Luloff, 1995; Post, 2002).

Some research has suggested that reliance on non-homeless family members is an especially critical coping method for rural homeless (Henry & Sermons, 2010; Nord & Luloff, 1995). Lack of rural shelters and transitional housing programs force many to seek family help. Scarcity of services may also increase non-homeless family members' tendencies to offer help, especially when faced with the reality that they may be all that stands between their relative(s) having to stay outdoors. Some researchers have also suggested that socio-cultural factors in rural areas, especially the importance of family and family responsibility, may also contribute to greater reliance on family as opposed to formal services in coping with homelessness; however, there are also indications that families and communities as a whole are often pushed beyond their capacities to help (Patton, 1988).

Hilton and DeJong (2010) found that the majority of their sample (91%) maintained regular contact with non-homeless family members and relied on family for several things including short-term shelter, food, transportation, storage and other basic necessities. A central question that emerged from their work was why most who received family help remained homeless. In response to this question, the authors suggested several hypotheses:

- First, often families are themselves struggling financially and simply lack resources to help their kin escape homelessness;
- Second, the homeless sometimes decide not to seek family shelter, at least not permanently, because such help comes with costs including lost freedom and autonomy, as well as expectations of contributing to the household financially (e.g., in-kind benefits like food stamps), and expectations of helping with household chores and other demands (e.g., child care);
- Third, family homes are often crowded and uncomfortable, causing some to leave, even without other shelter options; and
- Fourth, many homeless are too proud to seek family help either because they feared the loss of family status or they felt their families were struggling themselves and should not make their homelessness a primary concern.

Hilton and DeJong (2010) explored coping mechanisms of homeless adults, who were mainly single. While they examined help received from non-homeless family members, their analysis of relationships between the homeless and their non-homeless relatives was limited. Building on their hypotheses, the current study examines relationships between homeless persons and their non-homeless family members, and explores relationship variations with non-homeless family members by homeless family type, individual homeless (adults who are not living with children) and homeless families (adults living with children).

The goals of this current study were to: (a) more fully understand the nature of relationships with non-homeless family; (b) describe the homeless persons' decision-making regarding whether or not to seek help from family; (c) identify the unique contexts within which these decisions are made; and (d) make policy and program recommendations for improving services for families and individuals experiencing homelessness, especially those in rural areas. We present the perspectives of this study sample regarding family help to better understand the functions families play in coping with rural homelessness, and illuminate the nuances and complexities of family assistance to inform policymakers and service providers.

Method

The sample

Using purposive sampling techniques, we conducted in-depth, semi-structured interviews with 114 homeless adults between 2009 and 2012. In most cases ($n = 76$) we conducted individual interviews. We interviewed 38 participants in couples or small groups at the request of the participants. In all cases group interview participants knew one other prior to the interview, and in several cases ($n = 20$) the interviews consisted of a married couple or romantic partners. The decision to terminate data collection at 114 participants was based on resource and time constraints, as well as theoretical saturation. Over time, patterns emerged from both samples relating to participants' relationships with non-homeless family members, and thus we felt confident there were sufficient data to illustrate significant patterns.

Our main recruitment concern during the initial stages of data collection was to create a geographically diverse sample that included shelter residents, homeless persons doubling-up with family and friends, and people living outdoors or in automobiles. We targeted homeless living throughout the UP and were successful in recruiting participants from the eastern three-quarters of the region. We attempted to recruit participants from communities of various sizes. Marquette, Escanaba and Sault Ste. Marie are the largest communities in the UP with populations around 15-20,000 each. As Table 1 shows, approximately 60% ($n = 69$) were living in these communities at the time of the interview, and roughly 40% ($n = 45$) were in smaller, more remote communities. About 45% of participants were staying in shelters at the time of the interview or during their most recent homelessness ($n = 51$). Twenty nine percent ($n = 34$) were primarily staying with family or friends, and 25% ($n = 29$) primarily living outdoors or in automobiles.

Table 1

Purposive Sampling of Rural Homeless (N=114)

	Total
<u>Community Residence</u>	
Large Communities (>15,000)	69
Small Communities (<15,000)	45
<u>Most Recent Homeless Experience</u>	
Shelter	51
Family or Friends	34
Outdoors or in Automobiles	29

Initial analyses suggested substantial differences in coping behaviors between individuals and families, so we began to recruit participants residing with children in 2011 and 2012. Of the 114 study participants, 72 reported having at least one biological child; however, only 33 had one or more children residing with them at the time of the interview. Our sample was predominately male (N = 69); however, we did interview 45 women. Age ranged from 18 to 68, with an overall average age of approximately 36.5. Our sample reflected the racial distribution in the general population of the UP, which is over 90% White (U.S. Census Bureau, 2010). One hundred nine participants were White, two were Native American, two were African American, and one was Latino. Table 2 presents sample demographics.

Table 2

Demographic Data of Homeless Individuals and Families (N= 114)

	Individuals	Families	Total		Individuals	Families	Total
<u>Children^a</u>				<u>Race</u>			
No	41	1	42	White	80	29	109
Yes	40	32	72	Native American	1	1	2
Total	81	33	114	Black	0	2	2
				Hispanic	0	1	1
				Total	81	33	114
<u>Sex</u>				<u>Family in Area^b</u>			
Male	58	11	69	No	14	8	22
Female	23	22	45	Yes	65	25	90
Total	81	33	114	Missing	2	0	2
				Total	81	33	114
<u>Age</u>				<u>Contact with Family^c</u>			
Mean	39	31	36	No	7	3	10
Range	18-68	20-48	18-68	Yes	73	29	102
				Missing	1	1	2
				Total	81	33	114

^a Biological Children; ^b Non-homeless relatives in UP/an hour away; ^c Physical/verbal contact with family in/outside the UP

We relied heavily on shelters and service agencies like the Department of Human Services and the Salvation Army to recruit participants, and posted flyers at coffee shops and restaurants throughout the region advertising the study (less than 5 participants responded to these flyers). We also used snowball sampling to recruit several non-shelter users by asking participants who were not staying in shelters to refer other non-shelter users. Each participant in the first two years of data collection was offered a \$10 and \$7 gift card for an area restaurant for agreeing to participate. During the second two years of data collection, each participant was offered \$20 and many were also given a meal (if the interview occurred during a meal time).

Northern Michigan University's Institutional Review Board (IRB) initially approved this research in 2008 with a renewal in 2010. The IRB's main concern was establishing an interview payment schedule valuable enough for participants, but not overly enticing as to persuade very reluctant potential respondents to participate. This led to using a \$10 and \$7 gift card for the first round of interviews, and \$20 in cash during the second.

A second concern was that some participants may have been experiencing great hardships at the time of their interview, but were unfamiliar with homeless resources in the area. This led to the development of a list of regional resources and connections that would help study subjects. To develop this list, we met with representatives from several organizations that regularly interact with homeless adults including three Salvation Army offices, four homeless shelters, two Michigan Department of Human Services offices, two community-based organization, two area food banks, and two police departments. These interviews helped identify available services throughout the region, and revealed important policy and service contexts affecting homeless adults and their families. As standard procedure, this list was offered to all participants.

Data collection and analysis

We used a semi-structured interview schedule. Participants reported on their social networks, especially relationships with family, friends and other homeless adults. We asked several specific questions about participants' families, including family size (their immediate families and families of origin), relationships with family members, and proximity to various family members. We also posed several questions pertaining to methods of meeting basic needs (food, shelter, clothing, and transportation), and use of and involvement with various human services.

Our primary data were audio recordings of semi-structured, in-depth interviews with homeless adults. We created interview narratives for each participant that included a summary of the individual's coping mechanisms (primarily methods of securing food, shelter, clothing, and transportation) as well as his/her relationships with family, friends and other associates (Charmaz, 2000). These narratives also included categorizations of family dynamics (both for the family of origin and the homeless family), shelter arrangements, and social services use. The narratives gave us a structured summary of each participant's interview as a preliminary step toward in-depth analysis of the recordings.

We then analyzed interview data (both the narratives and audio recordings) using NVivo software. Directly coding audio recordings saved time and other resources associated with transcribing interviews. It also allowed us to code the tone of participants' voices, their

intonation, and their timing (e.g., did they speak quickly or slowly, did they pause). This capability was especially valuable for capturing participants' felt experiences (Downes, 2000), particularly emotional aspects of their relationships with non-homeless family members.

We employed a grounded theory approach to analysis because there was limited existing research on relationships between homeless persons and their non-homeless family members in rural areas (Charmaz, 2000; Glaser, 1992; Wasserman, Clair, & Wilson, 2009). Our purpose was to: (a) identify participants' relationship patterns with non-homeless family, (b) identify factors that explain whether or not these relationships provide substantial help in managing homelessness, and (c) create new hypotheses or theoretical propositions related to homeless persons' social networks, specifically relationships with non-homeless family.

Issues of reliability and internal validity. Initial interviews were conducted under the observation of other team members to assure consistent data collection. We wrote narrative summaries shortly after each interview. Together we analyzed the first six interviews to ensure uniform coding scheme application. Subsequently, interviews were coded independently. We reviewed each other's work while spot checking to ensure consistent coding.

We met regularly during data analysis to review coding issues whenever it was unclear how to classify an interview segment, and these discussions often led to the creation of new codes. Several existing codes and categories were modified as new variations emerged from the data. We also compared homeless adult interview data with data collected from staff from service agencies. This allowed us to identify unusual cases and assess the credibility of interview data. It also permitted us to compare the nature of available services with homeless adult participants' perceptions of these services. We also compared emerging concepts and themes pertaining to homeless adults' use of social networks, particularly non-homeless family members, to findings from previous studies of homelessness (Charmaz, 2001). Although data were collected over a span of four years, we do not believe that coping options, particularly those related to use of non-homeless family members, friends or social services, changed drastically during this timeframe.

Results

Below we present results from our analyses of interview data. First we present data on participants' contacts with non-homeless family members while highlighting variations and patterns with respect to individuals and families. We then present data on help sought and received from non-homeless family members while again highlighting variations and patterns for individuals and families.

Family contact

Almost all homeless individuals and families maintained at least some contact with non-homeless family members living in the UP or within an hour of where the homeless were currently residing at the time of interview. Compared to homeless families, individuals tended to have more sporadic and less intense contact with their non-homeless relatives. Homeless individuals had access to and made use of a larger number of shelters that were tailored to individual homeless persons. These settings often required users to tolerate austere and

potentially dangerous sleeping conditions. A female participant, Robin, described her reluctance to stay at a shelter for two reasons. First, she would have had to leave her children with family because the shelter did not allow children; and second, she would have been one of few women in the shelter. As she explained, "There was no way I was going to stay down there with a bunch of men...I mean there was only like one other woman in the place." Ultimately, Robin had to place her children with family but she was able to rent a single room for \$160 a month.

Individuals typically had larger social networks that they could rely on for help. They generally required modest assistance, and a couch offered sufficient bedding. Individuals were able to make themselves welcome with friends by bartering food, food stamps, child care, and chore provision. Jen and Mike explained how they made themselves welcome houseguests:

[We] started bouncing around with friends...you can't really stay at somebody's house forever...You can have food stamps and stuff to help them out but it's not like you can go stay there for months and months. It's two compared to one.

As these participants indicated, individuals were also highly mobile and could easily move from house to house and stay with a variety of people and places. Lara, 43 years old, explained that she preferred to move around frequently so as to not overstay her welcome:

[I would only stay] two days...I have a backpack with me all the time...I keep my clothes at a friend's house, but I always make sure I have my toothpaste and a couple changes of clothes in my backpack...I never wanted to put anyone out or stay too long. It is hard for me 'cause I always supported myself.

Bartering for shelter and moving around frequently allowed individuals to retain their social networks and not risk exhausting help from any one source.

Unencumbered by children, the single homeless person was adaptable and could be housed in various environments and conditions. Bill, a 46 year old transient, described his austere living conditions: "I have one comforter. Once I slept in a little cave...if you go back in the woods there's like a little cave...and then the last two nights I've slept over with a friend." These kinds of arrangements would be nearly impossible with children.

Without caregiving responsibilities and able to use extensive friendship and social service networks, homeless individuals were more likely to cope with homelessness. Curt, 50 years old, described being homeless alone:

[I] stayed with [a friend] for a few weeks then came this way. Been pretty much [homeless] the whole month, stayed with a friend for a little while and you know but they get tired of that too. Last couple of nights I've been staying at [a shelter]. Depression gets me down and I start drinking...If I'm not at the [shelter] I go sit on the hillside out in the woods...I got a tent but I ain't got it set up. I figure it's too late to set it up now. I'm getting old. I mean I suppose I could but there ain't really no place to set it up around here for free in the city limits. I just curl up on a hillside over by the harbor.

Like Curt, other homeless individuals demonstrated a higher personal threshold for physical and psychological discomfort but were unwilling to subject children to these same circumstances. Cam, 44 years old, suggested that being homeless is easier without children:

[It's easier being homeless] alone. 'Cause then you don't have to worry 'bout no one else. I wouldn't be homeless [if I had kids now]. I would never be homeless if I had kids. I was never homeless when I had kids, ever. I made it happen. Now um I'm tough. I am [making it happen for myself]...it just takes time.

Like Cam, several participants remarked that while homelessness was often physically and psychologically taxing, at least they did not have the added burden of caring for children.

We found that, compared to homeless individuals, homeless families tended to maintain more frequent and prolonged contact with non-homeless family members and the nature of help received was greater. Families frequently sought help from non-homeless relatives because they were seen as the only viable option for keeping everyone together. This is especially true in rural areas where social services are limited and there are few, if any, shelters that can accommodate families without splitting up partners (Vissing, 1996). Tamara described having to lie about being abused by her partner when she sought refuge at a women's shelter, the only available shelter at the time—for herself and her four children:

And I went and honestly, I went to a shelter at the time. I lied. Steve couldn't go to the shelter... 'cause it's a shelter for domestic violence and the only way you could get in there is if you're being abused. Because what was I going to do? I had to have somewhere to go with my kids. And Steve went and stayed pretty much house to house until we were able to find a place.

As with Tamara and Steve, several participants described the need to carefully craft what they told service providers to get the right help.

Many parents were less willing to ask friends to house their families because this was viewed as a major imposition. Friends may be willing to let a homeless individual *couch surf* for the night, but were less likely to house a homeless family for the significant period of time that is typically required. Gabe, homeless with a toddler and infant, explained the difficulty of finding someone to house his entire family:

Well we've probably been roughing it here for the last month. We've been with a couple friends, family. Point is, you can't stick a family of four in the middle of most households. So we've been bouncing around here and there and slept in our truck a few nights...No one has really volunteered [to help]. We've asked a few of our friends but we don't want to overuse anybody. It's stressful enough on us but we don't want to ask anyone else.

Parents were particularly doubtful of their friends' willingness to offer shelter for any substantial time given their inability to offer an equitable exchange of goods or services. Parents generally only felt comfortable asking for such extensive help from family members who they believed would help because of lifelong connections and responsibilities. Further, parents were less likely

to expect family members to ask for compensation in return for providing assistance, at least not immediately or regularly.

Homeless parents were sometimes forced to seek help more readily from non-homeless relatives in the area for fear of social service involvement. Teachers, medical professionals, social workers and other professionals are mandated to report potential cases of child abuse and neglect. Many mandated reporters view being homeless with children as neglectful, and immediately report such families to child protection services. Parents sometimes maintained ties with non-homeless relatives to ensure they had a permanent residence in the event social service agencies were notified of their housing instability. Danielle, mother of one, described using her mother's permanent address and phone as contact information when Child Protective Services (CPS) inquired about the conditions at the campground where she was temporarily staying with her daughter:

People were getting wind of it that I was living in a campground, and I had CPS called on me because of it. Through the grapevine of all the gossip it got thrown to the Department of Human Services protective service worker that I was living in a tent with nothing with my child in a campground. They contacted me through my mother. They contact her and talk to her to ask what was the explanation...She contacted me through somebody else who gave me the message. I didn't have a phone at the time, so I came straight here to use the telephone to sort out all the rough edges on 'he said, she said' miscommunication...I just briefly told them I was in a cabin and no, it didn't have running water or toilet facilities, but we had 'em right across the driveway in the shower stalls...We did have electricity.

Homeless families have to prepare for all contingencies to avoid having their children taken away, exposed to the elements, or deprived. Joe, homeless with two children, explained how he and his wife made arrangements with non-homeless relatives to ensure their children were not outdoors: "We always make sure we have a backup plan, someplace we can bring the kids if we need to...right now it's my parent's [house]." Faced with unpredictable circumstances, parents tried to maintain some semblance of normalcy and consistency in their children's lives. This included maintaining contact with extended family.

Help received from family

Non-homeless family members provided a variety of types and degrees of help to homeless kin. Non-homeless relatives were often better equipped to assist individuals, as opposed to families, with short-term housing (1 or 2 nights) where they could sleep on a couch or floor. With only one person to house, there was less physical space used and generally less burden placed on relatives. Ron, 44 years old, described the sleeping arrangements in his nephew's large house where he was staying temporarily:

They got a big house...I don't got a room. I sleep on a mat on the living room floor. The kids...They got 4 bedrooms. Each of the kids has got a room and [the parents] sleep in a room. I sleep on a mat in the living room...not a couch. It's a mat. [I: Is that comfortable?] Yeah, for me the mat's fine. It's one of those hospital mats, it's comfortable.

Individuals also spent time at relatives' homes during the day when shelters require guests to leave the premises. During this time non-homeless family members would often provide food and allow individuals to shower and use laundry facilities. Brett, 22 years old, explained that his mother would provide what she could for him when he stopped by her house: "My ma is pretty cool, ya know. Like if I go over there she'll let me eat. You know, she ain't got much food herself." Brett and many other homeless individuals knew they could get help from relatives, but they also understood there were limits to their families' resources.

Lacking a permanent residence means that homeless individuals were unable to transport more than the basic necessities with them. Non-homeless family members sometimes allowed individuals to store larger and more expensive belongings with them while they were moving around the area. Brett, mentioned previously, explained how he showered and stored clothing at his mother's house:

[My mom] kind of looks at me like an outcast sometimes...So that's why it's been hard for me to go there. So I just keep all my clothes in a big, red duffle bag. Whenever I go there and like shower I take a few pairs of clothes [back] with me so I'll have them.

While family offer some help, relationship dynamics may make it difficult to feel entirely welcome.

In addition to storage, non-homeless family members provided valuable help transporting homeless individuals around the area. This was a particularly significant help in a rural area where public transportation is limited and often unreliable. Don, 43 years old, noted:

I'll call relatives and I'll say, 'do you have time to provide me a ride?' Nine out of 10 times it'll be 'Yah'...When I ask somebody for a ride it is usually for something important. I won't do that unless I'm unable [to get there on my own].

Homeless individuals maintained numerous appointments with various social service agencies which were rarely in close proximity to one another. They often relied on their non-homeless relatives for small amounts of money. These transactions were infrequent because many family members of the homeless were themselves struggling financially. Ryan, 28 years old, explained that his family's financial struggles and a desire to stay in the area with his son precluded him from receiving much support:

Some family members I do have, I'd love for them...they'd love to help me but they're on fixed income. Some of them are elderly so they live...a lot of the family that's there they don't really have the means for me to do anything. And I don't want to be that far away from my son so I'm kinda stuck.

Similarly, Eric, 26 years old, was hesitant to accept money from his mother because she was struggling financially:

My mother...She's offering, but she ain't doing really too good herself. So I wouldn't feel too good taking it. She needs it just as bad as I do...Just my sister

and friends, they help me out as much as they can. I could be worse off, definitely.

Accepting money from family who are struggling themselves is often not an attractive or viable option.

Homeless individuals tended to have extensive social networks that they could call on to obtain emergency housing and support. They were also keenly aware of the risks associated with over-reliance on any one person in their network. For this reason, and because they were more mobile than homeless families, individuals tended not to stay in one place for more than a few days. *Couch hoppers* like 28 year old Jared, lived a transient life, relying on the generosity of multiple family and friends, none of whom provide a stable housing option. Here he described spending time living with extended family:

[I: Have you ever been a couch hopper?] Oh, definitely. Kind of hard having to go back to the place where you were the past night 'cause you don't like the scene where you're at...Like you're hoping you're not imposing. You're hoping they're in the mood. Hoping they'll want some company. Hoping they won't have a girl over. Things like that...But I never stayed anywhere I didn't feel welcome—even though I knew I was being a vagrant. But I had a few people who would offer for me to stay—even for extended periods. Kind of surprising, you know? 'Cause I wasn't offering to pay some rent.

The homeless were particularly sensitive to the burdens they pose for others. Jared, mentioned above, noted that he was often surprised by others' willingness to house him given his inability to provide much in return for being sheltered:

I was always amazed that I was able to do what I did for so long and never become a burden or have a bad name...I always tried to keep a certain level of standard and had some pride. 'Cause I never wanted to be a burden. I knew some people in a similar situation. Some people who when they came to the driveway everyone would say 'shhh, maybe he'll go away.' I never wanted to be like that. I never tried to overstay my welcome or anything like that.

Jared and other homeless who made use of others' generosity were typically cognizant of the potential burdens they posed and thought strategically about maintaining these social networks.

Compared to individuals, homeless families have a greater need for long-term housing because it is particularly difficult to make frequent moves with children. However, housing an entire family when space is limited is difficult. Marissa, mother of three, described her parents' inability to provide shelter:

My mom and dad live in [small town in central UP], but they have four—three younger brothers and a sister—at home and they all live in a three-bedroom house. And I have three children and a baby due any day now, so there's no room at home. They'd like to help, but there is just no room for us anywhere.

Carol, a mother of two, described having to share a couch with her two children while staying at her mother's house:

It was tiny. [My mother] had a little living room and a little kitchen. It was one of those older houses like from a hundred years ago...it only had two bedrooms...The kids wouldn't sleep unless they're with me, they just won't, so I ended up sleeping on the couch with both of them. There were two couches so I put my son on one, and I was on the other one with my daughter.

Having to reside in cramped living quarters invariably resulted in increased tensions and stress among family members. The homeless often felt, or were made to feel, as though they were imposing. Further, they were generally unable to contribute financially to the household in return for receiving shelter. Alex, mother of four, described the crowded living conditions that eventually forced their exit from her mother's home:

It was me and my boyfriend, our son, his mom and his sister. [The mother's boyfriend] just...it was crowded in there and he didn't like all the people there—and he's like 'If it would be just you and the baby it would be a different story, but it's too many people' and he's like 'You gotta get out.'

These compounding factors suggest that homeless families are at greater risk of exhausting vital family relationships more quickly than individuals.

In lieu of housing the entire homeless family, for lack of space or because of limited resources, non-homeless family members would sometimes offer to house a portion of the family or only the children. Anna, mother of three, explained that her mother's boyfriend eventually demanded that she and her boyfriend leave, though he was willing to continue housing her children: "It was pretty ridiculous...like my mom was with her boyfriend and it was his house and he basically told her she can take the kids or help the kids or whatever, but not me."

Other times, existing family discord dictated a family's willingness to house their homeless relatives. Rachel, mother of one, explained that reconciling with her boyfriend was unacceptable to his father: "We were homeless 'cause at Christmas time he pretty much wanted to get back together and his dad just said 'Get out! Take your son and get out!' He didn't want us to be together." For some homeless like Rachel, accepting help from family could potentially come at the loss of control over personal aspects of their lives.

Non-homeless family members would sometimes provide small amounts of money to homeless families to help cover the cost of daily expenses. However, in many cases these relatives were also struggling financially and unable to offer much assistance. Marissa, mentioned above, noted the following about her family:

There's not much they can do. Both my parents are older, disabled and have Social Security. Plus with my brothers and sisters at home, there's really no room. If they had more of an income they would help, but they just can't.

In other cases, homeless families were sometimes asked to contribute to the household finances while being housed by their relatives. This was usually difficult as many of the homeless parents

were unemployed. Rachel, mentioned previously, described how her relatives asked her to start contributing to the household when they lost their jobs:

At that point, when we moved down there, [my mother] did not have a job and shortly thereafter her—it was her boyfriend at the time—lost his job. And they were just swearing and yelling at us [for not bringing in money], and we're in a trailer park in the middle of nowhere. It was like a 10 mile walk [to town] and it was like 90 degrees in the summer. It was unbelievable. I think maybe because I was pregnant, but my God it was hot. They wanted me to go and get work, I was like 'Hello, I'm ready to pop. They're not gonna hire me.'

When homeless families were doubling-up, or sharing living quarters with their relatives, the strain of limited resources was felt even more acutely. Kiera, mother of two, lost the supplemental income she relied on from her brother's disability insurance and her son's child support payments when her brother and son moved away. Unable to pay the rent on her salary alone, she was forced to leave her apartment and stay with an on-again-off-again boyfriend:

I got an apartment...with my family. My handicapped brother decided to go move with my sister...so I didn't have his income anymore. My youngest son went into foster care and then decided to get adopted by the foster family so I didn't have his child support income anymore. All I had was my working money from work and I just couldn't pay the bills or nothing. I couldn't afford it. So I lost my apartment. I lost everything in it. And then from then on I had nowhere else to go but my boyfriend's.

For some homeless like Kiera, relying solely on family for help was risky as the support could be withdrawn at any time.

Families often provided temporary housing or child care to ensure homeless families maintained good standing with social service agencies that monitor child welfare. Carol, mentioned previously, explained how her mother-in-law, herself once homeless with children, provided temporary housing and child care, thus ensuring CPS did not remove her children:

The same thing happened to my mother-in-law, and she had to go stay with her mother-in-law. She said she'd rather do that than have the kids taken away, because if the kids got taken away she'd have to step in and take the kids, so she figured to help us this way would keep her from having to raise her grandkids.

Having children removed was a legitimate fear among homeless families. As mentioned, some agency staff (e.g., CPS) view homelessness as a form of parental neglect, therefore, parents often had to rely on family and friends to attain adequate housing or risk losing their children to foster care. Debbie, mother of three, explained the difficulty of negotiating the social service network while receiving only limited and temporary child care assistance from her non-homeless relatives:

My CPS worker told me my brother didn't want to take care of my daughter anymore and that I was going to have find somewhere else for her to go, so I talked to my son's girlfriend's mother...and she said 'I'll take her'...So I called the

CPS worker and she called me back the next day and said... 'Is she going to take [daughter] for the next 8 years?' And I said 'why would she have to take her for the next eight years?'...She said 'I need something more legal and stable than that. You're going to court.'

Debbie eventually lost custody of her daughter who was subsequently placed in foster care.

Sometimes non-homeless family members intervened on behalf of CPS and attempted to gain custody of the children from their homeless relatives. This was often the case in situations where there were existing animosities between family members, and children were viewed as the innocent victims of their parents' bad choices. Nina, mother of three, explained how her father attempted to attain guardianship of her eldest son who was currently living with him:

We were not stable so I left. I brought my son to my parents because they were more stable. So ever since then he's been with them. I've tried to get him back and it's just kind of like a family dynamic or argument...they won't release him back. My father recently went and filed for guardianship behind my back in the courts and had a court hearing that I never knew about and my dad got guardianship.

While homelessness was rarely the sole factor in the loss of child custody, having unstable housing was a major contributing factor. Being unable to provide stable housing for children led to many CPS investigations, though not all of these investigations resulted in child removal; however, the lack of stable housing made it difficult for many parents to comply with imposed CPS requirements. In cases where children were removed and placed in foster care, homelessness made it extremely difficult to get children back.

Discussion

Understanding family contact and help received does not explain the entire dynamic between the homeless and their non-homeless relatives. It is important to understand the homeless person's perspective, specifically when and how frequently they ask for help from relatives. The homeless are active and strategic agents in their own coping. They make choices rationally within unique contexts, evaluating the costs associated with asking for and receiving help. This help-seeking and decision-making behavior is situated within the broader familial context—one that accounts for family history and dynamics in addition to the homeless persons' unique attributes (values, skills, and adaptability). Both the homeless and their non-homeless relatives weigh the pros and cons of asking for and giving help that can change the nature of familial networks from relational to transactional. Study data suggest two conceptual categories of homeless that differ in the frequency with which they seek help from non-homeless relatives and the amount of help they request: high and low threshold help-seekers (see Table 3). These categories are not static identifiers. Homeless individuals and families have, at various times and in different contexts, exhibited both types of help-seeking behavior. This study's goal is not to explain or predict thresholds for help-seeking behavior; rather, it describes variation in the distinctive characteristics of each.

Table 3

Thresholds for Help-Seeking Behavior

	High Threshold	Low Threshold
<u>Help Seeking Behavior</u>	Only seeks help in unique circumstances considered especially "dire."	Asks for help to meet basic needs on an ongoing basis.
<u>Attribution of Homelessness</u>	Personal	Circumstantial Environmental
<u>Perception of Family Responsibility</u>	Based on dynamic of social exchange and reciprocity.	Expectation and presumption of help are embedded in the nature of family relations.
<u>Perceived Needs</u>	Low	High
<u>Alternative Networks</u>	Numerous	Few

High threshold help-seeking behavior

Individuals who exhibited high threshold help-seeking behavior were characterized by their tendencies to ask for help only in unique circumstances that they define as especially "dire". Their help-seeking tended to be infrequent and the help received was in relatively modest amounts. This help-seeking behavior can be understood in two ways. First, individuals who exhibited high-threshold behavior were more likely to attribute their homelessness to personal failures or shortcomings, often related to past relationships with family members. For example, Jackson, 39 years old, did not seek help readily or ask for much help from family members, in part, because he envisioned having already burned bridges with them. He recounted a strained relationship with his mother:

I was hoping to go back to my mom's, but she brought me to [a homeless shelter]. It's just too much, ya know? They're getting older. She's seen a lot of stuff through me, through the years. Bad things. And they don't deserve that. They deserve a life of their own and I understand that...It was very depressing...but sometimes you gotta do what you gotta do. And that's what she did. Sometimes you just gotta let someone go.

Jackson's comments reflected a focus on personal accountability associated with his homelessness.

A second way to understand high-threshold help-seeking behavior is to recognize that individuals with these tendencies required fewer resources to be helped and tended to have greater mobility, more flexibility in their coping options, and more extensive social networks that

allowed them to limit help sought from family, thus preserving these vital relationships. Lawrence, 23 years old, preferred to seek help from friends because they tended to have less complicated living circumstances (no partners or children) so he would not feel as though he were imposing:

It's easier to ask a friend. It's easier asking one of them than a relative or a girlfriend or an ex-girlfriend...The ex-girlfriend I just don't get along with very well...Family, I don't care to stay there. They got their own kids and stuff.

For Lawrence and several others, having several options for help meant not having to deal with complicated relational dynamics.

Perception of family responsibility. Individuals who exhibited high-threshold help-seeking behavior tended to view family members' responsibility to help as conditional. They had less expectation of help and were more willing to take whatever was offered to them because they tended to have strained relationships with their non-homeless relatives, were often unable to provide much in exchange for help received, and recognized that their relatives were often struggling themselves.

George, 62 years old, is a divorced homeless father of two sons. The relationship with his sons deteriorated after his divorce and subsequent homelessness, yet they managed to maintain tenuous relations that were undoubtedly influenced by these shifts in the family dynamic. George recounted an evening spent sleeping while parked in a son's driveway during a particularly bad winter storm:

I didn't go to [my youngest son] for help...Even my oldest son...him and I never had a good relationship, but he never threw me out either. I knew I couldn't stay long [at oldest son's house]. But maybe an hour or two to warm up...[My oldest son] helped me the most...[He is] the one that I went to live the closest to in the city itself. And a couple of times [My oldest said] 'If you kinda want to back up [your car] between the house and the garage if the wind's real bad go ahead. Go ahead and do that.'

George was almost completely estranged from his youngest son. His oldest son was not able or willing to house him, but the help he did provide, shelter to warm up for an hour or two and a place to park the car out of the wind, was, in George's estimation, more than he deserved. George's conception of this help as "enough" has to be understood within the context of his family and the nature of the relationships that exist therein.

Many relatives of the homeless were themselves financially, psychologically, and materially taxed; therefore, even if they desired to help, they were often unable to offer much more than emotional support. Don, 42 years old, explained that he avoided asking for assistance from family members who may have wanted to help because they were dealing with their own problems:

My parents live here also....they can't right now. [I: Are they aware of your circumstances? Can they help you out?] Their health is real bad so they can't

really [help] either...I try not to [ask for help]. I don't want to be a burden to them in any way. I try not to [ask for help].

For Nathan, 28 years old, repeated previous requests for assistance had subsequently decreased his family's willingness to help and had diminished available resources:

[My family members] want to help as much as they can, but here's the thing; when you move four times in four years and it's just you're used to it you do kind of ask for help from your family and I think eventually they start...You know everybody has the point where they're like, okay, we've helped, we've helped, we really don't want to help anymore.

Like others who had turned to family many times in the past, Nathan no longer viewed his family as a viable source of help.

Individuals who demonstrated high-threshold help-seeking behavior made calculated assessments of their capacity to garner help from non-homeless family members within the broader context of family histories and the current non-homeless family's circumstances. The willingness of non-homeless family members to help hinged on a combination of factors that, taken together, allowed them to assess the extent to which assisting their homeless relatives outweighed the costs of not helping. A key factor in determining merit simply entailed defining what it meant to be an independent adult. Anya, 26 years old, elected not to seek assistance because she perceived the norm within her family was to be independent by adulthood:

I always felt uncomfortable asking my mom for help. 'Cause she's always been the kind of lady that will kick you out and say 'You know this is the real world. You have to figure it out on your own.' She's got a point 'cause people got to start living their own life and not depending on their parents. It was crowded and I felt uncomfortable and I always felt like I was overstaying my welcome. I always felt like I had to get out...I wanted to be out on my own, but I didn't know how to go about that because I didn't have a job. I figured I had to go and try like low-income [housing].

Anya understood her mother's position and chose to seek alternative housing rather than risk exhausting family help networks. For others, like 24 year-old Hank, being an adult meant taking responsibility for his decisions and understanding the consequences of having burned bridges in the past:

As you get older...I think it's the equivalent of nature. A bird is going to be less likely to return to its mother's roost after a few years than the second day after it got kicked out. Eventually they'll be less willing to have that back. I feel like I'm not in a position to ask for help because I already know what the answer is going to be.

Hank did not perceive his family as a viable source of assistance because as an adult he should presumably have been self-sufficient.

Low threshold help-seeking behavior

Individuals who demonstrated low threshold help-seeking behavior were characterized by their tendencies to regularly ask for help and by their needs for high levels of assistance. Low-threshold help-seeking behavior can be understood in two ways. First, some homeless tended to see their homelessness as circumstantial, a product of their environments, especially the failure of people within their social networks to help, as opposed to their personal inability to provide for themselves. Anna, 26 years old, described being frustrated with her parents' refusal to take custody of her daughter when she was in rehabilitation treatment for alcoholism. As a result, her daughter was subsequently placed in foster care: "They are missing out on so much of my daughter's life...It hurt a lot. It really did. 'Cause that's family. You don't mess with family. You try and help out family as much as you can." Anna's comments deflected focus from her personal problems (alcoholism) onto her parents and suggested that their failure to provide continued assistance is the primary reason for her problems. Homeless individuals' help-seeking behavior, and their families' responses, must be situated in larger relationship histories and dynamics. In this case, Anna had exhausted her family's help over time, yet believed that the familial bond should continue to extend privileges. Help-seeking behavior must also be understood within the larger family context. Anna further chastised her parents for failing to provide her with financial support while they supported her unemployed brother. She viewed this dynamic as unfair because she believed her situation was more serious because she was a single mother:

So my dad makes very, very good money...It is not a question of my parents don't have the money. It's just that they believe I should be doing it on my own, but my brother who is three years younger than me...He has not had a job, he has not gone to college. He lives at home with mom and dad and gets everything paid for. And look at me, I'm the one that's up here with a kid. It's just an unfair dynamic, I think.

Viewing her parents' financial assistance as unfair allowed Anna to reconcile her continued requests for help. She felt as though she had not been given her fair share.

The second way to understand low-threshold help-seeking behavior is to recognize that some homeless, especially homeless families, had few viable alternatives for obtaining needed assistance and were often forced to turn to non-homeless family members for help. Rachel, mother of one, explained the difficulty of having her son while staying with friends:

We had lots of friends [in town]. My friend, Janie, she felt bad when she asked us to leave 'cause I had my son—she asked us to leave because Robby was too loud at night...I didn't like [couch hopping]. Different people's houses every night. I feel like I'm imposing.

Rachel was forced to seek help from family members who she perceived as more sympathetic to her plight. Another concern for homeless families in particular was the cost associated with *not* asking for help from family, namely the risk of CPS involvement. As Rachel, mentioned above, explained:

The lady who runs the [shelter] down there she does the practice of calling CPS because families are homeless...They never had a chance with me 'cause I sent him to live with my mother so he couldn't be taken away.

As with Rachel, relatives sometimes provided shelter and child care that could protect homeless families from CPS scrutiny.

Perception of family responsibility. Homeless exhibiting low threshold help-seeking behavior tended to believe that family helps family, unconditionally and regardless of need or history. This belief led to different patterns of help-seeking for homeless individuals and families. For individuals, family was often one of several practical options for garnering necessary resources. Turning to family when there were other alternatives for help (especially friends) was often the result of individuals' insistence that they were owed something from some family members. For some, their homelessness could be attributed to the failure of family to provide more, as opposed to their own failure.

In contrast, homeless families were more often forced to turn to relatives for help because there were few, if any, alternative sources of help that could meet their needs. While they asked for help from family in great amounts and for prolonged periods, they tended to exhibit a high threshold help-seeking mindset in that they were more willing to take whatever was offered to them. These families understood the immense burden they placed on non-homeless relatives and were often forced by necessity to seek help. They tended to view non-homeless family members' occasional reluctance to provide as understandable.

Understanding decisions about whether to seek help from family requires knowledge of social contexts (i.e., family dynamics and history, social networks and community resources), unique attributes of homeless individuals and families (e.g., values, skills, adaptability) and the meaning homeless ascribe to their circumstances. Focusing on homeless persons' coping behaviors reveals substantial costs to requesting and receiving help from family members. Feelings of guilt, shame, and discord are common among participants who must rely on family assistance. This is especially true of those who exhibit high-threshold help-seeking behavior who readily view their homelessness as a personal failing rather than a complex, systematic failure of their social contexts. Homeless families, who more often demonstrated characteristics associated with low-threshold help-seeking behavior, were also acutely aware of the unique burden they posed for non-homeless relatives. Homeless individuals and families were generally reluctant to overburden any one component of their help-seeking networks. Ideally, they wanted to be self-sufficient, and in lieu of that, they wanted to establish an equitable share of assistance from available family, friends, and social services.

Vital family relationships were often strained, and sometimes exhausted, because of a lack of alternative assistive options. While the homeless may be concerned about maintaining their social networks, dire circumstances might preclude them from fostering these relationships. Further, in some circumstances the homeless were forced to accept inequitable and seemingly unjust circumstances from their non-homeless family members because they lacked any alternative sources of help. These included being verbally shamed, being financially extorted and blackmailed, having family threaten to call CPS on homeless parents, giving up authority over daily parenting tasks, and having to accept rules and restrictions associated with living in a

relative's house. These costs are arguably unique to the family domain (wherein one may presume existing relationship ties give one license to enact these injustices) and ultimately undermine the strength of familial relations. Requesting and receiving help from family is not an isolated singular event—these occurrences must be situated in the larger context of the family history and dynamic to fully gauge the rationale of the homeless' decision-making processes.

The rural context of this study is also an important consideration in understanding decisions of both the help-seeking homeless and the non-homeless family helpers. The costs of homelessness can be great in areas like the UP where services (including shelters) are scant and weather extreme. This may partially explain both homeless persons' propensity to seek help from non-homeless family members and family members' extension of many forms of assistance.

Policy Implications

Data suggest that service providers and policymakers should pay more attention to the critical roles of non-homeless family in helping the homeless, especially in rural areas where human services are scarce. Policies and programs to support non-homeless family members who help the homeless and help maintain or restore strong relationships between homeless persons and their families would be a major contribution to the social welfare of many people struggling with homelessness and extreme poverty, especially in rural areas where families tend to be major coping resources.

Providing tangible assistance in the form of utility payment offsets, increased food stamp allowances, and housing subsidies to family members who house otherwise homeless kin could be an effective and efficient means of extending housing to many homeless. It would also permit them to stay in their own communities instead of migrating to larger cities away from their extended families. Helping families who help the homeless would be an especially effective strategy in rural areas where there are few shelters and housing options for those who are homeless with children. Shelters, and other agencies serving the homeless, should include non-homeless family in their service plans, even including them in counseling sessions and case management services aimed at helping their homeless relatives. Cook-Craig and Koehly (2011) argued that this approach could strengthen the abilities of those within a homeless person's social network to provide valuable supports. These services could also address past family conflicts and other issues that make it difficult for homeless persons to seek help from family members or for the non-homeless family members to provide assistance. Polgar et al. (2009) argued that non-homeless family members often experience many forms of caregiver stress when helping homeless relatives. Counseling services for the homeless should reach out to their clients' relatives to help them relieve and manage this stress.

Many of the homeless participants in this study expressed both a desire to "earn their keep" when staying with others and not to be seen as a burden. Shelter- and community-based programs that allow the homeless to earn money and other valuables (e.g., food, tools, bicycles, food stamps, coupons, etc.), in return for what would otherwise be considered volunteer work, may improve their abilities to maintain positive relationships within helping networks (United States Employment and Training Administration & James Bell Associates, 1997). Valuables could be exchanged for shelter, transportation assistance, child care or other necessities within the homeless' helping networks. Such an exchange would help preserve positive relationships

with people who may provide critical assistance, including non-homeless family, while allowing the homeless to contribute to the household when staying with relatives and friends.

Limitations and future research

This research explored relationships between the homeless and their non-homeless family members; however, data are only from the perspectives of the homeless. While we do gain some insights into how non-homeless family members view these relationships, there are undoubtedly many aspects of these relationships that could be illuminated by collecting data directly from non-homeless family members and other help providers. A few studies have examined how homelessness may impact non-homeless family members (e.g., Polgar, 2011); however, we know of none that include non-homeless family members as study participants. Our future research will examine the perspectives of non-homeless relatives supporting their homeless kin.

Another study limitation is that the data are cross-sectional. Because we rely on interview data that captures homeless participants' experiences and feelings at a single point in time, we may not fully understand how relationships with non-homeless family members change during and after bouts of homelessness. A follow-up study that includes some of these study participants could examine how relationships with family members and others change over time, especially as some experience extended homelessness, some secure stable housing, and others experience sporadic bouts of homelessness.

The sample size (N = 114) is extensive for a qualitative study, and to the best of our knowledge it is reasonably representative of the homeless population within the UP. The sample is limited by geography; however, and is not generalizable to other areas. We believe many of the experiences, perceptions, and feelings of participants uncovered in the data will be similar to homeless individuals and families throughout the U.S. and certainly to those in rural areas where formal social services are scarce. Additional research that includes other regions in the U.S. (including both rural and urban areas) would strengthen the external validity of our findings.

This study relied on descriptive data in evaluating participants' perceptions of the costs and benefits of seeking and receiving help from non-homeless family members. While data were helpful in creating deeper understandings of decision-making processes among the homeless, we were not able to fully capture the value of help received. This made it difficult to compare levels of help received between groups in our sample (e.g., individuals versus families). Follow-up research will include a more systematic measure of both the costs and benefits of seeking and receiving help.

This study offers a unique perspective on the value and limitations of family networks in coping with homelessness. Help from non-homeless family members is critical to survival for many people who are homeless in rural areas where support services are scarce. However, seeking help from family can sometimes strain and alter relationship dynamics. Our data offer a snapshot of family networks among individuals and families experiencing homelessness and help paint a more complete picture of the family context of rural homelessness. Knowledge of this context may help policymakers and service providers better understand the unique experiences of homeless individuals and families in rural areas as they relate to family history and dynamics,

seek ways to involve non-homeless relatives in the assistance of their relatives, and design services that better meet the needs of homeless individuals and families.

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Differences Between Children with Fetal Alcohol Spectrum Disorders and Attention Deficit Hyperactivity Disorders: Rural Social Work Implications for Prevention, Assessment, and Treatment

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Abstract. This literature review examined nine quantitative research studies published between 1992-2013 that compared children with Fetal Alcohol Spectrum Disorders (FASD) and Attention Deficit Hyperactivity Disorder (ADHD) to identify: (a) the differences between these children (e.g., intellectual, behavioral); and (b) the diagnostic tools that may be used to distinguish between them, thereby providing a differential diagnosis. Special focus was placed on rural treatment implications. These studies revealed differences between the intellectual, executive functioning, adaptive behavior, motor, and behavioral skills of children with FASD and ADHD. This review identified neurodevelopmental assessments used in these nine research studies that appear to support learning and behavior differences between children with FASD and ADHD. Implications for prevention, assessment, and mental health treatment in rural social work practice are offered.

Keywords: Fetal Alcohol Syndrome (FAS), Fetal Alcohol Spectrum Disorders (FASD), Attention Deficit Hyperactivity Disorder (ADHD), differential diagnosis, neurodevelopmental disorders, rural social work, rural mental health

This review examined quantitative research comparing Fetal Alcohol Spectrum Disorders (FASD) and Attention Deficit Hyperactivity Disorders (ADHD) to ascertain clinical and diagnostic overlap that often results in FASD being misdiagnosed as ADHD. Implications suggesting differences in prevention and intervention strategies for rural social workers and other mental and public health practitioners providing services to individuals with FASD and ADHD are highlighted.

FASD is the umbrella term used to denote the set of conditions arising from prenatal exposure to the teratogen alcohol that encompass various physical, cognitive, behavioral, emotional, and adaptive functioning deficits (Greenbaum, Stevens, Nash, Koren, & Rovet, 2009; Interagency Coordinating Committee on Fetal Alcohol Spectrum Disorders, 2011; Streissguth, 1997). FASD includes diagnoses such as Fetal Alcohol Syndrome (FAS), partial FAS (pFAS), Alcohol Related Neurodevelopmental Disorders (ARND), and Alcohol-Related Birth Defects (ARBD). Astley and Clarren (2000) established the clinical 4-digit diagnostic code for FAS identifying four primary criteria: (a) growth deficiencies that stunt prenatal and/or postnatal growth; (b) permanent brain damage resulting in neurological abnormalities, delay in development, intellectual impairment, and learning/behavior disabilities; (c) abnormal facial

features, including short eye opening, thin upper lip, and reduced or absent philtrum; and (d) maternal alcohol use during pregnancy.

Regarding all levels of FAS, May et al. (2009) found that the prevalence in younger school children may be as high as 2-5% in the United States and some Western European countries. Sampson et al. (1997) speculated that the combined rate of FAS and ARND, or all FASDs, is estimated to be at least 9.1/1,000 live births.

FASD/ADHD in rural areas

Generalist social work practice, the “best suited model” for rural social workers and other mental health providers, recognizes the unique cultural and diverse aspects of rural settings (Berg-Weger, 2013, p. 259). Rural social workers may be the only resource to deal with challenges such as FASD (Daley & Avant, 2014). Knowledge of the incidence of FASD, the overlap in characteristics between FASD and ADHD, and the subsequent challenge of accurate diagnosis are important for rural social workers and other mental health practitioners.

Relevant to this discussion, the incidence of FASD may be higher in rural, remote, isolated, and geographically dispersed regions of the United States and rural communities of other countries (May et al., 2009). For example, the Aboriginal Mental Health Research Unit in Quebec identified increased rates of alcohol consumption in rural communities as their number one health concern and as a contributing factor to the increase in FASD in rural villages, towns and communities (Tait, 2003). The Centers for Disease Control and Prevention (CDC) (2010) published data on state specific weighted prevalence estimates of alcohol use among women aged 18-44. Results indicate that six of the ten states with the highest rates of alcohol consumption reported by women in this age range are also states with high rural populations. According to the CDC, alcohol use before pregnancy is a significant predictor of alcohol use during pregnancy (Floyd, Decouflé, & Hungerford, 1999; Zammit, Skouteris, Wertheim, Paxton & Milgrom, 2008). As approximately 40% of women realize they are pregnant after four weeks, a portion of women who use alcohol will continue during the early weeks of gestation. These data are of particular relevance for rural social workers because of implications for FASD in rural areas due high alcohol consumption (Heise, 2010).

Despite the prevalence of FASD, it is under-diagnosed (Vaurio, Riley & Mattson, 2008) and more often misdiagnosed as Attention Deficit Hyperactivity Disorder (ADHD) (Crocker, Vaurio, Riley, & Mattson, 2011). Misdiagnosis or under-diagnosis is a concern for social workers and other professionals in a variety of mental health, school, and community settings. Children with FASD have a greater than average rate of (a) IQs that measure within the intellectual disabilities category, suggesting the need for special education services and learning supports; (b) problems following directions, poor memory and judgment skills; and (c) poor academic performance leading to an increased school dropout rate (Abkarian, 1992; Burgess & Streissguth, 1990; Coggins, Friet, & Morgan, 1998; Kleinfeld & Wescott, 1993; National Research Council, 2001; Timler & Olswang, 2001).

Under- or misdiagnosis of FASD and the subsequent lack of appropriate special education services has been cited as a concern by rural special educators, behavior specialists, and other mental health practitioners (Ryan & Chionnaith, 2006; Ryan & Ferguson, 2006a; Ryan & Ferguson, 2006b). A 5-year study of rural special educators and mental health providers

indicated that rural practitioners were ill-prepared to meet the education and mental health needs of a growing number of children and youth with FASD in their rural classrooms and communities, children who had previously been diagnosed with other disorders including ADHD (Ryan & Ferguson, 2006a, 2006b).

Nash et al. (2006) described the need for effective screening and diagnostic tools that may distinguish between children with FASD and ADHD, particularly for those living in rural and remote areas with limited access to diagnostic and mental health services. Even when such services are available, waitlists are typically lengthy and travel distances considerable (Nash et al., 2006; Ryan & Ferguson, 2006a, 2006b). Therefore the need for accessible, accurate, and differential diagnosis is critical for underserved persons in areas.

Children affected by FASD have also been found to be at increased risk for juvenile justice involvement, and had not been appropriately diagnosed and treated until after they entered the legal system (Fast, Conry, & Looock, 1999). Understanding the legal charges, culpability, and the negative consequences individuals with FASD face may be challenging for practitioners. However, punitive sanctions or traditional behavioral modification approaches may be ineffective as viable treatments for people with FASD (Malbin, 2004). Furthermore, individuals with FASD may experience additional victimization in the justice system; and given comorbid mental health and executive functioning challenges, may be more susceptible to negative peer influences.

Many educational or clinical phenomena seen in children with ADHD also characterize those with FASD (Kooistra, Ramage et al., 2009). For example, characteristics often attributed to children with prenatal exposure to alcohol are poor attention and hyperactivity. Early identification and diagnosis can lead to effective intervention protocols that assist students with FASD-related developmental problems (May et al., 2009), students who might otherwise have been inappropriately treated (Coles et al. 1997).

This article reviews existing quantitative research in which children with FASD were compared to children with ADHD in an effort to identify unique differences. A second purpose is to identify what diagnostic/assessment tools may be used to distinguish between children with FASD and ADHD, thereby facilitating differential diagnostic options for rural professionals including social workers, mental health professionals, and special educators.

Method

Selected articles were published between 1992-2013 from electronic databases and are listed in Table 1. Educational Resources Information Centers (ERIC), Academic Search Premier, PsychInfo, and PubMed search terms included:

- Fetal Alcohol Spectrum Disorder;
- Attention Deficit Hyperactivity Disorder;
- Fetal Alcohol Syndrome;
- Attention Deficit Disorder with Hyperactivity;
- Prenatal Alcohol Exposure;
- Attention Disorders; and
- Teratogenicity.

Reference lists of these articles were analyzed to determine additional articles, and a hand search of the following journals was also conducted:

- *Journal of Attention Disorders*;
- *Exceptional Children*;
- *The Journal of the National Institute on Alcohol Abuse and Alcoholism*;
- *Alcoholism, Clinical and Experimental Research*;
- *Journal of Child and Adolescent Psychopharmacology*;
- *Developmental Medicine and Child Neurology*;
- *Human Movement Science*; and
- *Rural Special Education Quarterly*.

Inclusion/exclusion criteria

Articles included in the review were (a) published in the United States or Canada, (b) published between 1992-2013, (c) reported quantitative results, and (d) included a research design that compared participants with FASD with those who had ADHD. Participants, study designs, dependent variables, and significant findings are summarized in Table 1.

Analysis of the literature

Nine articles met all search criteria, and were reviewed as follows:

- authors and date;
- purpose and objectives of the study;
- participant demographic information;
- setting (when available);
- research design;
- instruments used/dependent variable;
- results; and
- study limitations.

Inter-rater reliability was determined across the nine articles by summing the total number of agreements, and dividing it by the total number of possible responses. The initial inter-rater reliability was 92%. Where there was disagreement, the authors discussed the article and criterion, and then recalculated reliability after consensus was reached. After discussions, the inter-rater reliability was 100%.

Results

The number of children who participated in the nine quantitative research studies included in this literature review ranged from a low of 54 (Nash et al., 2006) to a high of 149 children (Coles et al., 1997). The children's age ranged from 7-10 years. All studies were conducted in clinical, lab, or hospital settings.

Study designs

The nine studies included in this review utilized quantitative descriptive and/or experimental designs across three and sometimes four distinct groups. Table 1 highlights the specific aspects of each research study including a description of the experimental and control groups.

Table 1

Research Using FASD/ADHD Samples

Authors	Participants	Study Design	Instruments/ Dependent Variables	Significant Findings
Coles et al. (1997)	FAS/FAE (N=25), PAE non-dysmorphic (N=62), ADHD (N=27), Control (N=35)	Compared 4 groups on maternal, child physical & neurocognitive traits, & behavioral indicators controlling for race/SES.	K-ABC; WISC-R; Test of visual/motor integration (VMI); SNAP; CBCL (parent & teacher versions); DISC; CPT; Four Factor Model of Attention (Mirsky et al., 1989).	FAS group had more visual/spatial skills, encoding information, & problem solving challenges; ADHD group had more attention & behavior problems.
Crocker et al. (2009)	ALC (N=22), ADHD(N=23), Control (N=20)	Matched sample control group design; Subjects were previously administered a battery of neuropsychological tests (e.g., measuring intelligence, language, learning)	VABS: Assessing adaptive behavior in communication, daily living skills, & socialization.	ALC group showed more communication & daily living skill impairments than ADHD & control groups Socialization scores decreased as ALC group grew older.
Crocker et al. (2011)	ALC (heavy prenatal exposure and ADHD) (N=22), ADHD (nonexposed) (N=22), Controls (N=22)	Experimental design across 3 groups compared performance of ADHD & FASD groups on the CVLT-C	CVLT-C including measures of verbal learning, recall, retention, & recognition.	ALC group showed impaired recognition of presented verbal material; ADHD group demonstrated impaired retention.
Greenbaum et al. (2009)	ALC (N=33), ADHD (N=30), Control (N=34)	Experimental design across the 3 groups: FASD, ADHD, & Normal Controls.	CBCL; Teacher Report Form (TRF); SSRS; Theory of Mind Task (Saltzman-Benaiah & Lalonde, 2007); Minnesota Test of Affective Processing; Weschsler Abbreviated Scale	FASD group had poorer performance on experimental measures of social cognition. Parents & teachers reported more behavior problems & poorer social skills in FASD & ADHD groups
Kooistra et al. (2011)	ADHD (N=47), FASD (N=28), Controls (N=38)	Experimental group design across the 3 groups	ADHD Checklist; Conners Parent Rating Scale-Revised; & Attentional Network Test (ANT)	FASD group had lower FSIQ. Both ADHD-C & FASD groups had higher conflict scores than control group.
Kooistra, Ramage et al. (2009)	ADHD (N=47), FASD (N=30), Control (N=39)	Experimental group design across 3 groups	Conners Parent Rating Scale-Revised; M-ABC; WISC-III; COMPS.	Both FASD & ADHD groups had problems with complex motor skills. ADHD also had problems with basic motor skills.
Kooistra, Crawford et al. (2009)	ADHD (N= 47), FASD (N=30), Control group (N=39)	Experimental group design across 3 groups.	Slow rate continuous performance task (CPT); Inhibitory control was tested using Go/No-Go task; Conners' Parent Rating Scale-Revised; WISC-III.	FSIQ & SES were lower for FASD group. CPT task performance decreased in ADHD & FASD groups. On the Go/No-Go task, children with ADHD-C and FASD groups performed more slowly and more variably.
Nash et al. (2006)	FASD (N= 54), Control (N= 30), ADHD (N=30)	Experimental design across 3 groups	Child Behavior Checklist (CBCL)	Children with FASD were more likely to <i>lie and steal</i> than children with ADHD.
Vaurio et al. (2008)	ADHD (N=20), ALC (N=20), Control (N=20)	Experimental design across 3 groups: ALC, ADHD, and Control (Non-alcohol/non ADHD group)	WCST; COWAT; TMT; WISC-III.	ALC group displayed overall deficits in letter fluency and impairment in category fluency.

We maintained the researchers' language to describe experimental groups. For example, many referred to students on the FASD spectrum as the *alcohol group* with the abbreviation *ALC*. When only the term *prenatal exposure to alcohol* was used, we used the Institute of Medicine (IOM) term Fetal Alcohol Spectrum Disorder (FASD) (IOM, 1996).

Dependent variables/instruments used to compare groups

Confirmation of FASD and diagnosis of ADHD. Substantiation of prenatal exposure to alcohol was determined using a variety of diagnostic methods. The FAS diagnosis, or documentation of prenatal exposure to alcohol (including FASD), was determined using the FAS 4-digit diagnostic code (Astley & Clarren, 2000) in three studies (Kooistra, Crawford et al., 2009; Kooistra, Ramage, et al., 2009; Kooistra et al., 2011). Coles et al. (1997) used an empirically based dysmorphia checklist to confirm the FAS diagnosis. An FAS diagnosis and documentation of FASD was confirmed through several mechanisms including confirmed maternal consumption of alcohol and verification of FAS by a dysmorphologist with expertise in alcohol teratogenesis in three studies (Crocker, Vaurio, Riley, & Mattson, 2009; Crocker et al., 2011; Vaurio et al., 2008). A unique profile of deficits and assets tool (Greenbaum, Nulman, Rovet, & Koren, 2002) was used in two studies to identify children with FASD (Greenbaum et al., 2009; Nash et al., 2006).

Researchers confirmed the ADHD diagnosis for children in the respective group by using a variety of instruments. The ADHD Checklist (Kaplan, Humphreys, Crawford, & Fisher, 1997) was used to confirm the diagnosis of ADHD and the Diagnostic Interview for Children and Adolescents-IV (Reich, Welner, & Herjanic, 1997) was used to re-confirm the diagnosis and assign ADHD subtype in three studies (Kooistra et al., 2011; Kooistra, Crawford et al., 2009; Kooistra, Ramage et al., 2009). Psychiatrists or behavioral pediatricians used the DSM-III (American Psychiatric Association, 1987) or DSM-IV ADHD diagnostic criteria (American Psychiatric Association, 1994, 2000) in seven studies (Coles, et al., 1997; Crocker et al., 2009, 2011; Greenbaum et al., 2009; Kooistra, Ramage et al., 2009; Nash et al., 2006; Vaurio et al., 2008). Vario et al. (2008) determined the ADHD diagnoses through the use of parent interviews including the National Institutes of Mental Health (NIMH) Diagnostic Interview Schedule for Children (DISC) (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) or the Schedule for Affective Disorders and Schizophrenia School Aged Children: Lifetime Version Interview (Kaufman et al., 1997).

General Intelligence Quotients. Of the nine studies only three included general intelligence as a dependent variable as measured by the Weschler Intelligence Scale for Children (WISC) (Weschler, 1991) or subtests including *coding* and *vocabulary* and *developmental test of visual/motor integration* (VMI) (Coles et al., 1997; Greenbaum et al., 2009; Vaurio et al., 2008).

Executive functioning and cognition. Several instruments were used to assess the dependent variables of executive functioning and cognition. Cognitive abilities including executive functioning skills, sequential functioning, reading and decoding were analyzed using several measures:

- Coles et al. (1997) used the Kaufman-Assessment Battery for Children (K-ABC) (Kaufman & Kaufman, 1983);
- Greenbaum et al. (2009) used the Minnesota Test of Affective Processing (Lai, Hughes, & Shapiro, 1991);

- Croker et al. (2011), used the California Verbal Learning Test, Children's Version (CVLT-C) (Delis, Kramer, Kaplan, & Ober, 1994);
- Vaurio et al. (2008) used the Wisconsin Card Sorting Test (WCST) (Heaton, Chelune, Talley, Kay, & Curtis, 1993); and
- Vaurio et al. (2008) used the Controlled Oral Word Association Test (COWAT) (Lezak, 1995); and the Trail Making Test (TMT) (Reitan, 1958).

Adaptive behavior. Only one of the nine studies included the dependent variable adaptive behavior. General adaptive behavior skills were assessed using the Vineland Adaptive Behavior Scales (VABS) (Sparrow, Balla, & Cicchetti, 1984) in the Crocker et al. (2009) study.

Attention and focus skills. The dependent variable attention and focus skills was used in two studies. Impairment in attention pathways and focus skills were assessed using the:

- Four Factor Model of Attention (Mirsky, Anthony, Duncan, Ahern, & Kellam, 1991) in the Coles et al. (1997);
- Slow Rate Continuous Performance Task (CPT) (Rosvold, Mirsky, Sarason, Bransome, & Beck, 1956) in the Coles et al. (1997) and Kooistra, Crawford et al. (2009) studies; and
- Go/No-Go task, developed by the authors, was used by Kooistra, Crawford et al. (2009).

Behavioral skills. Behavior skills were a dependent variable in several sample studies. Behavioral skills including aggressive behavior, as well as anxiety/depression, attention problems, delinquent rule-breaking behavior, social problems, somatic complaints, thought problems, withdrawn behavior, externalizing, and internalizing were assessed as follows:

- Achenbach Child Behavior Checklist (CBCL) (parent and teacher versions) (Achenbach, 1991) in three studies (Coles et al., 1997; Greenbaum et al., 2009; Nash et al., 2006);
- Social Skills Rating Scale (SSRS) (Gresham & Elliott, 1990) in the Greenbaum et al. (2009) study; and
- SNAP (Swanson, Nolan, & Pelham, 1982) in the Coles et al. (1997) study. Parent and teacher rating of children's behavior was measured using the Conners Parent Rating Scale (Revised) (Conners, 1997) in two studies (Kooistra, Crawford et al., 2009; Kooistra et al., 2011)

Motor and movement skills. Skills involving motor and movement were measured using various instruments including the Movement Assessment Battery for Children (M-ABC) (Henderson & Sugden, 1992) and Clinical Observation of Motor and Postural Skills (COMPS) (Wilson, Pollock, Kaplan, & Law, 2000) in the Kooistra, Ramage et al. (2009) study.

Study findings

Each study reviewed sought to compare children from a control group and those with FASD and ADHD. Findings from the studies reported differences between children with FASD and children with ADHD across five specific domains: (a) general intellectual functioning; (b) executive functioning; (c) adaptive behavior skills; (d) social and behavioral skills; and (e) motor skills.

Tests and Measurements Distinguishing FASD and ADHD. This literature review demonstrated that social workers, mental health providers, and school special educators routinely administered at least eight neurodevelopmental tests and measurements that may reveal

differences between FASD and ADHD; however clinical cut points were not provided. The eight neurodevelopmental measurements are:

- Triangles, Matrix Analogies, and the Arithmetic subscales of the Kaufman-Assessment Battery for Children (Kaufman & Kaufman, 1983);
- Wisconsin Card Sorting Task (Heaton et al., 1993);
- Go/No-Go Task tests (Kooistra, Crawford et al., 2009);
- Trail Making Test (Reitan, 1958);
- Daily Living and Social domains of the Vineland Adaptive Behavior Scales-Interview Edition (Sparrow et al., 1984);
- Social Skills Rating Scale (Gresham & Elliot, 1990);
- Child Behavior Checklist (Achenbach, 1991); and the
- Movement Assessment Battery for Children (Henderson & Sugden, 1992).

The Coles et al. study (1997) indicated that the Triangles, Matrix Analogies, and Arithmetic subscales of the K-ABC (Kaufman & Kaufman, 1983) were sensitive enough to reveal that children with FASD performed less well than children with ADHD in the areas of visual/spatial reasoning and encoding dimensions. The Vaurio et al. (2008) study indicated that the WCST (Heaton et al., 1993) highlighted that children with FASD, not children with ADHD, performed less well in the areas of encoding dimension, retrieval of information, shift variables, and the number of categories completed (Coles et al., 1997, p. 154). The Kooistra, Crawford et al. study (2009) indicated that the Go/No-Go Task tests found that children with FASD had difficulties with encoding and shifting attention, while children with ADHD had problems with focusing and sustaining attention. The Vaurio et al. (2008) study suggests that the TMT instrument (Reitan, 1958) revealed a difference between the ALC and the ADHD groups, in that only the ALC group displayed overall deficits on letter fluency and relative weakness indicative of left frontal damage and temporal lobe abnormality. The Crocker et al. (2009) study indicated that the subscales of the VABS (Sparrow et al., 1984), specifically the *Daily Living Skills* and the *Socialization Domains*, revealed that children with FASD were significantly more impaired in the areas of daily living and social skills than children with ADHD. Both Greenbaum et al. (2009) using the SSRS (Gresham & Elliot, 1990), and Coles (1997), Greenbaum et al. (2009) using the CBCL (Achenbach, 1991), identified particular behavioral characteristic differences between children with FASD and children with ADHD. Children with FASD were found to have more significant behaviors in the area of no guilt, lying and cheating, cannot concentrate, restless, impulsive, disobedient, and acts young. Finally, Kooistra, Ramage et al. (2009) discovered that the M-ABC (Henderson & Sugden, 1992) revealed that children with ADHD had more problems with both basic and complex motor skills, while children with FASD were more affected in their complex motor skills.

Discussion

Neurodevelopmental tests and measurements with potential to distinguish between FASD and ADHD

Columns 4 and 5 of Table 1 highlight the neurodevelopmental tests and measurements that appear to reveal differences between children with FASD and ADHD in the areas of executive functioning, adaptive behavior, behavior and motor. A closer look at a child's performance on these measures may assist professionals in distinguishing between children who

have ADHD, children who are misdiagnosed with ADHD, and children who may have FASD. Further testing or referral to an FASD specialist may be warranted.

Implications and suggestions for rural social workers and practitioners

Review findings have implications for rural social workers and other practitioners providing services and supports to children and youth who have FASD and their families. In addition to the suggestions highlighted in this section, we provide resources for social workers and mental health care providers (see Table 2).

Table 2

FASD Resources for Social Workers and Mental Health Care Providers

Resource	Description	URL
Substance Abuse and Mental Health Services Administration	U.S. Department of Health and Human Services agency	http://www.samhsa.gov
National Institute of Alcohol Abuse and Alcoholism	Part of National Institute of Health that conducts and supports research on alcohol's impact	http://www.niaaa.nih.gov
National Organization on Fetal Alcohol Syndrome	Provides information and resources nationally	http://www.nofas.org
Public Health Agency of Canada Awareness Campaign	PDF of the results of Canadian awareness campaigns about prenatal alcohol exposure	http://www.phac-aspc.gc.ca/publicat/fasd-ac-etcaf-cs/pdf/fasd-ac-etcaf-cs_e.pdf
Centers for Disease Control and Prevention	Overview of facts, research, statistics, and trainings to provide information on prevention and intervention	<p><i>General:</i> http://www.cdc.gov/ncbddd/fasd</p> <p><i>Intervention:</i> http://www.cdc.gov/ncbddd/fasd/research-intervention.html</p> <p><i>Competency-Based Curriculum Guide:</i> http://www.cdc.gov/ncbddd/fasd/research-intervention.html</p>

(1) Conduct FAS/FASD prevention campaigns. FASD prevalence rates in rural areas suggest the need for primary prevention campaigns that target communities at higher risk for FAS or FASD. Although prenatal exposure to alcohol is certainly not limited to rural areas or native populations, evidence suggests that the rate of FASD may be a cause for particular concern in rural states (Bohjanen, Humphrey, & Ryan, 2009). In fact, the prevalence is as high as 10 to 20 percent in some First Nation communities (Sampson et al., 1997; Sokol, Delaney-Black, & Nordstrom, 2003). The CDC data reported through the Behavioral Risk Factor Surveillance System (BRFSS) Annual Survey (CDC, 2010) warrant serious attention by rural interdisciplinary practitioners including mental and public health providers, school personnel including educators, parent associations, policy makers, and interagency councils. Rural states should invest in prevention campaigns and education programs directed at women between ages 18-44. Prevention campaigns initiated by rural grass roots organizations and policy makers are shown effective and are roles typical of the generalist social worker working in rural communities (Berg-Weger, 2013). Rural communities in Alaska have undertaken such campaigns in an effort to prevent prenatal exposure to alcohol (University of Alaska Anchorage, 2012).

(2) Diagnose FASD early and accurately. Recently the National Institute of Health, specifically the National Institute on Alcohol Abuse and Alcoholism (NIAAA), through their Interagency Coordinating Committee on Fetal Alcohol Spectrum Disorders (ICCFASD), published a consensus statement making the following recommendation: “investigations of other complex developmental disorders (including ADHD) should include inquiry about prenatal alcohol exposure to identify the contribution of prenatal exposure to alcohol to phenotypes of other developmental disabilities” (ICCFASD, 2011, p. 5).

Identifying, understanding, and addressing complex needs of children with executive functioning deficits, and emotional and behavioral disorders resulting from FASD are challenging for social workers and all mental health practitioners, particularly in rural and remote communities. Despite the challenges of obtaining an accurate diagnosis, children with FASD deserve an early and accurate diagnosis followed by appropriate treatment because children with FASD are at particular risk of academic failure and juvenile justice involvement (Ryan & Ferguson, 2006a; Streissguth, 1997).

Rural and remote practitioners including social workers, mental and public health professionals, physicians, and educators may find it helpful to create a FASD task force and FASD diagnostic clinic. The task force can assemble an interdisciplinary team of practitioners to advocate for training, public awareness, and FASD programming. A diagnostic clinic in a rural community could conduct preliminary FASD screenings and make referrals to qualified urban physicians. Making such referrals often require additional resources such as transportation, assistance with making a referral, or help with payment arrangements. Rural social workers or other mental health professionals could facilitate the acquisition of these supports, which are actions rural generalist social workers often take as part of their practice.

Before the creation of diagnostic clinics in rural Alaska, children were referred to the FASD clinic in Washington. Today, there are 14 rural FASD clinics throughout Alaska, staffed by rural mental and public health professionals with expertise in screening, diagnosis and treatment of children with FASD. These rural diagnostic teams received training from national specialists and are now able to conduct diagnosis and treatment. Funding for this training came from a variety of sources including grants, state agency support, and local native corporations.

(3) Pay particular attention to results of CBCL. The Child Behavioral Checklist (CBCL) can provide valuable diagnostic information to help distinguish children with FASD from children with ADHD. The CBCL is routinely used by social workers in a variety of mental health agencies in both rural and urban settings that serve children and families. Assessing skills on competence items measured by the CBCL, like the scores on *activities, social, school,* and *total competence* scales, as well as *externalizing* and *internalizing* scale scores may help determine whether or not a child has FASD. As cited in this review, Greenbaum et al. (2009) found that children with FASD exhibited clinically significant problems on CBCL items dealing with externalizing behaviors. Nash et al. (2006) found that *impulsivity, issues of guilt* and *remorse* and other factors distinguished children with FAS from their counterparts (see Table 1). If the CBCL administered by rural social workers or other mental health practitioners reveals deficits in the aforementioned areas, referral to an FASD specialist is suggested. If the rural community does not have an FASD specialist, a referral to a regional specialist may be warranted.

(4) Carefully monitor and support children with FASD in Foster Care or juvenile justice settings. Victor, Wozniak, and Chang (2008) explored associations between foster care placement and cognitive and behavioral functioning, and found that children with FASD who experienced single or multiple placements, struggled with impulse control, internalizing disorders, and assessment of verbal and mathematical achievement more than children who were never removed from their biological home. These findings suggest that greater consideration of environmental factors, such as family and educational stability, disorganized attachments and verbal interaction between caregivers and their children, is affecting verbal IQ, learning, and internalizing symptoms among children with FASD. One recommendation would be for rural social workers and other practitioners to work with community grass root organizations (e.g., Boys and Girls Clubs, religious groups, or Big Brothers/Big Sisters) to develop informal infrastructures within grass roots organizations that may develop and sustain support groups/friendship circles or other informal natural support systems for children with FASD who are in foster care or a juvenile justice system.

Children affected by FASD have also been found to be at increased risk for juvenile justice involvement and many had not been appropriately diagnosed and treated until after they entered the legal system (Fast et al., 1999). Rural Social workers and other mental health providers can educate juvenile and criminal justice staff about FASD, which may promote alternatives to incarceration. If, however, individuals with FASD become involved in juvenile justice or the criminal justice system, rural attorneys or judges might consider alternatives to treatment and incarceration. For example, the Superior Court of Barrow Alaska has pioneered the concept of mitigating conditions to be used in the sentencing of individuals with FASD (Alaska State Legislature, 2011; Jeffery, 2010).

(5) Include rural community elders and indigenous support systems in the treatment plans of children and youth with FASD. Given the importance of prevention, there are initiatives prioritizing prevention of alcohol-related disabilities. These include screenings for women and interventions that address the needs of high-risk women living in rural settings (Kotrla & Martin, 2009). For example, in the case of Alaska's Comprehensive Fetal Alcohol Syndrome Project, substance abuse prevention practitioners collaborated with tribal organizations and village elders to target rural villages and communities when providing

behavioral health intervention. Working with community leaders including First Nation elders has also been an effective strategy used by the Canadian FASD projects (Pacey, 2010)

(6) Establish evidence based intervention unique to, and effective for, children with FASD. Lastly, evidence-based research and intervention is limited in the area of FASD, and researchers and practitioners call for the development of evidence-based practices for FASD. The assumption that children with FASD should receive intervention found effective on children with Autism Spectrum Disorders (ASD) or ADHD is not appropriate (Ryan & Ferguson, 2006a; Streissguth, 1997).

Limitations of the Study

The results of this review should be interpreted carefully. First, relatively little work has been done on this topic since an extensive literature search located only nine research articles fitting search criteria. A second limitation was researchers' use of multiple measures to substantiate a diagnosis of FASD or ADHD. Although this is an acceptable practice in the field, it makes any comparisons across the 9 studies regarding use of diagnostic tools suspect. Third, the studies reviewed did not use similar dependent or independent variables. The use of multiple and varied instruments/variables confounds the ability to make complete conclusions across the studies. Only studies using experimental group designs were included; and other research methods, such as qualitative or single subject research designs, were not included in this review, yet they might offer significant information related to the similarities and differences between children with FASD and ADHD. Fourth, although the studies resulted in identification of performance differences on particular subtests between children with FASD and ADHD, no study provided clinical cut points that might help practitioners identify FASD specifically. Further research must establish clinical cut points to identify FASD. Additionally, none of the articles specifically defined differences between rural and urban populations. While it is possible that the clinics where study data were collected included rural participants, that information is missing from the articles reviewed. However, this also speaks to the lack of empirical data currently available specifically linking rural issues associated with effectively treating FASD, which is a goal of this paper.

Summary and Conclusions

This article reviewed quantitative research that highlight similarities and differences in children with the disorders of FASD or ADHD, and sought to make relevant connections between research and rural practice. Another purpose of this review was to identify tests and measurements that distinguish between FASD and ADHD, thereby providing a differential diagnosis. This review highlighted at least eight neurodevelopmental tests and measurements, frequently administered by physicians, psychologists and rural social workers and mental health providers with the ability to assist practitioners in accurately diagnosis of FASD. Depending on the performance of the child on these specific neurodevelopmental assessments, social workers and other mental health providers might consider follow-up for FAS diagnostic testing thereby avoiding misdiagnosis. The expectation is that all practitioners seeking to properly diagnose and treat FASD, and understand differences between FASD and ADHD, will benefit from this review. Practitioners in rural areas will find this review especially helpful, as they continue to struggle to effectively address challenges associated with FASD.

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Impact of Providers' Cultural Competence on Clients' Satisfaction and Hopefulness in Rural Family Services: A Pilot Study

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Abstract. Cultural competence has been discussed in professional disciplines. However, previous studies focused on ethnic sensitivity in practice, and limited work has addressed the cultural competence of rural social work practitioners. This study examined relationships between families' perceptions of cultural competence, therapeutic alliance, and practice outcomes in rural practice settings. Forty-five youth and their parents receiving intensive in-home family preservation services at Integrated Services of Appalachian Ohio completed a questionnaire regarding their providers' cultural competence in rural settings, and their therapeutic alliance, hopefulness, and satisfaction with services. Families rated their provider as culturally competent in rural practice settings; and provider competence in rural culture was positively associated with practice outcomes – satisfaction and hopefulness. Suggestions for enhancing social work practitioners' cultural competence in rural settings are provided.

Keywords: cultural competence, rural family services, therapeutic alliance, practice outcomes

Cultural diversity is an increasingly important concern among social workers and other behavioral health practitioners in the United States. Racial and ethnic minority populations accounted for 30 percent of the U.S. population in 2000, and are projected to increase to 40 percent by 2015 (U.S. Department of Health and Human Services, 2001). Responding to demographic shifts, cultural competence has been frequently discussed in professional disciplines (Campinha-Bacote, 2003, 2007; Cox, Sullivan, Reiman & Vang, 2009; Musolino et al., 2010). Previous studies regarding cultural competence have focused on ethnic sensitivity and concerns in practice (Fong, 2001; LaVeist, Diala, & Jarrett, 2000; Lum, 2004; Sue & Sue, 1999). The National Association of Social Workers *Code of Ethics (NASW Code)* (NASW, 2008) frequently refers to the importance of cultural competence on the part of practitioners serving diverse client populations; however, cultural competence is rarely defined. Culture includes the ways in which a group of people experience their world, and can include thoughts, actions, communications, customs, beliefs, values, and institutions (NASW, 2001). Citing Sue (1998), Cox et al. (2009) suggest practitioners need to "...avoid drawing premature conclusions about the status of their culturally different clients," and "...avoid stereotypes..." (n.p.). Additionally they suggest practitioners learn to "... appreciate the importance of culture and acquire culture specific expertise" (n.p.) However, few studies have examined practitioners working with rural families to assess providers' cultural competence in the treatment process. This study looked at youth and parents in a rural, impoverished location within the Appalachian region. Because both

service resources and their access are limited, it is important to plan how to use resources wisely to effectively respond to the needs of rural families.

The purpose of this study is to explore families' perceptions of cultural competence and therapeutic alliance in rural family services. This study also examines the relationship between families' perceptions of their provider's competence in rural culture, therapeutic alliance, and practice outcomes: satisfaction and hopefulness with treatment. Additionally, relationships between clients' perceptions and their personal characteristics are examined.

Cultural Competence and Therapeutic Alliance in Social Work Practice

Cultural competence has been identified as an essential part of treatment when social workers and other behavioral health providers work with all people, not just those who are racially or ethnically different from themselves (Black, 2005; Dyche & Zayas, 2001; Pope-Davis, Toporek, Ligiero, Ortega, Bashshur, Brittan Powell, Liu, Codrington, & Liang, 2002). The list of possible differences commonly includes gender, race, ethnic group, nationality, religion, disability, sexual orientation, age, and social class. In many cases, clients and their providers share commonalities, but in some they differ. Both similarities and differences, however, can be tools in relationship building, problem identification, assessment, the development of intervention strategies, and methods of evaluating and terminating clients (Rothman, 2008).

Cultural competence is defined in various ways, sometimes as cultural awareness, cultural sensitivity, or cultural empathy. Additionally, definitions commonly address ethical commitments and social justice as an essential part of social work and behavioral health profession (Hohm & Glynn, 2002; Lum, 2004). A strong commitment to working with vulnerable populations has always been a foundational principle of professions. Particularly, cultural competence in social work practice involves "responding respectfully and effectively" to "people of all cultures, languages, classes, races, ethnic backgrounds, religious, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each" (NASW, 2001).

For the social work profession, cultural competence has been addressed through practice standards and policy statements. For example, the Council on Social Work Education's (2008) Education Policy and Accreditation Standard (EPAS) requires social work schools and programs to provide content related to cultural diversity throughout the curriculum. The EPAS establishes that social workers "recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power; gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups; recognize and communicate their understanding of the importance of difference in shaping life experience; and view themselves as learners and engage those with whom they work as informants" (Educational Policy 2.1.4).

The NASW *Code of Ethics* (2008) provides guidance on multicultural practice. Social workers should understand culture and its function in human behavior, recognize the strengths among all cultures, and be knowledgeable of their clients' cultures to demonstrate competence in the service provision (Standard 1.05). NASW Standards for Cultural Competence in Social Work Practice were also developed and adopted by the NASW Board of Directors in 2001 (NASW,

2001). The Standards charged social workers with ethical responsibility to be culturally competent. As an extension of the Standards, the Cultural Competence Indicators were also published to provide additional guidance on the implementation and realization of culturally competent practice (NASW, 2007).

Cultural competence is as an important factor in treatment (Hancock, 2005; Tseng, 2004). Indeed, cultural competence involves actively seeking advice, consultation, and a commitment to incorporating new knowledge and experience into a wider range of practice (Goode, 2004; Pope-Davis et al., 2002). For example, a culturally sensitive practitioner makes efforts to learn about availability of resources to support clients' cultural identity (Coakley & Orme, 2006). Understanding different cultures is also critical to engaging clients in treatment. In the treatment process, therapeutic alliance represents interactive, collaborative elements of the relationship in the context of an affective bond (Constantino, Castonguay, & Schut, 2002). Being knowledgeable about clients' cultural background improves the therapeutic relationship (Black, 2005; Dyche & Zayas, 2001; Pope-Davis et al., 2002). Engagement between clients and practitioners contributes to persistence in treatment efforts and is extremely relevant in its contribution to positive therapeutic alliance (Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006; Tapia, Schwartz, Prado, Lopez, & Pantin, 2006).

Therapeutic alliance also has been consistently linked with practice outcomes (Hatcher & Gillasp, 2006; Horvath & Symonds, 1991). For example, a positive alliance provides a safe environment for clients to explore themselves and promotes engagement and mutual agreement on goal setting (Erdur, Rude, Baron, Draper, & Shankar, 2000; Fraser & Solovey, 2007). Goal setting collaboration also can help clients have a more desirable vision that they can achieve their treatment goal (Fraser & Solovey, 2007).

Integrated Services of Appalachian Ohio Family Preservation Programming

Integrated Services of Appalachian Ohio (IS) in Athens, OH is a nonprofit agency that develops, manages, and provides community-based services in southeastern Ohio. Working directly with individuals, families, organizations, governmental entities and private service agencies, central goals of IS are to improve quality, cost efficiency, and access to rural services for individuals and families.

IS provides therapeutic family preservation services for youths, ages 4-17, with emotional disturbances, behavioral disorders, or dual diagnoses. These youth are at risk for significant long-term involvement across public sector systems, particularly in the juvenile justice and/or child protection systems. Though still at home, youth may be at risk of placement, or returning home from out of home placement, including foster care, residential treatment, detention or jail, generally within 30 days. IS centralized intake accepts referrals from the juvenile court or the county public child welfare agency. An assigned coordinator conducts an assessment to determine an appropriate level of service. Like other multisystem providers, family services are typically problem focused and competency based. Interventions are designed to respond to identified needs and may be directed toward individuals, families, family subsystems, peer relationships, school adjustment, academic performance, and any other social system believed to be involved in the problem behavior's etiology. Mental health services including a

community support program, counseling and psychotherapy, diagnostic assessment including psychological testing, and psychiatric services, are provided.

Though IS serves counties and communities throughout southeastern Ohio, the current study focused on one county. In this county, IS provided two models of therapeutic family preservation services: an intensive and a less intensive program. The intensive model was intended for families of youths generally between 14-16 years who were at immediate risk for out-of-home placement. This model sought to empower parents to better manage challenging behaviors while helping youth better cope with friends, school and community life. Though IS family programming evolved from Multisystemic Therapy (MST), much of the current model was based on a family therapy approach that incorporates behavior modification training (Sells, 1998). For example, parents are taught skills to help them regain control of their adolescent and family. Peer intervention strategies and school interventions were also developed to improve the youths' behavior and academic performance. Because each family is unique, practitioners must be flexible in planning services to accommodate individual family needs. Services are provided in the home with continuous staff support. In the less intensive process, a combination of formal and informal services and supports targeting essential life domains was provided, based on a foundation of family strengths. Generally, there was weekly contact between the family and the practitioner in this model.

Based on the literature reviewed, we hypothesized that higher practitioner competence in rural culture and related increases in therapeutic alliance should result in more positive practice outcomes in rural family services. Specifically, youth and their parents who rated their provider more culturally competent in rural practice settings would be more satisfied with as well as more hopeful about treatment. Higher levels of satisfaction and hopefulness would be related to families' willingness to persist in treatment. Additionally, it was hypothesized that some family characteristics would be related to their perception of cultural competence and therapeutic alliance in family services. For example, families who reported lower incomes would rate their provider less culturally competent and would be less positive about the therapeutic alliance with their provider.

Methods

Sampling procedure

The sample was recruited in 2008-2009 from youth and their parents receiving IS services. This study was reviewed and approved by the Institutional Review Board for the Protection of Human Subjects at Ohio University. After we received IRB approval, youth and their parents receiving intensive in-home family preservation services were asked to complete survey questionnaires after two weeks of service. The questionnaire included youth and parents' perceptions of current therapeutic alliance, hopefulness, and satisfaction with services, as well as an assessment of their provider's cultural competence. Other demographic information was collected. Providers also completed the questionnaire measuring therapeutic alliance with youth and parents.

Instruments

Cultural competence. The Client Cultural Competence Inventory (CCCI) (Switzer, Scholle, Johnson, & Kellerher, 1998) was used to assess youth and parent perceptions of providers' cultural competence. The 12-item inventory measured three different areas of provider competence: (a) community and family involvement; (b) respect for ethnic differences; and (c) parent easy access to care. A five-point scale (1 = *never true* to 5 = *always true*) was used to measure constructs. Initially, this instrument was piloted with 7 African American and White parents of severely emotionally disturbed children. Clients reportedly "...experienced no difficulty in understanding the content of the inventory" (Switzer et al., 1998, p. 486). Switzer et al. (1998) also used interviews of families with children ages 5-17 with prior intensive mental health service use in Allegheny County to establish the 3 factor loadings. Of these 151 families, 38 were African American, 61 were White, and 1 was "other," suggesting the CCCI is a valid measure when used with diverse ethnic/cultural groups. The Allegheny County poverty rate in 2011 was 12.4%; and our sample included 33 families (73.2%) with yearly incomes at or below \$25,000, with 20 families (48.6%) reporting a yearly income at or below \$15,000 (Table 1).

Table 1

Participants' Characteristics

	Characteristics	N	Percent
Parents' Gender	Female	45	100
Parents' Ethnicity	White	45	100
Parents' Education Level	Less than High School	8	16.7
	High School	29	69.0
	Some College/Associate's Degree	4	9.5
	Bachelor's/College Degree	2	4.8
Family Income	Less than \$24,999	30	73.2
	\$25,000 and over	2	26.8
Months of Parenting Services	0-6	32	80.0
	7 and over	4	20.0
Number of People in Home	2	4	8.9
	3	10	22.2
	4	15	33.3
	5	10	22.2
	6	4	8.9
	7	1	2.2
	8	1	2.2
Children's Gender	Male	19	42.2
	Female	25	56.8
Children's Age (Years)		$M = 14.00$	$(SD = 3.64)$

Though our sample is White and rural, poverty is a characteristic they share with other populations with whom the CCCI has been studied. As Jack and Gill (2012) state: “Whilst each context will be unique in many respects, the majority of families involved with social workers will share the experience of living in impoverished circumstances” (Abstract). Constructs measured by the CCCI share characteristics important to people living in impoverished circumstances (see Table 2), suggesting that the CCCI is a valid measure for use with this Appalachian study sample. The internal consistence was acceptable with an alpha of 0.67.

Table 2

Mean Scores of Cultural Competence, Therapeutic Alliance, and Practice Outcomes (Hopefulness and Satisfaction with Services)

Items	<i>M</i>	<i>SD</i>
Satisfaction with Treatment	1.79	.73
Hopefulness with Treatment	2.91	.96
Therapeutic Alliance (WAI-SR)	2.83	.24
Cultural Competence (Overall average)	4.35	.38
CCCI Parent Community and Family Involvement		
The caregiver involves other family members in the therapy process whenever possible.	4.27	.78
The caregiver helps to get services we need from other agencies.	4.46	.94
The caregiver accepts our family as important members of a team.	4.66	.56
The caregiver encourages us to meet with other community professionals.	3.37	1.57
The caregiver makes it clear that we as a family are responsible for deciding what is done for our child/family.	4.26	.86
The caregiver encourages us to evaluate child's progress.	4.48	.63
CCCI Caregiver's Respect for Cultural Differences		
The caregiver respects my family's beliefs, customs, and ways that we do things in our family.	4.42	.78
The caregiver uses everyday languages we can understand.	4.68	.59
The caregiver makes negative judgments about us because we are different (reverse scored).	4.36	1.06
CCCI Parent Easy Access to Care		
My child receives mental health services in a location near (or in) our home.	4.38	1.10
The caregiver's flexible hours make it easy to schedule appointments for my child.	4.55	.75

Therapeutic alliance. Therapeutic alliance was conceptualized as the relationship between clients and their practitioner, and measured with the Working Alliance Inventory-Short Revised (WAI-SR) (Hatcher & Gillaspay, 2006). From the WAI-SR, youth, parents, and

providers rated 12 items of the therapeutic alliance. Items were rated on a 4-point scale (1 = *strongly agree* to 5 = *strongly disagree*). Internal consistencies were at least 0.84 among youth, parents, and providers; the mean score of the WAI-SR was used to measure therapeutic alliance.

Practice outcomes: Satisfaction and hopefulness. Practice outcomes, satisfaction and hopefulness about treatment, were measured using the Ohio Scale (Ogles, Melendez, & Davis, 1998). For treatment satisfaction, youth and parents rated 4 items on a 6-point scale (1 = *extremely satisfied* to 6 = *extremely dissatisfied*). Hopefulness also measured 4 items on a 6-point scale (1 = *a great deal* to 5 = *not at all*). Internal consistencies of satisfaction and hopefulness were excellent with an alpha of 0.84 and 0.90 respectively. Again, mean scores were used to measure these outcomes.

Personal information. Personal information was also collected, including age of parent and children, gender, ethnicity, family income, education level, number of people in home, and length in treatment.

Data Analysis

First, this study calculated mean scores to explore youth and parent perception of providers' cultural competence, therapeutic alliance, hopefulness, and satisfaction with service. It then examined the bivariate relationships between variables and personal characteristics of families. To determine which family characteristics were influencing their perceptions, t-tests and analysis of variance were conducted. Finally, Spearman's correlation was used to determine direct relationships among cultural competence, therapeutic alliance, and the outcome variables of hopefulness and satisfaction with services.

Findings

Participant Characteristics

Forty-five families, including youth and their parents, completed the questionnaire from the IS in-home family preservation program. All parents were White and female. The majority of parents reported an income of \$25,000 or below (73.2%, $n = 30$), and less than high school or a high school education (85.7%, $n = 37$). A significant percentage (80.0%, $n = 32$) had been involved with parenting services for 6 months or less. Among the youth, 56.8% were female. Youth's ages ranged from 1 to 20 years with an average of 14.09 years ($SD = 3.64$) (Table 1).

Cultural Competency, Therapeutic Alliance, and Practice Outcomes

Youth and parents reportedly perceived high cultural competency in their provider ($M = 4.35$, $SD = .38$; 5 point scale). However, their responses showed slight differences in the following subcategories: (a) community and family involvement ($M = 4.22$, $SD = .48$); (b) respect for cultural difference ($M = 4.55$, $SD = .48$); and (c) easy access to care ($M = 4.50$, $SD = .53$) (Table 2). Youth and parents also reported moderate therapeutic alliance scores ($M = 2.83$, $SD = .24$). For practice outcomes, youth and parents rated the received treatment as moderately satisfying ($M = 1.79$, $SD = .73$) and reported they were generally hopeful ($M = 2.91$, $SD = .96$). Items were measured on a 6 point scale where lower numbers indicate higher satisfaction and hopefulness.

As we hypothesized, families' perceptions of providers' cultural competence and hopefulness about treatment were significantly related to their personal characteristics. Families whose incomes were less than \$25,000 reported less treatment hopefulness ($M = 3.03$, $SD = .91$) than families whose incomes were over \$25,000 ($M = 2.31$, $SD = .67$) ($t = 2.36$, $p < .05$). In addition, families with lower incomes rated their provider's cultural competence lower (Mean = 4.25, $SD = .35$) compared to families with higher incomes (Mean = 4.65, $SD = .29$) ($t = -3.40$, $p < .01$). Families' perception of their provider's cultural competence was also significantly related to the number of people in the home. Larger families perceived lower cultural competence about their therapist ($r = -.304$, $p < .05$). Parents' education level was also significantly related to their ratings of therapeutic alliance. Parents with a high school degree ($M = 2.68$, $SD = .27$) or less than high school ($M = 2.67$, $SD = .37$) rated therapeutic alliance lower than parents with some college or bachelor's degree ($M = 2.95$, $SD = .35$) ($F = 3.71$, $p < .05$).

Relationships among cultural competence, therapeutic alliance, hopefulness, and satisfaction with services

Spearman's correlations indicated moderate and significant relationships between families' ratings of the cultural competence of their provider and practice outcomes. Overall, youth and their parents who perceived greater cultural competence in their provider rated the treatment as more satisfying ($r_s = -.402$, $p < .01$) and more hopeful ($r_s = -.417$, $p < .01$). Particularly, provider's cultural competence in community and family involvement was significantly correlated to both practice outcomes – satisfaction with treatment ($r_s = -.383$, $p < .05$) and hopefulness about treatment ($r_s = -.449$, $p < .01$). However, none of the practice outcomes were associated with the measure of therapeutic alliance (Table 3).

Table 3

Spearman's Correlation among Cultural Competence, Therapeutic Alliance, and Practice Outcomes

	Treatment Satisfaction	Treatment Hopefulness	Therapeutic Alliance
Overall Cultural Competence	-.402**	-.417**	-.056
Cultural Competence: Community/Family Involvement	-.383*	-.449**	.071
Cultural Competence: Respect for Cultural Difference	-.163	-.290*	-.175
Cultural Competence: Access to Care	-.269	-.257	-.147
Therapeutic Alliance	-.198	-.130	

* $p < .05$; ** $p < .01$

Specifically, youth and their parent's treatment satisfaction was significantly correlated to their provider's following cultural competences: accepting them as important members of a team ($r_s = -.585$, $p < .01$), helping to get services from other agencies ($r_s = -.473$, $p < .01$), respecting their family's beliefs, customs, and ways ($r_s = -.420$, $p < .01$), making families responsible for decisions during treatment ($r_s = -.407$, $p < .01$), and encouraging families to evaluate their child's progress ($r_s = -.377$, $p < .05$) (Table 4).

Table 4

Spearman's Correlation between Cultural Competence and Ohio Scales: Satisfaction and Hopefulness

Client Cultural Competence Inventory	Satisfaction	Hopefulness
The caregiver involves other family members in the therapy process whenever possible.	-.275	-.159
The caregiver respects my family's beliefs, customs, and ways that we do things in our family.	-.420**	-.402**
The caregiver uses everyday languages that we can understand.	-.261	-.142
My child receives mental health services in a location near (or in) our home.	-.157	-.229
The caregiver's flexible hours make it easy to schedule appointments for my child.	-.247	-.175
The caregiver helps to get services we need from other agencies.	-.473**	-.479**
The caregiver makes negative judgments about us because we are different .	-.148	-.045
The caregiver accepts our family as important members of a team.	-.585**	-.380*
The caregiver encourages us to meet with other community professionals.	-.035	-.102
The caregiver makes it clear that we as a family are responsible for deciding what is done for our child/family.	-.407**	-.465**
The caregiver encourages us to evaluate child's progress.	-.377*	-.303*

* $p < .05$; ** $p < .01$

In addition, youth and parents' hopefulness about treatment was significantly correlated to the same items in their provider's cultural competences: helping to get services from other agencies ($r_s = -.479$, $p < .01$), making families responsible for decision during treatment ($r_s = -.465$, $p < .01$), respecting their family's beliefs, customs, and ways ($r_s = -.402$, $p < .01$), accepting them as important members of a team ($r_s = -.380$, $p < .05$), and encouraging families to evaluate their child's progress ($r_s = -.303$, $p < .05$).

Limitations

This study has several limitations that must be considered. First, the results are based on a small sample which limits sample representativeness and generalization. Next, all participants' families and providers were volunteers. It is possible that the respondents who chose to participate were more satisfied with current treatment than those who did not participate, and providers could have been more aware of, or consider, cultural competence a more important factor, compared to those who did not participate. Also, all participants are youth and parents from one location in southeastern Ohio. Therefore, sample representativeness is unknown.

Additionally, this study attempted to identify providers' ability to deliver culturally competent service in rural settings with a use of the standardized instrument. However, the CCCI was initially developed to identify ethnic sensitivity in practice. Thus, this study may have measurement errors between providers' true cultural competence in rural practice settings and the values of cultural competence identified with the instrument.

Finally, this study measured family perception of provider cultural competence in treatment process. There is a risk of social desirability bias in that respondents may tend to report more positive ratings on their practice outcomes and provider cultural competence. At the beginning of treatment process, families may feel concerned if they rated their provider and treatment negatively. Since data were collected at a "point-in-time," we cannot appraise whether these factors and services actually contributed to reduced out-of-home placement for youth. Thus, future research should examine the impact of cultural competence on practice outcomes over the process of treatment. Moreover, with larger samples and more statistical power, future research could use multivariate analyses in a longitudinal study context.

Discussion and Implications

This study indicated that youth and parents generally rated their provider as culturally competent. However, in some instances the perception of cultural competence was related to the family's characteristics. Particularly, the family's socioeconomic status was regarded as an important consideration when the family evaluated their ideas about the provider's cultural competence. The county in which this study was conducted has undergone substantial change in economic opportunity, such as the closing of a paper mill and loss of a television manufacturing facility. Findings revealed that the majority of these rural clients were poor and almost half of families reported their income level was below \$15,000. Family income and family size were significantly related to their perception of the provider's cultural competence. Some authors have noted the danger of equalizing the minority and poor population (Javier, Herron & Yanos, 1995). Equalization and stereotype of the minority population do not allow for a more sophisticated discussion on the unique issues. Thus, it will be necessary to develop methods to separate cultural issues linked to socio-economic status from those central to the ethnicity of the client (Switzer et al., 1998). However, the results are consistent with previous studies indicating that poverty is frequently a more serious and entrenched problem in rural areas than urban areas (Fitchen, 1998; Miller & Conway, 2002; Morris, 1995). This study suggests that rural practitioners should develop a high degree of sensitivity to, and skills in relating to, various socioeconomic classes and ethnic groups (Ginsberg, 2005).

As hypothesized, provider cultural competence was associated with positive practice outcomes in rural family services. Youth and parents who perceived their provider as culturally competent reported greater satisfaction and more hopefulness during their treatment. Specifically, youth and parents reported higher levels of satisfaction and hopefulness when the provider respected their family culture, accepted them as important members of a team, and helped them to get services from other agencies.

Achieving cultural competence involves knowledge, skills, practices, and actions. With regard to achieving cultural competence, providers need to receive, understand, and interpret information from clients in a culturally competent and sensitive manner. Lynch and Hansen

(1993) (as discussed in Cox et al., 2009) suggest cultural competence is the ability to “think, feel, and act in ways that acknowledge, respect, and build upon ethnic, sociocultural, and linguistic diversity” (p. 50). Practitioners need to ensure that the presenting problems and issues are understood as the family understands them, and processed in culturally appropriate and relevant ways. Service plans must also be conceptualized and organized with identified cultural values (Simmons, Diaz, Jackson, & Takahashi, 2008).

One of interesting findings in the current study is family's need of services from other agencies. In rural communities, there are fewer formal organizations and resources. Other agencies are likely to be informal and may not be listed in a directory of social services (Jacobson, 2002; Newfield, Pratt, & Locke, 2003; Riebschleger, 2007). For better practice outcomes, providers need to identify and use informal as well as formal resources in order to provide culturally competent services from community collaboration. Culturally competent practice is related to provider's ability to match services that support clients' cultural values and then incorporate the appropriate interventions (Lum, 2010).

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Gun Control: College Student Attitudes and the Meaning for Appalachian Social Workers

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Abstract. Senseless and tragic shootings across communities such as Newtown, Connecticut have riveted public attention on gun control. Bombarded by pro- and anti-gun-control forces, policy makers are often reactionary. Social workers must deal with these policies and the clients who fear them. Social scientists have suggested that cultural world views have greater influence on this issue than any other predictors. A survey of rural Appalachian college students (N=294) explored gun control attitudes in order to consider what makes compromise and consensus on the issue of gun control so difficult. It considers these influences and their implications for rural social workers.

Keywords: rural social work, gun control, Appalachia, culture, attitudes

The December 2012 Newtown tragedy resulting in the deaths of 27 school children and adults reignited gun control debates nationwide (CBS New York, 2013). However, immediate public outcry to change registration requirements, restrict certain types of weapons and ammunition, and arm teachers and college students has largely faded. Politicians' promises to work with "both sides of the aisle" have led to little progress and few cooperative policies (Saad, 2013).

A few states have changed their gun control laws with some enacting much stricter gun control legislation. For example, Connecticut (CBS New York, 2013) and New York (Walshe, 2013) placed restrictions on people with a history of mental illness, banned assault weapons, limited magazine capacity, and implemented stricter background checks and tougher penalties. Colorado enacted universal background checks and limited ammunition sizes (Cordon, 2013). In some states, though, law enforcement officers are refusing to comply with new restrictive laws (CBS DC, 2013); and in other states, social workers are complaining of the lack of understanding and discrimination that new laws place on individuals with mental health issues (Arieta, 2013; Columbia University, 2013; NASW New York, 2013).

Other states have loosened their gun control laws. Kentucky citizens may now carry guns into government buildings, civic centers and the zoo (Halladay, 2013). The state also passed a nullification bill which prohibits enforcement of new federal gun control laws if enacted (CBS DC, 2013). According to Brockman (2013), even Kentucky citizens were surprised that new gun laws passed so quietly that public officials and various institutions were caught off guard.

Arkansas, North and South Dakota, and Georgia also loosened their gun restrictions (Parnass, 2013). In April 2013, West Virginia passed five laws relaxing gun control regulations. At the time of this writing, Garrett (2014) suggests that West Virginia laws are considered the least restrictive in the United States. Like Kentucky, a bill has been introduced to the West Virginia legislature to nullify federal gun control laws if enacted (Boldin, 2014).

Given the plethora of legislative activity, the question remains: Why is it so difficult for citizens on either side of the gun control debates to hear one another and find areas of agreement and cooperation? Motivated by this question, the current study gathered data relevant to student attitudes expressed in informal conversations and college courses. The authors are professors in a small college in rural, central Appalachia. It is not unusual for students to volunteer in general conversation or class discussions how many guns they own, the types of firearms and their magazine sizes, and how they buy or trade firearms without registration. In fact, occasionally a student has volunteered his or her fear of “the government taking control of our lives.” Thus, informal comments and discussions such as these motivated this study.

This paper contributes to the current literature on cultural and ideological perspectives of Appalachia and gun owners. The purpose is to explore the powerful influence of culture and ideology on the issue of guns, and to consider what is known about influence and attitude change that makes it so difficult to find compromise and consensus, particularly in Appalachia.

Development of Gun Culture in the United States

Historians have suggested that a solid attachment to guns was initiated during the Revolutionary War. Although the militia system was inefficient and undisciplined, the use of improved rifles created the popular belief that guns made the average citizen soldier superior to professional European soldiers. In Appalachia, the Civil War was about states’ rights and autonomy (Miller, 2011).

William Church and George Wingate established the National Rifle Association (NRA) after the Civil War. The intent of the NRA, in close cooperation with the national government, was to improve the marksmanship of American soldiers (Utter & True, 2000). The New York legislature provided land for a rifle range in 1872; and in the early 1900s Congress authorized the sale, at cost, of surplus military firearms to rifle clubs, and later provided free ammunition to NRA sponsored clubs.

Utter and True (2000) describe how in the 1930s “mob gangsters” and outlaws like Bonnie and Clyde introduced advanced firearms such as the Thompson machine gun and sawed off shotgun. Roosevelt and Congress responded with laws prohibiting the sale and transportation of these weapons used by the gangsters.

According to Utter (2000), the “Wild West” has been credited for its influence on American gun culture. The earliest Wild West shows, and then television productions of the 1950s glamorized cowboys as heroes who epitomized strength and independence, and a willingness to use violence. Cowboys needed guns for safety, but historians indicate that the level of violence and disruption from fights, accidents, and murders soared when cowboys came to town. Regulations prohibiting guns in cattle towns were widely ignored until employers, wishing to avoid physical altercations and property damage in their establishments, were able to limit firearms in their businesses.

It was also at this time when the NRA, “initially an organization that cooperated with the national government to improve marksmanship among American soldiers, began its long history of opposition to gun control legislation” (p. 72). According to Melzer (2012), the NRA believed

that the assassinations of President Kennedy, Martin Luther King Jr. and Robert Kennedy in the 1960s were watersheds in history. By the late 1970s the organization was “primarily, if not solely, dedicated to preserving gun rights” (p. 38).

Melzer (2012) conducted a multi-year, multi-faceted, ethnographic study of the NRA wherein he describes frontier masculinity values such as independence, freedom, and self-reliance as key features of NRA culture (p. 253). Melzer contended that the NRA’s most palpable emotion is fear – that gun rights are under attack, and that a threat to guns is a threat to all individual rights and freedoms. The organization asserts that gun control is a “slippery slope,” and if gun rights are jeopardized, then American democracy is undermined.

Appalachian Culture

Appalachia, and particularly West Virginia and eastern Kentucky, was initially settled by the Scots-Irish, a group of people who came from economic and political disenfranchisement. They had a defensive outlook, a propensity for fierceness, and an eye-for-an-eye mentality. The Scots-Irish were determined to establish a life independent from restraints of law. They were passionate for freedom, prized autonomy, and resented collective interference. They developed a system of private justice based on personal relationships common to their clan (Miller, 2011).

Their physical isolation was enforced by the mountains, cultural isolation, and clan mentality already present in the settlers. Young adults settled close to parents, grandparents, and kin. The geography and low population density increased the culture-of-honor tendencies. The remoteness and ruggedness of the land made law enforcement difficult (Nesbitt & Cohen, 1996). The mountain man was the provider, protector, and lawman. He who was most economically and socially independent was most respected. Laws such as prohibition refreshed the mountain family’s resentment and suspicion of outsiders, and solidified family clannishness (Miller, 2011). According to Sloan (2009), the law and its enforcers were considered enemies, and anything and everything was fair in trying to outwit them. “Settlers perceived their isolation as inevitable, and bore it with stoical fortitude, until the mountain family grew to love solitude for its own sake” (Weller, 1965, p. 72).

First suggested by Robert Merton in 1938, strain theory suggests that reduced or frustrated economic opportunities produce resentment and feelings of injustice (Lilly, Cullen & Ball, 2010). Contributing to the Appalachians’ attitudes towards outsiders and government agencies was the exploitation of the region’s natural resources. Appalachia has a long history of conflict with “outside” people and organizations that captured land, timber and natural resources (Nesbitt & Weiner, 2001). Businessmen took advantage of the mountaineer’s isolation and ignorance. “Coal operators and their allies in government and business formed powerful economic and political alliances to combat legislative remedies that would threaten their control over the industry or lead to higher costs” (Rakes, 2002, p. ii). Industrialists opened coal mines, cut down trees, built saw mills, and operated quarries, all with cheap labor. The mountaineer signed contracts that he could not read, bargained away rights that he unknowingly had, and only much later discovered that he barely owned a scrap of land to consider home.

Though fabulous wealth was generated in Appalachia, the mountaineer’s share was minimized. The mountain family came to see all forms of business and government as dishonest

and scheming against him. They were exploited by government and business often enough to justify these feelings (Weller, 1965).¹

Appalachian Tradition

Weller (1965) noted that tradition is a significant trait of the mountaineer. The mountain family is amazingly bound to the past, a bond that others cannot understand. Guns are a common gift from parents to their sons and daughters, oftentimes at birth. Many schools close during hunting season, or hunting is considered an excused absence. This sentimental attachment to guns is a part of the culture. Guns symbolize honor, human mastery over nature, independence, and confident self-sufficiency – the very characteristics which lead to a good society (Primm, Regoli & Hewitt, 2009). Frontier masculinity, as characterized by self-reliance, self-defense and self-determination, is an identity that many NRA members believe is threatened (Melzer, 2009).

Honor is difficult to operationalize and subsequently seldom measured; however, it is consistently implicated through Appalachian literature and culture (Miller, 2011). According to Miller, while active support of violence has faded, the culturally embedded ideals validating violent behavior survive. They pass from one generation to another as normative behavior, heavily conditioned by an honor ethos (p. 283). As described by Nesbitt and Cohen (1996), honor in this sense is based not on good character, but on a man's strength and power to enforce his will on others (p. 4). Cohen, Nesbitt, Bowdle and Schwarz (1996) argue that states with culture-of-honor norms tend to have "looser gun control laws, less restrictive self-defense statutes and more hawkish voting by federal legislators on foreign policy issues" (p. 948). The persistence of these norms, despite changes to historical conditions that led to them, has been described by Vandello, Cohen and Ransom (2008). Their studies found that men from culture-of-honor areas are more likely to endorse norms for "honorable violence" (p. 162).

Rural versus Urban Aggression

Swaim, Henry, and Kelly (2006) found that the predictors of aggressive behavior among rural youth also predicted urban youth aggression: family actions against violence, peer violence, gender, anger, academic performance, and alcohol and tobacco use (p. 432). Cunningham, Henggeler, Limber, Melton and Nation (2000), and Slovak and Singer (2001, 2002) examined links among gun ownership and anti-social behavior. Urban youth tend to carry guns for protection and intimidation, to gain respect, and to frighten others, while rural youth tend to own guns for sport. Cunningham et al. suggested that the reason for urban youth gun ownership is strongly associated with rates of anti-social behavior (p. 432). These authors found that rural youth who owned guns had a relatively low rate of antisocial behavior, only slightly higher than rural students who owned no gun.

Gun Control Debates

The gun control debate has been heated for at least four decades without a compromise or solution that satisfies either side. For example, according to Braman and Kahan (2006), the problem has been that the debate tends to focus on a factual question: do guns make society more or less safe? Both parties offer statistics to justify their argument, and both argue that the

¹ For a comprehensive history of the culture, the violence and hardships endured, and the exploitation of West Virginia and Appalachia, see Bailey (2008) and Lewis (1998).

opposing side is providing misleading information (“Guns”, n.d.; National Rifle Association, 2013).

According to the 2011 Uniform Crime Report, violent crime has decreased 3.8% from 2010, and has decreased 15.5% since 2002. If violent crime and murder rates are down, why does the gun control debate remain so passionate and volatile?

Modern television offers a variety of crime shows, and media coverage of local and national crime tends to fuel misconceptions: if it bleeds, it leads (Stevens, 2011). People use these misconceptions to make judgments and decisions regarding crime and crime policy, sometimes called the “CSI Effect” (Lilly, Cullen & Ball, 2010). Indeed, Robbers (2005) found that students were susceptible to media suggestions when formulating opinions about criminal justice policy, even when they knew the source was biased.

Researchers have known for many years about “priming;” that the mere presence of a weapon leads people to behave more aggressively (Franzoi, 2012; Turner, Simons, Berkowitz & Frodi, 1977). The “weapons effect” depends on the meaning people attach to guns. Bartholow, Anderson, Carnagey and Benjamin (2004) found that because of the hunter’s knowledge, experience and comfort with guns, the individual is not primed to aggressive thoughts as is a non-hunter. In addition, Primm et al. (2009) found that the hunter’s day to day familiarity with guns inoculates him against fear of firearms.

People crave certainty and the feeling of being right. Neuroscience suggests that the state of not being certain is extremely uncomfortable (DiSalvo, 2011). Social scientists tell us that people attempt to avoid cognitive dissonance – the experience of having conflicting beliefs at the same time. Individuals will therefore make every effort to minimize or reject one of the conflicting beliefs. It is more comforting to believe that what is noble and honorable is also benign, and what is ignoble is dangerous (Braman & Kahan, 2006). In Appalachia, guns are considered noble, honorable and benign. In contrast, outsiders and government intervention are considered dangerous.

Kahan and Braman (2003) and Braman, Kahan, and Grimmelmann (2005) suggest that people assess risk according to context. Evaluation of risk must take into account the value that individuals attach to distinctive social meanings. Braman and Kahan (2006) proposed that culture comes before facts in the gun debate. They stress that cultural orientations more powerfully predict individual attributions toward risk than any other influences such as education, personality type, political orientation, race, south/north, and urban/rural (p. 579).

Individuals trust people who share their worldview. They defer to those who share cultural allegiances. Studies have shown that once we trust a source, we are less likely to scrutinize future information from that source (DiSalvo, 2011). Who individuals regard as trustworthy tends to be governed by the norms that they are socialized to accept. If an adversary disagrees with one’s beliefs, that challenger is rejecting the authority and institution to which the individual defers. One might decide that the adversary is not merely misinformed, but dangerous or evil. Zealots reinforce the perception to citizens on each side of the debate that they are facing an unreasonable adversary bent on cultural domination (Braman & Kahan, 2006).

According to Braman and Kahan (2006), it is unlikely that individuals will accept social science data that contradicts prior beliefs or those that they trust on assessment of gun risk. No matter how compelling the statistical proofs, citizens who care passionately about the meaning of guns are unlikely to change their minds (p. 606). “Those who generate empirical data on gun control will always be preaching to the choir” (Kahan & Braman, 2003, p. 1324).

Method

The survey was conducted in a small, undergraduate state college in central West Virginia, the only state whose boundaries fall entirely within the Appalachian region (Nesbitt & Weiner, 2001). The study was approved by the college IRB, and the questionnaire was sent electronically through Survey Monkey to all full-time students enrolled in the college. Descriptive data was calculated and compared to relevant studies in the literature.

There were 294 respondents to this survey, approximately a 25% response rate. Ninety percent of the respondents were from West Virginia and 97% were Caucasian. Respondents were nearly evenly split with 49% male and 51% female. A little more than 52% of the respondents reported that they were from communities with less than 2500 people (Table 1).

Table 1

Size of Home Community

Population	Percentage of Respondents
Less than 2500	52.4%
2501-8000	34.2%
8001-25,000	6.8%
More than 25,000	6.5%

Results

Of the respondents, 70% reportedly owned at least one gun. As expected, males were more likely to own a firearm (86%) compared to females (57%). Also expected, students (75%) disagreed that there should be a limit on the number of firearms in any one household. Eleven percent reported that they had a working firearm at college. The majority of students (78%) indicated that “firearms are an important part of family tradition.” Most (75%) reported that they would worry about safety in their home if they had no firearm. A majority (67.3%) consider themselves to be religious.

Seventy-eight percent of respondents agreed that there should be mandatory background checks for any gun purchase, no matter where or how purchased. Fifty-eight percent indicated

that all firearms should be registered. Students were equally divided that assault rifles should be available only to military and law enforcement (48% agreed, 45% disagreed). Exactly 50% indicated that there was no need to change federal firearms laws (Table 2).

Table 2

Survey Questions

Gun Control Attitudes	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Firearms are an important part of my family time.	58.5%	19.0%	12.2%	6.8%	3.4%
I worry about the safety of myself and family if I do not have a firearm in my home.	48.3%	26.4%	12.0%	9.2%	4.1%
I worry about safety if I do not have a firearm in my vehicle.	18.5%	20.5%	33.6%	16.1%	11.3%
I consider myself a religious person.	41.8%	25.7%	19.2%	5.1%	8.2%
There should be mandatory background checks for any gun purchase, no matter where or how purchased.	53.1%	24.5%	11.6%	7.8%	3.1%
Assault rifles should only be available to military and law enforcement officers.	23.8%	14.6%	16.3%	14.6%	30.6%
All firearms (handguns, shotguns, rifles) should be registered.	38.8%	19.6%	17.5%	10.3%	13.7%
There should be a limit on the number of firearms in any one household.	8.2%	6.1%	10.2%	18.7%	56.8%
There is no need to change the federal firearm laws.	30.6%	18.6%	27.5%	13.4%	10.0%

Discussion

According to White (2012), 55.4% of West Virginia citizens reportedly own a firearm; and the percentage of gun ownership in surrounding states ranged from 21.3% in Maryland to 47.7% in Kentucky. This is considerably lower than the 70% reported by students in this study. Another national poll indicated that self-reported gun ownership is the highest it has been since 1993 (Saad, 2011). However, the number of gun owners nationally is approximately half of student participants in the current study (Table 3).

Table 3

Gun Ownership: Comparison of National Average to Appalachian Student Participants

Population	National Poll	Current Study
Adults	34%	70%
Males	46%	86%
Females	23%	57%

Half of the students in this study did not see a need to change laws governing gun registration. Results from this study are very similar to those of a national Gallup Poll where 49% of Americans believe that the sale of firearms should be stricter, and half believe that laws should remain the same or be less strict (Saad, 2013).

Considering that students in class discussions often describe owning dozens of guns, frequently purchased at informal gun shows or from friends and acquaintances, the investigators were surprised that 78% of participants believed there should be mandatory background checks for every gun purchase. Similarly, although students voluntarily admit that many of their guns are not registered, 58% believed that all firearms should be licensed. Perhaps students did not perceive their discordant thinking, or other factors were involved. Or perhaps it is “federal” laws that participants do not want changed, as they may prefer states to make this determination. This would be consistent with Appalachia’s historic system of private justice (Miller, 2011) and their resentment, suspicion and conflict with outsiders (Nesbitt & Weiner, 2001; Sloan, 2009).

Another possible explanation for what appears to be a contradiction in attitudes and behavior is cognitive dissonance. According to Tavris and Aronson (2007), the need for consonance is so powerful that when forced to look at disconfirming or contradictory evidence, people may criticize, minimize, or dismiss the information in order to maintain existing beliefs. Self-justification reduces dissonance and protects self-esteem. It allows people to have “blind spots,” a comforting delusion that enables individuals to see the errors of others but not themselves. “Blind spots enhance our pride and activate our prejudices” (p. 44).

The Appalachian culture of “us versus them” may contribute to the need for self-justification. Student responses may reflect safety for themselves and suspicion of others. Since

75% of the students worried that family safety would be jeopardized if they did not have a firearm at home, they may simply not consider their unregistered gun as illegal, but rather a necessary tool in their home. The cultural tendency to distrust outsiders could lead to thinking that restrictive gun laws are necessary for others, but not relevant for family protection.

The symbolism of the gun for Appalachian students may simply be cultural. Because of their familiarity with firearms, guns in the home may be as common as fishing poles, and considered no more dangerous than any other recreational equipment. Their perception of risk is minimal. When they consider gun laws, students may be thinking of violence as portrayed in the media and perpetrated by others.

It is also interesting to note that while 11% of our study participants reportedly had a working firearm on campus, Miller, Hemenway and Wechsler's (2002) study of college students in 38 states and the District of Columbia found that 4.3% of students sampled had a gun at college. Miller et al.'s (2002) study was conducted over ten years ago, however, so their findings may not reflect current college student behavior. Although a number of two and four year institutions now legally allow guns on campus, no other studies could be found that provide these specific data.

Study Limitations

There are many limitations to this study. First, it represents the opinions of a relatively small sample from only one college in a rural area of Appalachia, and attitudes of sampled college students are likely not representative of the larger regional population. Thus, results cannot be generalized to other areas of Appalachia or to college students elsewhere. Next, it would have been informative if survey questions had differentiated federal and state background checks, restrictions and laws. Student apprehension of federal regulation may be significantly different than of state intervention. Finally, students with particularly strong opinions regarding gun control might have been more or less likely to participate in the survey. Students who speak freely with peers and faculty about their unregistered firearms may have been reluctant to be honest in a survey. The outspoken fears of government expressed verbally by students may represent a small, but vocal minority, or those students may not understand the relationship to questions as asked in the survey.

Implications for Practice for Appalachian Social Workers

Considering Appalachian history, tradition, and culture, a social worker practicing in the rural areas of the region should expect that clients will have easy access to firearms. As a family outsider and possibly a government representative, the social worker is unlikely to be quickly or easily trusted. Indeed, the social worker may be perceived as more of a risk than violence occurring in the home, such as spouse abuse, child abuse, or erratic and disorderly behavior stemming from mental illness or drug and alcohol use.

As citizens of the culture of hunting, autonomy, and self-sufficiency, law enforcement officers may sympathize with clients' desire to keep their guns. They may therefore minimize, or be slow to file appropriate charges for offenses that involve firearms. This might intensify a

social worker's anxiety for potential victims and influence intervention plans and decision making. Additionally, social workers may have reason to fear retribution from angry clients.

The NASW Code of Ethics (2006) is clear that social workers do not have the right or the responsibility to try to change the culture or attitudes of clients; however, it is the social worker's responsibility to understand their culture and attitudes. Social workers must consider the value and distinct social meaning attached to guns in Appalachia. It would be unethical, undoubtedly ineffective, as well as foolish and unsafe to try to change the gun control attitudes of clients with whom they work.

Slovak, Brewer and Carlson (2008) found that the majority of social workers in their study did not assess for firearms and safety on a routine basis. In rural Appalachian areas, social workers must monitor safety issues, maintaining constant vigilance. Effective and responsible social workers must understand and appreciate the client's culture. They must consider clients' perception of risk, both of guns and of government intervention, as represented by the social worker. They must also consider the value and distinctive social meanings that guns represent. The client's cultural orientation and identity must be affirmed rather than denigrated. A basic social work precept is to "start where the client is." Therefore, social workers must be ever mindful to consider cultural perspectives and to promote socially responsible self-determination.

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Black Gold and the Dark Underside of its Development on Human Service Delivery

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Abstract. This paper examines perceptions of human service workers regarding their employment experiences and adaptations in oil-impacted rural communities in the Upper Missouri Valley of North Dakota. This study is part of larger pilot project designed to better inform health and human service professionals and elected officials about the nature of human service delivery systems in boomtowns. Qualitative methodologies were employed to analyze information gathered by interviews conducted with 40 human service workers. Both individual interviews and focus groups were conducted. Study findings indicate that the impact of oil on the human service network is complicated. Human service workers in the study were burdened with new and more complex challenges than before the boom, and had fewer resources to address these additional challenges. Their burden was eloquently summarized by one worker who stated, “While somebody else benefits, we carry the burden of oil boom repercussions.” Smaller scale local strategies appear to creatively meet many needs, and show signs of worker resilience in strategy adaptation.

Keywords: Boomtowns; oil booms, human service workers, human service sector burdens, human service sector adaptation, rural social work

During the past few years, North Dakota has experienced unprecedented growth and expansion due to oil development in the Bakken region (Bangsund & Hodur, 2013). Energy experts celebrate the increase in oil production in the United States that currently exceeds consumption (Koch, 2013) for the first time. This upward trend contributes significantly to the U.S. economy. The two largest oil-producing states, Texas and North Dakota, were responsible for 18% of the U.S. economic growth between 2009 and 2013. In fact, North Dakota experienced a 23% increase in employment since 2007, followed by Texas with a 6.6% increase in employment (Prah, 2013). Noteworthy is that while the United States economy plummeted with the crash of the housing market, the oil industry created an economic bubble in oil rich states and/or created an easier upward post-recession transition in others. Yet, these significant economic and industrial contributions have a human cost resulting in many viewing oil production as both a blessing and a curse (Holywell, 2011). The oil boom is viewed as a blessing in terms of providing needed revenue to state government and an expansion of the job market, while it is a curse in terms of the stress on existing infrastructure and the increased demand for support services in rural communities where oil extraction projects have typically taken place (Dooley & Ruzicka, 2013; England, & Albrecht, 1984).

Since the Industrial Revolution and consequent advances in capitalism, social workers have been impelled to be the first responders in addressing the human service needs created by the human victory over the environment. Consequently, issues of this nature have high relevance

to the field of social work because, while some influences like economic growth are positive, boom and bust cycles can lead to major social problems in these communities (Luthra, 2006). In the past, the nature of oil production, historical trends, and the positive and negative social and economic impacts were widely documented in the local and national media and by academics (as cited in Heitkamp & Jayasundara, 2012). Yet the views and perspectives of human service providers in these oil-impacted communities have been unreported. Especially lacking in attention in the academic community is their perception of the needs and solutions as they apply to rural social work.

As mentioned, large-scale oil extraction projects have historically taken place in rural communities (Brown, 2010; Jacquet, 2009). While there is no clear consensus on what constitutes a rural community, some common elements exist (Ginsberg, 2005). They generally include areas with low population densities that are geographically isolated. Resources and opportunities are generally scarcer, contributing to higher poverty rates, with a greater proportion of jobs requiring intensive physical labor and a higher reliance on informal networks. Rural communities also tend to be made up of more homogenous populations that have a strong emphasis on traditional values and community, often leading to enhanced friendliness and trust among community members, but suspicion towards outsiders and a reluctance to change (Ambrosino, Heffernan, Shuttlesworth, & Ambrosino, 2012; Brown, 2010; Daley, 2010; Flora & Flora, 2013; Riebschleger, 2007). Yet, due to high demand for skilled labor in the initial phase of oil extraction projects, there is a high level of in-migration of people from outside to meet these needs, impacting the rural nature of these communities and how services are conducted. Human service agencies, whose mission is to alleviate social problems, grapple with the magnitude of the changes and problems faced in their rural communities due to oil (Bohnenkamp et al., 2011).

Rural human services providers have traditionally encountered challenges in terms of service delivery (Ginsberg, 2005; Mackie, 2012). Numerous variables have been identified as reasons for these challenges including transportation, funding, limited support services, and the lack of affordable housing (Rural Policy Research Institute, 2010). Issues of accessibility, availability, and acceptability present serious challenges to mental health care and other related services (Health Resources and Services Administration, 2005; Smith, 2003). The issue of access to mental health services becomes paramount when coping with social transitions associated with oil development, including responding to crisis situations that arise due to oil extractions (Locke & Werner, 2013). These services are needed both by those who have migrated, often times a transient group in search of jobs and opportunities, as well as those who have been longtime residents of these boomtown communities. Longtime residents are often overlooked. Yet, coping with the sense of loss from community change can create issues that need to be addressed.

Additionally, affordable housing is an ongoing challenge, and agencies to address these challenges are limited. In fact, housing is a key unmet need in rural boomtowns (Ennis, Finlayson & Speering, 2013). This study, then, is an attempt to remedy this paucity in the literature by looking at the human service workers' employment experiences as they apply to rural social work and strategies they use to overcome their difficulties in affected areas of one oil rich state. This study was conducted in the region that is currently impacted by the oil boom in rural western North Dakota, called the Bakken, in the Upper Missouri Valley. This paper begins with a literature discussion of the nature and impact oil booms in general, followed by a more

focused literature discussion on the Bakken in North Dakota. Later, the methods are presented with a discussion of the results and implications for rural social work.

Literature Review

Nature and Impact of Oil Booms

Rural communities experiencing oil development are typically referred to as boomtowns due to a cyclic pattern of economic growth and failure they experience related to oil production (Investor, n.d.; Jacquet, 2009). Research on boomtowns identifies a three-phase cycle of the oil development lifespan, beginning with a relatively short construction phase that includes drilling of wells, fracturing, construction of pipelines, and other beginning oil related developments. This phase requires an abrupt necessity for employment; and as a result, a need for change in the community infrastructure. This is followed by the production phase which is longer in duration than the construction phase, but demands a much smaller labor force. Lastly, the decommissioning phase leads to closing of the wells and often-unused housing projects (Brown, 2010; Gramling & Brabant, 1986; Jacquet, 2009). This results in the loss of the need for infrastructure and the labor created in the previous phases.

The resultant socioeconomic impacts on boomtown communities are enormous. This is due largely to the initial labor demands caused by the newfound oil projects and the inability of rural communities to supply this labor demand. A majority of oil work requires a specialized skill set that community members often lack. This entices outsiders to migrate in and take advantage of new job opportunities to fill this void. The increase in transient populations creates dramatic community change. Finally, this in-migration is followed by an out-migration of these same labor forces when the projects go into production and when the final dismantling of the projects occur (Brown, 2010; Carrington & Perieura, 2011; Frick, 2010; Jacquet, 2009).

This influx of transient individuals causes rapid population growth (Bohnenkamp, Finken, McCallum, Putz, & Goreham, 2011). The harmful effects of rapid population growth are well documented (Carrington & Perieura, 2011; Jacquet, 2009; Lee & Thomas, 2010; Rudell, 2011). Typically, local communities do not have the infrastructure capacities to accommodate this growth and are unable to mitigate the social problems that accompany these new workers and their families (Jacquet, 2009; Wirtz, 2013). Thus, significant increases in criminal activity, mental health issues, and a lowered quality of life are typically experienced in these boomtowns. These sharp increases easily overwhelm the modestly sized support systems that were designed to help alleviate these social problems for a much smaller population (Carrington & Perieura, 2011; England & Albrecht, 1984; Freudenburg, 1991; Jacquet, 2009). The economic impact in the local community is mixed because some residents, businesses and/or communities, benefit financially more than others. Community residents not directly working for the energy industry must cope with inflationary pressures, while not seeing concurrent increases in income (Jacquet, 2009). Gilmore calls this the *problem triangle* (as cited in Jacquet, 2009) where the inadequate goods and services lead to a decrease in quality of life and a subsequent drop in workforce productivity. An inadequate workforce contributes to a reduction in industrial activity such that the level of public or private investment in the community does not meet the current need for services.

Additionally, local residents are likely to experience feelings of uncertainty and an increase in conflicts or community divisions (Bohnenkamp et al., 2011; Jacquet, 2009). Rural communities located within the oil production area must cope with the loss of their former community identity due to changing relationships. Complicating this issue is that these communities have multigenerational members who value the history and culture of their communities, and miss “what was a farm community...” (Bohnenkamp et al., 2011, p. 7).

The term *gemeinschaft* describes the sociocultural ecologies of rural communities (Greenfield, 2009). Strong interpersonal relationships, interdependence, and social institutions and services that are informal and responsive to local needs, characterize these communities. As stated, rural communities have tended to be homogenous in demographic and socio-economic characteristics (Greenfield, 2009). Boomtown expansion often erodes these relationships, undermining mutually dependent behaviors that allow for the care and support of one another. Changes associated with rapid growth present stressful challenges and a sense of social and community disorganization as these communities transition and incorporate more diverse populations and tackle more complex human needs (Luthra, 2006). The new diversity created by the newcomers can also bring about culture clashes between the new and old residents; as mentioned, the latter is accustomed to more homogenous populations and are used to knowing their community members (Heitkamp & Jayasundara, 2012).

Modern sociological theory, whether social capital, social disorganization, or a civic community perspective, all postulate that rapid social change/population growth can erode community well-being. Additionally, change is most disruptive when it is abrupt (Kassover & McKeown, 1981; Lee & Thomas, 2010). To Durkheim (1893), rapid social change is accompanied by anomie, or an erosion of social norms in a community (Brown, 2010; Freudenburg, 1984; Lee & Thomas, 2010).

Gilmore (1976) outlines four stages of attitude change that boomtown communities experience when coping with rapid population growth and industrialization. These were later modified by Freudenburg (1981). These stages are:

1. The early enthusiasm stage where the focus is on the positive economic impacts of job growth, with the potential negative impacts being either unknown or dismissed;
2. The uncertainty stage where change occurs due to new workers arriving in significant numbers. During this stage there is a realization of some negative impacts beginning with the dawning expectation that concerns about development will likely grow. Divisions within the community regarding whether growth is positive or negative begin to develop;
3. The near panic stage emerges, as the oil industry and associated impacts grow much faster than expected, and the character of the community changes dramatically. In this stage, government services become overwhelmed and service quality declines, as revenue for new resources is inadequate. Officials are not equipped to make the necessary policy decisions, while long term community residents become disgruntled with the change in their historic way of life; and
4. The adaptation stage, as the fundamental issues are finally identified and strategies to mitigate them are developed. Residents begin to accept the reality of their situation and may feel a sense of progress (as cited in Jacquet, 2009).

The Bakken Oil Development in North Dakota

The Bakken is a 350 million year old shale rock formation that stretches across western North Dakota, Northeast Montana, and the Saskatchewan Province in Canada (Hargreaves, 2011; Langton, 2008; MATIC & NDSLIC, 2012). Oil was first discovered in the Bakken in 1953 by geologist J.W. Nordquist, and named after Henry Bakken, the owner of the Montana farm where it was first drilled (Langton, 2008). The current oil boom is the third wave of oil development that the Bakken Valley has experienced within the past 40 years (Bohnenkamp et al., 2011). The current oil expansion began during the early 2000's (Dobb, 2013; MATIC & NDSLIC, 2012) and has accelerated since 2008. It is anticipated to last for at least the next two decades (Haggerty, 2012). The current area of production is centered in western North Dakota, primarily around the Williston basin.

It is estimated that 3.5 billion barrels of oil will be extracted from the Bakken formation (Dobb, 2013; MATIC & NDSLIC, 2012). The most recent Department of Mineral Resources press release states that North Dakota reached a record high in oil production by producing 941,637 barrels a day (Helms, 2013). Today it has become one of the largest suppliers of oil in the United States, second only to Texas (Dobb, 2013).

The current wave of oil activity in the Bakken is in the production phase of boomtown development. This phase is expected to last at least several more years. The reason for this extended period of expansion, and record high oil production, is due to the development of technology. This technology, called fracking or horizontal drilling, allows for enhanced penetration of the ground to extract oil reserves. Until recently, the extraction of oil occurred through vertical drilling only; and vertical extraction limited the amount of oil that could be produced from an oil well (Haggerty, 2012). Horizontal drilling, however, allows increased access to oil that could not be extracted in the past.

At a time when the rest of the U.S. economy suffered from economic recession, North Dakota continued to contribute significantly to the nation's gross national product, with a taxpayer surplus of \$16,100 in 2012 (North Dakota State Data Labs, 2013). North Dakota had the lowest unemployment rates at 3.1% in 2012 and the highest increase in employment (North Dakota State Data Labs, 2013; Prah, 2013).

Along with economic growth, this period of oil production has created a protracted period of population growth. During the past few years, there has been an estimated 17% increase in the population around the Williston Basin due to expansion of the oil industry (MATIC & NDSLIC, 2012). In fact, Williams County was ranked among the top 5 fastest growing counties in the country in 2012, and Williston was the fastest growing city (with a population between 10,000 and 49,999) in the U.S. with a 9.3 increase (U.S. Census Bureau, 2013). This put North Dakota at the highest population growth by percentage in the nation with a 2.7 increase (U.S. Census Bureau, 2012), and North Dakota population estimates at the end of 2013 reached 723,393 (U.S. Census Bureau, 2014). They conclude that the oil boom was driving this growth (US Census Bureau, 2013).

This growth in population, however, has caused significant social upheaval in the impacted areas as they adjust to these new economic conditions. This population growth has

strained the current housing market and workforce availability and continues to stress the current infrastructure and health and human services delivery systems. These problems have received increased attention through a series of news reports locally and nationally (Taber, 2013). The media has obviously been crucial in providing information and keeping community members informed of developments (Dispensa & Brulle, 2003), particularly during the period when the Bakken communities are in transition. However, information is not currently being collected or analyzed scientifically or systematically, and some question the way the media presents problems (e.g., Willard, 2011).

Limited empirical studies have examined the human service response in the Bakken or any boomtown. However, three notable published studies examined the criminal justice response to crime (Archbold, 2013; Dooley & Ruzicka, 2013; MATIC & NDSLIC, 2012). Dooley and Ruzicka (2013) examined the perceptions and experiences of law enforcement officers regarding domestic violence and sexual abuse. They found that with an increase in incidents of crime, additional training needs exist. The majority of police officers knew of available services and coordinated with other local service agencies; but the greatest barrier to accessing training is the lack of time to attend. A joint study by MATIC & NDSLIC (2012) on oil impact and law enforcement response is also extremely significant. This study found:

“Increases in calls for service, arrests, index crimes, fatal and nonfatal motor vehicle crashes, and sexual offenders, as well as significant turnover and recruitment issues have exacerbated the challenges experienced by law enforcement agencies. Law enforcement officials attribute much of the turnover and recruitment difficulties to employees seeking employment outside of law enforcement, low salary, and lack of available housing. The majority of law enforcement agencies reported a need for additional sworn and non-sworn positions within the next year and indicated a need for additional protective equipment and training” (MATIC & NDSLIC, 2012, p. 2).

They concluded by predicting that the problems would continue. The latest released study by Archbold (2013) also revealed increases in law enforcement calls that are more stressful in nature, with the majority of the workers feeling that the nature of their work has changed due to the oil impact. In addition to these criminal justice response studies, a small number of studies have discussed the medical response to the oil boom. One city found that the ratio of medical staff, physicians and other medical personnel to the city’s population decreased; yet, at the same time, the numbers of patients treated increased (Sauve, 2007). A survey conducted with health service personnel in North Dakota identified a shortage of first responders with a primary concern being an increase in social problems related to the disproportionate number of single men (Graner & Pederson, 2011).

A final notable study (Bohnenkamp et al., 2011) examined the community extension and non-extension workers’ perspectives on their community concerns in the oil booms and their solutions. This study found that workers struggled with a variety of concerns because of the poor quality of living conditions, limited available housing, and the increased cost of housing. They also noted problems with hiring personnel, which resulted in difficulties for service organization staff who were over-extended. Also noteworthy were the increase in traffic, more demands on educational establishments as population increases, and the increase in crime. The description in

the literature relative to social and community disorganization resulting from oil expansion underscores the need for further study of the various challenges that are emerging from this oil expansion, especially those issues related to the human service sector. It is important to study these issues in more depth than has been done previously.

Method

This work is part of a larger exploratory study focused upon the human service needs of rural communities in transition in western North Dakota as the result of the oil expansion. The study attempts to understand a range of changes occurring in these communities and the human resource needs that exist because of these changes. The larger study was based on a critical theory approach.

A critical theory approach to fieldwork advances the research beyond studying society to using findings to bring about social change and raise consciousness (Patton, 2002). A variety of research methods may be employed if the findings help bring about social change for oppressed communities (Kulwicki & Miller, 1999). This paper focused on the study of human service worker perceptions and their proposed solutions. This qualitative study included health and human service workers employed in the Upper Missouri Valley of North Dakota. The Upper Missouri Valley was chosen because it lies in the heart of the oil rich Bakken, where the majority of western North Dakota oil counties are clustered, including the county most impacted by oil development, Williams County.

This study utilized purposive sampling as its primary method. Agency personnel who served as study participants were identified through the North Dakota Department of Human Services Directory. Administrators and workers from county social service agencies, healthcare providers, and non-profit agencies such as domestic violence centers, child care centers, foster care agencies, long-term care facilities, youth group homes, aging and disability centers, and clergy participated in the study. A few participants were also recruited using a snowball method where participants themselves referred the researchers to additional participants. All study participants were over the age of 18 and served in a leadership position in their community; and all served in the human service sector, and served the Upper Missouri Valley area of North Dakota. They all held supervisory/leadership positions such as director, executive director, and/or program director. All but 10 were female, and all were Caucasian. Their years of service ranged from 6 months to 40 years. For about 70% of participants, this was the first oil boom during which they served in a supervisory capacity.

The study involved a total of 40 human service workers. These researchers conducted both individual telephone interviews and three focus groups. Both are widely used qualitative data gathering techniques (Rubin & Babbie, 2011; Sommer & Sommer, 1997). The study was conducted in two phases. The first phase involved telephone interviews. This was followed by focus group interviews, which constituted the second phase. Focus groups included some participants involved in the first study phase, along with other directors and individuals who were approached to participate through the snowball sampling strategy. Both phases utilized a semi-structured interview format which provided participants flexibility to share salient experiences and perspectives. Further, this allowed for exploration of consistent and unique topics (Patton, 2002). It also insured interview consistency and probing when needed, and the

pursuit of new topics without a complete deviation. All participants completed the necessary consent forms prior to the interviews as required by the Institutional Review Board. No remuneration was given for participation.

Telephone interviews were not tape-recorded to ensure a greater degree of confidentiality. The focus groups were tape-recorded with permission of the participants. A small number of participants were re-contacted for follow-up calls to explore gaps in the information and to refine emergent themes. In addition to tape recording the focus groups, extensive notes were taken with each interview transcribed as verbatim as possible, especially with telephone interviews. This was accomplished to help ensure the validity of information shared. Two researchers participated in the interviews and note-taking.

Data were analyzed using coding techniques consistent with content analysis that systematically identifies and categorizes themes to develop significant themes in qualitative analysis (Hsieh & Shannon, 2005; Patton, 2002). There were two researchers who analyzed the data in order to increase reliability.

Results

Participants identified a myriad of human service-related problems they frequently address as a result of their employment in a rural oil-impacted area. As one worker eloquently stated, “while somebody else benefits, we carry the burden of oil boom repercussions.” When questioned about aspects they liked about the oil boom, most participants indicated “nothing.” Despite their burden, workers also discussed many methods they employed to meet local-level needs.

Changes in the Nature of the Service Delivery

Human service workers described a host of changes that impacted how they deliver post oil boom services. These included an increase in caseloads, more complexity in the problems presented by their clients, and changes in the nature and type of services requested. All human service workers stated their workload has increased tremendously. The perception is best reflected in the statement by a worker who said her “caseload has skyrocketed.” Others talked about the number of new service requests that were different, more intense in nature, and confounded by several reporting issues. They eloquently described the totality of the problem as not being reflected by reporting numbers alone. In fact, several respondents stated that data released by government officials did not reflect the realities of their caseloads. An agency director described the need for their agency to report data, separate from state reporting structures, because official sources were not reflective of service needs and were updated infrequently.

The impact of multi-layered changes in services, combined with increased caseloads, does not appear to be adequately presented in the numbers reported by official agencies (Ruddell, Jayasundara, Mayzer, & Heitkamp, in press). As participants stated, the number of clients served alone did not adequately reflect the changes to their workload, as they did not reveal the increased intensity in the needs in the transient populations they served. The majority of participants agreed that the client problems they address were more severe in nature than in

the past. Clients arrived with a multiplicity of intersecting factors, complicating their situations and service needs. For example, workers noted issues of increased substance abuse and mental health concerns in both local and transient clients. This is articulated by one worker's comment: "Everything is more complicated with client problems... so we see a lot of addiction. We are seeing a lot more mental illness coming through; just harder clients to work with..."

In addition to the severity of problems, workers are also faced with addressing service requests not addressed before. For example one health worker said, "We are seeing different types of medical problems now...the other day a man came with a mosquito bite we have never seen before...it was a type of spider found in Texas..."

Human service workers described client profiles that were different than in the past. This includes serving clients who represent different racial, ethnic and religious backgrounds than their former caseload prior to the oil boom. Workers noted regional differences in clients they served and the inability to identify the "typical client" who is primarily faced with limited access to services in rural communities. As one worker stated, "...we used to get our child protection order from law enforcement and we knew their extended family, and now it is different." Several workers also described the stress the boom is placing on families who are long-term residents of the community, particularly related to increased housing costs. One statement in particular exemplifies this: "We are getting even more reports on our local families I think because of the stress and things that are going on, and they are all living in the same household. We have 2 and 3 families in that household. They have all been clients before, but they move in together because they have to live...so, our clients are not the typical client anymore."

Difficulties in Hiring and Retention

The vast majority of professionals interviewed stated they have experienced a critical staff shortage. Fueling this shortage was the difficulty in staff recruiting and retention. This was reflected in the following statement: "We haven't been able to hire staff. We had a staff person that left. We haven't been able to hire." So, even when funds are available to hire new employees, or replace employees who leave the agency, they are unable to recruit. Another comment by a participant supports this concern: "Agencies often don't have the staff to provide the service, and parenting classes we have been without a parent resource center here; it's been almost 3 years. We have tried to hire a staff person...and it's been one failure after another." With this shortage, existing staff were forced to assume multiple roles. This was an issue because staff members needed to be on-call more often, carry larger caseloads, and endure difficult travel to work. Hence human service administrators constantly feared losing their workers. As one supervisor said: "Every one of us worry about losing our social workers, or any of our staff, because it is literally impossible to replace them. We ask what will it take for me to get you here when making job offers."

A critical issue in staff recruitment and retention was the lack of affordable housing (Bohnenkamp et al., 2011). Workers in the study were unanimous that housing was the number one issue creating problems with hiring staff. Even if they can recruit staff, the cost and lack of housing were prohibitive. Some agencies were renting, even building space, but difficulties remained. Participants described how challenging it was to ask employees to move to an area

with inadequate and unaffordable housing. The only way to respond was to offer higher wages to new and existing employees, and housing access to new hires. Some administrators stated they have been somewhat successful by assuring higher wages and housing access, but challenges remained.

Access to office space was another issue. Oil companies have more resources than human service agencies. As a result, they could offer more in rent. One focus group member underscored this point when stating, "...Where do you put everyone because now we have oil companies in office space that we would consider; and we, as a social service office, can't pay the prices oil fields do. So, what do we do?" The outcome was constant worry for administrators that they would lose rented office space to a higher bidder. This limited confidence in hiring new employees and assuring them adequate workspace. A respondent stated, "I mean, even right down to office space, if we had to hire, we would not have office space."

Adding to a housing shortage were insufficient wages that create problem with recruitment and retention. While salaries have increased, wages were still not enough to compete with oil industry salaries and the increased cost of living as a result of oil development. Competition for quality employees was evident in respondent comments. As one worker stated: "...and a lot of our problems are the same as at the hospital...it is recruitment and retention. It is so difficult...trying to have competitive wages is absolutely impossible. It's not only the oil fields that are paying higher wages. It's your convenience stores, paying \$15-17 an hour..." Yet, an additional problem was voiced by another worker: "One of the things that I don't think the system really understands about local social services is that we're the...welfare end of it. That is what is increasing; and, yet when they give a \$500 per month increase on top of their wages in a state agency we can't compete at other government levels here."

Complicating the issues of inadequate wages was that some employees are benefiting from oil revenue, so they no longer need to work or can now work part-time. As one worker stated, "...I have a lot of staff, whose spouses are making big money, and they don't need to work full-time anymore. They are working part-time. Most of my therapy staff is working part-time."

Some respondents described the difficulty in traveling to work due to a dramatic increase in traffic accidents that caused them to worry about themselves and staff. This fear was due to an increase in the number of vehicles, especially semi-trailer trucks driven by drivers participants felt were not sufficiently trained in driving big trucks in general, nor sufficiently experienced to maneuver in the icy North Dakota roads in winter. They were also concerned about potential substance abuse among drivers. Fearful of accidents, driving to work from a rural or farm area was even more stressful. "It is taking employees over twice the time to arrive at work." One respondent described the fears her child is having regarding her traveling to work outside their home community. Her child learned about all the traffic accidents in his elementary school. This concern was also real for many other workers. For example, a human service worker recently died in a car accident while traveling to a professional meeting. In 2012, a semi-truck crashed into a school lunchroom, injuring students and killing one person (Donovan, 2012). The issue of unsafe traffic has compromised respondents' ability to conduct work related tasks such as home visits.

Lack of Training to Meet Changing Needs

Workers identified the need for additional staff training to reflect changing client needs. With caseload work being more complex and safety issues surrounding increased family violence, training and supports were critical. However, attending training was difficult because there was little time. Caseloads were so high that agency release time for training was difficult to secure. The problem was exacerbated with part-time staff because training cuts more intensively into their direct service hours, and costs the agency money and time. As one worker explained, “We need more money, so I could hire more staff, and get more training. I was just talking with my residential supervisor today. And, she said she just came back from the shelter meeting in Bismarck. I said, ‘How did that go? And, she said, ‘We talked a lot about training the staff to help victims.’” But, the additional funds for training were often not provided, travel to the training is difficult, and time away from direct services was not available.

Services are Insufficient to Address Needs

Several participants stated that current services were not meeting the needs of clients. As one worker stated, “We just don’t have the services to help these people.” Another said, “And I can think of, I mean, we have right now seven high needs kids with mental health trauma. And, I mean that may not seem like a lot but for our rural county, I mean they are all intense...that is how I look at it. We just don’t have the services to help these people...” This statement underscores the unique issues of rural social work practice when policy makers do not understand that even seven high-risk cases can be overwhelming in geographically isolated, weather trodden remote areas, with little access to services.

Even when services were available, they were inadequate to meet client need. A non-profit agency serving primarily domestic violence and sexual assault clients described an increase in client need and insufficient service access. The housing vouchers were cited as an excellent example: “They can’t use the vouchers and find affordable housing to use the vouchers. So, they are turning them back. So, it looks like you don’t need any vouchers. Well, no the rents are so high the vouchers don’t help at all.” In addition to physical resources, the previously discussed lack of human resources also causes delays in effectively serving clients. For example, one worker said, “But, we end up with our kids involved in non-caretaker sexual abuse cases and have to call in law enforcement or serious charges...where we have a death or something like that. And, law enforcement gets involved. Our cases go on forever because law enforcement can’t finish them up because they are so busy...even though they also try their hardest.”

Yet another burden of service delivery was created by the rural nature of the communities where they might not have services within their catchment areas, and workers had to refer clients to other counties. This created additional service delivery problems, however, due to the lack of transportation for clients because of the time needed to travel to service locations. One interviewee stated, “I get their point when they say okay now I am supposed to go to low intensity outpatient. I live in a rural area, and I am supposed to get to Williston three times a week. I have no vehicle, I have no money. I mean, we can get gas cards and then they’re like well I think that you need to provide staff to bring me.”

In attempting to provide services, workers were further burdened with added roles in already short-staffed work environments. Of concern was the increased time and cost to transport clients to service providers. One worker said, "I would need to have a full tank cuz it's three hours of drive time just to get you to the next county and then that is a 2-3 hour group. I mean that's a full day." Yet another stated, "And, if you have their kids in care and the parents have no driver's license or transportation, you are transporting them both for visitations. It's like you feel like you are a taxi driver, and then they wonder why you can't get your paperwork done. The amount of windshield time is ridiculous." Another worker described the lack of human resources that prevent some agencies from providing these same services: "Well, just not only just that, it's just that we just don't have the staff. Like I said, we've reduced the amount of individuals we serve. So, in two of the homes, we can get five with one staff at a time. But, at Stanley, we need two staff at a time because of the severity of the disabilities."

Economic Realities of Resource Allocations

Some workers felt that even though the demand for services increased, the response was not adequate due to the politics and economics of resource allocation and service delivery. When services were most needed, they have had to cut back on those very services. One worker said, "I think the most frustrating is you really can't help people...you can always pull something out or figure something out or make a plan, and, there are times when you are in these cases and you are like I literally have no options for you to make...and, then you send them down the road, and that is hard." Unfortunately, it appears that clients who needed the most services were the very people not served because services and their access did not exist in the Bakken. As one worker said, "The hardest thing is that...in my county, it's...the people who struggle the most, that are cut out. They can't afford housing; they are on restricted incomes...it's that aging population and the people who are the waitresses...."

Workers described how the political nature and economic climate of the region work against the clients they served. Respondents described decisions about service resources and access that were beyond their control. Frequent and clear frustration was expressed about the lack of help from governmental officials in solving the complex needs of people with fewer resources in the Bakken. As one worker explained, "The fact is this. When you've got an area of the state producing the amount of money we are producing out here, the state needs to reinvest in that. If this were a private business, they wouldn't just be milking the funds, and not re-investing in it. And, I don't see them. They talk a lot about what they are doing; but, I don't see them really making a re-investment in it."

Yet, other workers who have experienced previous booms and busts were aware of the added complications created by investing in their municipalities to enhance services, when the threat of the oil bust is looming. One participant underscored concerns about delays in planning (and zoning) as a result of the past boom and bust cycles in the community. This participant stated the perception as "oh yeah, you guys [oil companies] will be gone in a couple of years. Because that's the way it went in the past." Another worker in response to this worker said, "Yeah, we got burned the last oil boom. So, people don't forget that. How you invest when they can all go away in a minute. But, they say this is here for few more years."

However, at the local level these larger factors created complications for agencies trying to provide services to meet new needs such as mental health assistance. A respondent stated: “The fact that the hospital closed their psych unit, addiction and mental health unit, right at the time it was needed the most...they wanted that space to put the cancer treatment center...it’s just about the bottom-line.” Another worker described losing intensive in-home services for youth and families experiencing concerns by stating it was a funding decision beyond their control: “Funding. They just took it away from us. We were the only region in the state that lost it.” Also cited as an issue were concerns about tight regulations preventing creative problem solving when trying to secure volunteer help or foster parents. There was concern among long-term community residents that those who come to work in the Bakken often do not have the same commitment to community.

It is important to note that respondents reportedly did not have time to attend meetings where they could adequately explain their needs. They may have had the monetary resources they needed; however, they still could not meet their local needs. For example, one worker said:

"One of the problems that I have seen is with emergency services. Is through these grants of the oil impact fund, the local fire department and emergency services can get all the money they want for equipment. The problem isn't equipment. The problem is staff. The smaller towns...for example...used to be places that [received] calls 3 times a month. Now, [they are] called out 2 to 3 times a day. They are all voluntary staff. These people all have other jobs...a developer was proposing a great development, and we were meeting with...city people and talking about it. I said to the head of emergency and fire...this is probably a point where you can no longer run this as a voluntary service. He said, where would we get people?"

This quote underscores concerns about the importance of voluntarism, yet it is becoming impractical on many levels.

Creative Solutions

When support did not coming in the form they needed from higher authorities, human service workers appeared to network and think of creative ways to solve the problem. The same human worker above went on to say, “I said one of the things we could do is require these developers to contribute to emergency services, because they said [they] can’t create a new fire district...I said they don’t need to, but they could be required to contribute enough to fund staff, at least a couple staff. If they are going to put 300 people or 2000 people there, they need to be assessed for that... If you required it, I think you could get them, if you paid decent salaries....” Similarly, many workers felt it was left for them to advocate for their community and agency needs. They felt compelled to take a very proactive approach in their advocacy defining their needs and asking for solutions, whether it was asking for salaries, advocating for housing, or more client services. All participant workers agreed that staying connected with other human service agencies and members was crucial for surviving the oil boom’s impact. They knew what services were available in the community and who provided them; and they knew many of the other workers personally. This increased their coordination and prevented effort duplication every time they needed services that were unavailable. They also felt that because of the oil

boom, networking between workers was better. As one human service worker put it, “I think we need to band together to get through it, because if you get isolated you are not going to make it.” This sentiment was echoed by all of the workers. Similarly, workers appeared to support each other through the oil boom. They stated that it was important to rely on each other to provide needed services, but were now in short supply due to oil impact activity. Consequently, if one city had an overflow of clients, the next city would help out by providing services for overflow clients. They were able to share workers and services. As one worker stated, “I think for us what I have seen is that we don’t have an outreach worker that comes to the county, so we now have had to lean on X county. ...They have been great to help us, through their main branch.”

Many talked about having alliances to support each other. For example, county social service directors started a regional group to address their needs, which were very different from the needs of other county directors statewide. They met every month to discuss their county issues and how to best serve their clients. Non-profit workers stated that they had private alliances with other non-profit agencies and churches, where the meetings in many ways serve as support groups. One said that they learned from each other, for example, about exploring different fundraising strategies. The recent development of a mental health coalition to effectively address mental health needs in the area is another example. Thus, networking, coordinating and supporting each other through the oil boom were seen as very important strategies. These meetings also served as a venue to brainstorm, strategize, and make action plans. This constant solution-seeking happened within agencies, through network sessions, or even at regional meetings. Sharing each other’s success stories was a creative way to find solutions.

In addition to networking and mutual support, some workers started reaching out to potential donors; agencies with which they had to interact and their constituents were very important. The majority of the workers who have received funding from oil companies advised their other focus group members that the best way to receive money from oil companies and other potential donors was to make personal contacts with them. Others, who have not received money from oil companies, also aired this sentiment as they said they have not aggressively attempted to make personal contact. Instead they prepared grants or requested money as part of their fundraising efforts. One worker shared that he knew individuals who have benefited from oil, and through personal efforts, came to sympathize with the needs of members of the community and donated money. “I got \$15,000 from an individual. It wasn’t an oil company, but just a company in town that decided they wanted to do something good for people and gave me the money, and said use it for kids. So, I use it at my discretion, and run it through my board, and say this is what I used it for.”

For many study participants, this was their first time experiencing an oil-boom professionally as they were new to working in oil-impacted environments. However, even workers who have been through past oil-boom and bust cycles found this boom different, more significant. Thus, problems they faced felt new, and solutions required creative thinking, especially given the limited resources they faced. As one worker stated, “we will get creative. We try to figure out an option...but we come up with creative ways [to] address our problems.” This meant improvising at many levels. Many of the workers’ discussions reflected that they have lowered their standards of living. For example, living in a trailer or getting a room for a staff member have become accepted living arrangements. Additionally, study respondents, the

majority of whom who were directors or in other supervisory capacities, felt they have had to take additional roles beyond their primary human service assignment. For example, as housing was a major issue for hiring and retaining staff, some attempted to provide housing through their agency. Thus, the employer became their landlord; and workers took on multiple roles beyond their designated duties.

Discussion

Rural human service workers impacted by oil booms have to be innovative in order to compensate for limited resources. Working in rural communities in general requires flexibility, imagination, and creativity to improvise and make up for the service deficits and effectively serve clients. Typically, rural communities have fewer professional workers; therefore, human service workers have to play multiple roles, coordinating multiple aspects of social services (Farley, Smith, & Boyle, 2005). As this study reveals, these already overextended rural human service worker capacities, conditions, and resources are even further spread thin due to the boomtown effects and the complexity of the problems they confront. Significant numbers of human service workers in the study stated that they see no benefits with oil; and, one worker very eloquently stated, “while somebody else benefits, we carry the burden of oil boom repercussions.” Due to structural changes to communities during booms, these towns go from being rural to having urban cluster conditions (U.S. Census Bureau, 2014) at least during the boom. However, as is reflected in the current study, human service sector resources didn’t appear to expand at the same pace because of inadequate resource structures and supports.

Consequently, despite North Dakota's economic security, not everybody benefitted equally from oil production (Jacquet, 2009). In fact, human service workers, who were directly caught in the midst of oil boom, appear to benefit least. Their burdens appeared to have significantly increased to the extent that one worker described oil booms as a “human tornado.” The consequence of not addressing these serious problems has been an outmigration of the population who has served as part of the volunteer infrastructure of the community. So, former volunteer firefighters, foster parents, volunteer aids and “church ladies” have moved to other communities. The impact of development and the “gentrification” occurring within these rural communities allows new residents to replace long-term community members who do not have the same level of community commitment. Additionally, the changing societal mores surrounding acceptable social behavior has been stressful for the community and compounds the level of engagement of existing volunteer respondents.

Exacerbating this issue was the fact that North Dakota ranks lowest among oil states for providing funds directly to its oil impacted counties. For example, North Dakota falls far behind states such as Colorado in direct funds (Haggerty, 2012). At the moment, human service workers appeared to play the role of *Atlas*, carrying the burden of the darker side of the oil booms but with no perceivable benefits. With resources lacking, workers improvised by finding creative solutions. It was unclear how sustainable their efforts can be in the long term as the current boom is predicted to last many more years (Haggerty, 2012; MATIC & NDSLIC, 2012). It seems people were learning on the job, making isolated efforts (Haggerty, 2012). However, more sustainable solutions may be needed in addition to what is already occurring. Policies and funding structures could be put in place to address these concerns through visionary leadership. Noteworthy is that local stakeholders were gathering to respond. For example, a coalition group

in Williston is looking at best practices in after school care to assure youth safety, and another group is addressing serious concerns about depression and suicide in a coordinated manner. Findings from the study were presented to these groups.

Others studying boomtowns have also cautioned that without concerted efforts by all parties involved, further negative consequences may result. Joint partnerships between human service workers, residents, industry leaders and local and state level governments must be in place to plan better and mitigate the unseen effects of boomtowns. In addition to creative bottom-up solutions by human service workers, open discussions, advocacy, and negotiations must take place between all involved stakeholders in order to better manage, mitigate and plan their community infrastructures (Carrington & Pereira, 2011).

It is clear that further systematic analyses are needed; however, this exploratory qualitative study of 40 workers is a start. This study was unable to provide perspectives from all human service workers. Additional studies are needed to examine different social issues, particularly at the community level, with policy research. Future studies can benefit from mixed methodologies that show trends and the reasons for these trends. Further studies are also needed to better assess what additional academic curricula and training needs would better prepare social work students to work in rural oil impacted areas. From the current study, it is unclear what protective factors human service workers use in practices associated with oil booms. For instance, what internal and external factors foster resilience in human service workers during times of great stress and uncertainty?

Training opportunities in the Bakken can provide an opportunity for rural social work education programs to train future workers. The human service workers who lived experiences as shared in this study can provide guidance to others who work in similar boomtowns as to how they might intervene at both micro and macro levels. In the end, understanding the problem in detail is a start. Beyond the Bakken Valley, these study findings provide themes of struggles and coping that can be transferable to rural social workers/human service workers in other oil booms and to rural social work in general, as they speak to the human sector burden of rapid change without concomitant infrastructure changes.

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Book Review***Rural Mental Health: Issues, Policies, and Best Practices***

K. Bryant Smalley, Jacob C. Warren, and Jackson P. Rainer (Eds.)

2012

New York, NY: Springer Publishing

368 pages

Paperback, \$65.00.

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E-book ISBN: 978-0-8261-0800-5

Even though the editors are a clinical psychologist, epidemiologist, and psychotherapist, this book is written primarily from the perspective of counseling psychology rather than clinical psychology or social work. *Rural Mental Health* attempts “to summarize the current status of rural mental health and to individually examine the many complex subcomponents of improving mental health throughout rural regions” (p. 4). The 21 chapters are grouped into four broad sections addressing introductory considerations relevant to rural mental health needs, modalities of rural mental health service delivery, specific populations and issues in rural mental health, and a short concluding chapter that addresses future considerations. Social workers and human service workers who may be attracted by the title should note that none of the 52 contributing authors holds the MSW credential, although some of the suggestions for improving the delivery of rural mental health services embrace concepts resembling wrap-around systems of care and community capacity building. The inclusion of *best practices* in the subtitle is almost unwarranted since best practices are only rarely addressed and never in sufficient detail to allow the reader to critically assess the claim.

Despite the large number of contributors, the writing is consistently strong. Only a few of the chapters refer to primary research conducted by the authors; accordingly, this as a series of brief literature reviews addressing rural mental health issues. I believe it is better to think of this book as a reference tool rather than a textbook because of the high degree of repetition in the chapters. The content presented in the first 11 chapters that address rural mental health in general are basically repackaged by topic in the 9 chapters that follow addressing specific populations (men, women, children and youth, racial and sexual minorities, veterans, seniors, and frontier communities) and issues (substance abuse and suicide). Relatively extensive reference lists accompany each chapter and comprise approximately 20 percent of the pages, citing over 1,000 sources. The index is comprehensive and useful. Because the last two sections of the book merely repackage the content of the first eleven chapters, this review will focus on the first eleven chapters.

The first section of eight chapters contains the most substance for readers. The first chapter summarizes the presuppositions throughout the book. These presuppositions include the barriers to mental health treatment in rural areas, comorbidity issues in rural areas, and the potential solutions for dealing with these barriers. Barriers are presumed to be accessibility (higher rural poverty and transportation barriers), availability (85 percent of counties with a shortage mental health providers are rural), and acceptability (higher rates of rural stigma and decreased anonymity in receipt of services). Comorbid conditions presumed to exacerbate mental health problems in rural areas include higher rates of substance abuse and suicide. Presumed

solutions include the integration of primary care and mental health care, telehealth delivery of mental health services, and preventive services in school settings.

Chapter two is a history of federal policies that have developed over the last 20 years to address the challenges of health and mental health in rural areas and summarizes the policy issues hindering expansion of telehealth and integrated health care centers. Because the implementation of the Affordable Care Act is ongoing, this chapter does seem to be a work in progress as well.

The third chapter may be the most controversial and the most valuable in the book. It argues that rural culture has developed in unique ways producing an under-recognized diversity issue. Mental health practitioners will need to develop specific cultural competencies to address the independence, self-reliance, and sense of personal responsibility that has developed due to rural remoteness and the agricultural work ethic. Poverty, a mistrust of public services, and southern religious beliefs also contribute to a rural resistance to mental health treatment. Permissive attitudes toward substance use, smoking, and sedentary lifestyles influence the need for mental health services. Practitioners may need specific training to cope with the rural cultural stigmatization of mental health issues. Evidence in chapter four suggests there are higher levels of rural stigma toward those with mental health needs which produce reluctance by those in need to pursue treatment, but this evidence is not addressed critically or exhaustively. Some readers may find themselves wishing that the studies cited were described more fully so that an independent assessment of the findings could be made.

Chapter five is about loneliness as a mental health issue, but there is no evidence presented that suggests that loneliness is more common in rural areas than in urban areas. The discussion is fairly interesting if the reader is not offended by equating mental illness with problems in adjustments to living. Chapter six is a relatively friendly account of the interactions between religion, spirituality, and mental health. Care is taken to note the strong regional influence of different ways that religion influences rural life, from the integration of religion and civic life in some areas to the more ideological and experiential in other areas. Practitioners are encouraged to remove any self-bias against religion, become familiar with evidence-based spiritually oriented therapies, and collaborate with clergy in developing faith-based community psychological approaches. Ethical challenges in rural practice (chapter seven) are addressed through an imaginative case study examined from the perspective of the American Psychological Association's Code of Ethics (2010). The concluding chapter of this first section (chapter eight) discusses self-care for the rural practitioner. Blending insights of Maslach with career sustaining behaviors (i.e., sense of humor, perceiving clients as interesting, renewing and relaxing leisure, and consultation with peers), and Bowen's family system theory, this chapter suggests a useful way to understand self-care in the context of rural professional isolation.

The second section defines three models of service delivery that may be useful in rural areas. Chapter nine explains integrated care using the Four Quadrant Model (a low-to-high severity matrix contrasting physical health and mental health) while acknowledging that current trends toward patient-centered medical homes and reverse integration are hampered by state funding limitations. Chapter ten summarizes evidence that mental health services provided through technology (telephone, computer, and mobile interventions) are as effective as face-to-face services; however, these studies are encouraging without being particularly rigorous.

Chapter eleven presents school-based mental health services as a public health multi-tiered problem solving model for prevention and intervention.

The eight chapters in the third section repackages content from the first eleven chapters in a relatively formulaic manner, first documenting the under-delivery of mental health services, then more extensively discussing barriers to delivery of services for that issue or population, then concluding with either a brief suggestion of solutions (e.g., telehealth, increasing community capacity for holistic services, or school-based services). A few chapters provide a case study of a local program that seems promising for replication. The concluding six-page chapter reaffirms the need for improvement in access, availability, and acceptability of mental health services in rural areas, notes the need for more extensive research related to rural mental health, and calls for advocacy to increase funding for rural mental health services.

As a social worker, I was somewhat distressed by the authors' unrelenting deficiency orientation. The possibility that there might be strengths associated with rural living receives no more than an offhand mention in a subordinate clause or two. The authors seem not to realize that rural poverty qualitatively differs from urban poverty, that the pace of rural life might be a substantial buffer against contemporary stressors, or that the interconnectedness of rural relationships might represent an untapped potential for addressing mental health needs. Even with this critique, however, I believe I will find this book useful when addressing mental health policy with my students. I expect to regularly consult the chapter on rural culture and stigma. Social work educators working in rural areas and interested in mental health issues may be well advised to keep a copy on hand for consultation.

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Book Review***Rural Social Work: Building and Sustaining Community Capacity, 2nd Edition***

T. Laine Scales, Calvin L. Streeter, and H. Stephen Cooper (Eds.)

2014

Hoboken, NJ: Wiley Press

384 pages

Softcover: \$55.00

ISBN-13: 978-1118445167

This essential text focuses on the strengths and assets of rural people and rural communities. The contributors assert that rural social work is a distinct practice area, with roots in community organizing and the strengths perspective. It challenges social workers to move away from viewing rural communities and their social services systems as inferior or lacking, and consider their role as a partner in the collective process. Strengths, asset and capacity building, and wraparound care are major themes.

Three distinguished editors, T. Laine Scales, Calvin L. Streeter, and H. Stephen Cooper, collaborated with another two dozen contributing authors on this second edition. Dr. Scales is Professor of Higher Education and Associate Dean of the Graduate School at Baylor University, in Waco, Texas. Dr. Streeter is the Meadows Foundation Centennial Professor in the Quality of Life in the Rural Environment and former chair of the Community and Administrative Leadership Concentration in Social Work at The University of Texas at Austin. Dr. Cooper is Associate Professor of Social Work and Associate Dean, College of Liberal and Applied Arts at Stephen F. Austin State University in Nacogdoches, Texas. The editors include chapters that knit nicely together, giving the reader the experience of a continuous volume, rather than a collection of articles. This was skillfully accomplished by including the strengths and assets models in all chapters, as well as the inclusion of cohesive section introductions. The five sections are (a) conceptual and historical foundations of rural social welfare, (b) human behavior and rural environments, (c) practice issues in rural contexts, (d) policy issues affecting rural populations, and (e) using research to evaluate practice in rural settings.

My BSW students, in a course also titled *Rural Social Work*, generally viewed the book as having three loosely defined “types” of chapters. First, there were the chapters on the history of rural social work and of the Rural Social Work Caucus. Secondly, there were chapters that addressed populations and issues in rural settings within the context of the strengths perspective and asset building. These are tangible concepts for students who might work with LGBT clients, homeless families, African Americans, Latinos, palliative care, or partner with rural congregations. Thirdly, there are chapters describing practice and research methods for rural social work including concept mapping, evidence-based practice, and global information systems (GIS). The chapters in this third group contain more advanced concepts, but the material is accessible to upper division BSW students. Each chapter closes with discussion questions and suggested activities and assignments.

One key message is that social workers must be willing to make cultural adaptations to interventions rather than expecting clients to adapt to a “one size fits all” service delivery system.

This model was helpful for students to understand that cultural competence is not just a matter of being knowledgeable about other cultures, or creating programs for a specific cultural group. They must also be flexible and adaptive in existing programs in order to effectively serve diverse client populations.

Another interesting thread in the text was personal considerations for social workers in rural settings. For example, rural social workers may need to consider professional development opportunities offered online through webinars or video streaming. Rural social workers are likely to spend more time travelling in their typical workday and may need supportive technology such as GPS and tablets. Dual and multiple relationships may be more difficult to avoid in rural communities, and social workers must be prepared to meet these challenges.

My students were also intrigued with the assertion that rural social workers should be willing to work collaboratively with local congregations. The role of faith communities in both informal and “home grown” human service delivery and local leadership was emphasized, as well as the social worker’s responsibility to learn to communicate effectively with the members of the congregation. Cultural and spiritual considerations in alternative healthcare were introduced. For example, clients may choose to consult with pharmacists, faith healers, and preachers or priests as their primary provider in an “ethnomedical” approach to healthcare.

The only minor criticism is that while the authors cautioned against romanticizing rural life, that notion still crept into a few places. When comparing rural to urban people, the rural individuals always sounded like better human beings. Still, this is a small critique to an excellent book.

The text is appropriate for BSW and MSW courses, and should be considered an essential volume for university libraries. In addition to being used in rural social work electives, the book would be useful in multicultural and research courses.

I also used this text as the foundation for a Rural Social Work alternative fall break trip. Our itinerary included visits to a rural homeless shelter, a very rural church, migrant farmworker camps and service agency, and a rural food justice movement. Students were the most impressed with our visit to Spring Hope, NC, where we spent an entire morning with the town manager and community development leaders. Even though 15 of the 16 students had grown up in rural settings, they were amazed at how much energy rural private citizens put into strengthening their communities. The text provided the foundation for students to understand that rural communities have existing resources and strengths, though they may look quite different from the urban model.

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Book Review***Waiting for Jose: The Minutemen's Pursuit of America***

Harel Shapira

2013

Princeton, NJ: Princeton University Press

152 pages

Hardcover: \$25.16

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Harel Shapira is an ethnographer, sociologist, and assistant professor at the University of Texas, Austin. Shapira's book, *Waiting for Jose*, is directed toward individuals willing to explore beyond the superficial depictions of the Minutemen and attempt to understand their motivations for patrolling the border. Shapira argues that the Minutemen, as an organization, is an outlet for generally older men with military experience to reproduce their lives as soldiers and, subsequently, gain a sense of purpose and meaning. Additionally, he asserts that the Minutemen construct Jose as the enemy in order to exhibit their patriotism and develop an identity founded on masculinity. Overall, Shapira explores the Minutemen's varied motivations exceptionally well, even noting the organization's internal conflicts. His sociological explanations are relevant and help to interpret the Minutemen's culture. Albeit at times adamant at reducing the Minutemen's motivations to causes other than xenophobia, ethnocentrism, racism, and discrimination, *Waiting for Jose* provides a unique vantage point of individuals experiencing a loss of place in an ever-increasing diverse America.

Within the Introduction, Shapira presents the Minutemen through the lens of behavior, of practices, and not ideology. The central argument here is that either/or frameworks do not accurately describe people, much less the Minutemen. As an ethnographic endeavor, Shapira also relates his need to *act* like the Minutemen to receive tentative acceptance by them, which itself is reflective of other Minutemen's experiences as they pursue integration into this exclusive civic organization. This organization, moreover, is stratified, with status distinctions that continuously involve performances and distinguish the real Minutemen from the false. Chapter 1 presents the Minutemen's central concern: the decline of America. For the Minutemen, the decline of America parallels their own decline, of their own dissipating utility and increasing sense of lack of belonging. It is this wish to reclaim America for "Americans" that the Minutemen create a social world, a social space that lauds nationalism and masculinity. Chapter 2 elaborates on the Minutemen's social interactions, specifically the performances conducted by the men to establish hierarchy and their individual identities. This performance is poignantly captured in Chapter 3, through Gordon, a Minuteman whose personal transformation highlights the power of the desire to be accepted.

Chapter 4 presents the psychological constructs the Minutemen use to engender their social world. Moreover, this chapter highlights the contradictory ideas these men hold about the *Other* and the often desperate fear they possess of both Jose and what he represents: themselves, "weak, marginalized, and separated from the country they want to call their own" (p. 123).

Chapter 5 provides an overview of the similarities and differences between the Minutemen and the Samaritans, a religious group that patrols the border to provide humanitarian assistance to migrants, and endorses the argument that despite different ideologies, both organizations essentially complete the same actions. That is, Shapira asserts, it is the meaning that each group attributes to their actions that “distinguishes” them from one another. Namely, both groups engage in civic initiative, albeit for different purposes. The Conclusion summarizes how, paradoxically, the Minutemen emerged from Chris Simcox’s, the Minutemen’s co-founder, inability to become an agent of the state. Namely, it appears that his exclusion prompted him to create a space for inclusion.

Shapira provides a different and detailed perspective of the Minutemen, focusing upon practices and behavior rather than ideology. This focus, however, is both its strength and weakness. The focus on practices is reductionistic – it implies that action is not guided by ideology. Through relevant sociological explanations, one may empathize with the Minutemen and their feelings of displacement. Notwithstanding, it often appears that Shapira wishes to justify their behavior. Additionally, although his individual characters are intriguing and revelatory, one wonders which Minutemen were excluded from this book.

This work can be relevant to individuals living along the U.S.-Mexico border, specifically people who encounter the varied groups interacting at the border. Arguably, human rights groups and the Minutemen themselves would benefit from this book. For the former, it would potentially allow them to see beyond superficial characterizations of these men. For the latter, it may challenge the Minutemen to analyze their reasons for being Minutemen. Overall, for rural social workers, this book may help sensitize them to the psychosocial needs of the Minutemen. More importantly, this book may prompt rural social workers to help these men locate (more productive) spaces to achieve meaning and purpose.

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Book Review

Daughters and Granddaughters of Farmworkers: Emerging from the Long Shadow of Farm Labor

Barbara Wells

2013

New Brunswick, NJ: Rutgers University Press

220 pages

Paperback: \$25.16

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Working long hours in the hot sun in a field is not everyone's ideal job; nor is being a single mother or sole family provider seeking the typical American Dream. Specializing in diversity among Latino families, sociologist Barbara Wells interviewed U.S. born Mexican women caught in the routine of working as farm laborers in her book *Daughters and Granddaughters of Farmworkers: Emerging from the Long Shadow of Farm Labor*. Wells wrote this piece because she believed the United States needed to be more aware of the daily problems that second to fourth generation Latinas face. Wells analyzed why they stay in their communities despite the hardships they face supporting their families.

The Structure of Agriculture and the Organization of Farm Labor

Since 1964, there has been a steady flow of immigrants from Mexico into the California labor force. Whether legal or illegal, immigrants have been justifiably considered cheap labor, especially in the farm labor work force. Many women interviewed were born in America. Their grandparents or parents immigrated to America to find better jobs which subsequently were in farm labor. Even these underpaid and hard labor jobs are valued because other immigrant workers stand ready and willing to take them. The continuous flow and cycle of available labor never stops.

Farmworker Origin

In the second chapter, Wells describes stories of how the women entered the farm labor force. Some women had parents who worked in fields and on farms. The women helped with farm work so they could earn an income. The husbands of other women got a different job while the women picked fruit or vegetables since picking was easy and quick. Work outside of farm labor is hard to obtain because stores near the border require workers to be bilingual, something that some U.S. born Mexicans lack.

Life in a Border Community

Interviewing U.S. born Mexican families, Wells found that living near the border created problems because of job competition from daily border crossers. In reality, the border is only a physical and political boundary. People from the Mexico side would cross daily to work in the United States; and after collecting their wages, they returned to their home country. The United States does not seem to be addressing this, but rather encouraging it by issuing border crossers cards that allow day workers into America. Not only are these border crossers taking jobs away

from the U.S. born Mexican citizens, they also bring the fear of drugs which worries many women interviewed.

Negotiating Work and Family

In Mexican culture, women are supposed to stay at home to cook, clean, and raise children. In this chapter, Wells explains the many factors challenging this tradition for second and later generation Latinas. American living standards require additional household income. Childcare, absence of extended family support, and eldercare make the decision to work more difficult. These women must consider conflicts between family issues, cultural values, and financial need. Work outside of the farm labor force is preferred, but no matter the circumstances, they are determined to build a better life.

The Legacy of Farm Labor

In previous chapters, Wells told stories of how these women began in farm labor. Usually this was because their parents or grandparents had been employed in farm work. Now, these women aspire to find a job they think is better than working in the fields, which is difficult to accomplish in their small, rural, agricultural community. Most women think that once they no longer work in the fields they are removed from farm work, but they can never really forget the lifestyle as some parents and spouses still are employed as farm laborers. The legacy of the farm not only pervades their personal sense of identity, but the communal nature of farming forms a network of social obligations that continues to be a part of them willingly or not.

Surviving Now and Building a Better Life for Later

Upward mobility becomes a challenge for these women. If they leave the farm and do not find other employment, it has become normal for them to receive food stamps and other government assistance. These benefits, however, do not lift them out of near poverty. Education is thought to hold opportunity, but conflicts with their drive to be wives and mothers. Some who were obtaining a higher education degree became pregnant and had to change their plans. Few seemed to realize that the promise of opportunity associated with an education would conflict with the legacy of farm labor and farm community.

Why Do They Stay?

This last chapter explores why these women have stayed in their community. One reason is their strong sense of family and community. They like the support of family. They also like the closeness they feel in a small community where everyone knows and helps each other. Even though there are problems within the community, it is hard for some of the women to imagine living elsewhere, especially if they are single mothers. They cannot envision moving to another area by themselves to start over on their own. In a sense, the farm community that nourished them, now constrains them.

Conclusion

The author's stories of U.S. born Mexican families captivates her audience by telling their heart wrenching stories and struggles as they strive toward a better living. Although this

book can touch anyone's heart, people who will benefit the most are those providing the best services possible to U.S. born Mexicans. Others who will benefit are those living near the Mexican/United States border and want to better understand this group's way of life. A situational benefit from this composition is that those who work with families can compare U.S. born Mexicans to other groups, such as low-income families. Many situations are comparable and one can better understand the daily challenges they face and help them accordingly.

Anyone with a strong sense of family and community will find much to consider. Low-income families often reside in interlocking communities of mutual support that are both nourishing and constraining. Many families are challenged by the same situations faced by their parents and grandparents. Even though some want to get out of their arrangement and find a better life, they are comfortable with their lifestyle and associating with others who are familiar. Some are afraid to change or step out of their comfort zone and take the challenge of further education or moving away. Others do not know and cannot imagine any other lifestyle. They are stuck in their situation and cannot escape. Social workers who reflect on this book will gain a deeper appreciation for the role community and family legacy play in sustaining low-income families. Those working with rural populations are encouraged to give this book serious consideration.

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Mental Health First Aid USA: The Implementation of a Mental Health First Aid Training Program in a Rural Healthcare Setting

Andrew M. O'Neill
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John A. Garcia

Abstract. Nearly one-quarter of adults in the United States suffer from a documented mental disorder. Consequently, anyone could encounter a person with symptoms of mental illness at some point as they carry out their daily life activities. Although laypersons may accurately identify physical illnesses, they may lack necessary skills to identify symptoms of mental disorders, or know how to adequately respond to persons in a mental health crisis. Mental Health First Aid USA is an evidence-based certification program designed to teach lay citizens to recognize certain symptoms of common mental illnesses, offer and provide first aid assistance, and guide a person toward appropriate services and other support. The program targets a broad audience, from teachers, police officers, clergy members, and healthcare professionals to the average citizen volunteer. This practice note describes a pilot implementation of Mental Health First Aid USA by a social worker at a rural hospital in Central California. The process and results of program implementation are discussed as well as implications for social work practice in rural healthcare settings.

Keywords: Mental health, social work, hospitals, Mental Health First Aid USA

Mental health awareness is an increasingly significant societal issue in the United States. An estimated one in four adults will be affected by a mental disorder each year (Kitchener, Jorm, & Kelly, 2009); however, the general public may lack the necessary information to recognize symptoms of mental health problems, and therefore may not be equipped to provide initial assistance to an individual experiencing a mental health crisis, nor help them obtain adequate help (Zanjani, Kruger, & Murray, 2012). Moreover, the widespread stigma attached to mental disorders in today's society may encourage individuals to conceal mental health problems and not seek proper treatment (Caine, 2013; Kitchener, Jorm, & Kelly 2009; Livingston, Tugwell, Korf-Uzan, Cianfrone, & Coniglio, 2013; O'Connor, Gaynes, Burda, Soh, Whitlock, 2013; Wasserman et al., 2012).

Clinical social workers provide more mental health care services than all other professionals (Sable, Schild, & Hipp, 2012). Those who work in healthcare settings bear witness to the intimate relationship between physical and mental health. However, not all members of a health care team necessarily aspire to a holistic approach in terms of how they treat their patients, preferring instead the traditional medical model. Many healthcare professionals focus primarily on presenting physical problems, and may not address possible emerging mental health issues due to inadequate information or awareness, lack of available reimbursable insurance, or the belief that mental health is simply not connected to the presenting physiological problems.

Trained in the bio-psycho-social-spiritual approach, social workers are uniquely positioned to develop individualized interventions that target and educate medical professionals who may benefit from further education and training in mental disorders (Buckner, Heimbeg, Ecker, & Vinci, 2013; Matzer et al., 2012). Social workers can assess systemic barriers to competent health care services, and utilize their expertise and skills to alleviate stigma associated with mental illness. Once stigma and isolation barriers are identified, it becomes possible to begin mitigating disparities in mental illness diagnosis and treatment (Sable, Schild, & Hipp, 2012).

Hospital social workers presently serve on multidisciplinary health care teams throughout medical settings, providing opportunities to enlighten doctors, nurses, nutritionists, physical therapists and respiratory therapists (Dziegielewski, 2013). Hospital social workers have competencies and skills that are needed to promote mental health awareness and literacy among various target audiences, including patients, family members, paraprofessional hospital staff, and administrators (Liechty, 2011). Social workers can use their front-line knowledge of policy and practice issues facing patients to advocate for changes at the organizational, community, regional, state, and national levels.

Mizrahi and Berger (2005) assert that hospital social workers “must be able to function at three levels: the hospital/macro level, the internal (department or program) level, and the external/community level” (p. 164). Thus, social workers in hospital settings have multiple responsibilities which oftentimes must be rapidly executed. It is critical that they perform patient interventions efficiently, simultaneously identify hospital system needs, and communicate effectively with administrators about viable solutions. All this must be achieved while monitoring ever-present pressures of internal services utilization review, timely discharges, and hospital accreditation by The Joint Commission.

Cultivating relationships within the hospital and community is one of the most crucial activities hospital social workers perform (Gregorian, 2005). Relationships among social workers and nurses, physicians, and hospital administrators often determine the status and scope of social work practice and stature within the institution. Social workers can ultimately add value to a medical team by voicing their willingness to help the hospital meet (even exceed) its goals at multiple levels, which can then hypothetically transcend to social work involvement in Joint Commission preparation, Board of Ethics, and Implementation of Educational Training Programs, including Mental Health First Aid, for employees.

Description of the Program

Mental Health First Aid USA (MHFA-USA) was designed to address invisible societal barriers of stigma and reluctance by training mental health first aid volunteers to recognize, guide, and refer individuals in mental health crisis to the appropriate mental health services and support.

MHFA-USA is an evidence-based program initiated in Australia in 2001 and has since expanded its curriculum worldwide to train natural helpers in 14 countries. The program, “...teaches the public how to recognize symptoms of mental health problems, how to offer and provide initial help, and how to guide a person toward appropriate treatments and other

supportive help” (Kitchener et al., 2009, p. 12). In the United States, MHFA-USA is administered by the National Council for Community Behavioral Healthcare, the Maryland State Department of Health and Mental Hygiene, and the Missouri Department of Mental Health (Jorm, Kitchener, Kanowski, & Kelly, 2007). MHFA-USA certification requires an interactive 12-hour training session delivered over either a two, three, or four day period. Participants learn basic risk factors, warning signs, and typical medical and psychological interventions for mental health disorders such as depression, anxiety, psychosis, and substance misuse. MHFA-USA certification is renewable every three years in order to remain current on emerging mental health knowledge. One program goal is certification of all professionals who provide direct human services (Jorm et al., 2007). Mental Health First Aid USA targets a vast audience including professionals in law enforcement, emergency medical first responders, nursing home staff, school teachers, staff and administrators, state and local policymakers, Chambers of Commerce members, as well as community volunteers.

This program is particularly well suited for implementation in rural community-based acute care hospitals, as such facilities are frequently the first to assist individuals suffering from mental health challenges and their families or caregivers. Rural medical settings continue to encounter multiple challenges as primary care providers migrate towards more urban areas (Bhattacharya, 2013). This phenomenon is not unique to the United States, but an increasingly global problem that constrains services for those in need (Carey, Wakerman, Humphreys, Buykx, & Lindeman, 2013; Lin, et al., 2013). Mental health needs of individuals in rural communities have been particularly difficult to address for multiple reasons, including lack of mental health professionals, spotty public transportation, and the stigma of seeking out mental health services (Humble, Lewis, Scott, & Hertzog, 2013). The MHFA-USA curriculum seeks to overcome such obstacles by expanding mental health awareness to multiple providers and natural laypersons within the broader rural community. In rural settings, one goal of implementing this training program would be the removal of stigmas associated with mental illness as no diagnoses are given, only informed support and referrals for appropriate care.

Pilot Program Implementation

This pilot project aimed to identify the necessary sequence in order to implement the Mental Health First Aid USA program by a healthcare social worker in any rural acute care setting. The Mental Health First Aid USA program was implemented within a rural hospital in Central California in May, 2013. In addition to receiving an overview of common mental disorders, interventions, and treatments, participants also developed individualized strategies to incorporate program information into various daily routines within the hospital. Multiple charge nurses attended the program, which is a major advantage for any new hospital program as charge nurses have power and authority within their managerial positions which directly influence the hospital system (Krugman, Heggem, Linney, & Frueh, 2013). These nurse leaders often function in multiple capacities as they mentor other nurses and paraprofessionals, and share knowledge on current medical practices. This enables them to teach and model appropriate patient and family interactions in numerous health and mental health situations.

Key Actions

Many steps were taken to prepare for this project's success. The first action included identifying key stakeholders in order to facilitate the necessary processes for MHFA-USA to be brought to the medical center. Next, a reasonable program implementation timeline had to be developed and implemented. Schiller, Winters, Hanson, and Ashe (2013) recognized the importance of involving community stakeholders in public health problems, and recommended concept mapping as one possible way to identify those who can impede program implementation. Logistical considerations were considered during the project-planning phase, such as finding an appropriate venue for training sessions, staffing considerations and coverage, and recertification planning for the MHFA-USA program.

Next, MHFA-USA curriculum was proposed as a program that could help various members of the medical staff identify and appropriately triage individuals suffering from mental health issues. Normalizing mental health into primary care has been a successful modality for treating patients at primary care hospitals (Reiss-Brennan, 2014; Sword, Busser, Gannan, McMillan, & Swinton, 2008). Therefore, rural hospital staff members might be better equipped to help this population once training on mental health was provided.

Rural hospitals are also uniquely positioned to provide outreach services to community members. Consequently, one project objective was to provide a new dimension in the hospital's educational activities focusing on increased awareness of common mental disorders. Implementing the MHFA-USA program might ideally help foster a hospital culture as competent in addressing psychiatric disorders as it is in addressing physiological disorders treated within this rural setting each day, thereby reducing the pervasive stigma associated with such diagnoses (Clark, et al., 2013; Cummings, Lucas, & Druss, 2013). The hospital might ultimately serve as a mental health resource by providing information and training for both hospital personnel and the general rural public.

Planned Change Process

Implementing new programs in hospital settings is complex and includes gathering input and obtaining approval from key administrators and personnel in many departments. Consequently, several steps were taken to implement the MHFA-USA program. This process was based on Kirst-Ashman's (2011) seven steps of the planned change process in generalist social work practice: engagement, assessment, planning, intervention, evaluation, termination, and follow-up.

The first step was for the program leader, in this case a social worker, to obtain certification in MHFA-USA in order to have a more thorough understanding of MHFA-USA program structure. This further comprehension of the program allowed for better presentation of MHFA-USA to key stakeholders within the hospital, including the Vice President of Patient Care Services, Emergency Department Medical Director, Bioethicist, Chaplain, and Nursing Directors. Further collaboration with the Vice President of Patient Care Services and senior nursing leadership included brainstorming which staff members would most benefit from becoming certified in MHFA-USA. A formal presentation about MHFA-USA to the Nursing Leadership Committee was made in February 2013. All members expressed their support for the

project and noted that increased mental health awareness among hospital staff was, indeed, a significant need at this time.

Next, a partnership was built between the hospital and local behavioral health center to explore timeframes for bringing the MHFA-USA program to the hospital, including the certified instructors who would conduct the sessions. The certified instructor is usually responsible for implementing the program in selected agencies throughout the county. In this case, the certified instructor provided trainings at no cost to the hospital. This individual stated that bringing the program to the hospital would mark the first time that MHFA-USA training would be provided at a hospital in rural Central California and they were very excited about this landmark partnership.

In early March of 2013, two MHFA-USA facilitators were selected to present the training at the hospital. These individuals were contacted by the social worker in order to coordinate dates given by hospital administrators. A follow-up meeting with the trainers and the social worker occurred shortly before the program commenced in May. This meeting facilitated tailoring some of the training examples to our specific audience which was, in this case, rural health care professionals.

All key stakeholders provided the essential support required to implement the Mental Health First Aid USA program at the rural hospital. The Vice President of Patient Care Services at the hospital chose the initial 22 hospital employees to participate in the training. The majority of those in attendance were Charge Nurses representing various medical units, including the Emergency Department, Medical-Oncology Floor, Surgical Floor, Progressive Care Unit, and House Supervision. As most of these attendees hold supervisory positions in the hospital, hopefully skills acquired in the Mental Health First Aid USA program will be shared with their line staff in their respective departments.

The initial feedback from program participants was generally positive. A few nurses discussed how the training would help with patient care, in particular how they could more effectively interact with patients who might exhibit signs of mental health issues. One of the nurses also said that this kind of training would be very beneficial to a broader cross-section of hospital employees including line nurses, nursing aides, unit secretaries, and even physicians. Two nurses remarked that the pace of the training was not quick enough for them, and that they wanted to learn more about how to apply this material to specific situations they are likely to encounter.

Word spread quickly throughout the hospital after the first graduating class completed their certification. Most charge nurses are known for their commanding take-charge attitudes and have the power to make or break a program such as MHFA-USA (Wilson, Talsma, & Martyn, 2011). In this case, the feedback thus far has been fairly positive, and charge nurses are allowing employees to attend trainings during their shifts which builds momentum; quarterly trainings were held as long as a minimum of fifteen people attended.

Conclusions and Implications for Social Work Practice

The successful implementation of this program has certain implications for the future of social work practice in rural health care settings, particularly as it is practiced in acute care hospitals. Social workers in hospitals are frequently the primary resource for colleagues who seek further guidance regarding patients with mental health diagnoses. Developing a program like MHFA-USA in a hospital further enhances social workers' reputation. It shows how they can use their unique training to proactively address identified hospital and community needs and mobilize necessary resources accordingly.

Beyond mental health issues, hospital social workers are increasingly involved in helping patients manage various chronic diseases, such as diabetes, heart disease, and HIV/AIDS. Implementing a mental health awareness program sets a precedent for the possibility of future program development at hospitals. For example, social workers could collaborate with colleagues from other disciplines (as well as community partners) to create programs and trainings that assist patients and caregivers in their efforts to manage chronic illnesses, including mental disorders.

The implementation of the MHFA-USA program demonstrates that social workers should have opportunities to utilize leadership skills in hospital settings. Indeed, the National Association of Social Workers Standards for Practice in Health Care Settings states that social workers "across all health care settings have a responsibility to provide leadership...to improve and maintain the quality of care provided by an agency or institution" (National Association of Social Workers, 2005). Social workers must demonstrate leadership skills by serving on key hospital committees (such as Quality Services) and spearheading community outreach activities. Obtaining administrative positions, thereby directly influencing hospital policy, would also help give more voice to the role of social work in any medical facility. The unique educational training that social workers receive in simultaneously developing micro and macro perspectives on complex issues will enable practitioners to play key roles in the provision of health care in the United States for many years to come.

Lastly, longitudinal data are needed to assess whether MHFA-USA is effective. Hypothetically, data to assess Mental Health First Aid USA should come from mixed methods evaluative research that assesses both staff awareness and patient outcomes. Currently, the only assessment occurring is a short open-ended questionnaire given after the final training. Although this provides useful information, more structured and larger scale assessment efforts will be needed as the program reaches larger hospitals.

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Building University-Community Partnerships in Rural Settings through a Community-Based Learning Assignment

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Abstract. Universities located in or near rural settings are uniquely positioned to partner with their community to offer invaluable resources often lacking within rural social service agencies. This teaching note describes a community-based research assignment implemented within an MSW advanced research methods course. The goal of this class was to teach students, through service learning, each phase of the evaluation process, and strategies to build and sustain rural community partnerships. Lessons learned and implications for social work practice and education are discussed.

Keywords: program evaluation, community-based research, teaching research, rural communities

Rural social work practice often frames social problems as community issues and therefore favors community-based approaches (Daley, 2010). Collaborating with communities through university guided service learning projects has the ability to empower and benefit students, practitioners, agencies, communities, and universities. Social work education has a long tradition of using sustainable methods through community-based learning assignments. Community partnerships provide applied learning opportunities for students, technical services to community organizations, and fresh practice perspectives to faculty. This call for universities to address social injustices in their surrounding communities (Schultz, Israel, Selig, & Bayer, 1999) is consistent with the National Association of Social Workers Code of Ethics (1998) which emphasizes social workers' need to advocate on behalf of disadvantaged groups.

Often, emphasis is placed on volunteerism and informal networks in rural settings to address the needs of its members (Templeman, 2005). Therefore, rural university-community partnerships are even more important because such reciprocal relationships can build sustainable partnerships (Thomas, Albaugh, & Albaugh, 2003) that can positively affect all key stakeholders.

Universities providing public service through community-based learning can become extensions of that community (Templeman, 2005). The obvious community benefit from this arrangement is the additional service provided to an organization that may otherwise lack time and resources necessary to make the service available; and insufficient time and resources abound in rural communities (Templeman, 2005). Organizations and communities are not the only beneficiaries from service learning because practitioners engaged in service learning may benefit through academic stimulation, and students can practice professional social work skills through exchanges with staff and other key stakeholders (Templeman, 2005).

Students commonly report that service learning assignments grounded in community partnerships make learning purposeful (Wells, 2006). For example, these university-community partnerships promote the social work values of social justice and advocacy (Marullo & Edwards,

2000; Scott, 2008) and dissemination of knowledge, which is challenging to illuminate through in-class lecture and discussion alone. Therefore, through experiential learning, students acquire skills in communicating with different stakeholders (Berg-Weger et al., 2004; Gronski & Pigg, 2000) while providing an invaluable service to the community.

Community-based learning curricula have also been touted as necessary in preparing students for professional social work practice (Scott, 2008). Community-based learning, like traditional field placement, has the ability to integrate classroom learning with actual practice experience. Utilization of service learning in social work courses can be found in statistics, macro/community practice, advanced research methods, gerontological social work research, and social welfare policies, to name a few (Berg-Weger, Herbers, McGillick, Rodriguez, & Svoboda, 2007; Mulroy, 2008; Rogge & Rocha, 2004; Scott, 2008; Wells, 2006; Wertheimer, Beck, Brooks, & Wolk, 2004).

Service learning that employs a community-based research project allows students to utilize research skills to impact specific community agencies or social problems (Wells, 2006). Historically, social workers have been perceived as “research reluctant” (Epstein, 1987), and recent research continues to support students’ negative attitudes toward research and lack of desire to learn course content and see its connection to social work practice (Adam, Zosky, & Unrau, 2004; Green, Bretzin, Leininger, & Stauffer, 2001; Kapp, 2006; Knee, 2002). Indeed, social workers who do not view themselves as researchers are skeptical of the value of research courses (Anderson, 2002). A primary goal of research professors is to develop pedagogical strategies that establish the connection between research application and improved practice delivery that benefits the lives of clients. Supplementing research courses with community-based learning assignments can accomplish this goal, but with the added benefit of curtailing many social work students’ intimidation of research and statistics by adding an experiential approach to learning (Forte, 1995; Hyde & Meyer, 2004; Pan & Tang, 2004). This teaching note outlines a service learning project utilized to teach program evaluation to MSW students enrolled in the required advanced research methods course and how this fosters university-community partnerships in a rural setting.

Community-Based Learning Assignment

This university-community partnership provided a community-based learning experience to graduate students enrolled in the MSW program at one mid-size Mid-Atlantic public university. Taken during the concentration year, students enrolled in this required advanced research course completed a program evaluation utilizing data obtained from a community agency. Assignments were completed throughout the semester, which guided students through a program evaluation. Students were held accountable by members of their group yet had individual assignments to demonstrate mastery of skills. At the conclusion of the course, the students presented findings and recommendations to the agency through a written report and oral presentation.

Course Description

This course was taken over a 15-week period during the spring semester of the academic year. This was the second of two research courses taken by non-advanced standing students and the only research course taken by advanced standing students. To prepare advanced standing students for this course, additional assignments, readings, and discussions were integrated into the bridge course, which was the first course taken by advanced standing students when they were admitted into the program. The focus of the course was on social work practice research paradigms, models, and methods, with particular attention to evaluation and assessment projects. The course also gave students a more in depth exploration of computer-assisted, descriptive, and inferential data analysis. In addition to work completed during the 15-week semester, implementation of this community-based learning assignment required pre- and post-course work, which will be described next.

Implementation

Pre-Course. Figure 1 depicts the implementation process, and Figure 2 presents the specific sequential steps taken throughout the process. Prior to the start of the semester, the course professor cultivated relationships with agency directors to identify a dataset. Many of these relationships evolved out of the first author's professional contacts from working in the community or through contacts with field instructors. This process began six months prior to the start of the course as considerable time was needed to develop a trusting relationship if one did not already exist, and to assist the agency with preparing a dataset.

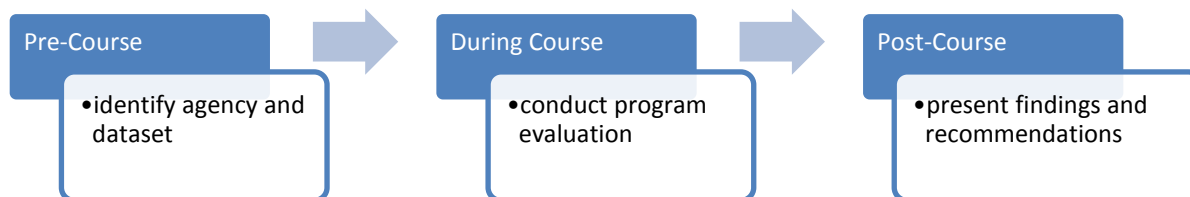


Figure 1. Implementation Process

To start the process, the professor met with the director of the agency to assess what data were already collected and currently available. During this initial meeting, the professor assessed what the agency wanted to glean from the evaluation. From this discussion, research questions were developed. Sometimes, the community agency was uncertain what they wanted to know; and therefore, it was often suggested to the director to propose a question to the board of directors, staff, and other key stakeholders.

Next, the professor assisted the community agency with preparing a dataset that included the essential variables necessary to answer the agency's proposed questions. Often during this process the agency was informed that the proposed questions could not be answered due to lack of information (e.g., data) collected. Together, the professor and director identified what could be answered with the data available. Afterward, the professor explained that it may be possible to explore the "unanswerable" questions through interviews with key stakeholders. Together, they

developed a research question to answer utilizing qualitative methods, listed potential questions to ask, and identified from whom to obtain responses.

Sequential Steps	By Whom	When
• Recruit Community Agency	• Professor	• Pre-course
• Prepare dataset and research questions	• Professor and Agency Director	• Pre-Course
• Select research group	• Students	• During Course
• Class meeting with agency staff	• Agency Director/Staff	• During Course
• Provide classroom instruction and guidance	• Professor	• During Course
• Collect and analyze data	• Students	• During Course
• Interpret findings and prepare results	• Students	• During Course
• Review and provide feedback	• Professor	• During Course
• Compile written evaluation	• Students	• During Course
• Present posters/findings	• Students/Professor	• During Course/Post-Course

Figure 2. Sequential Steps throughout the Implementation Process

Once the research questions, dataset, and key stakeholders were identified, a letter of agreement was typed and signed by the agency and professor of the course. At this point, the professor completed and submitted a research proposal to be reviewed by the university's Institutional Review Board. The director of the agency shared the letter of agreement with his/her board of directors and staff, if necessary.

During Course. As this was an advanced research course, students come with basic research methodology knowledge so lectures on research design, sampling strategies, data collection methods, and data analysis options were unnecessary. However, students were instructed on program evaluation theory and the pragmatic issues in evaluation research. This occurred during the first two to three weeks of the course. During this time, students were also introduced to the evaluation project they would complete throughout the semester. Students were provided a brief overview of the agency and the research questions they would examine. Students were assigned to a research group, and the size of each group was dependent upon the number of students within the class and number of research questions explored. In general, there were typically six research questions and five to six students in each group. Student assignment to the research groups was based on individual interest in the research question. Each research group was provided a packet of information about the program and reading material about the population, issue/topic, and/or program, when applicable. Students were expected to read this material and come to the next class meeting with questions for the agency staff.

Agency staff were invited to attend the second class meeting to share information about the agency/program, collection of data, and answer any questions the students had based on their readings from the week. Based on this knowledge, students worked within their research group to develop a logic model and measurement plan based on their research question. Once students identified the data needed to answer their group's research question, they began preparing their dataset from the data obtained pre-course. Preparation of the dataset included recoding variables, creating new variables, and collapsing value categories.

Over the next eight to nine two-hour class periods, students met in the computer lab to analyze and interpret their data. The first hour was usually spent in lecture, discussion, and small-group activities to process issues that arose throughout the evaluation as well as reinforce analytical skills before having the students complete the analyses on their own. The professor circulated among groups during the remaining class time to answer questions, provide guidance, and offer reassurance.

During this time, students completed a number of individual and group projects related to and separate from the program evaluation being completed for the community agency. The assignments unrelated to the evaluation project were to test each student's knowledge and skills in designing a program evaluation and analyzing and interpreting data because, as is common in most group research assignments, the student most comfortable with math will be the student who handles the analyses. These individual assignments allowed the professor to test each student's ability to meet the course competencies. Students also developed a semi-structured interview guide to collect qualitative data from the list of key stakeholders identified between the professor and agency director pre-course. Every student was assigned one person to interview who could shed light on the qualitative research question being explored as part of the program evaluation but not assigned to a specific research group.

The last few weeks of the course were spent compiling findings from each research group into one report that was shared with the community agency in written form. This document included all the standard components of a program evaluation report (executive summary, program description, evaluation methodology, results, discussion, and recommendations). Each research group prepared a poster with the findings and recommendations relevant to their research question in order to share with agency staff during a presentation held during the last class meeting.

Post-Course. Although students presented findings and recommendations in written and oral format at the end of the course, most agency directors had follow-up questions and requested additional clarification and insight. The majority of post-course work was conducted by the professor and the length of involvement varied among agencies. In general, most requested a follow-up presentation at a board of directors meeting. However, other post-course involvement comprised presentations at local and/or state conferences, consultation with grant writing, and development of training material.

Discussion and Feedback on Attainment of Course Objectives

This teaching note outlines one approach to preparing graduate social work students for evaluation research in rural settings through the utilization of a community-based learning assignment. Feedback received from the agency regarding the benefits of this assignment is favorable and greatly appreciated due to limited resources and knowledge preventing the rural agency staff from completing the evaluation done by the students. Many rural social service agencies lack resources needed to undertake a comprehensive program evaluation, and administrator feedback support the need for rural universities to partner with organizations to help provide this invaluable resource. Further, this experience also provides students with a realistic hands-on experience that augments their research training, which also mitigates their deep fear of the subject.

Course evaluations revealed students believe in their ability to implement course material and that their knowledge of course content increased as a result of taking the course. It is unknown whether the structure of the course was the cause, but written comments suggest it was a contributing factor. One student stated, "Taught material in class thoroughly and exactly how we needed to do it; step by step which was very helpful." When asked what they liked most about the course, students reported being surprised with how much they enjoyed the content: "Stats, I didn't think I would enjoy it but I did," "My ability to learn research and apply it." Another student appreciated its application to social work practice. "Research is my least favorite aspect of social work; however, I enjoyed that the master level research class related to a community agency."

Lessons Learned

This assignment has been successfully implemented by the first author three straight academic years. Although this assignment provides students with hands-on activities to promote knowledge, skills, and benefits of research in social work practice, there were some lessons learned. First, over the years, the size of the class has increased. To maintain manageable group

sizes that ensure group accountability, it was necessary to recruit a community agency that had enough data to garner a minimum of six research questions.

Second, given the amount of pre-course time required of the professor and commitment on the part of the agency, it is important to assess whether this approach to teaching research to MSW students is viewed positively by the students enrolled in the course. Much time was needed before the start of the semester to prepare the data as often the data are still in raw form (e.g., the professor is often provided with de-identified completed surveys). Not only was it essential to set a deadline for access to the data, but having a student research assistant to aid with inputting data into SPSS was a valuable resource. Although data cleaning was done by the professor before the start of the semester and was necessary due to time constraints within an academic semester, the raw dataset was shared with the students for those who wished to practice data cleaning.

Despite having signed the letter of agreement before the start of the semester stating students will be given access to key stakeholders to complete the qualitative interview assignment, issues arose that delayed and/or prevented students' access to informants. Therefore, a back-up plan is necessary to ensure students are able to complete this assignment. This can also be a good learning opportunity and aid students in properly identifying their frustrations and not generalizing them to how they feel about research and/or the agency.

Reserving in-class time for groups to work on data analyses and interpretation was essential as graduate students often dislike group work due to their already busy schedules, which makes finding time to meet with classmates outside of class difficult. Further, students appreciated time to run their analyses in class and having immediate access to the professor to ensure they were accurately computing the statistics and interpreting the results.

Implications for Social Work Education and Beyond

The benefits of community-based learning assignments in rural settings are vast. They extend beyond the parameters of traditional academic settings by providing countless benefits to students, human service agencies, and the community at large (Hyde & Meyer, 2004). This assignment provides students with the opportunity to apply and strengthen their research skills. Upon completion of their program evaluations, students received feedback from multiple sources including the instructor, other social work faculty members, peers, community members, and professional social workers regarding their finished products. Feedback from different vantage points and varied interests provides students with a unique perspective they may not experience in other courses or assignments (Balciūnienė & Mazeikienė, 2008). In addition to the increased knowledge and skills students developed from this experience, after completion of this assignment, there is a greater likelihood that students will have enhanced confidence in their research abilities. In turn, there may be a greater likelihood that upon graduation, the students will continue to employ research in their practice.

This increased competence in the area of “practice informed research and research informed practice” is consistent with the CSWE educational and policy standards (2008) as well as the NASW Code of Ethics (1999). Evaluation of one's practice, including the efficacy of programs and services, is not only an ethical mandate, but also improves service delivery and

program effectiveness, and promotes social change and economic justice (Mitschke & Petrovich, 2011). It helps ensure professional accountability across system levels and ultimately benefits recipients of social work interventions. In fact, additional opportunities for such applied research in other core social work courses at the foundation level (e.g., courses in research and macro practice) as well at the concentration level (e.g., such as the program evaluation assignment previously discussed) allow social work faculty to increase students' knowledge, skills, and competence. In turn, there is accountability to the profession and service to the community at large, significant foci in rural social work practice (Daley, 2010).

Beyond the benefits to students and the profession, the program evaluation community service learning assignment provides an invaluable resource to community agencies being evaluated (Hyde & Meyer, 2004), especially in rural settings. In many cases, such agencies face restrictive budgets that include limited funds for administrative costs such as evaluation, along with other capacity building valuations and appraisals. Upon completion of the evaluation, students provide a final report to agency directors, and when applicable, other key stakeholders. In addition to the final report, in many instances, directors and stakeholders meet with the student-evaluators to address follow up questions and may present findings to larger bodies including boards of directors, community organizations, and professional bodies. In turn, agencies use results to inform service delivery and support best practices, especially practice in rural communities where reciprocal exchanges are encouraged (Daley, 2010).

Conclusion

Offering a community-based learning assignment to graduate students enrolled in an advanced research methods course provides a real-life learning opportunity that benefits the student, university, agency, and community. Students gain research knowledge and skills while simultaneously providing an invaluable service to a local non-profit organization which is often unavailable to rural social service agencies due to limited resources. In turn, the organization is able to utilize the findings outlined in the evaluation report to enhance service delivery. These university-community partnerships may help social work departments better prepare students to adhere to the profession's mandates of using research to guide practice and practice to guide research, as the limitations embedded in traditional pedagogy may be resolved through the use of a community-based research project. Further, the rural social service organizations obtain a resource that provides them with data to utilize in order to justify ongoing and/or additional funding for their program. In the end, both the university and the organization benefit.

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Iterative Ethical Discussion in Hybridized Practice Classes

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Abstract. An increasing number of social work programs at both the bachelor's and master's levels utilize online or hybridized instruction, including practice courses. These courses may be of particular advantage to students in rural communities by minimizing commute times and making social work education more available. However, a concern is whether these venues allow essential content, such as the development of professional ethics, to be adequately addressed. This teaching note is based on the authors' experiences with conducting online ethics discussions and provides suggestions for incorporating online scenarios that reflect practice dilemmas, which students must consider critically before responding to posted questions.

Keywords: ethics, ethics instruction, online instruction

An increasing number of social work programs at both the bachelor's and master's levels utilize online or hybridized instruction, including practice courses. Expanded online and hybridized courses may be of particular advantage to programs that serve students who live in rural communities by minimizing commute times and making social work education available to a wider variety of students. However, a concern that educators frequently express is whether these venues allow essential content, such as the development of professional ethics, to be adequately addressed. In their own virtual teaching experience, the authors have offered online scenarios that reflect ethical practice dilemmas, which students must consider critically before responding to posted questions following a specified format. In some instances, although not all, these postings expanded upon in-vivo class material. Since both the BSW and MSW programs at the authors' university have a generalist focus, many scenarios included issues affecting micro, mezzo, and macro practice.

Wallace (2003) noted the potential benefits of online instruction, including increased interaction and collaboration between instructors, thereby creating a "learning community" (p. 263) and the need for learners both to examine cognitively and engage affectively with content. Maidment (2005) outlined such challenges as inequalities in internet access and the occasional ambiguity of written communication while simultaneously recognizing the richness of online pedagogy's constructivist roots and potential for "collaborative peer learning" (p. 192). Ayala (2009) discussed hybridized courses, or *blended learning* (p. 277), as a way to combine the respective strengths of both in-vivo and online components. The present authors deemed these qualities as creating the ideal environment for teaching values and ethics.

Sanders and Hoffman (2010) described the identification of issues and awareness of one's actions as crucial elements of the Council on Social Work Education's required ethical decision making competency (EPAS 2.1.2). Reamer (2003) noted the increasing attention to social work ethics within the profession's literature base, including risk management concerns and decision-making guides. Daley and Hickman (2011) described special challenges that may confront workers in rural communities, including the unavailability of certain dual relationships,

access to supervision, and aspects of rural culture, such as barter exchange and a lack of privacy. For these reasons, they recommended utilizing a culturally sensitive *relativistic* (Daley & Hickman, 2011) approach incorporating the identification of potential ethical conflicts, judicious use of supervision, informed consent, and careful documentation.

Anderson and Boland-Prom (2005) described two approaches to teaching ethics. Process methods focus on interweaving practice and ethical concerns, where technical approaches offer specific examination of the NASW Code of Ethics. Characteristic of the process model is Dybicz's (2012) description of social work values as "part of a hermeneutic inquiry which emphasizes meaning and values, the application of social work values both generates knowledge and actively drives treatment planning and implementation" (p. 277). Gray and Gibbons (2007) advocated that educators "teach students to reflect on the way in which their reasoning, actions, and decisions are affected by their values, because without values the helping process becomes a rational-technical endeavor" (p. 223). Allen and Friedman (2010) reiterated the importance of affective learning in the teaching of values and ethics. With regard to models of ethical decision making, Anderson and Boland-Prom (2005) noted that "the true test of utility is in the application of each to difficult ethical questions faced by practitioners" (p. 497).

Multiple venues exist for teaching ethics and the resolution of dilemmas. Most of us probably had our first ethics training in face-to-face classrooms. Cromartin and Gonzalez-Prendez (2011) described the first author's use of her field internship to identify the value-based conflict a particular practice situation created for her. Currently, however, the growth of online and hybridized courses is causing scholars to explore online options for teaching ethics.

Vernon, Vakalahi, Pierce, Pittman-Munke, and Adkins (2009) reported the value of technology as a tool for teaching critical and reflective thought processes and decision-making skills. Wilke, Randolph, and Vinton (2009) discussed the importance of mutual aid and dialogue in enhancing learning communities. Marson, Wei, and Marson (2010) noted that previous studies indicated distance education students had better test scores but did not do as well as face-to-face learners in applying concepts to actual practice situations. Marson and colleagues further noted that while students in face-to-face classes are not required to comment or discuss each standard introduced, online students are required to participate in every conversation. Students who miss a session in the face-to-face classroom miss the discussion that day, which is not the case in online classes. Marson and colleagues further recommended that social work educators look deeper into the implications of teaching ethics online.

Course Development

Both authors of this work have recently taught practice classes that included online ethics discussions. While the specific classes are not named in order to protect student confidentiality, one class was taught exclusively online, and the other was hybridized. One was an upper-level undergraduate course, and the other was at the Master's level. Both courses contained between 10 and 20 students. Both cohorts contained traditional and non-traditional learners, with many of the graduate students having considerable work experience. Many students at both the graduate and undergraduate levels also have connections with the military.

The undergraduate class was offered exclusively online, and the hybridized MSW class discussed the Code of Ethics and the Ethical Rules and Ethical Principles Screen (Dolgoff, Lowenberg, & Harrington, 2009). In both instances, students were given case scenarios depicting

a dilemma or otherwise challenging ethical situation. Students were to respond to the scenario, identifying the challenges within the situation, relevant points to consider, and possible responses. One scenario addressed a video presentation. Some utilized situations portrayed at a local continuing education workshop (Nichols, 2009; 2011). Still others were created by the authors for their own class use. These five scenarios are included in the Appendix. Students were aware that their work would be evaluated for thoroughness of response and evidence of critical thinking. Previous discussions addressed the process of ethical decision making and emphasized that it was possible for ethical social workers to reach different conclusions and pursue different courses of action. Since course delivery was asynchronous, students could read and consider one another's work. The assignment required students to respond to a minimum of two classmates, and many chose to respond more frequently.

The authors incorporated the ideas described above by alternatively asking students to respond to ethical dilemmas based on their own reading of the NASW Code of Ethics and the application of the Ethical Rules Screen and Ethical Principles Screen (Dolgoft, et al., 2009). The Ethical Rules Screen asks users to consider whether a situation is addressed within the Code. If it is, the social worker should follow the Code regardless of personal belief. If the situation is not covered, the social worker should consider the following eight principles in ascending order: (a) truthfulness and full disclosure, (b) privacy and confidentiality, (c) quality of life, (d) least harm, (e) self-determination, (f) autonomy and freedom, and (g) the protection of life (p. 80).

As the authors begin formal data collection, domain analysis or other qualitative techniques will be appropriate. However, in this teaching note, the authors were interested in ethical and practice concerns the students identified, their ability to separate personal and professional values, and their ability to apply the Ethical Rules Screen and Ethical Principles Screen and/or their own reasoning strategies. A representative of the authors' Institutional Review Board stated that IRB review was not necessary for reporting student responses since names and specific course titles were withheld (Dr. Omie Shepherd, personal communication, July 10, 2013).

Discussion Content

As anticipated, discussion board forums thus far have provided opportunities for thinking about ethical dilemmas that extend beyond those of the typical face-to face classroom. The first discussion asked students to consider euthanasia. Use of the online format apparently prompted spontaneous internet research, as one student quoted the modern version of the Hippocratic Oath. Another student compared U.S. practices to European practices, and a third discussed pain management.

Personal values figured into this first discussion more than any other, perhaps because of its controversial nature, or because it was offered at the undergraduate level. Some statements reflected the impact of personal values on interpretations of ethical situations, such as the observation, "As future social workers we must work to find out patients a way to cope with their illness and find resources to help them maintain an acceptable quality of life until the time that they pass away."

One strength noted was that even as students voiced differing opinions, they expressed respect for one another along with recognition that euthanasia "is a polarizing debate." One

voiced the realization, “I don’t think any of us really knows what we would do unless we have been in this situation.”

Other scenarios posed to undergraduates included a client’s revealing domestic violence to her therapist along with her fear that her spouse will kill her if she reports or tries to leave. In another, a school social worker sees an image on MySpace of a minor client having sex with another student. In responding to these cases, both students and instructor considered such legal concerns as state variations in mandated reporting of domestic violence, reporting the minor client’s parent to Department of Children’s Services (DCS) for neglect based on lack of supervision, child pornography, and age of consent for sexual activity. A theme that arose relative to both cases was educating clients and parents about *normal* behavioral expectations.

Two scenarios dealt with professional sexual misconduct. In one, a new social worker learns that her supervisor, who is also the president of the licensing board, is having a sexual relationship with a client. In another, a social worker confides to a close friend, also a social worker, that he is having an affair with a client. In the former instance, discussion points included the appropriate chain of reporting, concerns about how the report against the supervisor would be received, and whether the supervisor’s professional prestige and power would result in his behavior being overlooked. In the latter instance, discussion included the possibility of reporting and whether this violated the client’s confidentiality, the social worker confronting his friend, using the Code’s position on sexual relationships, and encouraging him to end the affair immediately.

In the final scenario, a therapist who is in recovery encounters a client at an AA meeting. The client confesses in the meeting that he has had a lapse in sobriety, which places him in violation of a court order. Discussion points included the therapist’s past drinking, current sobriety, and the need for him to attend a different meeting. One position was that he might need to consult with his supervisor about the client’s behavior. Another was that any mention of the client or his relapse would go against AA policies and practices.

The apparent advantages of conducting these discussions in an online forum were that students could review all other comments made, consider new aspects of the dilemma based on those comments, and give a rationale for their agreement or disagreement with a particular stance.

Graduate students responded to five ethics scenarios. Three were completely fictional, with one modified from a practice situation that occurred early in one author’s career (see Appendix for ethical scenarios).

The first scenario dealt with a 25-year-old Latino man with limited English who was hospitalized for a relatively minor surgical procedure but was not able to understand the Advanced Directive. Students considered the appropriateness of the Ethical Rules Screen, the Ethical Principles Screen, and addressed pertinent micro, mezzo, and macro concerns. The majority of students saw the Ethical Rules Screen as adequate, since the issue could be related to Informed Consent content contained within the Code of Ethics. One individual referred to the Ethical Principles Screen’s emphasis on the Protection of Life. Several referred to the Code of Ethics and/or the Dolgoff et al. text and referenced the need for professional translators rather than relying on family members. Reasons such as the client’s privacy and possible conflicts of interest were cited as justification for not using relatives to translate. There were also several

references to NASW's (2001) emphasis on cultural competence. Some advocated for the ready availability of Spanish forms and directives. Others emphasized the desirability of activism and organization within the Latino community to ensure access to adequate health care resources and bilingual providers and materials.

Scenario 2 asked students to assume the role of social worker to a man with terminal cancer who has expressed his intent to end his life by rolling his wheelchair into traffic. The social worker encounters him as he wheels through a deserted lobby one night, presumably to carry out his plan. Classroom discussion had previously addressed Sam's right to self-determination, legal responsibilities, and possible trauma to motorists potentially involved. The discussion board more fully addressed the Ethical Principles Screen and the precedence of protection of life over the right to self-determination. There was some debate about Sam's mental status given his recent hallucinatory experience. While the class was fairly evenly divided on whether Sam had the right to end his life, given the circumstances, it was agreed that the only ethical course of action would be to prevent his suicide. As one individual stated, "The Code of Ethics ... should always take place over the social worker's personal values. We are not in a role where we have the option to decide what is best for the client, and we therefore have to do what is right, legally..." Another student noted:

I think so far in the forum, we have all suggested that the protection of life must come first and foremost above all other principles; however, it is interesting to read what other principles other students have talked about considering when making their decision. And I guess that's what it is, our Code of Ethics, the Ethical Rules Screen, and the Ethical Principles Screen are there for guidelines, they are not concrete, and every one of us at one time or another may look at the same issue in a different perspective.

The third vignette described a same-sex household in which one partner, the biological mother of the couple's child, was being screened for possible breast cancer. Responses included offering emotional support to the partners, community activism and advocacy, and the possible repair of relationships with estranged family members. Most of the discussion centered on the welfare of the couple's son should anything happen to his biological parent. Legal considerations, such as finding the boy's absent father and petitioning him to relinquish parental rights, were a focal point. One student found that while this state does not recognize same sex unions, it does allow same sex adoption. The Code of Ethics' stance on social justice, diversity, and the need to educate oneself with regard to diversity were discussed. Several students mentioned that professional ethics would take precedence over any personal opinions of a social worker. One individual mentioned the NASW's (2001) recognition of strengths in all cultures. Resource organizations such as the Human Rights Campaign and Freedom to Marry were named. Someone recommended rallying sympathetic legislators. One student said:

If this couple wished to have their voices heard in regard to legal issues and custody problems with children for same sex couples, this could be used as a media attention getter and for "the softening role" in policy advocacy.

In the fourth scenario, students were asked to think about ethical concerns facing a social worker who was starting a private practice. Responses included content regarding HIPAA provisions, record keeping and access, bartering, fees, confidentiality, representation of competence, involuntary hospitalization, and emergency coverage. Since a focal point of his practice was men with eating disorders, some respondents addressed the need for consultation

with other professionals. One individual suggested that if this had ever been an issue for the social worker, that professional would need to make sure that his own health was *in check* and that he was modeling healthy behaviors for clients.

The fifth scenario elicited some of the strongest emotional responses from students. A hospital social worker's client has non-Hodgkin's lymphoma. Thus far, none of his family has been a suitable match for a bone marrow transplant, and he refuses to reveal his diagnosis to his daughter who is in the military and about to be deployed. However, the daughter is the social worker's high school acquaintance and asks for an honest assessment of her father's condition.

Responses included one person's admission that she would want to know what was going on with her father, and would find it difficult not to be able to share the information, although she stated that even in this case, the Code of Ethics and Ethical Rules Screen would take precedence over personal feelings. Some posts reflected on the importance of bearing in mind who the client truly is. Some respondents suggested talking with the client to see if he might change his mind about talking with his daughter. Everyone agreed that the professional relationship would take precedence over personal considerations. One person observed that part of the importance of the Code of Ethics is that it provides objective guidance in emotional situations.

Informal student feedback about the online learning experience was positive. One individual commented, "I have found most of the ethical dilemmas fairly straightforward especially when you look at them ethically and not emotionally. In Vignette 4, I would definitely empathize with the patient's daughter, but the confidentiality restrictions are clear."

Another stated:

Working through the course and these vignettes have taught me that things are not always straightforward or black and white and that there will not always be a "right" answer to the issues that we face. Having resources such as the ERS and EPS will be helpful throughout practice in providing a framework for some challenging decision making.

Discussion

It is apparent to the authors that asynchronous discussion board activities can indeed be an effective way to engage students in the study of ethics. The fact that many of the students have had multiple classes together probably increased the level of honesty and vulnerability among many participants. The respectful communication of different opinions hopefully served as a model for future professional behavior. The expression of commonly held concerns, such as the tension between personal feelings and professional obligations, seemed to serve as a source of mutual empowerment.

The authors hope to expand their exploration of the online teaching of ethics with a more formal qualitative study that examines commonly expressed themes and questions. A more systematic assessment of student response would be valuable. In any case, the particular groups of students in these classes approached the task with willingness to learn, professionalism, and maturity. They provide every reason to be hopeful about the future of the profession.

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Appendix

Ethical Scenarios Used in Graduate Class

Ethical Scenario 1

The Code of Ethics is clear about our obligation to ensure that clients understand treatment, its implications, limitations, and outcomes, and other options they have.

Assume that you are a hospital social worker who speaks little or no Spanish. Your client is 25-year-old Miguel Sanchez, who is being admitted to the hospital for surgical repair of a torn Achilles tendon. All surgical admissions are asked to sign an Advanced Directive prior to surgery. Mr. Sanchez has only moderate fluency in English. How can you help to ensure that he understands the provisions of this "Living Will" and the choices he must make before he signs the document?

What are the particular micro level concerns you have in relation to Mr. Sanchez? Are there any macro level concerns you wish to address?

Ethical Scenario 2

Sam is a former police officer in his early 60s who is on permanent disability and resides in a nursing home. He has end-stage lung cancer, which has metastasized to his bones, and a recent visual hallucination suggests that metastasis may have spread to the brain as well. He is confined to a wheelchair but is able to move about the facility and grounds at will. His wife has advanced Multiple Sclerosis and is unable to visit. He has no surviving children.

Yesterday at his Care Plan meeting, the Director of Nursing reported that he had offered one of the CNAs money to push him out to the street—a fairly major thoroughfare—so that he could wheel himself into traffic. The CNA refused and reported the event.

You are the facility's social worker and you have stayed well into the evening to catch up on paperwork. You step into the lobby to pass pleasantries with the receptionist and purchase a soda. Sam wheels himself off the elevator, speaks to you briefly, and heads toward the automatic front door and out toward the parking lot. Based on yesterday's report and his general demeanor,

you are reasonably certain that he plans to cross the parking lot and head toward the street. What is your response?

Ethical Scenario 3

Julie was already pregnant from a casual sexual encounter when she met Lisa 10 years ago. Although they live in a state that does not recognize the right of same-sex couples to marry, they formalized their relationship in a covenant ceremony a few weeks before Micah, whom they both regard as their son, was born. Although he has never formally relinquished custody, Micah's father has had no contact with Julie (or his son) since the night she told him she was pregnant.

Lisa's parents and sisters have been supportive of the couple and actively involved in Micah's life ever since he was born. Julie's father is the minister of a church that opposes homosexuality and has forbidden his wife to have any contact with his daughter or her "aberrant" lifestyle, thereby estranging her from her only child.

Julie and Lisa have come to see you as a result of the breast lump Julie discovered in the shower last week. Her gynecologist performed a needle biopsy yesterday, but the results will not be available until after the weekend. Both are concerned not only about Julie's health, but also about Micah's future since he is not legally related to Lisa.

Ethical Scenario 4

Ben is about to realize his dream of opening a private practice. One of his areas of specialization is men with eating disorders. What kinds of things does the Code of Ethics address that he will need to pay attention to? What does it say about record keeping? Billing and payment for services? Bartering for services? Confidentiality? Consulting with other professionals?

What are some of the other practical things Ben needs to consider, such as emergency on-call, "relief" if he goes on vacation, gets sick, or has a family emergency?

Also, we are assuming that this is happening because Ben recently became licensed at the clinical level. What did he have to do in order to do this, either in this state or the state in which you anticipate practicing?

Ethical Scenario 5

You are a social worker in a large hospital in the community where you grew up. It is a fairly large city, and your high school graduating class had 325 seniors. You decided to move back only last year, so you are reasonably new at your job.

Mr. Jones has been admitted to the hospital for the third time since you began working there, and he is one of your favorite clients. His diagnosis is non-Hodgkin's lymphoma, and his recent blood tests were not good. He is running out of options, and his oncologist is recommending a bone marrow transplant and suggests that all family members be tested to find the best possible match. His only sibling is a half-brother and turns out not to be a good match. His oldest daughter is actually a step daughter and is not related by blood. His younger daughter is six months pregnant and is therefore not a good candidate. He is adamant that his youngest daughter, who is active duty military and will probably be deployed to Afghanistan within the next three months, not be told of the seriousness of his condition and refuses to let you ask her to be tested as a match.

That weekend, however, his daughter manages to obtain a 48-hour pass to visit her father since "Mom sounds like something's up, but she won't tell me what it is."

When you see her, the two of you immediately recognize each other. While you weren't close friends in high school, you were both active in the Service Club and so were involved in many of the same activities. Since she went by a nickname in high school, you didn't make the connection before.

After you leave his room, Sgt. Jones catches up with you and says, "Please level with me. How is my father, really?"

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Introduction to Animal- and Nature-Assisted Therapies: A Service-Learning Model for Rural Social Work

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Abstract. This teaching note details the teaching philosophy and practices of an innovative university service-learning course in nature- and animal-assisted therapies. The course took place at a wildlife rehabilitation center, and students engaged as counselors, putting academic theories into action by facilitating an “animal camp” for 25 at-risk children. The course represented a “best practice” in rural social work given its intensive focus upon social work’s ecological and person-in-environment perspectives; multidisciplinary, collaborative community-based partnerships; and evocation of a rural schoolhouse model.

Keywords: rural social work, nature therapy, service-learning, animal-assisted therapy, nature-assisted therapy

For the past ten summers, a 22-acre homestead and wildlife rehabilitation center has provided the setting for an innovative university service-learning course entitled *Introduction to Animal- and Nature-Assisted Therapies*. The course takes place at the homestead of the second author, a former camp director, teacher and counselor, certified state wildlife rehabilitator, therapist, and university professor. Once a farm and hog lot, the acreage has been restored to natural prairie with a menagerie of rescued animals including a horse, several goats, dogs, cats, owls, and rabbits, along with itinerant rehabilitating foxes, fawns, birds, and raccoons. Many of these animals were discussed and cared for during the duration of the course.

Course Description

This four-week multidisciplinary course is unique in that students become engaged as scholars as well as counselors, putting academic theories into action by planning and implementing an “animal camp” for 25 at-risk children during the last two weeks of the course. Our course employed a type of experiential learning termed *service-learning*, which integrates academic and experiential elements through service that meets vital community needs. As Jeavons (1997) notes, service-learning entails a threefold engagement through “classroom preparation through explanation and analysis of theories and ideas; service activity that emerges from and informs classroom context; and structured reflection tying service experience back to specific learning goals” (p. 135). This teaching note explores the benefits of such a service-learning course for social work educators seeking innovative, collaborative approaches to rural social work teaching and practice.

Nature-assisted therapy (NAT) and *animal-assisted therapy* (AAT) may be incorporated under the broader term of *nature therapy* (Nebbe, 1995). As such, they refer to goal-directed interventions that intentionally integrate elements of the natural world to enhance human physical or psychosocial functioning. These interventions include practices and

techniques that are planned, monitored, and evaluated by licensed professionals within therapeutic contexts, in contrast to more informal nature- and animal-assisted *activities* conducted by volunteers or paraprofessionals (PetPartners, 2013; Nebbe, 1995).

We believe our course represents a “best practice” for rural social work given its: (a) intense focus upon social work’s ecological and person-in-environment perspectives (Germain, 1979; Germain & Bloom, 1991; Germain & Gitterman, 1987) through its exploration of nature- and animal-assisted interventions; (b) location at an acreage that doubled as a wildlife rehabilitation center; and (c) evocation of a rural schoolhouse model featuring non-hierarchical, cross-disciplinary patterns of teaching and learning which created new knowledge and resource exchanges (Coward, Healy, & Warnick, 2012). A new development this year involved enhanced collaboration with our university’s Biology Department, via a federal and state-funded grant from the Science, Technology, Engineering and Mathematics (STEM) program. STEM partners with educational institutions to implement K-12 programs that encourage the pursuit of careers in math and science (University of Northern Iowa, STEM, n.d.). Our role in the STEM initiative was to encourage a deepened appreciation and connection to the natural environment among campers and student-counselors.

Held in the farm’s pole barn, the class met three to four hours daily for four weeks. Our classroom instruction featured lectures and PowerPoint presentations, as well as discussions of assigned readings and short videos. We Skyped with the internationally-acclaimed director of Green Chimneys, a residential treatment center for children renowned for its implementation of animal-assisted therapy (Green Chimneys, 2013). Students also engaged in creative nature-based exercises, including scavenger hunts and arts and crafts, some of which they later re-created with their campers. Student homework included readings, multiple reflection papers, and activities related to planning and creating materials for the upcoming animal camp.

There are a myriad of useful ways to structure a similar course, depending on available resources, curricular expectations, and student or community expectations and needs. To help meet educational policy accreditation standards of the Council of Social Work Education (CSWE, 2008), Table 1 presents measurable practice behaviors stemming from our learning objectives. Indeed, these very behaviors may be integrated into a wide range of social work courses (CSWE, 2008; Hash, Chase, & Rishel, 2012).

Table 1

CSWE EPAS and Accompanying Practice Behaviors by Course

Educational Policy and Accreditation Standard (EPAS)	Accompanying Practice Behaviors/ Competencies	Relevant Social Work Courses
EPAS 2.1.3	Further develop critical thinking skills by conducting and analyzing qualitative interviews	research methods; field practica
EPAS 2.1.4, 2.17	Engage diversity and difference in practice	practice courses; HBSE; field practica
EPAS 2.1.9	Promote sustainable changes in service delivery and continuously discover, appraise, or attend to changing locales and populations	social administration courses that focus on leadership, program evaluation/grant writing
EPAS 2.1.10a, b, c, d	Develop and evaluate skills in individual, group, family and community engagement, assessment, intervention, and evaluation	

First Learning Objective: Grasping the Conceptual Framework

Table 2 presents our four broad course learning objectives. The first objective was met by introducing students to a conceptual framework for understanding nature therapy. We learned that although humans have throughout time found a deep sense of connection and enrichment with the natural world, it was only in the early 1970's that NAT/AAT as a field of therapy received widespread attention due in large part to the burgeoning ecological movement. The instructor detailed foundational field pioneers such as psychiatrist Boris Levinson's (1972) work in animal-assisted therapy. Students learned that nature therapy embraces the philosophy that "health and well-being among humans, animals, and the environment are inextricably linked" (Roulund, 2012), and that a deep emotional connection between humans and the natural world is needed to sustain and fulfill human life. This philosophy is underscored by Urie Bronfenbrenner's ecological framework for human development (Bronfenbrenner, 1979, 2005), and E.O. Wilson's biophilia hypothesis (Kellert & Wilson, 1993; Wilson, 1984). Further, it is found in broader movements in the natural and social sciences that include ecotherapy (Chalquist, 2009; Clinebell, 1996; Roszak, Gomes & Kanner, 1995). Wilson's hypothesis also finds a central place in ecosocial work (Besthorn, 2003; Molyneux, 2010), which expands social work's ecological and person-in-environment perspectives to suggest a further "interdependence and relatedness of all life, connectedness with nature and the importance of place" (Coates, Gray, & Hetherington, 2006, p. 8). Although not always explicitly acknowledged, instructors may wish to note that these movements are often deeply rooted in the world views of Buddhism, romanticism or transcendentalism (Buzzell & Chalquist, 2009).

Table 2

Course Learning Objectives

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- 1 To introduce students to a conceptual framework for understanding nature therapy, including its history and philosophy;
 - 2 To comprehend the benefits of nature therapy as well as the wide variety of its interventive approaches;
 - 3 To fathom some of the challenges involved in creating, implementing, and evaluating nature therapy programs in varied settings and with different client populations; and
 - 4 To allow opportunities for observation and subsequent practice of some NAT/AAT interventions within a service-learning format that integrates knowledge, skills, and community service.
-

Nature therapy, alongside ecotherapy and ecosocial work, attempts to counter the trend of increasing alienation from natural environments (Bronfenbrenner, 2005; Louv, 2008) often attributed to the effects of widespread urbanization and industrialization (Durkheim, 1893/1997; Berger, 1967). Of particular interest to social work is the ecotherapeutic movement's emphasis on a collective mandate to promote social justice by building sustainable, resilient communities. This suggests that "[r]elationships of healing with nature, place, creatures, and earth require us to acknowledge our participation in industrial, governmental, or organizational actions that harm the environment and to seek alternative actions whenever possible" (Buzzell & Chalquist, 2009, para. 2). Ecosocial work also upholds the enriching value of diversity--whether "cultural, ecological, epistemological, [or] spiritual" (Buzzell & Chalquist, 2009, para. 7)--and resists trends that marginalize any community members. As Hunter (2006) notes, "Doors closed by language, discrimination, or disability can be opened by teaching youth and families that they are naturally an important part of the interconnection of all beings" (para. 2).

Our course drew upon the strengths and capacities of a vibrant community base, as we interacted with neighbors, parents and siblings of campers, educators, and professionals in a wide variety of fields. Biology and veterinary science interns also conducted their academic practica on site: wildlife conservation officers brought fawns orphaned by recent woodland flooding; and a European psychiatrist visited to compare notes about conducting animal-assisted therapeutic approaches. The sharing of knowledge that emerged naturally from our multidisciplinary roles and duties led to enhanced community-building and patterns of natural helping (Patterson, Memmott, Brennan, & Germain, 1992). This underscores Rhodes's (2012) observation that rural social work is highly "familiar with the needs and advantages of working in interdisciplinary partnerships" (p. 104).

Second Course Objective: Benefits of Nature Therapy

Students met our second course objective, comprehending nature therapy's benefits, by reflecting upon core human needs for belonging, independence, and generosity (Brendtro,

Brokenleg, & Van Bockern, 1990). A variety of natural environment experiences offered potential satisfaction of those needs through opportunities for connection, achievement, or self-discipline and altruistic behavior development (Brendtro, et al., 1990). Feeding domestic animals, for instance, encouraged nurture of another creature, alongside increasing positive attachment and a sense of mastery and generosity. Developing such competencies helps build client trust, respect for self and others, and self-esteem (Beck & Katcher, 1996; Fine, 2010). Recent studies augment these observations, offering statistically significant evidence of physical and psychological benefits of nature- and animal-assisted interventions, such as reduction of anxiety and greater immunity (HABRI Central, 2013). These results have captured the attention of the National Institutes of Health's Institute for Child Health and Human Development, which has published its findings of health benefits of AAT as a complementary intervention (McCardle, McCune, Griffin, Esposito, & Freund, 2011; McCardle, McCune, Griffin, & Maholmes, 2011). Promising new research in social and developmental neuroscience also considers human-animal interaction as it impacts emotional development, cognition, motivation, and social affiliation (Social Neuroscience of Human-Animal Interactions, 2011).

Third Learning Objective: Approaches, Applications, and Guidelines for Practice

The instructor addressed our third learning objective: to understand specific approaches and applications of nature therapy and general guidelines for practice. We focused on selection and care of various animals, as well as creating and implementing programs designed for populations as varied as autistic children, veterans, and elders. We also discussed settings in which NAT/AAT is employed, such as schools, hospitals, nursing homes, prisons, and residential treatment and rehabilitation facilities. The course then covered challenges posed in developing, managing, and supervising nature therapy programs, including issues of visitation, safety, and cost (Altschiller, 2011; Fine, 2010; Granger & Kogan, 2006; HABRI, 2013; Nebbe, 1995; PetPartners, n.d.). One breakout activity involved brainstorming about risk management where students listed potential problems that the upcoming animal camp might present. We broadly categorized these problems, formed focus groups to examine possible solutions, and then asked each group to report back with their suggestions.

It is vitally important to provide students with resources detailing interventions for various populations, as well as information about professional organizations and avenues for further inquiry. Via a course listserv, we sent out web links to local, national and international organizations. It is also helpful to place this information in the syllabus and course website. Included were the following links: (a) American Humane Association (2013); (b) Animals and Society Institute (2011); (c) HABRI Central's Study of the Human-Animal Bond (2013); (d) the International Association of Human-Animal Interaction Organizations (2013); (e) the International Society for Anthrozoology (2013); (f) the Latham Foundation (2013); and (g) PetPartners (2013).

University-based instruction in nature therapy tends to be interdisciplinary, and varies in length and breadth of instruction, rigor, opportunities for observation and practice, and research requirements. We found students eager for information about programs, courses, and certificate programs, and subsequently provided web links to this information. NAT programs tend to be found in environmental education and recreation therapy courses, while social work and counseling departments tend to focus on interventions involving animals. Some programs have

an online component, of great benefit to remote rural areas. Several exemplary university-based programs include the University of Denver's graduate level social work certificate programs (University of Denver Graduate School of Social Work, n.d.) and Arizona State University's animal-assisted social work certificates, including one focused upon animal abuse (Arizona State University, n.d.). Other significant programs are found at Michigan State University's School of Social Work, Veterinary Social Work Services (n.d.), the University of Missouri College of Veterinary Medicine and Nursing's Research Center for Human-Animal Interaction (n.d.), the University of Tennessee, College of Social Work's Veterinary Social Work Certificate Program (n.d.), and Virginia Commonwealth University School of Medicine, Center for Human-Animal Interaction (n.d.). Many of these programs focus on how to protect the welfare of both animals and human clients, therefore upholding the dignity and worth of all species.

Fourth Learning Objective: Service-Learning and "Animal Camp"

Conducting the animal camp itself met the final learning objective of our course: to allow opportunities for observation and subsequent practice of nature therapy within a service-learning format. Students creatively integrated academic theory and hands-on experience by becoming counselors. Camp goals were to offer youth deemed "at-risk" by school guidance counselors, an extended opportunity for one-on-one bonding experiences with a caring adult through nature activities and therapeutic interactions. Unlike other camps where the social community is primary, animal camp focuses on one-to-one personal relationships. The counselor and camper spend two weeks connecting to each other and to the environment, allowing each camper the autonomy to choose from a range of personally appealing activities.

The culture undergirding our animal camp was humanistic and person-centered, reflecting Carl Rogers's psychology: congruence (genuineness), unconditional positive regard (acceptance), and empathic understanding (an ability to deeply grasp another's subjective world) (Corey, 2009; Rogers, 1961). In such an environment, humans are most likely to reach their potential, "given their inherent capacity to move away from maladjustment and toward psychological health and growth" (Corey, 2009, p. 178). Camp rules were simply two: move and speak gently and quietly; and treat all other life in the way you want to be treated. The one-to-one ratio between camper and student-counselor allowed easy enforcement of these rules and redirected potentially problematic behaviors, many of which disappeared quickly as the camper acclimatized to the nurturing milieu. A pre-camp visit by the counselor to the camper's home also introduced the child and family to the camp's culture and expectations. At this meeting, the counselor asked the child to read and sign a contract detailing behavioral expectations at camp. If these were not met, the camper would be taken home, but could return the next day. In its many years of operation, the staff has never needed to enforce this option.

Service-learning requires thorough preparation and planning, clearly articulated expectations, and commitments by all parties through orientation, monitoring and evaluation (Honnet & Poulson, 1989). The fact that our course met at a 22-acre wildlife rehabilitation center facilitated many activities, including observations of a release of a rehabilitated bird and the feeding of orphan fawns. During periodic group activities in which camper and counselor remained together, we engaged in songs, arts and crafts, scavenger hunts, canoeing, and insect collecting and release (Nebbe, 1995). We also discussed the effect of pesticides upon trophic

levels, and constructed solar ovens out of cardboard and aluminum foil to demonstrate safer and more energy-efficient ways to cook food.

To integrate text- and classroom-based content, successful service-learning programs also require structured, ongoing student reflection upon their experience (Bringle & Hatcher, 1995; Jeavons, 1995; Kolb, 1984). We found that the best vehicles to encourage such reflection were daily journaling and progress reports. Qualitative pre- and post-interviews with campers and their families also provided opportunities for analysis and reflection, and served as evaluatory instruments. Interview questions focused upon student-counselor and camper learning experiences, changes in feelings, motivations, and attitudes, as well as observed modifications in camper behaviors. At the programmatic level of evaluation, we focused on performance- or outcomes-based analysis, and asked two types of questions of students, school counselors, and campers and their families: how well the program was carried out, and what was its impact (Gilbert & Terrell, 2005). The first question was formative and attempted to monitor the implementation process, while the second question was summative and focused on program outcomes. Overall, our evaluation approach was summative, given that the majority of our questions were asked after the course concluded. We asked students to consider why they believed our various interventions were effective, and asked for recommendations to improve the course content and activities. In a less compressed course offered over an entire semester, it would be helpful to also include mid-semester formative evaluations.

Finally, we wish to point out a promising but little studied phenomenon in evaluating service-learning courses: assessing affective outcomes. By identifying those learning or educational activities that incorporate feelings, values, motivations, and attitudes, Krathwohl's taxonomy of the affective domain (Krathwohl, 2002; Krathwohl, Bloom, & Masia, 1973) proved helpful in assessing how well students have met course objectives. Although this domain is often overlooked in the traditional academic classroom (Owen-Smith, 2004), we believe that encouraging and then assessing the deep connections between cognitive and affective dimensions is essential for integrating academic with experiential elements of service-learning. We believe our course in animal- and nature-assisted therapies was ultimately successful because of its ability to bridge this cognitive-affective divide. By so doing, it helped promote and sustain an enduring sense of healing and connection vital for rural social work teaching and practice.

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The Inclusion of Poetry in *Contemporary Rural Social Work*

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Editorial Comments

Poetry has a way of crossing geographic and cultural distances to create communities between people from various backgrounds and locations. For many years I have invited poets to visit my poetry writing classes at Southern Utah University, and frequently the students respond to the poets as if the poems speak to them personally. I have also had a long-term interest in how poetry can benefit the field of human services and am currently involved with an interdisciplinary research team assessing the effectiveness of a co-facilitated poetry therapy curriculum. Therefore, I was honored to be invited as the inaugural poetry editor of *Contemporary Rural Social Work*. The poems included in this issue provide unique perspectives to both the journal and to the community of poets living in rural areas. I have selected the poems based on how these poets use concrete and detailed language to convey rural experiences through the lens of human services.

“Makayla” by Shawn Fawson is inspired by photojournalist Katie Falkenburg’s photograph *The Human Toll: Mountaintop Removal Mining*. Through stark imagery, Fawson describes a child surviving despite the way her hometown has been affected by mining. David Salner’s “Horse Trailer” portrays the anonymity of service through a brief encounter between a farmer and someone who volunteers at the food pantry. Both of these poems tell a story in a snapshot made of words. And each poem ends, interestingly enough, with a similar gesture. I was not looking for such a pattern when I selected these poems, but their endings attest to the ways in which we define ourselves through simple reassurances during challenging times.

Another aspect of including poetry in *CRSW* is a highlighting of poets whose work pertains to the region in which the annual Rural Social Work Conference takes place. Since the 2014 conference host is Western New Mexico University in Silver City, the poets listed below have connections to the southwest or to New Mexico in particular. I have appreciated this opportunity to introduce poetry to *Contemporary Rural Social Work* and look forward to continuing to discover poets whose work gives insight into both rural experience and human services. The next reading period for poetry submissions will be August 1-November 30, 2014.

Poets of New Mexico and the Southwest

Bonnie Buckley Maldonado became the first Poet Laureate of Silver City/Grant County New Mexico in 2012. She is also a professor and dean emeritus in education and counseling from Western New Mexico University. Her book *It's Only Raven Laughing: Fifty Years in the Southwest—A Book of Narrative Poems* was awarded the WILLA Literary Award for Poetry Finalist by Women Writing the West. In the following excerpt from her poem “Where Wild Geese Fly,” Maldonado overlays images of quilting with that of the southwest landscape:

I stitch a near-dawn sky,
 scattering pinpoint stars
 even as they burst free
 to race with Canadian geese

A moon pearled in silk
 blesses ancient pueblo
 and santuario.
 High-rise and mountain lion
 sleep along the eastern rise
 of a continent.
 (p. 67)

Bonnie Buckley Maldonado’s website: <http://bonniebuckleymaldonado.com>.

Levi Romero was selected to be the centennial poet for New Mexico in 2012. He is also the co-author of *Sagrado: A Photopoetics Across the Chicano Homeland*. This book is a collaborative work of poetry, prose and photography that captures sacred places in the midst of economic or environmental adversity. In the following excerpt from his poem “I Breathe the Cottonwood,” Romero uses the images of the southwest landscape to create solidarity between himself and those who are incarcerated:

I take the sagebrush scent in
 The folding hills
 The heat of the asphalt
 Twenty-seven minutes past noon

Past the historic marker
 And the twisted metal road sign
 The yellow apple dotted orchards
 The alfalfa

I take it all in

For you my brothers

And sisters
 Lying on rubber mattresses
 In your jail pods
 Finger-nailing the names
 Of your loved ones
 On styrofoam cups
 (p. 105)

Levi Romero's website: <http://www.poetryfoundation.org/bio/levi-romero>.

Laura Tohe is from the eastern border of the Dine' Homeland, near the Chuksa Mountains. She teaches at Arizona State University. Her book *No Parole Today* describes in both poetry and prose her experience of leaving the Navajo Reservation to attend a boarding school in the 1950's. In her poem "The Names" Tohe describes how her identity and those of her classmates is erased as their names are Anglicized by a teacher not interested in their native pronunciation:

"Leonard T-sosie"
 (His name is Tsosie.) Silent first letter as in ptomaine,
 Ptolemy.
 Silent as in never asking questions.
 Another hand from the back goes up. No voice.

Suddenly we are immigrants,
 waiting for the names that obliterate the past.
 Tohe, from T'o □□ hii means Towards water.
 Tsosie. Ts'o □.si□ means slender

The teacher closes the book and
 we are little checkmarks beside our names.
 (p. 4)

Laura Tohe's Website: <http://www.luratohe.com>.

Works Cited

Herrera, S., Kaiser, R., Romero, L., & Valdez, L. (2013). *Sagrado: A Photopoetics Across the Chicano Homeland*. Albuquerque: University of New Mexico Press.

Maldonado, B. (2010). *It's Only Raven Laughing: Fifty Years in the Southwest—A Book of Narrative Poems*. Tuscon: Wheatmark.

Tohe, L. (1999) *No Parole Today*. Albuquerque: West End Press.

Horse Trailer

By David Salner

One night, I heard a farmer unhooking a horse trailer
on the street in front of my house. I hurried out
as he was fumbling in the darkness, loosening

the coupler, dropping it on the road, leaving me
with three tons of pintos. He couldn't wait for the thanks
I would have given on behalf of the food pantry—

he had to drive home, to fields full of corn and pintos,
soybeans, a herd of beef cattle, to a life that would leave him
with nothing but the dirt under his nails and who he is.

Makayla

By Shawn Fawson

*After the photo by Katie Falkenberg, "The Human Toll:
Mountaintop Removal Mining," West Virginia, 2012*

A five-year-old girl has been drawn a bath
and asked to sit, fixed and wary,
having just stepped in a tub
filled with red-brown water and coal sludge.

Flat suds: a mountain-top blown to pieces
and going up in blasts outside.
Grey smoke scribbles its dust
over roofs, swings, cans, dolls,
and whatever else a house still holds.

Someone's washed her hair,
but she's hardly a little girl,
looking down as if the truth
might reveal itself in stages:
this is still her home, her house
found only by tearing up the map,
her town without paved streets,
well with no clean water trickling
through stone. Here, the seepage
of metallic runoff fills a tub
where a child bathes,
hunched down and scared;
her small hands, clasped together,
claim the one thing she knows.