SPECIALIZATIONS AND CLINICAL JUDGMENTS OF SOCIAL WORKERS IN CASES OF CHILDREN OF ALCOHOL ABUSERS

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ABSTRACT

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ALAN J. LEVY

A nationally drawn sample of 228 clinical social workers made clinical judgments on three case vignettes that represented typical cases involving children of alcohol abusers. Each vignette contained parental alcohol abuse, adult mental health problems, child behavior problems, and problems in family functioning. Respondents were classified as specialists in children and youth, families, mental health, or alcohol/drug abuse, generalists (three or more specialization areas), or non-specialists (no specialization areas) on specialization scales. Scales measuring case problem perceptions, referral patterns, and treatments were developed from factor scores of responses to vignettes. Construct and content validity were established.

The primary hypothesis was that specialists would assess and develop treatment plans that were congruent with their specializations. Differences among groups in case problem perception, referral pattern, and treatment scales were analyzed via analyses of variance. Hierarchical
regressions were employed to determine whether particular specialization groups developed congruent case perceptions and treatment plans.

Some systematic differences in clinical judgments among specialists were found, primarily in predicted directions. Generalists were the most likely to make comprehensive clinical judgments. Regressions partially supported the main hypothesis. Specialization accounted for modest portions of the variance. Case perceptions accounted for little of the variance in referrals but for none of the variance in treatment.

It was concluded that specialization interacts with other contextual factors to influence clinical judgments. Implications included the necessity for broad assessments that are connected to treatment plans and broader training for clinicians to better address the complex nature of these cases.
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It was concluded that specialization interacts with other contextual factors to influence clinical judgments. Implications included the necessity for broad assessments that are connected to treatment plans and broader training for clinicians to better address the complex nature of these cases.
# TABLE OF CONTENTS

| LIST OF TABLES | iii |
| ACKNOWLEDGMENTS | v |
| DEDICATION | ix |

## Chapter

1. RESEARCH PROBLEM STATEMENT ........... 1

2. RELATED LITERATURE AND THEORETICAL CONSIDERATIONS ........... 4

   - Prevalence of Alcohol Abuse in Relation to Children and Families .... 4
   - Recognition of the Effects of Parental Alcohol Abuse upon Children .... 7
   - Alcohol Abuse and Families .... 8
   - Children in Alcohol Abusing Families .... 14
   - Parental Alcohol Abuse and Children .... 30
   - Clinical Judgment and Children of Alcohol Abusers .... 44

3. METHOD ........... 62

   - Overview .... 62
   - Definition of Concepts .... 64
     - Specialization
     - Specialist
     - Generalist
     - Non-Specialist
     - Clinical Judgment
   - Alcohol Abuse
   - Children of Alcohol Abusers
   - Child Behavior Problems
   - Family Problems
   - Sampling .... 67
   - Instrument Development .... 68
   - Data Analysis Procedures .... 74

   - Development of Specialization Scales
   - Development of Case Perception Scales
Chapter

Development of Treatment and Referral Scales

Major Statistical Analyses ............... 87

4. RESULTS .................................................. 90

Response Rate ........................................... 90
Demographic Data ................................. 90
Representativeness of the Sample ........... 92
Analysis of Specialization ..................... 97
  Analysis of Children and Youth Specialists
  Analysis of Family Specialists
  Analysis of Mental Health Specialists
  Analysis of Alcohol/Drug Abuse Specialists
  Analysis of Generalists
  Analysis of Non-Specialists
Analysis of Case Perceptions ............... 102
Analysis of Referrals ......................... 110
Analysis of Treatment ......................... 118

5. DISCUSSION OF THE FINDINGS ............. 132

Introduction ........................................... 132
Limitations of the Study ........................ 133
Strengths of the Study ............................ 136
Factors That Underlie Specialization ....... 137
Factors That Relate to Case Perception ....... 148
Factors That Account for Case Referrals .... 152
Factors That Relate to Treatment Differences ........................................ 157
Summary ............................................... 162

6. IMPLICATIONS ............................................ 165

Implications for the Profession .......... 165
Implications for Practice ................... 167
Implications for the Staffing of Programs .. 168
Implications for Social Work Education .... 170
Implications for Future Research .......... 172
Summary ............................................... 174

LIST OF REFERENCES ..................................... 175

BIBLIOGRAPHY ............................................ 187

APPENDIX ............................................... 196
LIST OF TABLES

Table | Page
-----|-----
1. Ratings of Vignettes by Panel of Experts | 71
2. Comparison of NASW Listed Specializations with Self-Reported Specializations | 75
3. Factor Loadings, Communality, and Factor Scores of Specialization Scale Items | 78
4. Frequency Distribution of Respondents Across Specialization Groups | 80
5. Factor Loadings, Communality, and Factor Scores of Perception Scale Items | 82
6. Factor Loadings, Communality, and Factor Scores of Referral Scale Items | 85
7. Factor Loadings, Communality, and Factor Scores of Treatment Scale Items | 86
8. Frequency Distribution of the Number of Children of Respondents | 93
9. Mean Year in Which MSW Was Granted and Standard Deviation of Respondents and Non-Respondents | 95
10. Crosstabulation Table Comparing Respondents and Non-Respondents by NASW Specialization Group | 96
11. Regression Analysis of the Relationship of Independent Variables to Mental Health Problem Perception | 106
12. Regression Analysis of the Relationship of Independent Variables to Alcohol/Drug Abuse Problem Perception | 108
13. Regression Analysis of the Relationship of Independent Variables to High Priority Family Referrals | 113
<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Regression Analysis of the Relationship of Independent Variables to High Priority Child Oriented Treatments</td>
<td>121</td>
</tr>
<tr>
<td>16. Regression Analysis of the Relationship of Independent Variables to High Priority Family Oriented Treatments</td>
<td>123</td>
</tr>
<tr>
<td>17. Regression Analysis of the Relationship of Independent Variables to High Priority Mental Health Oriented Treatments</td>
<td>126</td>
</tr>
<tr>
<td>18. Regression Analysis of the Relationship of Independent Variables to High Priority Alcohol/Drug Abuse Oriented Treatments</td>
<td>129</td>
</tr>
</tbody>
</table>
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Dedication

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CHAPTER 1
RESEARCH PROBLEM STATEMENT

The needs of children of alcohol abusing parents have, until recently, received very little attention from social scientists and human service professionals. The review of relevant literature will demonstrate:

1. The high prevalence of alcohol problems in the United States.

2. The large number of people who have been reared in families that contain at least one alcohol abusing parent.

3. The risks incurred by children of alcohol abusers.

4. Factors which may account for the limited response to the needs of this population.

5. Factors which may influence and truncate the judgments of social workers who encounter this population.

This study will examine the clinical judgment of social workers in relation to cases that involve children, families, and alcohol abuse. The literature review will reveal that these cases typically involve the following: (1) alcohol abuse, (2) child behavior problems, (3) family problems, and (4) mental health problems.
It will address the following questions:

1. Do the judgments of clinical social workers with different practice specializations systematically differ from one another with regard to children of alcohol abusers?

2. How do the typical treatment plans of clinicians in these specialization groups vary in regard to their focus upon alcohol abuse, child behavior problems, family problems and mental health problems?

3. How do these groups differ in their estimation of the import of these and related problems, as well as in their estimation of their abilities to identify and address these problems?

4. What variables in the backgrounds of these social workers are related to these differences?

Should the results indicate that systematic variation between these groups of social workers indeed exist, and that important case aspects are omitted from consideration or given little weight by large groups of clinicians, the lack of a consistent approach to a large, at-risk population will be demonstrated.

This study should have several clear implications for social work. First, this study should help social work educators and trainers in developing curricula that would provide the knowledge and skills that would enable clinicians to address the needs of this population in a
more consistent, comprehensive manner. Second, identification of how clinicians differ in their service provision will permit policy makers, program planners, and agency administrators to differentially direct scarce resources to better serve this population. Third, by establishing the existence of the differential perceptions of these clinicians, the importance of a comprehensive, systematic assessment will be underscored. In regard to this particular population, the need for an assessment that is based upon an eco-systems perspective will be demonstrated.
CHAPTER 2
RELATED LITERATURE AND THEORETICAL CONSIDERATIONS

Prevalence of Alcohol Abuse in Relation to Children and Families

One criterion for determining the significance of this research topic is to consider the prevalence of the problem in the United States. Although estimates will vary according to the definitional criteria used, research methods employed and the statistical assumptions made, there are clear indications that a large proportion of the population have had some experience with alcohol abusers and/or alcohol abusing family members.

The 1979 National Drinking Practices Survey estimated that 10 percent of the sample reported that they had a drinking problem (Clark and Midanik 1982). This study was based upon a probability sample of persons eighteen years of age or older who were living in homes in the contiguous United States. Problem drinking was defined as a score of 1 or more on a loss of control (of drinking) scale or 2 or more on an alcohol dependence scale. Of note, only 1 percent of the population is estimated to have directly requested some form of
assistance for their drinking problems. It has been estimated that approximately 10 million American adults and 3.3 million youths have drinking problems (U.S. Department of Health 1980b).

The U.S. Department of Health and Human Services report that in 1982, one third of the respondents to a survey indicated that alcohol use had caused problems in their families (U.S. Department of Health 1983). A 1980 survey by the Gallup organization indicated that 25 percent of the respondents reported that an alcohol related problem had adversely afflicted their family and that 60 percent reported that alcohol abuse is one of the most harmful influences on family life (U.S. Department of Health 1980a). The National Institute on Alcohol Abuse and Alcoholism (NIAAA) reported that there is an estimated 36 million family members of alcohol abusers (Kellerman 1974).

In 1974 it was estimated that there were 28.3 million children of alcohol abusers in the United States (Booz-Allen and Hamilton 1974). This includes all of the progeny of alcohol abusers, regardless of age. The figure was derived by multiplying an estimate of the number of alcohol abusers (14,099,459) by the overall proportion of adults to children in the general population. This statistic is apparently based upon the assumption that alcohol abusers are randomly distributed throughout the
adult population and that the ratio of alcohol abusing parents to their children is equal to the ratio of all parents to children. In reality, this may not be the case and this estimate may therefore be inaccurate.

The 1979 National Drinking Practices Survey indicated that 11 percent of male and 16 percent of female respondents reported that at least one of their parents were alcohol abusers (Russell, Henderson, and Blume 1985). There is a potential source of error since this information is based upon the reports of participants without direct measurement of parental alcohol use (Midanik 1983). Russell, Henderson, and Blume (1985) applied this estimate to 1980 census data and estimated that there are 22 million children of alcohol abusers aged eighteen years old or older and 6.6 million children of alcohol abusers under the age of eighteen years. Therefore, they conclude that there are 28.6 million children of alcohol abusers in the United States, or one out of eight Americans. While the validity of these statistics is questionable, one may conclude that a substantial segment of the population abuses alcohol. An even greater number of people have been intimately involved with individuals who have abused alcohol. Given these conclusions, attention will now be directed to the familial consequences of alcohol abuse.
Recognition of the Effects of Parental Alcohol Abuse upon Children

Although the neglect of alcoholism and alcohol abuse by the government and service providers is generally well known, recognition of the familial effects of alcohol abusers, especially upon children, has only recently become clear. The 1974 Booz-Allen and Hamilton (1974) report stated that: "There is not a large body of literature on the population of children of alcoholics, as a problem it has not yet been studied in depth. Much of what does exist involves a subjective qualitative analysis of the psycho-social aspects of parental alcoholism derived from the authors' treatment experience (p. 11). Of these empirically based studies performed prior to the mid-1970s, most contained serious methodological flaws including:

1. Lack of control or comparison groups.
2. Inadequate matching of children of alcohol abusers and comparison group children.
3. Over reliance upon self-reports (Jacob et al. 1978).

For example, in an early clinical paper entitled "The Effect of Alcoholism on Children," the author (Fox 1963) primarily discusses alcohol abuse, but barely mentions the responses of children and families to this condition. The author lists family treatment as a mere
adjunct to the treatment of alcohol abusers in individual sessions. She does not mention the treatment of children at all.

In confirmation of this lack of attention, Nardi (1981) states that "Despite the recognition of alcoholism as a 'family disease,' most research in the area focuses . . . on the alcoholic. Studies that do go beyond the alcoholic concentrate on the spouse; relatively few study the children of alcoholics" (p. 237).

Given the relative dearth of literature about children of alcohol abusers, a review of the effects of alcohol abuse on children is indicated. The next section will address the effects of alcohol abuse upon families. Special attention will be given to those effects which especially affect children. Following this, literature that directly addresses the effects of parental alcohol abuse upon children will be reviewed.

Alcohol Abuse and Families

Many authors have commented upon the deleterious effects that alcohol abuse has on family systems and its members. Indeed, Vaillant (1983) went so far as to state that "outside of residence in a concentration camp, there are very few sustained human experiences that make one the recipient of as much sadism as does being close family member of an alcoholic" (p. 20). Wegscheider (1981) notes
the destructive reciprocal effects of the interaction between alcohol abusers and their families. She states that as the pattern of alcohol abuse progresses, and as its consequences become more severe, family members become "caught up" in a destructive cycle. She reports that family members may also be abusing alcohol, present with severe psychopathology, and may unconsciously perpetuate the alcohol abuse.

Straussner, Weinstein, and Hernandez (1979) state that family members experience symptoms which parallel those of the alcohol abusing family members. This includes denial, rationalization of alcohol-related behaviors, projection, isolation from social supports, deterioration of physical health, and personality changes. They state that meaningful family communication disappears because of the difficulty inherent in speaking with a family member whose thought process is distorted by alcohol and because the family system maintains its homeostasis by denial of the alcohol abuse.

Deutsch (1982) asserts that there is a "striking similarity" among families that have nothing else in common but their alcohol abuse. He states that these families are more or less dominated by the following five conditions: "1. The centricity of the alcoholic and of alcohol-related behavior. 2. Denial and shame."
3. Inconsistency, insecurity, and fear. 4. Anger and hatred. 5. Guilt and blame" (p. 31).

As the pattern of alcohol abuse escalates, and as alcohol consumption becomes a higher and higher priority for the alcohol abusing family member, family roles and patterns of behavior are reported to become rigid. Wegscheider (1981) identifies five roles for family members of alcohol abusers. They are:

1. Enabler--Usually the spouse of the alcohol abuser. Although deeply concerned about the consequences of alcohol abuse, this family member attempts to maintain a veneer of normality in family life. In essence, the enabler attempts to maintain family homeostasis by denying or rationalizing the behavior of the alcohol abuser. This then makes it easier for the alcohol abuser to continue to drink.

2. Hero--Usually an older child. She/he tends to be driven to succeed in an effort to compensate for the maladaptive behavior of the alcohol abuser. This may be to provide a source of pride for the family and/or to fill a legitimate need for the family (e.g., winning scholarships, contributing to the family's income, etc.).

3. Scapegoat--Usually a younger sibling. This child develops behavioral problems and is labeled as "bad" by the family. This behavior reportedly maintains family homeostasis by diverting attention from the alcohol
abusing parent and by uniting the parental subsystem against this child.

4. Lost Child--This child is reported to react to the alcohol abuse by withdrawing from interaction. As a result, this child does not place demands upon the family system for role appropriate behavior. As a result, the alcohol abusing parent may be left to continue the pattern of abuse.

5. Mascot--Usually the youngest child. This child tends to divert attention from the alcohol abuse and its consequences by clowning or cajoling behavior. Family homeostasis is thus maintained.

Claudia Black (1981) has also identified family roles for children of alcohol abusers. They are:

1. The Responsible One--Assumes much of the burden for the care and maintenance of the family.
2. The Adjuster--Withdraws from the family.
3. The Placater--Makes others feel better by diverting attention away from the alcohol abusing parent.
4. The Acting Out Child--Diverts attention from the alcohol abuser by antisocial behavior.

As one can see, there is a rough equivalence between Wegscheider's and Black's role classifications for children of alcohol abusers. They may be paired as follows:
What are the adaptations that family members make to alcohol abusers over time? Very little empirical information is available on this subject. One of the earliest studies in the area of familial alcohol abuse attempted to address this question. Over a period of three years, Jackson (1954) analyzed statements made by over fifty wives of active and recovering alcoholics who were meeting in Alanon groups. She also obtained information from other wives of alcohol abusers and from human service providers. From these data, she developed seven "stages":

Stage 1--Incidents of excessive drinking begin, placing strain on marital interaction. Wives attempt to minimize their husband's drinking in order to improve marital relations.

Stage 2--Social isolation begins as incidents of excessive drinking increases. Behavior and thought become centered upon alcohol use. Marital tensions increase and wives' self-esteem decrease as attempts to control husband's drinking fail. Attempts continue to maintain original family structure and functioning despite
alcohol-related disruptions. Children begin to show emotional disturbance.

Stage 3--Families give up attempts to control drinking. Tension-reducing behavior increases, but families no longer attempt to support the alcohol abusers in their roles as fathers and as husbands. Child behavioral disturbances become more marked. Wives begin to worry about their own sanity and their ability to control or change the situation.

Stage 4--Wives take over control of families as executives. Pity and protective feelings for husbands replace hostility. Husbands are viewed as recalcitrant children. Families become stable and organized to minimize disruptive behavior of the fathers. Wives regain self-confidence.

Stage 5--Wives separate from husbands if they can resolve the conflict regarding this action.

Stage 6--Wives and children reorganize as families without the husbands.

Stage 7--Husbands may achieve sobriety and families may reorganize to accommodate them.

It should be noted that while this study is unique in that it addressed familial adaptation over time, its methodological rigor is questionable.

Procedures for content analysis were not specified. Therefore, results may not be reliable or valid.
Also, this study utilized an accidental sample, i.e., wives who attended Alanon group meetings. As a result, the external validity of this study is in question.

Given this brief presentation about the general patterns of family functioning when a family contains an alcohol abusing member, a more in-depth review of the literature regarding specific areas affecting children in families with alcohol abusing members is in order.

Children in Alcohol Abusing Families

The U.S. Department of Health (1980b) reports that less than 5 percent of all alcoholics are of the "skid row" variety (p. 16). Therefore, one may conclude that the majority of alcohol abusers are employed or reside in families with at least one wage earner. Given the deleterious effects of alcohol abuse on job performance (p. 93), however, one may question the socioeconomic status of the families of alcohol abusers. Kammeier (1971) studied the school records of 371 adolescent students in a midwestern Roman Catholic high school. She found that children of alcohol abusers were significantly more likely to have fathers of lower socioeconomic status than did other children in her sample. She also found that these children were also more likely to have more siblings than were children of non-alcohol abusing parents. The validity of this study is limited however,
since those students who were enrolled in a private parochial school may not be representative of the general adolescent population. In addition, this study did not fully specify the procedures for determining whether a particular adolescent's parent abused alcohol. Some confirmation of Kammeier's (1971) findings reporting increased size of alcoholic families was provided by Corrigan (1980), who found that alcoholic mothers tended to have more children than the national norm.

Frances, Timm, and Bucky (1980) also provided partial support for Kammeier's (1971) study, as they found that those alcoholics who themselves have a family history of alcoholism were more likely to have larger families than alcoholics without a history of familial alcoholism. In a survey of the perceptions of 288 spouses involved in divorce proceedings, Cleek and Pearson (1985), upon performing a factor analysis, found that the alcohol abuse of a spouse (usually the husband) positively loaded with financial problems and physical abuse as causes of divorce. Studying self-reports by adolescent problem drinkers, McKay (1961) noted that all were children of alcohol abusers and that financial difficulties were prevalent in their families.

These studies provide some evidence that children of alcohol abusers are more likely to be reared in lower socioeconomic status families. In addition to the more
limited finances of these families, the actual amount of resources available to these families may be even lower since family size appears to be larger. Nylander and Rydelius (1982) performed a retrospective study of children of alcohol abusers from high and low socioeco-
nomic status, comparing their social functioning. Because this study was performed in Sweden, these researchers were able to obtain their data from such sources as child welfare agency records, rather than relying upon self-reports. The results indicated that high socioeco-
nomic status (SES) children of alcohol abusers were as likely to develop difficulties as low SES children. This study therefore provides evidence that parental alcohol abuse may impair social functioning independently of SES.

A number of studies have noted that children of alcohol abusers (COAs) live in families in which parents frequently argue. McKay (1961) found that violent arguments between parents were common in his sample of adolescents who themselves abused alcohol. Margaret Cork (1969), one of the first researchers to study COAs, noted that "almost all" of the 115 children and adolescents interviewed were concerned about parental fighting. She states that this concern outweighed their concerns about parental alcohol consumption per se (p. 65). In their study of COAs and control group children, Chafetz, Blane, and Hill (1971) found that COAs reported poor
relationships between parents in two parent families. Both COAs and control group children were drawn from a population of child guidance clinic clients.

The Booz-Allen and Hamilton (1974) study reported that over half (60 percent) of the COAs in their self-selected sample reported experiencing their parents fighting or the non-alcoholic spouse "being victimized" (p. 20). This pattern of parental conflict was also found by Wilson and Orford (1978), who based their conclusion on a small sample of COAs and an extensive review of the literature.

Perhaps the most compelling evidence for marital conflict in alcohol abusing families was provided by Billings and Weiner (1979). They directly observed communication between couples with an alcohol abusing member, maritally distressed non-alcohol abusing couples, and non-alcohol abusing nondistressed couples. The communication of alcohol abusing couples and distressed couples were indistinguishable from one another. Both groups' communications were found to be more hostile, more negative and less rationally problem-solving when confronted with dilemmas than nondistressed non-alcoholic couples. No differences were found in alcoholic couples' communications between those periods when alcoholic spouses were drinking or when they were not drinking.
It therefore seems safe to conclude that COAs are more apt to be reared in families in which their parents' relationships are conflictual.

Given the evidence of conflict between spouses in alcohol abusing families, it is not surprising to find a link between alcohol abuse and divorce. In their survey of 288 spouses involved in divorce proceedings, Cleek and Pearson (1985) found that 30 percent of women cited their husbands' alcohol abuse as a cause of the divorce. In her study of alcohol abusing women in treatment, Corrigan (1980) found that 42 percent of those women who had married were separated or divorced. She further points out that this figure exceeds the reported prevalence of divorce. Although it is possible that those women in Corrigan's sample who were separated may reunite with their spouses, it still seems likely that this figure is higher than the norm (p. 88).

Couples who were comprised of at least one alcohol abusing member and whose children were seen in a child guidance clinic were found to have a higher rate of divorce than non-alcohol abusing couples whose children were seen by the clinic (Chafetz, Blane, and Hill (1971).

What is the relationship between growing up in a family with an alcohol abusing parent and the development of difficulties in one's own marriage? First, as has been previously established, children who develop alcohol
problems may experience more marital conflicts or divorce on the part of their parents than others. The evidence for inter-generational transmission of alcohol abuse will be presented in the section dealing with such factors associated with children of alcohol abusers.

Second, a significant statistical association was found between being a female child of an alcohol abusing parent and subsequently marrying an alcohol abusing spouse (Nici 1979; Stewart and DeBlois 1981).

Third, a quasi-experimental study of Danish children of alcohol abusers who were adopted shortly after birth and a matched comparison group of non-COA adoptees found that biological children of alcohol abusers were three times as likely to divorce than were comparison group members. This result occurred even though these children were reared in families who did not abuse alcohol (Goodwin et al. 1973).

Given the extent of marital conflict and instability evident in families of alcohol abusers, it is perhaps not surprising to find an association between alcohol abuse and spouse battering. Eberle (1982) performed a discriminant analysis of alcohol abusing and non-alcohol abusing batterers. It was found that the victims of alcohol abusing batterers were more likely to abuse alcohol themselves than those in the other group. There was some weak indication that alcohol abusers are a
more physically violent group, but the author called for more research on this topic. It was not clear how, if at all, children witnessed or were involved in the violence. Of interest, the group of alcohol abusing batterers were older than comparison group batterers. This may indicate that children may have left the home and were not available to buffer the conflict between the spouses. However, the higher age may merely be an artifact of the length of time it takes to develop a problem with alcohol. The external validity of this study is jeopardized by the self-selected nature of the sample.

Byles (1978) studied the relationship between alcohol abuse and domestic violence in 139 persons who appeared in a family court. Data were collected via interview schedules. Participants tended to be victims of domestic violence rather than perpetrators. There was a significant association between alcohol abuse and violence. Further, there was no association between either of these problems another major complaints such as indebtedness. It is interesting to note that this finding conflicts with Cleek and Pearson's (1985) study which notes an association between alcohol abuse and low socioeconomic status in divorcing families. This discrepancy may be attributable to sample differences (the latter sampled divorcing families, the former sampled families appearing before family court and whose spouses
may not be divorcing). However, more research is clearly needed to clarify the relationship between domestic violence, alcohol abuse, and financial problems. It is important to note that both studies found a relationship between alcohol abuse and domestic violence, however.

The study by Wilson and Orford (1978) also noted a relationship between alcohol abuse and violence directed toward spouses. Stewart and DeBlois (1981) found that physically abused mothers of boys who attended a child psychiatry clinic tended to be married to fathers who carried a diagnosis of antisocial personality, alcoholism, or both. They found that 41 percent of the mothers of the children in their sample (N = 122) were physically abused. The authors also note that these mothers were significantly more likely to be children of alcohol abusers or of antisocial men, even when socioeconomic status was controlled. However, the validity of this finding is hampered by the lack of direct observation of these women's fathers.

The association between parental alcohol abuse and child abuse has received some attention in recent years. There is no unanimity concerning the existence of such a link as well as the directionality of causation (i.e., whether alcohol abuse results in child abuse, or vice versa). Orme and Rimmer (1981) reviewed research concerning this topic and found no empirical data to
support the existence of a correlation between alcohol abuse and child abuse. They, therefore, cautioned against concluding that a causal link exists. Midway in this spectrum is the Booz-Allen and Hamilton (1974) study of children of alcohol abusers, which reported that "verbal" abuse and conflict between parents and children occurs less frequently than conflicts between parents. When it does occur, usually only one child is singled out as the target. Wilson and Orford's (1978) literature review and study of a small sample of children of alcohol abusers noted evidence that child abuse does occur in families with alcohol abusing members.

Behling's (1979) study contrasts with Orme and Rimmer's (1981). This author interviewed parents of 51 children who were identified as either physically abused, neglected, or sexually abused, and reviewed their medical records. It was determined that a large percentage of these children did indeed come from alcohol abusing families. Fully 69 percent of these children reportedly had at least one parent who abused alcohol. However, this study suffers from the lack of a comparison group. It is therefore subject to questions regarding its internal and external validity. This is of more concern when one considers the fact that subjects were selected from a military population, thereby restricting the generalizability of these findings. Despite methodological flaws,
this finding appears notable given the high incidence of alcohol abuse in this sample.

In his landmark study of child abuse, David Gil (1973) reported that "alcoholic intoxication of the perpetrator at the time of the abusive act was noted in nearly 13 percent of the cases" (p. 129). This also positively correlated with caretaker quarrels. As with other studies of violence already discussed, Gil did not obtain data regarding the prevalence of alcohol abuse in the child abusing population. However, if one accepts that 10 percent of American adults have a drinking problems (Clark and Midanik 1982), and one assumes that most of the 13 percent of intoxicated child abusers are also alcohol abusers, then the magnitude of the distribution of alcohol abusers in the child abusing population may not be much greater than it is in the general population.

Two studies of child abusing parents who also have substance abuse problems indicate divergent views on the causal influence of alcohol abuse and child abuse. Lightfoot, Lippman, and Suffet (1983) collected self-report responses of inner-city clients who were participants in a special program designed to intervene with families in which both parental substance abuse (i.e., alcohol and other drug abuse) and child abuse existed. They noted that clients considered substance abuse to lead
to child abuse rather than the other way around. However, the authors report low but significant correlations between clients' perceptions that abuse of children leads to abuse of wine, liquor, and cocaine. Flanzer and Sturkie's (1982) study of dual alcohol and child abusing parents in Arkansas indicated that "parents viewed their drinking as following their inappropriate or inadequate discipline of their children or else they viewed drinking and discipline (abuse) as mutually exclusive" (p. 13). The authors claim that their findings "support misuse of alcohol as exacerbating a problem originating elsewhere" (p. 58). However, they obtained a low response rate and a large proportion of the heavier drinkers refused to provide data.

What then could be said about the relationship between child abuse and alcohol abuse? First, given the variability of findings, more research studies which employ tighter designs are indicated before one can be more confident in attributing an association between these two problems. Second, given the literature in support of the association between alcohol abuse and other forms of violence, one could speculate that an association between alcohol abuse and child abuse also exists. Last, if such an association exists, the direction of causation is unclear. It seems most likely that the variability of responses obtained by the last two studies cited can be
explained by a cyclical pattern of child abuse and substance abuse, rather than a unidirectional model of causation. The confusing results, especially in the study by Lightfoot, Lippman, and Suffet (1983), may be an artifact of a unidirectional causal bias in their instruments rather than confusion among the study participants.

There are numerous anecdotal accounts of the relationship between parental alcohol abuse and the sexual abuse of children. However, there is a dearth of research describing the relationship between these variables. Although Black (1981) states that research concerning incest and alcohol abuse is limited, she claims that "a number of studies document that over 50 percent of known incest victims lived in homes where alcohol abuse was a major problem" (p. 141). This author fails to cite these studies, however. A search of the literature concerning the relationship between child sexual abuse and parental alcohol abuse has only yielded three empirical studies. The Booz-Allen and Hamilton (1974) study, which analyzed the responses of an accidental sample of children of alcohol abusers noted that these children experienced "inappropriate physical behavior (hugging, kissing, petting, tickling, and pinching)" when their parents were drunk (p. 22). The reported prevalence of these behaviors was apparently less than 50 percent. Browning and Boatman
(1977) reviewed a sample of fourteen incest cases which were treated in a hospital child psychiatry clinic. They reported that eight fathers were reported by their wives to abuse alcohol. However, these results are constrained by the small size of the clinical sample, the indirect measure of alcohol abuse, and the lack of a definition for descriptive terms employed such as "alcoholic," "periodic drinker," etc.

Virkkunen (1974) examined mental health records of forty-five cases of incest treated at a teaching hospital in Finland. Of these cases, twenty-two (48.9 percent) had some indication of alcohol abuse in the family. It was also found that these alcohol abusing incest offenders exhibited more violent behavior at home and more past criminal offenses (especially violent offenses). This study, although it provides some evidence of an association between incest and parental alcohol abuse, suffers from some limitations. First, data were obtained from case records. Direct validation of these behaviors was therefore not obtained. Second, definitions of variables such as alcohol abuse and aggressive behavior were vague. Third, generalizability of these results are questionable since they were obtained from a clinical sample drawn from another culture. Therefore, while there is evidence for an association between child sexual abuse and parental alcohol abuse, the degree of association, the nature of
association, the existence of a causal relationship, and
the percentage of coexistence of both conditions in the
United States is not yet established.

Is there a relationship between parental alcohol
abuse and child neglect? Krimmel (1971), writing on
issues related to alcohol abuse for social work education,
states that

In the atmosphere of inconsistency and instability,
periods of sobriety may provide interludes of peace or
even a measure of happiness for the family. But they
are only interludes. For children, there may be
scarcely time to readjust their thinking before the
alcoholic parent is off and running again. The
violence is repeated, the promises with their hopes of
joy are unfulfilled, cherished goals are abandoned,
and the sharing [sic] of pleasure in the family is
impossible. Children become bitter and hostile when
they are repeatedly let down. (p. 107).

What empirical evidence is there for this
statement? The Booz-Allen and Hamilton (1974) study
reports that "over 60% of the children we talked with
expressed that they felt neglected by one or both parents.
Their experiences ranged from mild to serious neglect" (p.
20). The authors of this study elaborate by stating that
"the alcoholic parent is almost 'not there' in the family.
This requires a child to deal with something that is
missing, rather than something which may be all too
present, like family conflict. As a result, many children
will simply accept the neglect rather than react against
it. Some may not even be aware of what they're missing"
( pp. 41-42).
In Cork's (1969) interviews with 115 children of alcohol abusing parents, she reports that "almost all" reported feeling unwanted by at least one of their parents (p. 61). She also states that "a large number of children said that they were rejected by both parents, the non-alcoholic one as well as the alcoholic. . . . clearly there is much resentment among the children about the consequences of drinking" (p. 65). Last, Wilson and Orford's (1978) study of a small sample of children and a review of the literature note that there is some evidence that children experience inconsistency, few joint family activities, and "too large" amounts of responsibility for household tasks.

While these studies suffer from small sample sizes, self-selection of study participants, and unsophisticated data analyses, it can be concluded that there is some empirical support for the almost common sense belief that parental alcohol abuse can result in some form of child neglect. The different characterization of parents (e.g., "not there," "rejecting") and of their children's response ("passive acceptance," "hostility") may be attributed to the differential effects of alcohol upon parents and to differences in such factors as family support, children's perceptions of drinking behavior, etc. As with previous studies discussed herein, the prevalence of alcohol abusers in the population of neglectful
parents has not been established. The degree of association between parental alcohol abuse and child neglect is also unknown.

Although the social stigma placed upon alcohol abuse is well known, there has been little attention given to the stigmatization suffered by children of alcohol abusers. DiCicco (1981) states that many of these children experience guilt, shame, and isolation. She also states that adults who are in contact with them never talk about alcohol abuse. While denial is recognized as a characteristic of alcohol abusers, it is also common among significant others, including relatives, co-workers, their children's teachers, etc. The Booz-Allen and Hamilton (1974) study stated that these children most frequently reported feelings of resentment and embarrassment. These authors report that community attitudes toward alcohol abusers primarily affect these children via peer relationships. In response to stigmatization, these children reportedly develop elaborate schemes in order to keep the problem a secret or to avoid contact with peers. This report also states that "The community attitudes toward alcoholism as expressed through relatives and social organizations also create problems for the children. Relatives ignore it. Ministers call it a sin. Doctors refuse to identify it. Schools rarely discuss it. Some
groups are glad children are experimenting with alcohol instead of [other] drugs" (p. 29).

In her interviews with these children, Cork (1969) notes that these children lacked self-confidence and that most stated that they constantly worried about being different. DiCicco (1981) identified other aspects that are related to the stigma attached to being the child of an alcohol abuser: "Seeking help is considered juvenile or unsophisticated [by peers]. Sober parents often deny that their children are affected. Parents with acute alcoholism forbid their children to seek help. Resources are not widely known" (p. 46).

It therefore seems clear that these children are stigmatized because of their parents' alcohol abuse and community attitudes toward it. This stigmatization results in feelings of guilt and shame, lowering of self-esteem, as well as social withdrawal and isolation from informal sources of support. Development and provision of services to this population are also impaired as a result.

**Parental Alcohol Abuse and Children**

Given the literature documenting the family experiences of children of alcohol abusers, a review of studies concerning their biopsychosocial functioning is in order.
There are indications that children of alcohol abusers are themselves at high risk for the development of substance abuse problems. Cotton (1979) reviewed thirty-nine studies and concluded that approximately one third of any sample of alcohol abusers had at least one parent who was also alcohol abuser. Most studies reviewed varied in methodological sophistication and tended to be retrospective, however. McKay (1961) interviewed twenty adolescent problem drinkers who were referred to a hospital alcoholism clinic. All of the males had a parent who abused alcohol and parental alcohol abuse was reportedly common among the adolescent females. The author noted that perception of parental role models by these adolescents were in relationship to alcohol abuse. Also, these children first approached drinking situations with uncertainty, ambivalence, and concern, but learned early that alcohol relieved many tensions and anxieties. The Booz-Allen and Hamilton (1974) study also noted that children of alcohol abusers were prone to alcohol and drug abuse.

Morehouse (1984) noted that parents' abuse of alcohol can impair recognition of their adolescents' alcohol abuse. She writes that when one or both parents drink excessively or are alcoholic and also in a state of denial about their alcoholism, excessive drinking by offspring may be denied. Acknowledging that the drinking may be psychologically or physically harmful for the
adolescent would force parents to acknowledge their own drinking. Parental alcoholism can also hinder an adolescent's identification of his or her own alcohol problem [since] . . . the adolescent rationalizes his or her use through comparisons with the drinking parents. (p. 15).

Goodwin et al. (1973) compared Danish adoptees whose biological parents abused alcohol with a matched comparison group of adoptees whose biological parents had no indication of alcohol abuse. Both groups were separated from their biological parents early in their lives so that environmental effects related to being reared in a family with an alcohol abusing member were minimized. These adoptees were also interviewed by trained clinical interviewers who were blind with respect to the group membership of study participants. The researchers found that adoptees with alcohol abusing biological parents had a significantly greater history of alcohol problems and of receiving psychiatric treatment. No differences were found in the occurrences of other forms of psychopathology. The authors take the results as indication for a genetic basis for the transmission of alcohol problems. Vaillant (1983), in his longitudinal study, determined that a family history of alcohol abuse and ethnicity predicted the occurrence of alcohol problems in his sample. Variables such as unhappy childhoods, depression, membership in multi-problem families and anxiety were not of etiological significance. Indeed, he
notes that "future alcoholics are more likely to be related to other alcoholics . . . and this relationship holds even with ethnicity controlled" (p. 331). Vaillant found that participants who have (had) an alcohol abusing parent but had stable families of origin were five times more likely to develop alcohol problems than were participants whose families of origin had multiple problems but did not include an alcohol abusing member. The factors that were non-etiological were seen as exacerbating the alcohol problem, and were thus seen as having some important influence in the development of alcohol abuse.

In its report to Congress, the U.S. Department of Health and Human Services (1983) concluded that "it has been firmly established that heredity plays a role in determining individual differences in susceptibility to the disorder. Genetic influences are identifiable in at least 35 to 40 percent of alcoholics and alcohol abusers" (p. 22). This report also indicates that animal studies have revealed that genetic factors affect individual differences in regard to drinking behavior, brain sensitivity to alcohol, acquisition of tolerance and development of physical dependence upon alcohol (p. 22). Therefore, there is good evidence that children of alcohol abusers are at greater risk for developing alcohol problems of their own. There appears to be an important
genetic component in the process of developing alcohol problems and that genetics and environmental factors interact in unspecified ways to produce this phenomenon.

In addition to the intergenerational transmission of alcohol abuse, studies indicate that children of alcohol abusers are more severely impaired by their own alcohol abuse than are others. Templer, Ruff, and Ayers (1974) studied thirty-three male alcohol abusers at a state psychiatric hospital. They found that those subjects who were themselves children of alcohol abusers were significantly more likely to be classified as essential alcoholics on the Rudie-McGaughran Scale than were others. They report that essential alcoholics are described as inadequate, psychosexually immature and beginning excessive drinking earlier without precipitating environmental stressors. They also noted that "essential alcoholics" have a poorer prognosis than do others.

Frances, Timm, and Bucky (1980) compared the responses of over seven thousand alcohol abusers to a biographical questionnaire. They found that those who had a family history of alcohol abuse had more severe symptoms of alcohol abuse themselves, a history of more severe antisocial behavior, worse academic and social school performance, less stable employment histories, more severe alcohol related physical symptoms, larger families, lower socioeconomic status, and families with more
psychopathology than those with no family history of alcohol abuse. While this study is limited because of its use of self-reports, the large sample size enhances its validity.

In a study by McKenna and Pickens (1983), elevations on MMPI measures of psychopathology (especially aggression) were directly correlated with the number of biological parents reported with alcohol problems. Subject MMPI scores did not differ by sex of the alcohol abusing parent nor were there interactions between sex of children and sex of the alcohol abusing parent. All participants were "chronic stage alcoholics" who were reared by both biological parents. Of note, approximately 75 percent of the subjects (N = 1929) reported that neither parent abused alcohol.

Given these studies, it seems clear that children of alcohol abusers are indeed at high risk for the development of severe alcohol problems. This population therefore appears to be a natural target for alcohol abuse prevention efforts.

There have also been a number of studies of childhood attention deficit disorder and its relationship to parental alcohol abuse. Morrison and Stewart (1971) compared fifty-nine "hyperactive" children to forty-one children who had general medical problems. This latter group was matched on key variables with the group of
hyperactive children. The parents of both groups of children were given semi-structured interviews. The results indicated that fathers of hyperactive children were more likely to be alcohol abusers and manifest symptoms of sociopathy than did fathers of comparison group children. Mothers of hyperactive children manifested symptoms of hysteria more frequently than did comparison group mothers. A significantly greater number of parents of hyperactive children reported that they themselves had been hyperactive as children. Of these parents, half were considered to be alcohol abusers on the basis of this interview. Alcohol abuse was also identified by parents of hyperactive children in other family members (Morrison and Stewart 1971). While this study did utilize a comparison group, it would have been on firmer methodological ground had it employed a comparison group consisting of parents of children with other mental health conditions, in addition to those of psychologically "normal" children. As such, one cannot relate hyperactivity to specific forms of parental psychopathology. It is possible that parents of children that have various forms of mental health conditions manifest the same forms and prevalence of psychopathology as parents of hyperactive children (Stewart, DeBlois, and Singer 1979).
Cantwell (1972) interviewed parents of fifty hyperactive children and fifty comparison group children. When the hyperactive children were divided into subgroups with and without conduct disorder, significant differences among the parents were found. Hyperactivity was more related to parental alcohol abuse while childhood conduct disorder was more related to parental antisocial personality disorder.

A study by Goodwin et al. (1975) compared fourteen Danish adoptees who were alcohol abusers with non-alcohol abusing adoptees. The alcohol abusing adoptees described themselves as hyperactive and aggressive as children more frequently than did comparison group children. However, this study suffers from the use of retrospective self-reports. Therefore, the validity of the results is open to question.

Last, Blouin, Bornstein, and Trites (1978) matched hyperactive children with a group of children that had school difficulties other than hyperactivity and followed them for five years. The hyperactive children (who were adolescents at the time of study) were reported to drink significantly more alcohol than did comparison group children. There was no difference between groups with regard to other forms of substance use. This study would have been strengthened had data been collected on parental alcohol use.
One may conclude that there is a relationship between childhood attention deficit disorder (with hyperactivity) and parental alcohol abuse. However, more research is needed to establish the pathways through which these disorders are linked.

Another area of study is the relationship of parental alcohol abuse to children's aggression and other behavioral disturbances. An early study by Aronson and Gilbert (1963) used blind teacher ratings to compare children of alcohol abusing parents with normal comparison group children. This study found that teachers consistently rated children of alcohol abusers as "evading unpleasantness," dependent, less personable, and more likely to demonstrate overt aggression. The authors considered these results as providing evidence that these children were manifesting some characteristics of alcohol abusers. Although providing useful data, this study was limited by its use of teacher ratings, rather than direct, clinical assessments.

Fine et al. (1976) interviewed parents (usually the non-alcohol abusing mother) of children with a parent who was in an alcohol abuse program. These children were matched with children whose parents manifested other mental health conditions, normals, and children who were hospitalized for psychoses. The parents were given the Devereaux Child Behavior Rating Scale or the Devereaux
Adolescent Behavior Rating Scale, depending upon the age of the child. Children of alcohol abusers manifested significantly more disturbances than normal children on twelve of seventeen behavioral measures. These children were also rated as more disturbed than psychotic children on pathological use of senses, emotional detachment, inadequate need for dependency, and social aggression.

Adolescents with alcohol abusing parents were rated as more disturbed on unethical behavior and paranoid thinking scales than were those in the group with parents who had mental health conditions (Fine et al. (1976). They concluded that

compared with normal children, those in a family with parental alcoholism are less able to maintain attention, less responsive to environmental stimulation and much more prone to emotional upset. They tend to be anxious, fearful individuals who have greater difficulty in containing or regulating their excitement or mood. They are subject to aggressive behavior and show evidence of deficient learning of certain moral codes of conduct. There is also evidence that they are socially isolated and pre-occupied with inner thoughts rather than with concern for what is going on around time. (p. 515)

The strengths of this study lie in the use of a variety of comparison groups and in the use of a structured behavior rating scale. However, given the denial and miscommunication that is evident in families with alcohol abusing members, the validity of the responses of these parents (alcohol abusers and non-alcohol abusers alike) are subject to question. Also, children whose
parents were in alcohol abuse treatment may not be representative of the entire population of children of alcohol abusers. It is also interesting to note that these children were described as having an inadequate need for dependency while teachers rated children of alcohol abusers as dependent in the Aronson and Gilbert (1963) study.

Haberman (1966) compared reports of mothers regarding the behavior of their children who were children of alcohol abusers to those of "normals." The children of alcohol abusers were reported to be more likely to have temper tantrums, fight with peers or have school problems. Although these results tend to confirm those of other studies, the use of indirect measures of behavior and the lack of application of statistical tests of significance are serious flaws.

Rydelius (1981) reported on the results of a study of a cohort of 229 Swedish children of alcohol abusing fathers and a comparison group. Although many results failed to reach statistical significance, a trend was noted whereby adult sons of alcohol abusing fathers tended to engage more often in criminal activities. Daughters of alcohol abusing fathers were more likely to be involved with the child welfare system than were other participants. Both sons and daughters of alcohol abusers tended to visit hospitals more frequently: males for
complications related to alcohol and other drug use and females for gynecological problems. Again, the findings tended to confirm that aggression is related to parental alcohol abuse, although it was not specified whether the sons' crimes were violent in nature nor whether the daughters were involved with child welfare agencies because of child abuse. However, this is a longitudinal study and it validated behavior from case records. As such, it is methodologically stronger than most other studies cited and its results are therefore more credible. In a follow-up study on this data set, it was noted that children of alcohol abusing fathers from upper socioeconomic status families were as likely to develop psychological difficulties as were children of alcohol abusing fathers from lower socioeconomic status families (Nylander and Rydelius 1982).

Chafetz, Blane, and Hill (1971) compared case records of one hundred children of alcohol abusing parents and one hundred other children, all of whom were seen in a child guidance clinic. It was found that children of alcohol abusers experienced a greater frequency of serious illness or accidents, school problems, as well as problems with police and courts. There was also a non-significantly higher frequency of aggression with children of alcohol abusers. No differences were found in referral sources or disposition following evaluation. The authors
state that "it seems safe to conclude that children of alcoholic families seen in a child guidance clinic are similar in many ways to those seen in the same setting whose parents have alcohol problems. Further ... children of alcoholics are not over-represented in the roles of child guidance clinics" (p. 696).

The Booz-Allen and Hamilton (1974) study notes that the children in their sample reported school problems, delinquency, temper tantrums, and fights as common experiences of this self-selected sample. The study also reports depression/suicidal tendencies, repressed emotions, and a lack of self-confidence as less frequent but clear experiences of this sample. This report also notes that 66 percent of suicidal adolescents and 66 percent of runaways are reported to come from families with alcohol abusing parents. However, sources for these latter two statistics were not well documented.

Kammeier studied school records of 271 students in a midwestern Catholic high school. Sixty-five were classified as children of alcohol abusers by school counselors. When compared to their classmates, these adolescents were indistinguishable on a range of problem behaviors. They were more likely to be absent from school, however (Kammeier 1971). As previously noted, this study suffers from the fact that the key variable (alcohol abuse, alcoholism) was not defined. School
counselors might have mis-assigned or arbitrarily assigned students to groups. Also, school records may have recorded only gross behavior problems and thus would not be a sensitive measure of behavior. Last, since the sample was drawn from a parochial school, this sample may have been biased. Students with gross problem behavior may have been transferred to public schools, thus restricting the sample. The combination of lack of definitions of key variables, insensitive measures for all but gross disturbances, and sample bias against those adolescents with gross disturbances could account for this study's atypical results.

O'Gorman compared twenty-nine adolescents from families with a parent who was abusing alcohol at the time of study with twenty-three adolescents with a parent who had a history of alcohol abuse, but no abuse at the time of study and with twenty-seven adolescents with parents who had no history of alcohol abuse. The first group of adolescents had an external locus of control and those with a history of alcohol abuse or current abuse had a lower self-esteem as measured by objective psychological tests. Prewitt, Spence, and Chaknis (1981) found that latency aged children of alcohol abusers also were significantly higher in external locus of control than were comparison group children.
Given the studies cited above, it seems safe to conclude that children of alcohol abusers are more likely to manifest aggressive behavior, including temper tantrums, delinquent behavior, low self-esteem, perceive control of their lives as externally determined, and have school problems (although the exact nature of this behavior was not specified in these studies). There are also indications that these children may also be at-risk for illnesses and accidents, depression, suicide, and runaway behavior.

**Clinical Judgment and Children of Alcohol Abusers**

Given the review of literature concerning the effects of parental alcohol abuse on the psychosocial functioning of children, attention must be paid to the literature concerning professional perception of this problem.

It is interesting to note that Mary Richmond, writing in 1917, recognized the association between alcohol use and the deleterious effects upon children and their families. She stated that family history of substance abuse was an important factor in the assessment of clients who may have abused alcohol and advocated for work with family groups of alcohol abusing clients.

Why are the perceptions of clinical social workers an important area to study? By studying these
perceptions, one may better understand and enhance identification of these children. The National Institute on Alcohol Abuse and Alcoholism (US Department of Health and Human Services 1981) lists four major purposes for identification of children of alcoholism:

1. Determination of the nature and extent of service needs.
2. Delivery and availability of appropriate services.
3. To help these children to understand their potential risk level and options and to make more informed choices about how they will deal with them.
4. Reduction of these children's sense of guilt, isolation, and stigma. (pp. 7-8).


Better understanding of clinical social workers' perception of these children and associated factors should provide valuable clues to remediying these problems. Bieri et al. (1966) state that "if we know something about how the individual judge characteristically organizes social inputs in his interpersonal behavior, we are in a position to make predictions concerning his ability to deal with varying types of input-output relations" (p. 11).

Therefore, through constant exposure to a specific range
of clients and problems, a clinician's judgment process becomes sensitized to clients and their problems that fall within that range. Conversely, these clinicians become desensitized to client stimuli that fall moderately outside of this range. When confronted with clients who present stimuli that fall moderately outside of this range, clinicians may actually perceive them as falling within this range. This is especially the case in practice settings which serve a restricted range of clients (Bieri et al. 1966).

Achenbach (1985) also notes this effect when discussing the clinical assessment of child and adolescent psychopathology: "Although mental pattern-matching is essential for applying knowledge, readily available patterns may inappropriately shape our judgment of new cases. . . . Available associations cause us to infer correlations where none exist" (p. 26). The consequences of this effect may (1) cause clinicians to miss the ways in which a new case differs from other cases it superficially resembles; (2) cause clinicians to match a case to an easily remembered pattern, despite greater similarity to a less available pattern; (3) lead clinicians to infer correlations where none exist; and (4) bias estimates and predictions to reflect events most vivid to us rather than most representative of what is to be estimated or predicted.
Therefore, in terms of this study, clinical social workers' practice specializations may skew their perceptions of cases involving parental alcohol abuse.

Greenley and Kirk (1980) note a related phenomenon. They hypothesized that:

When some problem categories are not contained in a set of claimed domains, there will tend to be an inflation of the number of applicants with problems defined in terms of those categories that are circumscribed by the existing claimed domains. For instance, if an agency upon evaluating an applicant, believes that his problem consists of the consumption of too much alcohol, but no agency in town claims to deal with alcoholics problems, it may refer the applicant to the family service agency, where his problem comes to be seen as a marital problem rather than an alcoholic problem. (p. 65)

Therefore, when client characteristics fall outside of the domain of an agency's function, the problem may be defined in terms of that agency's or another's function. It is easy to see that agency and social worker experience interact to skew clinical judgment so that they are consistent with agency domain and worker experience.

A study by Billingsley (1964) found that differences indeed exist among social workers practicing in different units. He presented case vignettes to workers in family service units and in protective service units. Family service workers tended to perceive cause and treatment of problems in psychological terms while
protective service workers tended to perceive cause and treatment in socially oriented terms.

According to Giavannoni and Becerra (1979), Gelles found differences between different professions when he presented them with thirteen case vignettes related to child abuse. He found discrepancies in responses by members of each professional group. There was agreement in extreme cases, however. Giavannoni and Becerra (1979) found systematic inter-professional disagreements in cases related to child abuse. Boehm (1962) also utilized case vignettes to ascertain whether there were differences of perception among different professional groups related to cases of child maltreatment. The author found differences, as well.

Similar trends can be found in the literature concerning alcohol abusers and their children. Fine et al. (1976), in their study of behavior disorders among children whose parents were being treated at an alcohol treatment center, notes that "despite in some cases extremely marked behavior disturbances, none of these children had been referred for help. This might be related to the severe degree of disruption, alienation and confusion in alcoholic families that allows a child to continue to behave pathologically with no attempt to seek help" (p. 516).
While this phenomenon may prevent referrals for treatment of children, other factors may also operate to impede referrals and service. Morehouse (1981) notes that alcohol abuse treatment agencies view the alcohol abuser as their primary client, and as the person who is most directly responsible for the recovery process. She also states that alcohol abuse treatment staff feel uncomfortable in working with the children of alcohol abusers and tend to refer to child guidance clinics when these problems are recognized.

However, it may be that many professionals do not recognize these problems. As previously discussed, in a classic paper entitled "The effects of alcoholism on children," Ruth Fox (1963) does not discuss this problem in relation to children. When she discusses treatment approaches, this author lists family treatment as an adjunct for alcoholism therapy. She does not mention direct treatment of children.

Also, as previously stated, Nardi (1981) asserts that "despite the recognition of alcoholism as a 'family disease,' most research in the area focuses . . . on the alcoholic. Studies that do go beyond the alcoholic concentrate predominantly on the spouse; relatively few study the children of alcoholics" (p. 237).

Woodside also notes that a "philosophical bias" exists among alcohol abuse treatment providers, who
believe that the best way to assist these children is to help the alcohol abusing parent to recover. She points out that this approach ignores the needs of the children to gain mastery over their feelings concerning their experiences in their alcohol abusing families. Even when experts recommend that services should be rendered to children and their families as an integral part of treatment for alcohol abuse, there has been relatively little effort to determine from family members what their needs actually are (Wilson and Orford 1978). In addition, when literature addresses alcohol abuse and family problems, there is often no recognition that these problems and abnormalities might be more general. Parallels between these problems and those of other dysfunctional families thus are ignored (Orford 1975).

In addition to philosophical biases by alcohol abuse treatment personnel, there is some evidence that organizational factors also influence this problem. The Booz-Allen and Hamilton (1974) study surveyed alcohol abuse treatment agencies. They found that while all maintained data bases concerning the status of their alcohol abusing clients, all but one failed to maintain data concerning the statuses of their clients' families. It may therefore be inferred that families and children of alcohol abusers are not included in these agency's "vocabularies." In a sense, they are nonentities to these
organizations. In a recent study by Regan et al. (1983), alcohol abuse treatment agencies that reportedly provided some services to families were surveyed concerning the nature and extent of the services rendered to families of alcohol abusers. The authors found that these families and children were peripheral to the treatment process. When they did receive services, it was usually individual treatment. Conjoint family treatment was rarely provided. Further, the nature of these family oriented services did not appear to be very extensive or intensive. The authors concluded that if provided at all, family services are likely to be isolated from alcohol abuse treatment services. Significant differences were found between agency type, agency setting, and degree of focus on alcohol abuse. They found that "programs that concerned themselves specifically with alcohol misusers were directed more toward the alcohol misusers themselves, whereas programs of a more general nature tended to see any alcohol-related problems beyond their mandate and expertise" (p. 1081). Overall, the research indicated that treatment and administrative procedures of agencies had more effect on services to families than did assessment of family need and that services to children were even more glaringly deficient than the inadequate services provided to families.
The specialization within alcohol abuse treatment services has also skewed clinical judgment, as noted by Brandsma and Welsh (1982): "Practitioners are either therapists or doctors, with one more likely to ignore physical complications, the other the meaning of the symptoms psychologically: both tend to be narrow in their approach" (p. 887).

The director of the National Institute on Alcohol Abuse and Alcoholism stated that health care professionals who do not specialize in alcohol abuse treatment do not identify alcohol programs because of a lack of training and experience in this area (Niven 1984). Therefore, in addition to organizational factors, the nature and extent of training will also affect clinical judgment.

Authors also noted that the difficulty in identifying alcohol abusers may be a consequence of the phenomenon itself. Ringer et al. (1977), in their study of the use of National Council on Alcoholism Criteria for the diagnosis of alcohol abuse, noted that "many alcoholics are overlooked in routine clinical [medical] examinations due to the apparently low specificity of symptoms" (pp. 1269-1270).

The vagueness of the phenomenon of alcohol abuse is also noted by Vaillant (1983), who stated that "alcohol abuse is not black and white; it is gray" (p. 4). Vaillant states that this is not compatible with the
thought processes of many clinicians, who tend to assess people's difficulties as falling within discrete categories. Pattison (1982) stated that there is "a legacy of folk science" which considers alcohol abuse as a unitary condition, rather than a complex, multidetermined phenomenon (p. 1094). He asserts that one consequence is the assumption that abstinence is the goal of treatment and that the person was fully recovered once abstinence was maintained. As a result, treatment efforts were directed in this area, to the neglect of emotional, social and physical dimensions. In effect, this simplistic view of the phenomenon has produced linear models of treatment, which does not adequately address the needs of families and children.

In summary, the literature indicates that clinical judgment in the field of alcohol abuse may be affected by several related factors:

1. Specialization in treating alcohol abusing clients may create a philosophical bias against working with children and their families.

2. Family problems when they are identified may be attributed to the special consequences of alcohol abuse. There may also be little recognition that these difficulties may be of a more general nature or that they may be similar to family problems that result from other difficulties.
3. Alcohol abuse treatment agencies may not define provision of child and family services as part of their service mandate. Staff clinicians consequently may not be encouraged to attend to their needs.

4. Identification of clients and referrals for a range of services may be hampered by the maintenance of alcohol abuse services as a specialized function.

5. The vague, non-specific symptoms of the phenomenon of alcohol abuse itself may mitigate against identification and appropriate treatment. Thus, specialized alcohol abuse treatment agencies may not serve the full range of the alcohol abusing population. Access to the population of children of alcohol abusers is thus restricted in these agencies.

6. The belief that alcohol abuse is a unitary condition may obscure recognition of associated difficulties and result in a linear approach to treatment.

   It is interesting to note that one prominent specialist in services for children of alcohol abusers asserts that agencies that specialize in alcohol abuse treatment should provide services to these children while child serving agencies should merely understand the effects of parental alcohol abuse (Morehouse 1979). She does not address the above listed obstacles to provision of these services by alcohol abuse treatment agencies when making this statement.
However, one must also question whether agencies that specialize in serving children and families are better able to meet the needs of this population.

Krimmel (1971) asserts that "in many social agencies, it is comparatively easy for the worker to focus on problems other than alcoholism. Despite its high incidence in caseloads, it is seldom the presenting problem" (p. 18). Woodside (1983) also notes this tendency and attributes it to child and family oriented workers' prejudices about alcohol abuse. She states that these workers may be ignorant of the effects of parental alcohol abuse upon children. In consequence, "many family and child agencies . . . are unaware [sic] of the caseloads and do not identify or help the children affected [sic]. In fact, some professionals mistakenly treat children for depression or other symptoms when parental alcoholism is the root cause of problems" (p. 29). One could certainly question the validity of the dichotomy between childhood depression and parental alcohol abuse which was apparent in this author's statement. However, the point is clear. Indeed, Deutsch (1982) also notes that only a minority of youth serving professionals are adequately prepared to meet the needs of these children. In regard to social work education, Humphreys (1983), asserted that:

while the number of courses and attention to alcohol and drug abuse content have increased in the last ten years, there are still many students who are never
exposed to any information about working with alcohol and drug abusers. . . . The issue of what and how much every social worker needs to know about alcohol and drug abuse problems remains largely unresolved, however. (p. 29)

Krimmel also notes that alcohol abuse is perceived by social workers as a problem for specialists but that the professional community may have the "erroneous impression that [alcohol abuse treatment agencies] can solve all the alcohol problems of a community" and that these agencies are equipped to cope with related problems (p. 18).

Margaret Cork (1969) also notes this problem when she writes that:

Family service agencies have always treated a few families in which alcoholism has been a major problem. In many instances, their efforts have been successful. Frequently however, the alcoholic and the family are rejected as "untreatable" once it is clear that excessive drinking is a persistent problem. There has been the attitude that alcoholism must be treated by an "expert". The alcoholic is quickly referred . . . [and] family problems as such are often more or less neglected. (p. 85)

The study by Regan et al. (1983) confirmed that those programs that specialized in treating alcohol abuse were more directed toward the alcohol abusers themselves while more general programs tended to consider alcohol abuse as beyond their mandate and expertise.

Flanzer and Sturkie (1982) in their research and demonstration project designed to treat families in which parents both abuse alcohol and physically abuse their children, note that referral services such as the public
child welfare agency and the juvenile court "could not be relied upon to appropriately screen for alcohol [sic]" p. 25).

The Booz-Allen and Hamilton (1974) study noted that:

child and family service agencies do not know how many children in their caseloads have alcoholic parents or who the children are, short of reviewing all individual case records. Half the agencies visited claimed they had not seen or were not aware of children of alcoholic parents among their clients. The other agencies recognized the impact of alcoholism on the families in their caseloads but gave widely varying estimates of incidence. (p. 10)

The authors attribute this to the treatment focus of the agency, the degree of sensitivity to alcohol abuse by professional staff and possible professional prejudice against working with alcohol abusers and their families.

In addition to these factors, it must be recalled that Chafetz, Blane, and Hill (1971) noted that children of alcohol abusers who were served by child guidance clinics were "similar in many ways to other children seen in these settings and that these children were not over represented among the client population of these agencies" (p. 696). Therefore, the difficulty in distinguishing these children from others may in itself be a problem. Like alcohol abuse, the lack of specificity of symptoms related to parental alcohol abuse may account for the lack of services geared to meet the needs of this population.
In summary, writers point to several factors which narrow the child and family specialists' clinical judgment in regard to this population:

1. These professionals may be prejudiced against alcohol abusers and thus fail to identify this problem in their caseloads and/or provide services to address it. In response to the social stigma and the dynamics of denial operating in families, clients may also respond to these professionals by keeping the alcohol abuse a secret.

2. These professionals may not be adequately trained to recognize, much less intervene in alcohol abuse cases. As such, services, when they are provided, do not address this aspect of the case.

3. These professionals may consider most alcohol abuse problems as necessitating specialized services. They may therefore refer these cases to specialized agencies and incorrectly assume that the needs of children and other family members will be met by those agencies.

4. Child and family service agencies may consider alcohol abuse problems as falling outside of their service mandates and competence. These cases are then either defined as falling under another problem category or are referred out. Staff may not therefore be encouraged to address this problem directly.

5. The effects of parental alcohol abuse upon children appears to be nonspecific. As a consequence,
child and family service specialists may not be able to differentiate these children from others in their caseload or to provide services which are geared specifically to these clients.

Therefore, like their colleagues who specialize in alcohol abuse services, the clinical judgment of child and family service providers may also be skewed when they come into contact with children whose parents abuse alcohol.

The difficulties inherent in specialization and in maintaining a narrow perceptual field is well recognized by social work scholars. Nelson (1975) writes that practitioners "limit his [sic] vision of reality until, literally he sees what he can do . . . . the trick is to be aware of when one has narrowed his focus, why, and especially what possibilities for thought or action have been ruled out in the process" (p. 265). The problem is not specialization per se, but the limitation of perception and action that occurs unconsciously, and which occurs due to factors that are not based upon the clients' problems or needs for services. Nelson also asserts that "when a given means of service becomes traditional in certain fields of practice, there is a danger in addition to the possible lessening of effectiveness, namely, the danger that clients will be selected to fit extant services without weighing the value choices of whom to
serve and toward what ends" (p. 267). She states that social worker familiarity and comfort with a particular way of thinking and practicing can prejudice these choices.

Meyer (1982) also recognizes this danger, and notes the centrality of a comprehensive, systemic assessment in providing services. She states that it is not sufficient to be guided by existing methodology at the outset, as this truncates the range of perceived problems, service goals and interventive possibilities. Therefore, when considering a particular model of practice, one must first ask: "What phenomena are to be grouped and addressed by the model?" (Meyer 1973, p. 90). This is important because no single interventive model can completely encompass and address complex psychosocial problems (Meyer 1983). Social workers must therefore select models of practice that appropriately fit the phenomena that they encounter, otherwise they will fit case phenomena to practice models.

Professional ethics require social workers to make comprehensive assessments and design their practice so that it is based upon client need:

I. D.1. The social worker should be alert to and resist the influences and pressures that interfere with the exercise of professional discretion and impartial judgment for the performance of professional functions.
II. F.6. The social worker should provide clients with accurate and complete information regarding the extent and nature of the services available to them.

II. F.7. The social worker should apprise clients of their risks, rights, opportunities, and obligations associated with social service to them. (Compton and Galaway 1984, p. 85-86)

It is readily apparent that the clinical judgment of social workers can be affected by a number of factors. This especially seems to be the case when social workers specialize in serving particular populations or when social workers encounter case conditions which are considered to be the domain of specialists. Cases involving alcohol abuse fit this profile. The literature indicates that alcohol abuse specialists may "center" upon alcohol abuse, but neglect other problems, such as family dysfunctioning and child behavior disorders. Conversely, the literature indicates that child and family service specialists, while serving their clients, may ignore parental alcohol abuse. Alternately, they may refer these cases to alcohol abuse specialists, and mistakenly assume that the service needs of children and families will be addressed. In these ways, truncated assessments by these specialists may result in treatment approaches which, to the detriment of their clients, fail to address important needs and problems. This study will determine if indeed a relationship exists between social workers' specializations and their clinical judgment in these cases.
CHAPTER 3

METHOD

Overview

This study surveyed a national sample of clinical social workers who reported their specializations to the National Association of Social Workers as either:

1. Children and Youth Services
2. Family Services
3. Mental Health Services
4. Alcohol and Drug Abuse Services

A mailed questionnaire was sent to prospective study participants. This instrument collected self-reported data concerning demographics, professional background, family background, attitudes, and clinical judgments of social workers with particular regard to variables concerning cases that involve children, families, and substance abuse. Study participants were presented with three written vignettes of this type of case. As will be discussed later in this chapter, each vignette included symptoms of parental alcohol abuse, child behavior problems, mental health problems, and family problems. Data thus obtained included such clinical judgments as:
1. Locus of the problem(s)
2. Nature of case problem(s)
3. Perceived necessity of resolution of each problem to achieve case improvement
4. Proposed treatment plan for each case vignette
5. Prognosis for improvement for each case vignette

Details of instrument construction will be discussed later in this chapter. Data were analyzed with bivariate and multivariate statistical procedures in order to determine the relationship between social worker specializations, background variables, attitudes, and clinical judgments.

The results thus obtained were descriptive. The relationships between variables were established. However, because there was no random assignment to groups of specialists, causality cannot be imputed. The literature review has provided support for the hypothesis that there is a relationship between social worker specialization and professional background variables on the one hand, and attitudes and clinical judgments on the other. Descriptive research in this particular area is lacking, however.
Definition of Concepts

Specialization

Conceptual. A concentration of social workers' knowledge, skills, and abilities in a particular field. For the purposes of this study, these fields shall include social work activities related to: a particular condition (alcohol abuse), a class of conditions (mental health), a particular population (children), or a particular social unit (families).

N.B. As these phenomena are not discrete, a particular client can be served by social workers of different specializations. This is a key point upon which this study rests.

Operational. The group assigned to survey respondents based upon their scores on specialization scales. The assignment criterion is a Z score of .67 on any of the four specialization scales. In those cases where respondents met the criterion for two specializations, they were assigned to the group which reflects their highest score.

Specialist

Conceptual. A social worker who concentrates her/his knowledge, skills, and abilities in a particular area. For the purposes of this study, these areas are
children and youth, families, mental health, and alcohol abuse.

**Operational.** A survey respondent who was assigned to the following specialization groups: children/youth, families, mental health, alcohol/drugs.

**Generalist**

**Conceptual.** A social worker whose knowledge, skills, and abilities extend to several areas.

**Operational.** A survey respondent who was assigned to the generalist group. This assignment is made when a respondent has attained a $Z$ score of .67 or greater on three or more specialization scales.

**Non-Specialist**

**Conceptual.** A social worker who has not developed the requisite knowledge, skills, and abilities to be considered a specialist or generalist.

**Operational.** A survey respondent who has not attained a $Z$ score of .67 or greater on any of the four specialization scales.

**Clinical Judgment**

**Conceptual.** Opinions, estimates and inferences formed by social workers which are based upon discernment
and comparison of information related to direct service activities.

Operational. Responses of clinical social workers to questionnaire items developed for this study which measure opinions, estimates, and inferences with regard to alcohol abuse, child behavior problems, family problems, mental health problems, and their treatment.

N.B. The following concepts will not be operationally defined as they are not phenomena that will be measured by this study.

Alcohol Abuse

A pattern of pathological alcohol use which results in impairment of physical, psychological, social and/or occupational functioning.

Children of Alcohol Abusers

Persons under the age of eighteen years who are currently or have been reared by at least one person who met the criteria for alcohol abuse while engaged in child rearing activities.

Child Behavior Problems

A pattern of deviation from age appropriate activities, thoughts, or feelings. This includes the grouping of disorders listed in the DSM III (Diagnostic and Statistical Manual of Mental Disorders 1980) as first
evident in infancy, childhood, or adolescence, as well as other forms of disorders that are applicable to children and adolescents (such as some forms of affective disorders, adjustment disorders, etc.).

Family Problems

A disorder in the structure and/or functioning of a family unit which produces conflicts between the family unit and its environment, between or among family members, or which inhibit the healthy development of its members.

Sampling

The sampling frame consisted of members of the National Association of Social Workers (NASW) residing throughout the United States, who held a master's degree in social work, who have listed themselves as direct practitioners, and who reported to NASW that their primary practice specialties were either children and youth, families, mental health, or alcohol and drugs. An attempt was made to draw a stratified random sample, but since the total number of cases in each stratum was unknown, this sample was not a true probability sample. One hundred-fifty participants were drawn from each of the four specializations listed above. Each group therefore consisted of 150 participants. Thus, a total of six hundred potential participants were sent copies of the questionnaire.
Disproportionate sampling was indicated in this study since the distribution of these groups within the sampling frame was uneven (National Association of Social Workers 1985). Since this study did not seek to describe the entire sampling frame, but to describe the differences between these groups, this strategy was warranted.

Instrument Development

A data collection instrument in the form of a self-administered questionnaire was constructed. Questionnaire items were designed to yield data concerning social worker background variables, as well as clinical judgments and attitudes in relation to children of alcohol abusers.

Three case vignettes were developed in order to serve as anchors for clinical judgment responses. Vignettes were developed from a combination of the author's practice experience with such cases, relevant literature, and actual (non-identifying) case data that were obtained from case records for the purposes of this study.

While the content of these vignettes varied, all vignettes were constructed so that the following characteristics were held in common:
1. Symptoms of alcohol abuse, child behavior
problems, family problems, and mental health problems
contained in each vignette.

2. Family composition (i.e., father, mother, son).

3. Race.

4. Approximate age of clients.

5. Alcohol abusing father.

6. Mother with moderate anxiety or depression.

7. Family (i.e., marital and parenting) problems
contained in each vignette.

8. Length of one to two typed double spaced pages.

Demographics of vignette "clients" were held
constant so that responses would not be confounded by
these variables.

Drafts of these vignettes and accompanying
clinical judgment questions were submitted to a national
panel of social work reviewers (N = 14), each of whom had
substantial clinical expertise in at least one of the
following areas:

1. Alcohol abuse.

2. Adult mental health.

3. Child behavior problems.

4. Family problems.
Responses of these experts were used to validate whether the vignettes actually contained symptoms of the above conditions. They also were asked to validate the verisimilitude of the vignettes. In addition, suggestions for the improvement of the vignettes and clinical judgment questions were solicited from this panel. The vignettes and judgment questions were then revised based upon a qualitative analysis of these responses. Portions of the vignettes were revised only if their mean ratings were less than 3 on a 5-point Likert scale. This analysis resulted in minor revisions in two of the vignettes (table 1). The high ratings of the panel of experts are seen as validation of the content areas of the vignettes, their verisimilitude and their clarity.

A draft of the entire questionnaire (i.e., social worker background, vignettes/clinical judgment, and attitudinal questions) was then circulated among colleagues with research expertise for further comments and reactions. This draft was subjected to another revision, based upon an analysis of these responses. This revision resulted in a reduced number of questions in the hope of increasing the response rate. The vignettes themselves, remained unchanged.

Following this, the questionnaire was pilot tested on a sample that was randomly drawn from the sampling frame. There were twenty respondents from each
Table 1.--Ratings of Vignettes by Panel of Experts ($N = 14$)

<table>
<thead>
<tr>
<th>Vignette #</th>
<th>Child Behavior Problems</th>
<th>Family Problems</th>
<th>Adult Mental Health Problems</th>
<th>Alcohol/Drug Problems</th>
<th>Verisimilitude</th>
<th>Clarity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$\bar{X} = 4.43$</td>
<td>$\bar{X} = 4.85$</td>
<td>$\bar{X} = 4.17$</td>
<td>$\bar{X} = 3.93$</td>
<td>$\bar{X} = 4.36$</td>
<td>$\bar{X} = 4.57$</td>
</tr>
<tr>
<td></td>
<td>SD = .73</td>
<td>SD = .36</td>
<td>SD = 1.14</td>
<td>SD = 1.28</td>
<td>SD = .48</td>
<td>SD = 1.05</td>
</tr>
<tr>
<td>2</td>
<td>$\bar{X} = 4.14$</td>
<td>$\bar{X} = 4.64$</td>
<td>$\bar{X} = 3.89$</td>
<td>$\bar{X} = 2.86^a$</td>
<td>$\bar{X} = 4.50$</td>
<td>$\bar{X} = 4.79$</td>
</tr>
<tr>
<td></td>
<td>SD = 1.19</td>
<td>SD = .48</td>
<td>SD = .99</td>
<td>SD = 1.36</td>
<td>SD = .73</td>
<td>SD = .41</td>
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<tr>
<td>3</td>
<td>$\bar{X} = 4.43$</td>
<td>$\bar{X} = 4.71$</td>
<td>$\bar{X} = 2.70^a$</td>
<td>$\bar{X} = 4.14$</td>
<td>$\bar{X} = 4.54$</td>
<td>$\bar{X} = 4.62$</td>
</tr>
<tr>
<td></td>
<td>SD = .45</td>
<td>SD = .45</td>
<td>SD = 1.19</td>
<td>SD = 1.13</td>
<td>SD = .84</td>
<td>SD = .63</td>
</tr>
</tbody>
</table>

Note: 1 = Definitely not present; 5 = definitely present.

$^a$Section of vignettes revised.
specialization group who were asked to participate in the pilot test \((N = 80)\). In addition to responding to the research instrument, this sub-sample rated the clarity (of wording and of content) of the questionnaire and made suggestions for its improvement. The response rate for the pilot test was 23.75 percent \((N = 19)\). While the respondents were generally positive in their ratings of the instrument, their comments indicated that it took too much time to complete (the modal length was one hour). They also stated that listing primary and secondary problem categories was unwieldy and confusing. The low response rate was taken as confirmation of the respondents' assessment. Analysis of the responses also indicated that respondents consistently failed to respond appropriately to questions which asked them to rank order their answers. Rather, they tended to respond to these questions as though they were Likert scales.

The questionnaire was subjected to a final revision based upon this analysis. The instrument was simplified and the number of questions was reduced by eliminating the secondary problem categories. Questions which had required ordinal responses were changed into Likert scales. The appendix contains the final draft of the data collection instrument.

The questionnaire was mailed in June, 1987. A cover letter was included with this mailing. It broadly
explained the nature and purpose of the study, assured the confidentiality of the participants, and invited the cooperation of those selected to participate. Participants were also offered an opportunity to learn the results of the study. A stamped, self-addressed envelope was included so that participants could conveniently return the questionnaire.

Four weeks following the mailing of the questionnaire packet, a reminder postcard was sent to those who had not returned the instrument at that time. Responses that were received after September 15, 1987 were not included in the data analysis. An analysis of non-respondents was performed in order to determine whether the sample could be considered to be representative of the population.

As the questionnaire did not contain open-ended questions, responses were coded directly from the questionnaire and entered onto computer tape. The data were double punched so that data entry errors were found immediately. A reliability check of coded data was performed so that at least 20 percent of the data (randomly selected) was reviewed. A 98 percent accuracy rate was the minimum acceptable standard. Should the accuracy rate have fallen below this standard, an additional 20 percent of the data would have been examined and so on, until the rate met the 98 percent standard.
The accuracy rate obtained for the first 20 percent of data was virtually 100 percent.

Data Analysis Procedures

Data analysis began with a simple frequency distribution of each variable as a further check of the accuracy and integrity of the data set. Other descriptive statistics were also calculated for all variables. No unusual results were obtained. It was thus concluded that the integrity of the data set was sound.

The reliability of social worker specialization as obtained from NASW membership lists was checked against respondents' self-report of specialization (table 2). There was an apparent lack of correspondence between these two measures of specialization. There were two possibilities that could account for this discrepancy: (1) error in the NASW data set and (2) instability of specialization among social workers. This raised the question of how to validly measure specialization. It would be risky to assume that the NASW data set was inaccurate and to assume that the self-reports were valid. If one would make that assumption and the reality is that specialization is unstable, the validity of the study would be in jeopardy. After considerable thought, it appeared prudent to assume the latter possibility as true. Given that neither of these two measures could be
Table 2.--Comparison of NASW Listed Specializations with Self-Reported Specializations (N = 208)

<table>
<thead>
<tr>
<th>NASW Listed Specialization</th>
<th>Self-Reported Specialization</th>
<th>Developmental Disabilities</th>
<th>Occupational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Youth</td>
<td>Children &amp; Youth</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Families</td>
<td>12</td>
<td>0</td>
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<tr>
<td></td>
<td>Corrections</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Medical/Health</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Public Assistance</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Schools</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Aging</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Alcohol &amp; Drugs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Families</td>
<td>Children &amp; Youth</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Families</td>
<td>20</td>
<td>0</td>
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<tr>
<td></td>
<td>Corrections</td>
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<td>0</td>
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<tr>
<td></td>
<td>Medical/Health</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>12</td>
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<td>Public Assistance</td>
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<td>Schools</td>
<td>0</td>
<td>1</td>
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<td>Aging</td>
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<td>Alcohol &amp; Drugs</td>
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<tr>
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<td>Children &amp; Youth</td>
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<td>0</td>
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<tr>
<td></td>
<td>Families</td>
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<tr>
<td></td>
<td>Corrections</td>
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<tr>
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<td>Medical/Health</td>
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<td>Public Assistance</td>
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<td>Schools</td>
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<td>Aging</td>
<td>0</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Alcohol &amp; Drugs</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>
assumed to be valid, the development of another, valid measurement strategy was necessary.

It was decided that one could not assume that specialization is a simple, categorical variable. Rather, it seems that specialization can be best conceptualized as a complex, multidimensional attribute. Each respondent in this study can thus be seen as more or less of a child specialist, more or less of a family specialist, etc. This conceptualization of specialization makes more intuitive sense and it fits the data. Given this assumption, it became necessary to develop a new methodology to measure these dimensions.

**Development of Specialization Scales**

Scales that measure the four specializations needed to be developed. Several methodological options for the construction of specialization scales were considered. It was clear that factor analyses needed to be performed on those variables (i.e., knowledge, skills, and abilities) that related to the four specialization areas. Varimax rotation and mean substitution for missing data were selected options for these analyses.

Specialization scales were constructed from variables that loaded on the first factor. Those variables that had factor loadings of .30 or less were dropped from the factor. Factor scores were then
calculated and comprised the specialization scales. Factor analysis was also deemed necessary in order to establish construct in addition to face validity for these scales. Table 3 indicates that these new specialization scales closely follow the conceptual definition of specialization. These constituent knowledge, skill, and ability variables loaded highly on the first factors for each specialization category. Virtually every knowledge, skill, and ability variable loaded on the first factor with a loading greater than .30. The fact that the same sorts of variables loaded on each of the four specialization categories can be taken as an indication of the underlying validity of these scales.

Respondents were assigned to one of the following six groups based on their scores on the four specialization scales:

1. Child and youth specialists
2. Family specialists
3. Mental health specialists
4. Alcohol and drug abuse specialists
5. Generalists (i.e., three or more specialties)
6. Non-specialists (i.e., no discernable specialty)

Respondents were considered to have a specialization if they received a Z score of .67 or higher on any of the four specialization scales. A cut off score of .67
### Table 3: Factor Loadings, Communality, and Factor Scores of Specialization Scale Items

<table>
<thead>
<tr>
<th>Specialization</th>
<th>Variable Name</th>
<th>Factor Loading</th>
<th>Communality</th>
<th>Factor Score Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Youth</td>
<td>Frequency of child seminar attendance</td>
<td>.62</td>
<td>.39</td>
<td>.16</td>
</tr>
<tr>
<td></td>
<td>Knowledge of child behavior problems</td>
<td>.91</td>
<td>.83</td>
<td>.24</td>
</tr>
<tr>
<td></td>
<td>Knowledge of child treatment methods</td>
<td>.88</td>
<td>.78</td>
<td>.23</td>
</tr>
<tr>
<td></td>
<td>Frequency of screening for child problems</td>
<td>.66</td>
<td>.44</td>
<td>.17</td>
</tr>
<tr>
<td></td>
<td>Skill in identifying child behavior problems</td>
<td>.89</td>
<td>.80</td>
<td>.23</td>
</tr>
<tr>
<td></td>
<td>Knowledge of resources for children</td>
<td>.79</td>
<td>.62</td>
<td>.21</td>
</tr>
<tr>
<td>Families</td>
<td>Frequency of family seminar attendance</td>
<td>.52</td>
<td>.27</td>
<td>.15</td>
</tr>
<tr>
<td></td>
<td>Knowledge of family problems</td>
<td>.89</td>
<td>.80</td>
<td>.26</td>
</tr>
<tr>
<td></td>
<td>Knowledge of family treatment methods</td>
<td>.88</td>
<td>.77</td>
<td>.26</td>
</tr>
<tr>
<td></td>
<td>Frequency of screening for family problems</td>
<td>.55</td>
<td>.30</td>
<td>.16</td>
</tr>
<tr>
<td></td>
<td>Skill in identifying family problems</td>
<td>.85</td>
<td>.73</td>
<td>.25</td>
</tr>
<tr>
<td></td>
<td>Knowledge of resources for families</td>
<td>.75</td>
<td>.57</td>
<td>.22</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Frequency of adult mental health seminar attendance</td>
<td>.51</td>
<td>.26</td>
<td>.16</td>
</tr>
<tr>
<td></td>
<td>Knowledge of chronic mental illness</td>
<td>.88</td>
<td>.77</td>
<td>.28</td>
</tr>
<tr>
<td></td>
<td>Knowledge of individual adult treatment</td>
<td>.66</td>
<td>.44</td>
<td>.21</td>
</tr>
<tr>
<td></td>
<td>Frequency of screening for adult mental disorders</td>
<td>.64</td>
<td>.41</td>
<td>.20</td>
</tr>
<tr>
<td></td>
<td>Skill in identifying adult chronic mental illnesses</td>
<td>.86</td>
<td>.73</td>
<td>.27</td>
</tr>
<tr>
<td></td>
<td>Knowledge of community psychiatric resources</td>
<td>.75</td>
<td>.57</td>
<td>.24</td>
</tr>
<tr>
<td>Alcohol &amp; Drugs</td>
<td>Frequency of alcohol/drug seminar attendance</td>
<td>.71</td>
<td>.50</td>
<td>.21</td>
</tr>
<tr>
<td></td>
<td>Knowledge of alcohol and drugs</td>
<td>.89</td>
<td>.79</td>
<td>.26</td>
</tr>
<tr>
<td></td>
<td>Knowledge of group treatment methods</td>
<td>.41</td>
<td>.17</td>
<td>.12</td>
</tr>
<tr>
<td></td>
<td>Frequency of screening for alcohol/drug problems</td>
<td>.64</td>
<td>.41</td>
<td>.19</td>
</tr>
<tr>
<td></td>
<td>Skill in identifying alcohol/drug problems</td>
<td>.93</td>
<td>.86</td>
<td>.27</td>
</tr>
<tr>
<td></td>
<td>Knowledge of resources for alcohol/drug problems</td>
<td>.82</td>
<td>.67</td>
<td>.24</td>
</tr>
</tbody>
</table>
was selected because 75 percent of respondents fell below that score. Those respondents who scored higher than 75 percent of the others in two areas of specialization were assigned to a specialization group on the basis of their highest score. Thus, specialists are operationally defined as those respondents who scored higher than three quarters of their colleagues on one or two specialization scales. Generalists were defined as those who scored higher than 75 percent of their colleagues on at least three of the specialization scales, while non-specialists were defined as those respondents who failed to score higher than three quarters of their colleagues on any of the four scales. Table 4 represents the distribution of respondents across the six specialization groups. It should be noted here that these categories are not independent from one another.

Development of Case Perception Scales

An overall measure of perception of child, family, mental health, and alcohol/drug problems was obtained for each respondent. Thus, respondents received scores on four separate perception scales. These scales measured respondents' degree of focus on the four problem areas identified in their assessments. Perception scales were constructed in the following manner:
Table 4.--Frequency Distribution of Respondents Across Specialization Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Number</th>
<th>%</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Youth</td>
<td>31</td>
<td>13.6</td>
<td>13.6</td>
</tr>
<tr>
<td>Families</td>
<td>21</td>
<td>9.2</td>
<td>22.8</td>
</tr>
<tr>
<td>Mental Health</td>
<td>33</td>
<td>14.5</td>
<td>37.3</td>
</tr>
<tr>
<td>Alcohol &amp; Drugs</td>
<td>44</td>
<td>19.3</td>
<td>56.6</td>
</tr>
<tr>
<td>Generalists</td>
<td>25</td>
<td>11.0</td>
<td>67.6</td>
</tr>
<tr>
<td>Non-Specialists</td>
<td>74</td>
<td>32.5</td>
<td>100.1(^a)</td>
</tr>
<tr>
<td>Total</td>
<td>228</td>
<td>100.0</td>
<td>100.1(^a)</td>
</tr>
</tbody>
</table>

\(^a\)Due to rounding error.
Respondents' identification of case problems were assigned as falling within one of the four specialization areas. For example, marital problems, parent-child problems, family communication problems, family hierarchical/structural problems were assigned to a family oriented problem group while anxiety disorder, personality disorder, depression, schizophrenia were assigned to a mental health oriented problem group. If respondents selected problems that fell into one of these problem groups, the severity of that identified problem, the necessity for resolution of that problem, and the degree of dysfunction of the person, family sub-unit, or family unit having that problem were included as values on the perception scale. These scales therefore measured respondents' degree of focus on these four dimensions of problems identified in their assessments.

Factor analyses were then performed on the variables that comprise these scales. Those variables that loaded below .30 were to have been dropped from the scale. This was not necessary, however, as all loaded rather highly on the factors. Table 5 indicates that these scales are internally consistent. One may thus conclude that construct as well as face validity was established. Factor scores for each variable was obtained and formed the basis of these scales. The factor scores are also listed in table 5.
Table 5.--Factor Loadings, Communality and Factor Scores of Perception Scale Items

<table>
<thead>
<tr>
<th>Perception</th>
<th>Variable Name</th>
<th>Vignette</th>
<th>Factor Loading</th>
<th>Communality</th>
<th>Factor Score Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Severity of Child Problem</td>
<td>Identified Child Problems</td>
<td>1</td>
<td>.72</td>
<td>.97</td>
<td>.14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>.71</td>
<td>.96</td>
<td>.14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>.83</td>
<td>.98</td>
<td>.16</td>
</tr>
<tr>
<td>Necessity for Child Resolution of Child Problems</td>
<td>1</td>
<td>.72</td>
<td>.95</td>
<td>.14</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>.66</td>
<td>.93</td>
<td>.13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>.82</td>
<td>.95</td>
<td>.16</td>
</tr>
<tr>
<td>Family Severity of Family Problem</td>
<td>Identified Family Problems</td>
<td>1</td>
<td>.73</td>
<td>.96</td>
<td>.15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>.81</td>
<td>.93</td>
<td>.16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>.78</td>
<td>.88</td>
<td>.16</td>
</tr>
<tr>
<td>Necessity for Family Resolution of Family Problems</td>
<td>1</td>
<td>.71</td>
<td>.93</td>
<td>.14</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>.78</td>
<td>.89</td>
<td>.16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>.64</td>
<td>.76</td>
<td>.13</td>
</tr>
<tr>
<td>Adult Severity of Adult Mental Health Problems</td>
<td>1</td>
<td>.72</td>
<td>.96</td>
<td>.13</td>
<td></td>
</tr>
<tr>
<td>Mental severity of Adult Mental Health Problems</td>
<td>2</td>
<td>.81</td>
<td>.93</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td>Health Mental Health Problems</td>
<td>3</td>
<td>.83</td>
<td>.96</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td>Necessity for Mental Health Problems</td>
<td>1</td>
<td>.73</td>
<td>.93</td>
<td>.13</td>
<td></td>
</tr>
<tr>
<td>Resolution of Mental Health Problems</td>
<td>2</td>
<td>.78</td>
<td>.94</td>
<td>.14</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health Problems</td>
<td>3</td>
<td>.80</td>
<td>.94</td>
<td>.14</td>
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</tr>
</tbody>
</table>
Table 5--Continued

<table>
<thead>
<tr>
<th>Perception</th>
<th>Variable Name</th>
<th>Vignette</th>
<th>Factor Loading</th>
<th>Communality</th>
<th>Factor Score Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Degree of Dysfunction of Adult(s) with Alcohol/Drug Problems</td>
<td>1</td>
<td>.82</td>
<td>.97</td>
<td>.13</td>
</tr>
<tr>
<td></td>
<td>Alcohol/Drug Problem</td>
<td>2</td>
<td>.86</td>
<td>.87</td>
<td>.13</td>
</tr>
<tr>
<td></td>
<td>Severity of Identified Alcohol/Drug Problems</td>
<td>3</td>
<td>.88</td>
<td>.80</td>
<td>.14</td>
</tr>
<tr>
<td></td>
<td>Necessity for Resolution of Alcohol/Drug Problems</td>
<td>1</td>
<td>.81</td>
<td>.98</td>
<td>.13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>.83</td>
<td>.86</td>
<td>.13</td>
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<td></td>
<td></td>
<td>3</td>
<td>.89</td>
<td>.80</td>
<td>.14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>.80</td>
<td>.95</td>
<td>.12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>.84</td>
<td>.83</td>
<td>.13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>.88</td>
<td>.81</td>
<td>.14</td>
</tr>
</tbody>
</table>
Development of Treatment and Referral Scales

Four sets of referral scales and four sets of treatment scales (i.e., one each for child, family, mental health, alcohol/drug activities) were constructed in order to determine the degree to which respondents' service plans centered upon each problem area. Respondents were given six referral and six treatment options for each vignette in the survey instrument. Referral and treatment responses to the vignettes were categorized as either child, family, mental health, alcohol/drug oriented. The number of child centered, family centered, mental health centered, and alcohol/drug centered activities was then obtained. Responses to these activity questions were subjected to a factor analysis. Those variables that failed to load on a factor with a value greater than .30 were to have been removed from the factor. However, no variables were removed as all exceeded this criterion. Referral and treatment responses that were listed first loaded highly on the respective first factor (see tables 6 and 7). Factor scores were computed from these factor loadings. First referral and treatment activities were interpreted as receiving higher priority from the respondents than those that were listed later. The factor scores thus comprise scales that reflect high priority given child, family, mental health,
<table>
<thead>
<tr>
<th>Referral Scale</th>
<th>First Referral</th>
<th>Factor Loading</th>
<th>Communality</th>
<th>Factor Score Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Referral</td>
<td>Vignette 1</td>
<td>.38</td>
<td>.88</td>
<td>- .06</td>
</tr>
<tr>
<td></td>
<td>Vignette 2</td>
<td>.66</td>
<td>.73</td>
<td>.71</td>
</tr>
<tr>
<td></td>
<td>Vignette 3</td>
<td>.79</td>
<td>.63</td>
<td>.58</td>
</tr>
<tr>
<td>Family Referral</td>
<td>Vignette 1</td>
<td>.74</td>
<td>.54</td>
<td>.44</td>
</tr>
<tr>
<td></td>
<td>Vignette 2</td>
<td>.82</td>
<td>.67</td>
<td>.49</td>
</tr>
<tr>
<td></td>
<td>Vignette 3</td>
<td>.68</td>
<td>.46</td>
<td>.41</td>
</tr>
<tr>
<td>Adult Mental Health Referral</td>
<td>Vignette 1</td>
<td>.78</td>
<td>.60</td>
<td>.45</td>
</tr>
<tr>
<td></td>
<td>Vignette 2</td>
<td>.82</td>
<td>.67</td>
<td>.47</td>
</tr>
<tr>
<td></td>
<td>Vignette 3</td>
<td>.68</td>
<td>.46</td>
<td>.39</td>
</tr>
<tr>
<td>Alcohol/Drug Abuse Referral</td>
<td>Vignette 1</td>
<td>.75</td>
<td>.56</td>
<td>.42</td>
</tr>
<tr>
<td></td>
<td>Vignette 2</td>
<td>.75</td>
<td>.56</td>
<td>.42</td>
</tr>
<tr>
<td></td>
<td>Vignette 3</td>
<td>.81</td>
<td>.66</td>
<td>.46</td>
</tr>
</tbody>
</table>
Table 7.--Factor Loadings, Communality and Factor Scores of Treatment Scale Items

<table>
<thead>
<tr>
<th>Treatment Scale</th>
<th>First Treatment</th>
<th>Factor Loading</th>
<th>Communality</th>
<th>Factor Score Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Treatment</td>
<td>Vignette 1</td>
<td>.77</td>
<td>.60</td>
<td>.44</td>
</tr>
<tr>
<td></td>
<td>Vignette 2</td>
<td>.80</td>
<td>.63</td>
<td>.45</td>
</tr>
<tr>
<td></td>
<td>Vignette 3</td>
<td>.73</td>
<td>.53</td>
<td>.41</td>
</tr>
<tr>
<td>Family Treatment</td>
<td>Vignette 1</td>
<td>.81</td>
<td>.66</td>
<td>.39</td>
</tr>
<tr>
<td></td>
<td>Vignette 2</td>
<td>.85</td>
<td>.71</td>
<td>.40</td>
</tr>
<tr>
<td></td>
<td>Vignette 3</td>
<td>.86</td>
<td>.74</td>
<td>.41</td>
</tr>
<tr>
<td>Adult Mental Health Treatment</td>
<td>Vignette 1</td>
<td>.79</td>
<td>.62</td>
<td>.39</td>
</tr>
<tr>
<td></td>
<td>Vignette 2</td>
<td>.83</td>
<td>.69</td>
<td>.41</td>
</tr>
<tr>
<td></td>
<td>Vignette 3</td>
<td>.85</td>
<td>.72</td>
<td>.42</td>
</tr>
<tr>
<td>Alcohol/Drug Abuse Treatment</td>
<td>Vignette 1</td>
<td>.78</td>
<td>.61</td>
<td>.39</td>
</tr>
<tr>
<td></td>
<td>Vignette 2</td>
<td>.85</td>
<td>.72</td>
<td>.43</td>
</tr>
<tr>
<td></td>
<td>Vignette 3</td>
<td>.81</td>
<td>.65</td>
<td>.41</td>
</tr>
</tbody>
</table>
and alcohol/drug referral and treatment activities. Tables 6 and 7 indicate that these scales were internally consistent. Thus, as with the other sets of scales, construct as well as face validity was established.

Major Statistical Analyses

Following the construction of these scales, the major statistical methods employed were analysis of variance and multiple regression. These techniques were employed to determine the nature and significance of between group differences in attitudes and judgments, and background variables that account for these differences. Pearson correlations were calculated for all independent variables in order to determine whether multicolinearity existed among them. Those variables that correlated at .70 or greater were either combined or eliminated from the study.

One way analysis of variance was employed to determine those demographic, educational, attitudinal, and family background variables that predict respondents' membership in the six specialization groups. Analysis of variance was performed on variables that appeared as interval level on the questionnaire and on dummy variables. Analysis of variance was deemed appropriate for dummy variables since these variables had only two values associated with them. Therefore, in contrast to
categorical variables, means of dummy variables are valid values since they reflect the proportion of subjects who were coded with a value of 1 for that variable. Post-hoc contrasts were performed between and among groups to determine which were significantly different from the others.

Analysis of variance was also employed to describe differences among the six groups with respect to case perception, case referral, and case treatment differences. Once differences were found and described, hierarchical regression was employed to test the relative contributions of specialization to explaining the differences in the four case perception scales. This model consisted of four blocks. The first block consisted of a dummy variable of group membership. Only the specialization group that corresponded to the dependent variable that was analyzed was included in the block. Therefore, child oriented case perceptions were analyzed using child specialization in the first block. The corresponding specialization group was selected for analysis as this model was designed to determine the relative contribution of that particular specialization group to explaining the variance of case perception. The second block consisted of educational background variables that were found to be related to specialization in the analyses of variance. The third block consisted of variables that describe
respondents' approaches to their own practices and in their overall approach to the case vignettes. Thus, respondents' pattern of referrals to community services and their overall level of confidence in their assessments of the case vignettes were included in this block. The fourth block consisted of variables which measured relevant aspects of respondents' family histories. For example, this block included whether respondents' had members with a history of alcohol/drug abuse in their immediate families.

Regression analyses of referrals and treatment were similar to those of case perception. The difference in this group of analyses was that case perception variables were added to the regression model as independent variables. As with specialization variables, only those case perception variables that corresponded to the dependent variable were included in this block. This variable was inserted between the specialization block and the educational background block. The analyses of referrals and treatment therefore consisted of five blocks.

Hierarchical regression was chosen since the research question required model testing rather than determining the combination of variables which could most powerfully explain the variance of the dependent variables.
CHAPTER 4
RESULTS

Response Rate
Two hundred forty-three responses were received out of a total of six hundred questionnaires. Therefore, the response rate was 40.5 percent. Of those returned questionnaires, 228 yielded data that was used in this study. As previously noted, some questionnaires were received after the deadline for receipt. Others only contained demographic information and thus could not be used in the analysis. Therefore, while the response rate was 40.5 percent, data analysis was conducted on 38 percent of the mailed questionnaires.

Demographic Data
The data indicated that 73.2 percent of the respondents were female ($N = 167$) and 26.8 percent were male ($N = 61$). Thus, nearly three quarters of the sample was comprised of females. Of the 228 respondents, the mean age was 42.29 ($SD = 9.31$).

Respondents were overwhelmingly white. Fully 94.7 percent ($N = 216$) of the sample reported themselves as Caucasian. The second largest group of respondents were Black, but this group comprised only 2.6 percent of the
sample (N = 6). Respondents of other racial groups comprised only 2.6 percent of the sample (N = 6). The sample was ethnically diverse. The largest ethnic group was Anglo-Saxon/Scot/Welsh (26.3 percent, N = 60) followed by Jews (21.5 percent, N = 49). Germans and Irish comprised the other two sizeable ethnic groups. They comprised 13.6 percent (N = 31) and 11.4 percent (N = 26) respectively.

Most of the respondents were Protestant (35.1 percent, N = 80). The second largest religious group represented in the sample was Jewish, comprising 22.4 percent of the sample (N = 51). There was also a relatively large group of Roman Catholics. This group comprised 20.6 percent of the sample (N = 47). A fairly large number of respondents reported that they belonged to no religious group (13.6 percent, N = 31). There were very few respondents who identified themselves as members of other religious groups.

Fully two thirds of the sample were married at the time of the survey (66.5 percent, N = 151). Nearly a fifth (17.2 percent, N = 39) were never married. Only 12.3 percent (N = 28) of respondents were divorced and unmarried at the time. Very few respondents were separated (2.6 percent, N = 6) or widowed (1.3 percent, N = 3). The mean number of children for this sample was 1.53 (SD = 1.54).
The median was one and the modal number of children was zero. An examination of table 8 reveals a bi-modal distribution. Respondents were most likely to have either no children or two children.

Respondents tended to have received their MSW degrees during the mid-1970s (mean year that MSW was granted = 1975.49, SD = 7.09). While the majority (75 percent, N = 168) had concentrated in clinical practice during their master's training, 17.4 percent (N = 39) had concentrated in generalist practice. Only 4.5 percent (N = 10) reported that they had concentrated in community organization, planning, or administration. Several respondents received graduate degrees in addition to the MSW. Of this group, most received a master's degree in another discipline (8.8 percent, N = 20). Only 2.6 percent of respondents received a doctorate in social work (N = 6), while only 1.6 percent (N = 3) received a doctorate in another discipline. There was a small group of respondents (2.2 percent, N = 5) who reported receiving an additional professional degree in a field other than social work.

Representativeness of the Sample

Analyses comparing respondents to non-respondents were performed. Membership numbers of all non-respondents were submitted to the National Association of Social Workers (NASW) which then provided data and summary
<table>
<thead>
<tr>
<th>Number of Children</th>
<th>N</th>
<th>Valid Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>76</td>
<td>33.5</td>
</tr>
<tr>
<td>1</td>
<td>38</td>
<td>16.7</td>
</tr>
<tr>
<td>2</td>
<td>68</td>
<td>30.0</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
<td>11.0</td>
</tr>
<tr>
<td>4</td>
<td>13</td>
<td>5.7</td>
</tr>
<tr>
<td>5 or more</td>
<td>7</td>
<td>3.1</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>--</td>
</tr>
<tr>
<td>Total</td>
<td>228</td>
<td>100.0</td>
</tr>
</tbody>
</table>
statistics on this group. Data concerning the sex, age, race, and year in which the MSW degree was granted for non-respondents were thus obtained. There were no significant differences between respondents and non-respondents with regard to age, sex, and race. However, as indicated by table 9, there was a significant difference in the year that the MSW degree was granted ($t = 5.46, p < .001$). The analysis revealed that respondents had an average of 3.66 years less experience than did non-respondents. Respondents, on the average, were less experienced. Although this difference may indicate that the sample may not be representative of the sampling frame, it should be noted that both groups were very experienced.

The reader should recall that the sample was originally stratified based upon members' specializations as listed in NASW records. An analysis was performed to compare respondents to non-respondents on the basis of membership in these groups. As revealed by table 10, those who were listed as family specialists were less likely to respond to the survey ($\chi^2 = 11.04, p < .01$). Further analyses were performed to determine if respondents who belonged to this group differed from those in this group who did not respond to the survey. There were no significant differences between this group of respondents and non-respondents with regard to sex, age, race, and year in which MSW was granted. Although one cannot be definite, it
Table 9.--Mean Year In Which MSW Was Granted and Standard Deviation of Respondents and Non-Respondents

<table>
<thead>
<tr>
<th></th>
<th>Mean Year In Which MSW Was Granted</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondents</td>
<td>1975.49</td>
<td>7.09</td>
</tr>
<tr>
<td>Non-Respondents</td>
<td>1971.83</td>
<td>7.85</td>
</tr>
</tbody>
</table>

Note. df = 454; \( t = 5.46; \) \( p < .001 \).
Table 10.--Cross-Tabulation Table Comparing Respondents and Non-Respondents by NASW Specialization Group

<table>
<thead>
<tr>
<th>NASW Specialization Group</th>
<th>Children &amp; Youth</th>
<th>Families</th>
<th>Mental Health</th>
<th>Alcohol/Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondents</td>
<td>64</td>
<td>40</td>
<td>61</td>
<td>63</td>
</tr>
<tr>
<td>Non-Respondents</td>
<td>86</td>
<td>110</td>
<td>89</td>
<td>87</td>
</tr>
</tbody>
</table>

Note. $df = 3; \chi^2 = 11.04; p < .01.$
is reasonable to conclude that respondents are roughly equivalent to non-respondents and that the sample is representative of the sampling frame.

Analysis of Specialization

Since social worker specialization is the key independent variable studied, an analysis of factors that underlie specialization was performed. The purpose of this analysis was to provide a description of the differences among members of the specialization groups. There were several significant differences and trends among the six groups.

Analysis of Children and Youth Specialists

Child and youth specialists were more likely to have received their MSW degrees earlier than were other respondents ($F = 4.8686, p = .0003$). In addition, this group of respondents were more likely to have been placed in an agency that serves children and youth during the second year of their MSW program than were others ($F = 2.6433, p = .0241$). This specialization group also was less likely to have had a member of their immediate family with a history of alcohol and/or drug abuse ($F = 3.117, p = .0097$).
Analysis of Family Specialists

Family specialists were more likely to have been placed in child and youth serving agencies than were other respondents, although to a lesser degree than were children and youth specialists. Family specialists on the whole were more pessimistic about the outcomes of the case vignettes following treatment than were all other groups, with the exception of non-specialists ($F = 3.9786, p = .0016$).

Two important attitudinal differences were noted. Family specialists were the least likely to believe that alcohol or drug problems were caused by underlying psychosocial stressors ($F = 2.4272, p = .0363$). In addition, this group was most likely to believe that child behavior problems are best treated in conjoint family therapy ($F = 2.8744, p = .0155$).

Analysis of Mental Health Specialists

Mental health specialists comprised the oldest group of respondents in the sample ($F = 2.6921, p = .0220$). There was a trend that members of this group were more likely to have been placed in mental health agencies during the second year of their MSW program ($F = 2.0985, p = .0666$). In contrast to child and youth specialists and to family specialists, mental health specialists were the least likely to have been placed in agencies that serve
children and youth. The main attitudinal difference was that mental health specialists were the most likely to believe that alcohol and/or drug abuse is best treated by addressing underlying stressful psychosocial conditions than were other groups.

Analysis of Alcohol/Drug Abuse Specialists

Males tended to be over-represented among alcohol/drug abuse specialists, as compared to other groups ($F = 2.7394, p = .0201$). Although there were only a few in this sample, there was a trend indicating that Blacks were concentrated in this group as well ($F = 1.9975, p = .08$). In contrast to other groups, particularly child and youth specialists, alcohol/drug abuse specialists were more likely to have received their MSW degrees more recently ($F = 4.8686, p = .0003$).

It is interesting to note that the data indicated that alcohol/drug abuse specialists were most likely to have been placed in alcohol/drug abuse agencies during both the first and second years of their MSW programs ($F = 2.0667, p = .0706; F = 5.155, p = .0002$; respectively). There was also some evidence that alcohol/drug abuse specialists were more likely to have a member of their immediate families with a history alcohol and/or drug abuse than were others in this sample ($F = 3.1177, p = .0097$). This finding should be qualified as a post-hoc analysis
indicated that this group difference failed to reach significance ($p = .066$). However, a trend still exists in this direction.

In analyzing this group's responses to the case vignettes, two general differences emerged. Alcohol/drug abuse specialists were more likely to report more optimistic prognoses for these cases ($F = 3.9786$, $p = .0016$). In addition, this group of specialists were more confident in their assessments of the case vignettes ($F = 5.9204$, $p < .0001$). However, a post-hoc comparison of this group to all other groups indicated that this difference constituted a trend ($p = .08$).

Two significant attitudinal differences were noted. Alcohol/drug abuse specialists were more likely to believe that the best way to help children of alcohol/drug abusing parents is to treat their parents' substance abuse conditions ($F = 2.4535$, $p = .0346$). In addition, this group was least likely to believe that substance abuse disorders were symptoms of underlying family problems than were others ($F = 4.7378$, $p = .0004$).

**Analysis of Generalists**

Generalists, along with mental health specialists, were more likely to be older than were others in the sample ($F = 2.6921$, $p = .0220$). Those few who were placed in correctional facilities for their first year internships
were more likely to be included in this group ($F = 2.3654, p = .0407$). A trend was noted that, next to mental health specialists, generalists were most likely to have been placed in mental health agencies during the second year of their MSW programs ($F = 2.0985, p = .0666$).

As with alcohol/drug abuse specialists, there was a trend indicating that generalists were more likely to have had a member of their immediate family with a history of drug and/or alcohol abuse. Indeed, generalists were slightly more likely to have members with these conditions than were alcohol/drug abuse specialists. Next to the alcohol/drug abuse specialists, generalists were the most optimistic in regard to the outcome of the case vignettes following treatment ($F = 3.9786, p = .0018$). Generalists were also the most confident about the accuracy of their assessments of the case vignettes ($F = 5.9204, p < .0001$).

**Analysis of Non-Specialists**

Women were more apt to be non-specialists than were men ($F = 2.7394, p = .0201$). This group of clinicians tended to have the most pessimistic prognoses in regard to the case vignettes ($F = 3.9786, p < .0018$). Non-specialists were also likely to have the least confidence in their assessments of these case vignettes ($F = 5.9204, p < .0001$).
Analysis of Case Perceptions

As stated in the previous chapter, four perception scales were developed for this analysis: child and youth oriented case perception, family oriented case perception, mental health oriented case perception, and alcohol/drug abuse oriented case perception. Each of these scales consisted of nine different variables.

The first three variables consisted of sums of respondents' ratings of the degree of dysfunction for clients in each of the three vignettes (survey questions 8, 17, 26). The second three variables consisted of the sums of ratings for the severity of case problems listed in the case vignettes. The third group of variables consisted of sums of respondents' estimation of the necessity for problem resolution in order to achieve significant case improvement for each vignette (survey questions 11, 20, 29). For example, the child and youth oriented perception scale consisted of the sums of respondents' ratings of the degree of dysfunction exhibited by clients who were identified as having or reacting to child oriented problems. It also consisted of respondents' ratings of the severity of these problems, and the necessity of their resolution. The other three perception scales had the same structure, but measured respondents' perceptions of family, mental health, and alcohol/drug abuse problems.
Child and youth oriented problems were defined as child behavior problems, child abuse/neglect, child sexual abuse, or being the child of an alcohol abuser. Family oriented problems were defined as marital problems, parent-child problems, as alcoholic family systems, family system problems, structural family problems, family communication problems, or family role problems. Mental health problems were defined as anxiety disorders, personality disorders, depression, other affective disorders, schizophrenia, and other thought disorders. Alcohol/drug abuse problems included co-dependency, being the child of an alcoholic, alcoholic family systems, as well as alcohol/drug abuse. All of these problem definitions may be found in questions 9, 18, and 27 of the research instrument. It should be noted that certain problem definitions were counted twice (e.g., alcoholic family systems were defined as both family and alcohol/drug oriented problems). These problem definitions were counted twice since they belonged equally in both scales.

Analyses of variance indicated that case perception systematically varied according to group membership. An analysis of group differences with regard to perception of child oriented case problems indicated that a trend existed in favor of differential perception ($F = 2.148, p = .0618$). Generalists tended to focus on child oriented problems more than did other groups. Non-specialists did
not tend to perceive cases in terms of child oriented problems. Surprisingly, child specialists were less likely to perceive case problems in child oriented terms than every other group, with the exception of non-specialists.

A trend was also noted in group differences with regard to family oriented case perceptions ($F = 2.051, p = .0738$). Family specialists were most likely to perceive case problems in terms of family oriented problems than were other groups. Next to family specialists, generalists were most likely to perceive case problems in family dimensions. In contrast, alcohol/drug abuse specialists and non-specialists were least likely to perceive case problems in this fashion.

Highly significant differences were found among groups with regard to alcohol/drug oriented case perceptions ($F = 9.819, p < .0001$). Alcohol/drug abuse specialists were most likely to perceive case problems in terms of alcohol/drug abuse. Although a good deal less likely to do so, generalists were the next most likely to perceive case problems in these terms. Child and youth specialists were the least likely to perceive alcohol/drug abuse in the case vignettes. There were no significant differences in perceptions of mental health oriented case problems ($F = 1.210, p = .3064$).
Results of hierarchical regression analyses indicated that the regression model did not explain much of the variance for perception of child and youth oriented problems, nor did it account for family oriented problem perceptions. However, the regression model did explain portions of the variance for mental health and for alcohol/drug abuse oriented problem perceptions.

As table 11 indicates, 11 percent of the variance of mental health oriented problem perceptions was explained by the regression model. Mental health specialization made an insignificant negative contribution to the model. The variables that made the largest contributions were those that pertained to respondents' current practices. The variable that made the largest contribution measured the percentage of respondents' caseloads referred to self-help groups in the past year. In addition, the percentage of respondents' caseloads referred to child treatment services also explained a significant portion of the variance. The relations of both of these variables to mental health oriented problem perceptions were positive. In contrast, the variable that made the third largest contribution, the percentage of respondents' caseload referred for child welfare services in the past year, was negatively associated with the dependent variable.

As table 12 indicates, nearly 26 percent of the variance of alcohol/drug abuse problem perceptions was
Table 11.--Regression Analysis of the Relationship of Independent Variables to Mental Health Problem Perception

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Specialization</td>
<td>-0.097</td>
<td>-0.047</td>
</tr>
<tr>
<td>Clinical Social Work Concentration</td>
<td>-0.008</td>
<td>-0.005</td>
</tr>
<tr>
<td>while in MSW Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year During which MSW was Granted</td>
<td>-0.005</td>
<td>-0.046</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred for Child Treatment in Past Year</td>
<td>0.007</td>
<td>0.177*</td>
</tr>
<tr>
<td>Estimated Length of Service for Case Vignettes</td>
<td>0.006</td>
<td>0.140*</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred for Child Treatment in Past Year</td>
<td>0.000</td>
<td>0.006</td>
</tr>
<tr>
<td>Degree of Respondents' Confidence in their Assessments of Case Vignettes</td>
<td>-0.011</td>
<td>0.047</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred to Self-Help Groups in Past Year</td>
<td>0.006</td>
<td>0.235**</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred for Alcohol/Drug Abuse Treatment in Past Year</td>
<td>-0.002</td>
<td>-0.063</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred for Family Treatment in Past Year</td>
<td>0.001</td>
<td>0.017</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred for Child Welfare Services in Past Year</td>
<td>-0.005</td>
<td>-0.144</td>
</tr>
<tr>
<td>History of Chronic Mental Illness in Respondents' Immediate Families</td>
<td>0.009</td>
<td>0.004</td>
</tr>
<tr>
<td>History of Alcohol/Drug Abuse in Respondents' Immediate Families</td>
<td>0.035</td>
<td>0.024</td>
</tr>
<tr>
<td>Independent Variables</td>
<td>( b )</td>
<td>Beta</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>History of Sexual Abuse in Respondents' Immediate Families</td>
<td>.006</td>
<td>.004</td>
</tr>
<tr>
<td>Intercept</td>
<td>.081</td>
<td></td>
</tr>
</tbody>
</table>

Note. \( N = 228; R = .33; R^2 = .11; F = 1.905; p = .0272. \)

\*\( p < .05 \).

\**\( p < .005 \).
Table 12.--Regression Analysis of the Relationship of Independent Variables to Alcohol/Drug Abuse Problem Perception

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drug Abuse Specialization</td>
<td>.375</td>
<td>.204**</td>
</tr>
<tr>
<td>Clinical Social Work Concentration While in MSW Program</td>
<td>.099</td>
<td>.060</td>
</tr>
<tr>
<td>Year During Which MSW Was Granted</td>
<td>.010</td>
<td>.092</td>
</tr>
<tr>
<td>Estimated Length of Service for Case Vignettes</td>
<td>.003</td>
<td>.070</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Treatment in Past Year</td>
<td>-.001</td>
<td>-.027</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Community Centers in Past Year</td>
<td>-.003</td>
<td>-.060</td>
</tr>
<tr>
<td>Degree of Respondents' Confidence in Their Assessment of Case Vignettes</td>
<td>.012</td>
<td>.056</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Alcohol/Drug Abuse Treatment in Past Year</td>
<td>-.004</td>
<td>-.125</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Family Treatment in Past Year</td>
<td>.007</td>
<td>.188*</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Self-Help Groups in Past Year</td>
<td>.005</td>
<td>.221***</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Welfare Services in Past Year</td>
<td>-.003</td>
<td>-.076</td>
</tr>
<tr>
<td>History of Alcohol/Drug Abuse in Respondents' Immediate Families</td>
<td>.060</td>
<td>.041</td>
</tr>
<tr>
<td>History of Chronic Mental Illness in Respondents' Immediate Families</td>
<td>.166</td>
<td>.084</td>
</tr>
</tbody>
</table>
### Table 12--Continued

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Sexual Abuse in Respondents' Immediate Families</td>
<td>.184</td>
<td>.101</td>
</tr>
<tr>
<td>Intercept</td>
<td>-1.469</td>
<td></td>
</tr>
</tbody>
</table>

Note. $N = 228; R = .51; R^2 = .26; F = 5.290; p < .0001.$

* $p < .05.$

** $p < .01.$

*** $p < .005.$
explained by the regression model. Alcohol/drug abuse specialization by itself made a strong positive contribution \((r = .39, p < .0001)\) in explaining the variance. In addition, the percentage of respondents' caseloads referred to self-help groups made the strongest contribution to the model. The direction of the association was positive. The percentage of respondents' caseloads referred for family treatment services also made a significant contribution to the model. Respondents with a history of sexual abuse in their immediate families were also more apt to perceive case problems in terms of alcohol/drug abuse. In contrast, the percentage of respondents' caseloads referred for alcohol/drug abuse treatment services was negatively associated with the dependent variable.

**Analysis of Referrals**

Four scales which measured high priority referrals were developed. These scales measured either high priority child and youth, family, mental health, or alcohol/drug abuse referrals. The scales consisted of the sum of the referrals that were listed first in the above categories for each of the vignettes (survey questions 12, 21, 30). Thus, the high priority child referral scale consisted of the number of first referrals to individual child treatment, children's groups, or child welfare services. The high priority family referral scale consisted of the number
of first referrals for multiple family group treatment, couples treatment, conjoint family treatment, or parent skills groups. The high priority mental health referral scale consisted of the number of first referrals for psychiatric consultation or psychological testing services for each of the vignettes. The last referral scale measured high priority alcohol/drug abuse referrals for the three vignettes. High priority alcohol/drug abuse referrals were defined as first referrals for alcohol/drug abuse evaluation, alcohol/drug abuse treatment or to self-help groups.

No significant differences were found among groups with regard to high priority child oriented referrals \( (F = .706, p = .6195) \), with regard to high priority family oriented referrals \( (F = 1.808, p = .1123) \), nor with high priority alcohol/drug abuse oriented referrals \( (F = .758, p = .5809) \).

Group differences in mental health referrals were highly significant \( (F = 2.839, p = .0166) \). Generalists were most likely to assign a high priority to such mental health services as psychiatric consultation and psychological testing. Mental health specialists were also likely to assign high priority to these referrals. In contrast, child and youth specialists were least likely to make such referrals high priority. Alcohol/drug abuse specialists were also unlikely to do so.
Regression analyses indicated that relationships existed between the independent variables of the model and high priority family and alcohol/drug abuse referrals. The regression model was not valid for child oriented referrals nor for mental health oriented referrals. While the regression analysis could not account for the variance of mental health oriented referrals, a bivariate analysis indicated that mental health specialization did make a small but significant contribution to explaining the variance of high priority mental health referrals ($r = .14, p = .0359$).

As table 13 indicates, the regression model was able to explain 11 percent of the variance for high priority family oriented referrals. Family specialization made virtually no contribution to the model. However, family oriented case perception made a significant, positive contribution. Although this relationship was quite strong, more of the variance was accounted for by the year during which respondents' MSW degrees were granted. That is, those social workers who were more recently graduated were more likely to have made high priority family referrals were also less likely to have reported that there were members in their immediate families with a history of chronic mental illness. In addition, those social workers who made these family
Table 13.--Regression Analysis of the Relationship of Independent Variables to High Priority Family Referrals

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Specialization</td>
<td>-.001</td>
<td>-.000</td>
</tr>
<tr>
<td>Degree of Family Oriented Case Perceptions</td>
<td>.179</td>
<td>.142*</td>
</tr>
<tr>
<td>Year During Which MSW Was Granted</td>
<td>.028</td>
<td>.198**</td>
</tr>
<tr>
<td>Clinical Social Work Concentration While in MSW Program</td>
<td>.127</td>
<td>.056</td>
</tr>
<tr>
<td>Estimated Length of Service for Case Vignettes</td>
<td>-.005</td>
<td>-.094</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Family Treatment in Past Year</td>
<td>.001</td>
<td>.012</td>
</tr>
<tr>
<td>Degree of Respondents' Confidence in Their Assessments of Case Vignettes</td>
<td>-.019</td>
<td>-.064</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Community Centers in Past Year</td>
<td>.001</td>
<td>.014</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Welfare Services in Past Year</td>
<td>-.006</td>
<td>-.123</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Self-Help Groups in Past Year</td>
<td>-.005</td>
<td>-.147*</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Alcohol/Drug Abuse Treatment in Past Year</td>
<td>-.003</td>
<td>-.064</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Treatment in Past Year</td>
<td>.003</td>
<td>.057</td>
</tr>
<tr>
<td>History of Chronic Mental Illness in Respondents' Immediate Families</td>
<td>-.384</td>
<td>-.141*</td>
</tr>
<tr>
<td>Independent Variables</td>
<td>b</td>
<td>Beta</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>History of Alcohol/Drug Abuse in Respondents' Immediate Families</td>
<td>.033</td>
<td>.016</td>
</tr>
<tr>
<td>History of Sexual Abuse in Respondents' Immediate Families</td>
<td>-.088</td>
<td>-.035</td>
</tr>
<tr>
<td>Intercept</td>
<td>-1.481</td>
<td></td>
</tr>
</tbody>
</table>

Note. \( N = 228; R = .33; R^2 = .11; F = 1.770; p = .0406. \)

*\( p < .05 \).

**\( p < .005 \).
referrals were less likely to have referred their clients to self-help groups in the past year. As indicated by table 14, the regression model was able to account for 18 percent of the variance of high priority alcohol/drug abuse referrals. High alcohol/drug abuse problem perception was associated with high priority alcohol/drug abuse referrals. This variable accounted for the most variance among the independent variables. The percentage of cases that were referred to self-help groups by respondents was positively related to high priority alcohol/drug abuse referrals. However, the contribution of this variable did not reach significance. Those social workers who had members of their immediate families with a history of alcohol/drug abuse were also more likely to assign these referrals high priorities. Thus, independent variables related to alcohol/drug abuse are positively associated with alcohol/drug abuse referrals. Although it failed to make a substantial contribution to explaining alcohol/drug abuse referrals, it should be recalled that alcohol/drug abuse specialization is strongly related to alcohol/drug abuse problem perception. Alcohol/drug abuse specialization should therefore be regarded as an antecedent variable to alcohol/drug abuse problem perception. This type of referral was also significantly associated with social workers who had concentrated in clinical social work while they were studying for their MSW degrees.
Table 14.--Regression Analysis of the Relationship of Independent Variables to High Priority Alcohol/Drug Abuse Referrals

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drug Abuse Specialization</td>
<td>-.210</td>
<td>-.083</td>
</tr>
<tr>
<td>Degree of Alcohol/Drug Abuse Oriented Case Perceptions</td>
<td>.401</td>
<td>.292*</td>
</tr>
<tr>
<td>Clinical Social Work Concentration While in MSW Program</td>
<td>.261</td>
<td>.115</td>
</tr>
<tr>
<td>Year During Which MSW Was Granted</td>
<td>.009</td>
<td>.062</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Treatment in Past Year</td>
<td>-.004</td>
<td>-.064</td>
</tr>
<tr>
<td>Estimated Length of Service for Case Vignettes</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Community Centers in Past Year</td>
<td>.007</td>
<td>.099</td>
</tr>
<tr>
<td>Degree of Respondents' Confidence in Their Assessments of Case Vignettes</td>
<td>.001</td>
<td>.005</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Alcohol/Drug Abuse Treatment in Past Year</td>
<td>.002</td>
<td>.043</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Family Treatment in Past Year</td>
<td>.004</td>
<td>.075</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Self-Help Groups in Past Year</td>
<td>.003</td>
<td>.101</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Welfare Services in Past Year</td>
<td>-.004</td>
<td>-.083</td>
</tr>
<tr>
<td>History of Alcohol/Drug Abuse in Respondents' Immediate Families</td>
<td>.29</td>
<td>.108</td>
</tr>
</tbody>
</table>
Table 14--Continued

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Chronic Mental Illness in Respondents' Immediate Families</td>
<td>-.068</td>
<td>-.025</td>
</tr>
<tr>
<td>History of Sexual Abuse in Respondents' Immediate Families</td>
<td>-.069</td>
<td>-.028</td>
</tr>
<tr>
<td>Intercept</td>
<td>-.989</td>
<td></td>
</tr>
</tbody>
</table>

Note.  \( N = 228; R = .43; R^2 = .18; F = 3.161; p = .0001. \)

\(*p < .0005.*
Pearson correlations were performed to determine whether child oriented problem perceptions were related to child oriented case referrals and whether mental health oriented problem perceptions were related to mental health oriented referrals. The correlations were small and failed to reach significance.

**Analysis of Treatment**

As discussed in the previous chapter, four scales were developed which measured either high priority child and youth, family, mental health, or alcohol/drug abuse treatment, which respondents indicated they would provide in response to the case vignettes (survey questions 13, 22, 31). The high priority child and youth treatment scale consisted of the number of first listed child and youth oriented treatments in response to each of the vignettes. Child and youth oriented treatments were defined as individual child treatment or group treatment of children.

High priority family oriented treatment consisted of the number of first listed family group treatments, parent skills groups, couples treatments, or conjoint family treatments that respondents indicated they would provide for the case vignettes. High priority mental health oriented treatments consisted of the number of first listed individual and group treatment of fathers and
mothers that respondents indicated that they would provide in response to the case vignettes.

The last scale measured high priority alcohol/drug abuse treatment. This scale was comprised of the number of first listed alcohol/drug abuse treatments that respondents indicated they would provide in response to the case vignettes. Alcohol/drug abuse treatment was defined as the provision of alcohol/drug abuse treatment and alcohol/drug abuse evaluation.

Significant group differences were found with respect to high priority child treatments ($F = 2.647, p = .0239$). Child and youth specialists were much more likely to provide child oriented treatment than were any other group. Next to this group of respondents, generalists were more likely to provide this form of treatment and to assign it high priority. Mental health specialists were least likely to provide this form of treatment to children.

No significant differences were found among groups with regard to high priority family treatments ($F = 1.513, p = .1869$) nor with regard to high priority mental health treatments ($F = 1.252, p = .2858$). Thus, it is assumed that all groups provide these forms of treatment equally and that they also assign equal priority to them.

There was a trend toward group differences with respect to high priority alcohol/drug abuse treatments ($F = 1.896, p = .0961$). Generalists were much more likely to
provide this form of treatment than any other group. Alcohol/drug abuse specialists were the second most likely group to provide this service. Child and youth specialists were least likely to provide high priority alcohol/drug abuse treatments in regard to the case vignettes.

The regression model was able to validly account for a portion of the variance for all four treatment variables. Table 15 indicates that the independent variables of the regression model were able to account for 12 percent of the variance for high priority child oriented treatment. The variable that accounted for the most variance measured whether or not respondents had a member of the immediate family with a history of sexual abuse. Those social workers who come from such families were more likely to provide this form of treatment to children. Child and youth specialization also accounted for a large share of the explained variance. Those social workers who were categorized as child and youth specialists were more likely to provide high priority child oriented treatment than were members of other groups. Although the contribution failed to reach significance, the percentage of respondents' caseloads that were referred for child welfare services was also a good predictor of high priority child treatment.

As indicated by table 16, 13 percent of the variance of high priority family treatment was accounted
Table 15.--Regression Analysis of the Relationship of Independent Variables to High Priority Child Oriented Treatments

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and Youth Oriented Specialization</td>
<td>.435</td>
<td>.150*</td>
</tr>
<tr>
<td>Degree of Child and Youth Oriented Case Perceptions</td>
<td>.028</td>
<td>.025</td>
</tr>
<tr>
<td>Clinical Social Work Concentration While in MSW Program</td>
<td>-.248</td>
<td>-.109</td>
</tr>
<tr>
<td>Year During Which MSW Was Granted</td>
<td>.002</td>
<td>.012</td>
</tr>
<tr>
<td>Estimated Length of Service for Case Vignettes</td>
<td>.003</td>
<td>.056</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Community Centers in Past Year</td>
<td>-.004</td>
<td>-.055</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Treatment in Past Year</td>
<td>-.002</td>
<td>-.028</td>
</tr>
<tr>
<td>Degree of Respondents' Confidence in Their Assessments of Case Vignettes</td>
<td>.027</td>
<td>.090</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Alcohol/Drug Abuse Treatment in Past Year</td>
<td>-.002</td>
<td>-.040</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Self-Help Groups in Past Year</td>
<td>-.002</td>
<td>-.065</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Family Treatment in Past Year</td>
<td>.001</td>
<td>.028</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Welfare Services in Past Year</td>
<td>.007</td>
<td>.141</td>
</tr>
<tr>
<td>History of Chronic Mental Illness in Respondents' Immediate Families</td>
<td>.022</td>
<td>.008</td>
</tr>
<tr>
<td>Independent Variables</td>
<td>b</td>
<td>Beta</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>----</td>
<td>------</td>
</tr>
<tr>
<td>History of Sexual Abuse in Respondents' Immediate Families</td>
<td>.469</td>
<td>.188**</td>
</tr>
<tr>
<td>History of Alcohol/Drug Abuse in Respondents' Immediate Families</td>
<td>-.103</td>
<td>.051</td>
</tr>
<tr>
<td>Intercept</td>
<td>-.558</td>
<td></td>
</tr>
</tbody>
</table>

Note.  \( N = 228; R = .35; R^2 = .12; F = 1.945; p = .0206. \)

*\( p < .05. \)

**\( p < .01. \)
Table 16.--Regression Analysis of the Relationship of Independent Variables to High Priority Family Oriented Treatments

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Specialization</td>
<td>.240</td>
<td>.070</td>
</tr>
<tr>
<td>Degree of Family Oriented Case Perceptions</td>
<td>.031</td>
<td>.025</td>
</tr>
<tr>
<td>Year During Which MSW Was Granted</td>
<td>.023</td>
<td>.159*</td>
</tr>
<tr>
<td>Clinical Social Work Concentration While in MSW Program</td>
<td>.485</td>
<td>.214**</td>
</tr>
<tr>
<td>Estimated Length of Service for Case Vignettes</td>
<td>-.004</td>
<td>-.077</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Family Treatment in Past Year</td>
<td>-.008</td>
<td>-.166*</td>
</tr>
<tr>
<td>Degree of Respondents' Confidence in Their Assessments of Case Vignettes</td>
<td>-.023</td>
<td>-.078</td>
</tr>
<tr>
<td>Percentage of Respondents' Referrals to Community Centers in Past Year</td>
<td>.009</td>
<td>.127</td>
</tr>
<tr>
<td>Percentage of Respondents' Referrals for Child Welfare Services in Past Year</td>
<td>-.001</td>
<td>-.010</td>
</tr>
<tr>
<td>Percentage of Respondents' Referrals to Self-Help Groups in Past Year</td>
<td>.002</td>
<td>.048</td>
</tr>
<tr>
<td>Percentage of Respondents' Referrals for Alcohol/Drug Abuse Treatment in Past Year</td>
<td>-.001</td>
<td>-.014</td>
</tr>
<tr>
<td>Percent of Respondents' Referrals for Child Treatment in Past Year</td>
<td>-.004</td>
<td>-.080</td>
</tr>
<tr>
<td>History of Chronic Mental Illness in Respondents' Immediate Families</td>
<td>.115</td>
<td>.042</td>
</tr>
<tr>
<td>History of Alcohol/Drug Abuse in Respondents' Immediate Families</td>
<td>-.021</td>
<td>-.010</td>
</tr>
</tbody>
</table>
Table 16--Continued

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Sexual Abuse in Respondents' Immediate Families</td>
<td>.088</td>
<td>.035</td>
</tr>
<tr>
<td>Intercept</td>
<td>-1.543</td>
<td></td>
</tr>
</tbody>
</table>

Note.  N = 228;  R = .36;  R^2 = .13;  F = 2.134;  p = .0096.
*p < .05.
**p < .005.
for by the regression model. Social workers who concentrated in clinical social work while studying for their MSW degrees were more likely to provide high-priority family treatment than were others. This variable accounted for the largest portion of explained variance. There was a significant inverse relationship between the percentage that respondents referred clients for family treatment services and high priority family treatment. That is, social workers who referred small portions of their caseloads tended to make high priority family treatments. As with family oriented referrals, social workers who recently received their MSW degrees were more likely to provide this form of treatment. Last, those social workers who referred larger percentages of their caseloads to community centers in the past year were more likely to provide high priority family treatment. Family specialization and family oriented case perception did not make significant contributions to the explained variance.

As seen in table 17, the regression model was able to account for 16 percent of the variance for the provision of high priority mental health treatment. Mental health specialization was able to contribute to explaining a fairly large portion of this variance, although this contribution did not reach significance. Social workers who had received their MSW degree earlier than others were also likely to provide this type of service. Of note,
Table 17.--Regression Analysis of the Relationship of Independent Variables to High Priority Mental Health Oriented Treatments

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Specialization</td>
<td>.316</td>
<td>.111</td>
</tr>
<tr>
<td>Degree of Mental Health Oriented. Case Perceptions</td>
<td>.002</td>
<td>.002</td>
</tr>
<tr>
<td>Clinical Social Work Concentration While in MSW Program</td>
<td>-.455</td>
<td>-.201**</td>
</tr>
<tr>
<td>Year During Which MSW Was Granted</td>
<td>-.031</td>
<td>-.218***</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Community Centers in Past Year</td>
<td>-.006</td>
<td>-.080</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Treatment in Past Year</td>
<td>.010</td>
<td>.176*</td>
</tr>
<tr>
<td>Estimated Length of Service for Case Vignettes</td>
<td>.008</td>
<td>.149*</td>
</tr>
<tr>
<td>Degree of Respondents' Confidence in Their Assessment of Case Vignettes</td>
<td>.044</td>
<td>.146*</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Alcohol/Drug Abuse Treatment in Past Year</td>
<td>.004</td>
<td>.092</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Self-Help Groups in Past Year</td>
<td>-.001</td>
<td>-.014</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Family Treatment in Past Year</td>
<td>.000</td>
<td>-.003</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Welfare Services in Past Year</td>
<td>-.003</td>
<td>-.056</td>
</tr>
<tr>
<td>History of Chronic Mental Illness in Respondents' Immediate Families</td>
<td>-.319</td>
<td>-.117</td>
</tr>
</tbody>
</table>
Table 17--Continued

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Alcohol/Drug Abuse in Respondents' Immediate Families</td>
<td>.000</td>
<td>-.001</td>
</tr>
<tr>
<td>History of Sexual Abuse in Respondents' Immediate Families</td>
<td>-.006</td>
<td>-.002</td>
</tr>
<tr>
<td>Intercept</td>
<td>1.600</td>
<td></td>
</tr>
</tbody>
</table>

Note. \( N = 228; R = .40; R^2 = .16; F = 2.751; P = .0007. \)

*\( P < .05. \)

**\( P < .005. \)

***\( P < .001. \)
social workers who did not concentrate in clinical social work while they were enrolled in their MSW program were more likely to provide high priority mental health treatment than those who had concentrated in clinical social work. Respondents' confidence in the accuracy of their assessments of the case vignettes was positively associated with mental health treatment. The estimated length of service for treatment of case vignettes was positively associated with this variable as well. Last, a history of chronic mental illness in respondents' immediate families was negatively associated with provision of high priority mental health treatment. It should be noted that while mental health specialization was associated with this variable, perception of mental health oriented problems was not.

As table 18 indicates, the regression model was able to predict 15 percent of the variance of high priority alcohol/drug abuse treatment. Those social workers who were relatively recent graduates of their MSW programs were more likely to provide this type of treatment than those who graduated earlier. Those who were apt to refer their cases for child treatment services in the past year were also more likely to provide high priority alcohol/drug abuse treatment. Those who were more apt to provide high priority alcohol/drug abuse treatment were less likely to have concentrated in clinical social work while they were
Table 18.--Regression Analysis of the Relationship of Independent Variables to High Priority Alcohol/Drug Abuse Oriented Treatments

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drug Abuse Specialization</td>
<td>-.140</td>
<td>-.055</td>
</tr>
<tr>
<td>Degree of Alcohol/Drug Abuse Oriented Case Perceptions</td>
<td>-.061</td>
<td>-.044</td>
</tr>
<tr>
<td>Clinical Social Work Concentration While in MSW Program</td>
<td>-.424</td>
<td>-.187**</td>
</tr>
<tr>
<td>Year During Which MSW Was Granted</td>
<td>-.034</td>
<td>.236***</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseload Referred for Child Treatment in Past Year</td>
<td>.011</td>
<td>.197*</td>
</tr>
<tr>
<td>Estimated Length of Service for Case Vignettes</td>
<td>.004</td>
<td>.076</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Community Centers in Past Year</td>
<td>-.002</td>
<td>-.035</td>
</tr>
<tr>
<td>Degree of Respondents' Confidence in Their Assessments of Case Vignettes</td>
<td>.018</td>
<td>.061</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Alcohol/Drug Abuse Treatment in Past Year</td>
<td>.003</td>
<td>.056</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Family Treatment in Past Year</td>
<td>-.003</td>
<td>-.064</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred to Self-Help Groups in Past Year</td>
<td>-.005</td>
<td>.160</td>
</tr>
<tr>
<td>Percentage of Respondents' Caseloads Referred for Child Welfare Services in Past Year</td>
<td>-.005</td>
<td>-.089</td>
</tr>
<tr>
<td>History of Alcohol/Drug Abuse in Respondents' Immediate Family</td>
<td>.044</td>
<td>.022</td>
</tr>
</tbody>
</table>
Table 18--Continued

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>b</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Chronic Mental Illness in Respondents' Immediate Families</td>
<td>-.185</td>
<td>-.068</td>
</tr>
<tr>
<td>History of Sexual Abuse in Respondents' Immediate Families</td>
<td>-.381</td>
<td>-.153*</td>
</tr>
<tr>
<td>Intercept</td>
<td>2.315</td>
<td></td>
</tr>
</tbody>
</table>

Note. N = 228; R = .39; R^2 = .15; F = 2.550; p = .0016.

*p < .05.

**p < .01.

***p < .001.
studying for their MSW degrees. However, those who tended to refer their clients to self-help groups were more likely to provide high priority [alcohol/drug abuse] treatment. In addition, respondents who had immediate family members with a history of sexual abuse were not apt to provide alcohol/drug abuse treatment.
CHAPTER 5
DISCUSSION OF THE FINDINGS

Introduction

This chapter will interpret the findings obtained by this study. Before this can be accomplished, however, an evaluation of the limitations and strengths of the study will be presented. This evaluation will appear before the discussion of the results so that the reader will be able to independently determine the validity of the inferences drawn from the findings.

Following the evaluation of the limitations and strengths of the study, a discussion of the factors that underlie specialization will be presented. This will then be followed by a discussion of the results relating to case problem perceptions. Once case perceptions are discussed, two more sub-chapters will be presented. The first will include a discussion of factors that relate to case referrals. The second sub-chapter will present inferences drawn from the data regarding differences in treatment services for the case vignettes. A summary of the key findings will then conclude the chapter.
Limitations of the Study

The inherent limitations of this study will be discussed in this section. It must be pointed out that this study was descriptive. As such, one cannot impute causality to the results. This is due to the fact that respondents were not randomly assigned to groups. Therefore, one cannot be sure that systematic bias in group membership did not exist. Antecedent variables or other unmeasured factors may thus better account for the results. In addition, the direction of the association between variables cannot be conclusively established. Any statement of directionality should therefore be treated as an inference.

Another limitation of this study lies in its reliance upon self-reports as the basis for its data. The study therefore assumes that the responses obtained from the study participants was valid. However, there is a possibility that this was not the case. While this remains a possibility, this is not considered to be likely as the responses do not appear especially unusual.

Another possible validity threat lies in the response rate. There was a decent response to the survey, especially given the length of the survey instrument. Nonetheless, it is possible that non-respondents differed significantly from those who responded to the survey on some key variables. Since this study employed a
probability sampling plan, the researcher was able to compare respondents and non-respondents in terms of demographic data. The results of this analysis indicated that there were no major differences between these two groups. Indeed, only two significant differences were found. The first, the year in which the MSW was granted, was significant but the actual magnitude of the difference was deemed to be small. It is therefore unlikely that this difference can threaten the validity of these findings.

The second significant difference was the low response rate among those social workers who were classified as family specialists by the National Association of Social Workers. When demographic differences between respondents and non-respondents in this group were analyzed, no significant differences were found. It is therefore reasonable to assume that this difference in response rate does not threaten the validity of this study.

The last limitation of this study lies in the fact that it utilized responses to case analogues as the basis of the clinical judgment data. These case vignettes were validated by a national panel of experts and the entire instrument was pilot tested. In addition to these apparently successful efforts at attaining content validity, the use of factor analysis in the construction of the scales established construct validity. It is
unlikely that construct validity would have been established had the vignettes not been valid.

The fact that there are inherent limitations in the use of analogues should not be overlooked. It is possible that the responses of social workers to actual cases would be substantially different from those in response to the case vignettes. The respondents were not free to respond to non-verbal cues of the vignette "clients." In addition, since case vignettes were written, respondents were dependent upon the relatively limited information contained in them. Clinical practice is much more dynamic than the clinical analogue. It is therefore possible that respondents would have obtained more information and have formed different clinical judgments as a result.

Thus, group differences may actually reflect different pathways to the same clinical judgments. It is possible, for example, that rather than perceive alcohol/drug abuse problems less frequently, child and youth specialists may perceive alcohol/drug problems in a slower, more circuitous fashion than do others. There is no way of knowing whether or not this is the case. The converse is also possible: respondents may not have discovered some of the information contained in the vignettes and their actual clinical judgments may be different for this reason. It is therefore equally possible that children and youth specialists were not likely to even obtain as much
information concerning alcohol/drug abuse in actual practice as was contained in the vignettes. As a result, these specialists may be even less likely to perceive alcohol/drug problems in actual practice than they were in response to the case vignettes. Nonetheless, the vignettes were validated by a national panel of experts and their verisimilitude was established. Therefore, while the process by which respondents' clinical judgments were formed was not explored, the content upon which they were based was presented to them.

**Strengths of the Study**

Just as limitations inherent to studies should not be overlooked, one should also be cognizant of their strengths. This study drew a national sample from a large sampling frame. As a result, the sample is free of local and regional biases. One is thus freer to make inferences that are applicable to social workers throughout the country.

The sample size was rather large, given the length of the survey instrument and the demanding nature of the responses required for completion of the questionnaire. The large number of respondents permitted the use of rather sophisticated data analysis techniques. This made it possible to answer key research questions.
Last, the use of clinical analogues posed an advantage as well as a liability. Rather than merely survey social workers' attitudes toward these sorts of case issues, or their reported practices with these sorts of cases, the vignettes served as an anchor so that there was a common base for comparison of respondents' responses. The use of case vignettes allowed the researcher to control for such factors as demographics and family structure. As a result, these variables did not confound the results. The use of common case stimuli therefore permitted a closer examination of the formation of clinical judgments. In addition, three case vignettes were used so that results could not be attributed to the idiosyncracies of any one case vignette.

Factors That Underlie Specialization

It may be concluded that several classes of variables underlie specialization. It appears that the second year field placement during MSW education can predict subsequent specialization for most of the groups. Although it was speculated that specialization was an unstable attribute, the fact that these variables can account for some of the variance may be taken as evidence that specialization is not totally unstable. Another variable related to the educational backgrounds of
respondents, i.e., year during which the MSW degree was granted, also was related to specialization group.

Demographic differences also accounted for group membership. Males were concentrated in the alcohol/drug abuse groups while females were concentrated among the non-specialists. Mental health specialists and generalists were more likely to be older than were members of other groups. In addition, Blacks were more likely to be alcohol/drug abuse specialists.

Family history also explained group differences. More specifically, respondents who had a substance abuser in their immediate families were more likely to be either alcohol/drug abuse specialists or generalists, while those who did not were more likely to specialize in children and youth.

Attitudinal differences were also related to group membership. Family specialists appeared to be more enthusiastic about the efficacy of family treatment and tended to explain substance abuse in terms of family problems. Mental health specialists, on the other hand, indicated that underlying stressors, presumably of an intrapsychic nature, accounted for substance abuse. In contrast, alcohol/drug abuse specialists were less apt to agree that family problems underlay substance abuse disorders. However, this group advocates its main

Last, general case approach, i.e., confidence and optimism, was also related to specialization. Generalists, those who have indicated competence in at least three specialization areas, and alcohol/drug abuse specialists tended to be the most confident and optimistic respondents. Non-specialists tended to report the least confidence and most pessimistic with regard to their approach to the case vignettes.

It is apparent from this study that specialization is a very complex attribute. This is due to the fact that it is comprised of several underlying variables. Each of these variables are of a continuous level of measurement. This is not generally apparent as most social workers seem to conceptualize specialization as a unidimensional, categorical variable. In addition, the study has demonstrated that specialization is influenced by sociodemographic, attitudinal, and training differences.

The remainder of this section will comprise the interpretation of the differences found with regard to those variables which underlie specialization. In general, these differences were not surprising.

Sociodemographic differences were, for the most part, consistent with expectations. Generalists tended to be older probably because of the time it takes to acquire
expertise in at least three specialization areas. The fact that mental health specialists tended to be older as well, is more puzzling, however. It is hypothesized that this is due to the fact that mental health has been a traditional field of practice for social work. In contrast, other specialization areas measured in this study, i.e., families and alcohol/drug abuse, tend to have become popular more recently. Therefore, the fact that mental health specialists tend to be older may be due to the fact that this cohort of social workers developed an interest in mental health prior to the popularity of these other fields.

The tendency for alcohol/drug abuse specialists to be comprised of a greater proportion of men may be a reflection of the fact that alcohol/drug abuse clients tend to be men as well. Thus, there may be a premium placed upon the recruitment of men in this field. This may also occur because the field of alcohol/drug abuse services is not responsive to the needs of female clinicians.

The fact that female clinicians are overrepresented among the group of non-specialists may be the result of their socialization. Women tend to be socialized to undervalue their competence and expertise. These respondents may therefore not think of themselves as having the requisite knowledge, skill and ability to be a specialist. An alternative explanation is that women tend
to specialize in areas of social work which were not measured in this study (e.g., health, aging, etc.). Therefore, they may have the knowledge, skill, and ability of a specialist or generalist, but in other areas.

The reason for the higher proportion of Blacks among alcohol/drug abuse specialists is unclear. However, the number of Blacks in the sample is so small that generalizations are risky.

The fact that alcohol/drug abuse specialists have a history of alcohol/drug abuse in their immediate families indicates that their personal experiences with this condition have propelled them into this field. They thus may have had a heightened awareness of the deleterious effects of alcohol/drug abuse. Perhaps they were helped by substance abuse services and wished to help others in the same way. It is also possible that they were unable to help those in their own families and thus concentrated on assisting those with alcohol/drug abuse problems that they could help.

That generalists also tend to have a positive history of alcohol/drug abuse in their immediate families may indicate that they have become high achievers as a result of compensating for family members who are impaired by their alcohol/drug abuse. Thus, they have mastered several specialization areas because of their need for achievement.
As with sociodemographic differences, differences in training were in expected directions. The fact that alcohol/drug abuse specialists received their MSW degrees more recently than others may be taken as support for the hypothesis that this is an artifact of the relatively recent interest in this area. By the same token, the fact that child and youth specialists received their MSW degrees earlier may be due to the fact that a family orientation is a recent alternative to a child orientation. Therefore, many child and youth specialists were trained before the development of family treatment methods. There would then be a tendency for those who were trained more recently to choose between a child and youth specialization and a family specialization. It would be harder for those who were trained earlier to have had such a choice.

It appears that second year internship placements in social work training may be important to study when considering the specialization of social workers. Social workers tend to have greater choice in selecting the type of agency in which they will intern for their second year. These placements may thus reflect early choice with regard to specialization.

It is not surprising that both child and youth specialists and family specialists tended to be placed in child and youth agencies during their MSW education. These agencies attend to the needs of families in such areas as
child rearing as well as the needs of the children themselves. While one would expect a greater proportion of family specialists to have been placed in family service agencies, several factors may explain why this was not the case. Family service agencies do not necessarily provide more family treatment nor other family oriented services than other agencies. Indeed, some mental health and children and youth agencies may provide the same type of services as family service agencies.

That mental health specialists were not any more likely to have been placed in mental health agencies may be because these agencies serve as generic training centers for social workers who will specialize in many different areas. Thus, social work students may be advised that they should receive a "solid training in mental health" before they specialize in "more narrow areas." This result can therefore be taken as a partial confirmation of the hypothesis that mental health is a rather broad specialization area. This may also explain why generalists tended to have been placed in mental health agencies.

In contrast, alcohol/drug abuse agencies tend to be more specialized. While mental health and family service agencies serve clients with a wide variety of conditions and problems, all clients who are served by alcohol/drug abuse agencies at least have alcohol/drug abuse problems. These clients most likely have several other problems as
well, of course. However, they have at least one common problem. This is usually not the case for the other agencies listed.

It is therefore not surprising that alcohol/drug abuse specialists were more likely to have been placed in these agencies during the first and second years of their MSW programs. One can interpret these results as an early interest in alcohol/drug problems by this group. This, along with this group's increased likelihood of a family history of alcohol/drug abuse indicates that alcohol/drug abuse specialists may have entered the profession intent on specializing in this field.

There were definite attitudinal differences among the groups. Family specialists tended to believe that the best way to treat child behavior problems is with conjoint family therapy. This is an indication that this group believes that their main method of treatment works better than individual child treatment. It is possible that this attitude extends beyond treatment of child behavior problems so that family specialists tend to believe that family therapy is the most efficacious treatment available.

That mental health specialists tend to believe that the best way to treat alcohol/drug abuse problems is to address underlying psychosocial stressors may indicate a preference for a more psychodynamic approach to treatment. This approach, if initially used when treating an
alcohol/drug abuser will most likely damage the client, since this treatment can only work once the client is not actively using alcohol or other drugs. Psychodynamic explanations for the "reasons" for the alcohol abuse are offered prematurely if these clients have not achieved abstinence. Indeed, they can serve as rationalizations for continued alcohol/drug abuse. However, such an approach may be quite helpful once these clients abstain from alcohol/drug abuse. While this attitude may or may not reflect a tendency for mental health specialists to initially apply psychodynamic methods when treating these clients, there is reason for concern.

In contrast, family specialists do not tend to address underlying psychosocial stressors when treating families, since this approach focusses upon family structure, power, and communication styles. It is therefore not surprising that family specialists did not tend to believe that alcohol/drug abuse is best treated by addressing underlying psychosocial stressors.

Alcohol and drug abuse specialists do not view alcohol/drug abuse problems as resulting from family problems. This group of specialists was trained to believe that such problems arise from myriad biopsychosocial factors. Regardless of these reasons, once an alcohol/drug abuse problem has developed, these professionals believe that alcohol/drug abuse problems maintain
themselves independently from them. Alcohol/drug abuse specialists therefore were less likely to believe that family problems cause alcohol/drug abuse problems or that one must address underlying psychosocial difficulties early in the treatment of substance abusers. However, when they were asked about the best way to help children of substance abusers, alcohol/drug abuse specialists were more likely to believe that the best way to help these children was by treating their parents' alcohol/drug abuse. This indicates a tendency for this group to view these children's problems in terms of their area of expertise.

It was expected that generalists would be more confident in their assessments of the case vignettes, since they have expertise in several of the problem areas contained in the vignettes. Thus, they tended to know more about the various problem areas than did other respondents. For this same reason, it is not surprising that non-sPECIALISTS were least confident in their assessments.

That alcohol/drug abuse specialists tended to be confident in their assessments may be due to their focus upon alcohol/drug abuse problems. Upon recognition of alcohol/drug abuse problems, they may have believed that they have found the key case problem. They therefore felt confident in their assessments upon identifying these specific problems in the case vignettes.
The fact that generalists were more optimistic in their prognoses for the case vignettes may be due to their general confidence in the efficacy of their interventions. They may view themselves as more skillful and see a greater probability that intervention will be successful. By the same token, non-specialists may see themselves as less competent and thus do not think that intervention will be helpful. Alcohol/drug abuse specialists may be optimistic because they tend to see alcohol/drug abuse as a chronic but very treatable disease. Thus, even though problems may seem intractable to others, this group of specialists are used to seeing both relapses and profound changes in their clients. It is easy to perceive progress among substance abusers if one gauges it in terms of abstinence from alcohol or drug use. Thus, they may have had more experience in seeing or expecting tangible progress in their clients.

One may wonder why family specialists were more pessimistic than were other groups. This may be a result of the view that family systems tend to resist making second order changes and that families therefore exert powerful pressure to resist these changes. If this was the case, then this group of respondents would certainly see progress as more difficult to achieve, especially in cases with several different problems in family functioning.
To summarize this section, there are some clear differences in the backgrounds of those who are drawn to one group or another. Specialization thus appears to be related to myriad sociodemographic, educational, attitudinal, and family history differences. This lends support to the contention that specialization is a very complex attribute. It is apparent that specialization and other related variables result in some differences in practice interests, views of cases and beliefs about treatment. The results provide some support for the hypothesis that specialization groups tend to view case problems and treatment efficacy in terms of their own interests and expertise. A more complete description and explanation of these differences will be discussed later in this chapter.

Factors That Relate to Case Perception

This section explores reasons for group differences with regard to case perceptions. Case perception includes the elements that comprise assessment: the degree of client dysfunctioning, problem identification, problem severity, and the importance of problem resolution to overall case improvement.

Group differences with regard to child and youth, family, and alcohol/drug abuse oriented case perceptions were found. Results indicated that social workers tended
to perceive case problems in accordance with their specializations. One striking difference was with regard to child and youth specialists, who tended not to perceive case problems in child oriented terms. The regression model was able to validly explain the variances of mental health and alcohol/drug abuse problem case perceptions. Specialization accounted for a sizable portion of the variance of alcohol/drug abuse oriented case perception. This was not the case for the role of mental health specialization in explaining mental health oriented problem perception. Variables which measure the current nature of respondents' practices accounted for a good deal of the variance explained by the model.

The analyses of variance supported the contention that specialization does influence case perceptions. Family specialists tended to view cases in terms of family problems, while alcohol/drug abuse specialists tended to view the same cases in terms of alcohol/drug abuse problems.

It is not clear why child and youth specialists did not tend to perceive cases in terms of child and youth problems. Perhaps this is because they viewed the children's problems as reactive to other problems listed in the case vignettes. The salience of child and youth problems were thus lessened for this group.
Of note, generalists tended to view case problems in terms of at least three of the four problem categories. They ranked as the most likely to perceive child and youth problems and second most likely to recognize family and alcohol/drug abuse problems. There were no group differences regarding mental health perception. Therefore generalists appear to be average in their degree of mental health oriented case perceptions. Alcohol/drug abuse specialists and non-specialists were least likely to perceive family oriented case problems while child and youth specialists were least likely to perceive alcohol/drug abuse problems. Thus, it seems reasonable to argue that these specialization groups are less able to make valid case assessments than are generalists.

The regression analyses indicated that mental health specialization does not significantly contribute to perception of mental health problems. This may be due to the fact that mental health problems tend to be viewed equally strongly by other groups of respondents. Since, as was discussed earlier, mental health training and mental health problem categories tend to be generic to social work, other groups of respondents are equally likely to perceive case problems in these terms. Thus, mental health specialization does not contribute to the perception of mental health problems.
In contrast, the regression model was able to predict a fairly large portion of variance for the perception of alcohol/drug abuse problems. Alcohol/drug abuse specialization made a large, significant contribution to the explained variance. It may thus be concluded that these specialists are more apt to view case problems in terms of alcohol/drug abuse. Indeed, when one considers the fact that other alcohol/drug abuse related variables also made significant contributions to the explained variance (i.e., referrals to self-help groups such as Alcoholics Anonymous and a family history of alcohol/drug abuse), one may conclude that the more alcohol centered social workers are, the more likely they are to perceive alcohol/drug abuse problems.

There are two possible explanations for this. First, alcohol/drug centered social workers may tend to perceive case problems in terms of alcohol/drug abuse because they are overly sensitive to these types of problem definitions. These types of problems are thus more salient to them and so these specialists may tend to overestimate the contributions of these problems to the dysfunctioning observed in their clients.

Second, alcohol/drug abuse problems may tend to be missed by other groups of social workers. Therefore, rather than alcohol/drug abuse specialists being overly sensitive to these problems, the others may not be
sensitive to them. The literature reviewed for this study support both hypotheses. The data cannot conclusively support one hypothesis over the other. However, because alcohol/drug abuse specialists tend to underestimate other case problems, and tend to enter their MSW programs focussed upon these sorts of problems, one could speculate that these specialists tend to be focussed upon alcohol/drug abuse problems to the relative exclusion of other problems. This is not absolute however, as the regression analysis indicated that these specialists also tended to refer for family treatment services, indicating that they may also perceive family problems (although they may view these problems as secondary to alcohol/drug abuse). Given the literature which indicates that many professionals fail to accurately perceive alcohol/drug abuse problems when they exist, it is also possible that other specialists are insensitive to these problems. Therefore, both hypotheses are most likely correct. However, only the hypothesis regarding the over-sensitivity of alcohol/drug abuse specialists was supported by the data.

Factors That Account for Case Referrals

There were significant group differences with regard to high priority mental health referrals. Generalists and mental health specialists were most likely to refer clients depicted in the case vignettes for mental
health services while child and youth specialists were least likely to do so. While the regression model could not explain the variance for mental health oriented referrals, a small but significant positive correlation between this variable and mental health specialization was found.

Regression models were able to successfully explain the variance for high priority family and high priority alcohol/drug abuse referrals. Family oriented case perceptions and alcohol/drug abuse oriented case perceptions explained significant portions of the variance of high priority family and alcohol/drug abuse referrals, respectively. Family and alcohol/drug abuse specializations made negligible contributions to their respective models.

Evidence suggests that alcohol/drug abuse specialization is an antecedent variable to alcohol/drug abuse oriented problem perception. This inference was based upon the fact that alcohol/drug abuse specialization accounts for a large portion of the explained variance of alcohol/drug abuse case perception. The variance in family oriented referrals were mostly explained by a combination of educational background, typical practice patterns, and family histories. The regression model could not explain the variance of high priority child and youth oriented referrals.
The fact that generalists and mental health specialists tend to make more high priority mental health referrals may be due to their greater sophistication and confidence in the efficacy of mental health services such as psychological testing or psychiatric consultation. While mental health related services may still be regarded as generic, mental health specialization tends to make a small but significant contribution toward explaining the variance of high priority mental health referrals.

It is interesting to note that the hypothesis that family specialization is related to high priority family referrals was not supported. One must therefore conclude that these specialists do not tend to rely on family oriented services in addition to those that they provide. Two explanations for this are possible. The first is that these specialists provide all or most family oriented services themselves and therefore would not make referrals. The second is that these specialists are not any more likely to see the importance of family treatment than are other groups of specialists. The data cannot conclusively support one hypothesis or the other. Nonetheless, there were indications that family specialists tended to view cases in family oriented terms and that their attitudes regarding the role of family factors in alcohol/drug abuse provides support for the former explanation. Perception of family problems does predict a small but significant
portion of the variance. This indicates that referrals are to some extent consistent with case perceptions.

One might wonder why there is an inverse relationship between a family history of chronic mental illness and high priority family referrals. This may indicate that those who have a family history of mental health problems tend to make mental health referrals and/or other types of case referrals. Those who tended to make high priority family oriented referrals in response to the vignettes tended not to refer clients in their own caseloads to self-help groups. This may indicate that these respondents are not oriented to making use of Alcoholics Anonymous, Al anon, and other community based support groups. This is of concern since both of these groups would be of benefit to the cases depicted in the vignettes.

The regression analysis indicated that the model was able to account for a relatively large portion of the variance for high priority alcohol/drug abuse referrals. Perception of alcohol/drug abuse problems made the strongest contribution to the model. Alcohol/drug abuse specialization did not make a significant contribution. While one is tempted to conclude that perception is the most essential element for making these referrals, one must also remember that alcohol/drug abuse specialization is an antecedent variable to alcohol/drug abuse perception. It should also be recalled that perception was added
to the regression equation following specialization. Yet, perception still accounted for more of the variance than specialization despite the fact that the first variable entered into the regression equation, i.e., alcohol/drug abuse specialization, would be more likely to have accounted for more of the variance in this regression model. Thus, one must conclude that both alcohol/drug abuse specialization and alcohol/drug abuse perception are strongly linked, that specialization may underlie perception, but that alcohol/drug abuse case perception is the key to high priority case referrals.

That the percentage of respondents' caseloads referred to self-help groups in the past year and that a positive family history of alcohol/drug abuse is also strongly related to high priority alcohol/drug abuse referrals indicates that those who make these referrals tend to be alcohol/drug abuse centered in their practices and in their personal lives.

It is distressing to note that there was no relationship between mental health or child and youth problem perception and referrals oriented to these problems. Thus, it appears that respondents' assessments of these problems do not influence referrals to appropriate services. The meaning of these results will be discussed in the next section of this chapter.
Factors That Relate to Treatment Differences

Analyses of variance found significant group differences with regard to high priority child treatment. A trend was also noted with regard to group differences in high priority alcohol/drug abuse treatment. Child and youth specialists were more likely to provide high priority child oriented treatments than were other groups. Surprisingly, generalists were much more likely to provide high priority alcohol/drug abuse treatment. Regression analyses were significant for all four treatment variables. Specialization made a significant contribution in explaining high priority child oriented treatment. Although it did not reach significance, mental health specialization also made a fairly large contribution to the regression model. Specialization was not a factor in the explanation of family or of alcohol/drug abuse treatments.

It is interesting to note that case perceptions did not make major contributions to explaining treatment variables. Rather, it appears that variables that describe respondents' educational backgrounds, typical practice patterns, and family histories along with specialization explained the most variance in treatment.

Child and youth specialists were more likely to provide child oriented treatment services in response to the case vignettes. Generalists were the second most likely group to do so. Mental health specialists were the
least likely to treat children. The regression analysis indicated that child and youth specialization accounted for a good portion of the explained variance. Those who provided high priority child treatment services in response to the case vignettes were also more likely to provide child welfare referrals for their own cases. This indicates that those who provided child treatment services were more oriented to children's services than were other respondents. In addition, the fact that these social workers had a positive family history of sexual abuse may indicate that a child oriented trauma such as child sexual abuse may have oriented them to treating children directly.

It is distressing to note that child oriented problem perception did not predict child oriented treatment. Since child oriented case perception does not relate to either high priority case referrals or to high priority case treatment, one must conclude that assessment of child and youth oriented problems does not influence case activity. The regression equation indicates that child and youth specialization does influence child and youth oriented treatment. It must therefore be concluded that child and youth oriented specialists tend to provide this form of treatment independently from their assessments of cases.

In contrast, the regression analysis of family treatment indicates that family specialization does not
explain high priority family treatment. However, perception of family oriented problems does not predict family treatment either. It therefore appears that family treatment is provided independently from respondents' case assessments. Since specialization does not account for the variance of family treatment, one must conclude that other factors must account for it.

Mental health specialization contributes to a fairly large portion of the variance explained by the regression model. The fact that a concentration in clinical social work during the respondents' MSW education was inversely related to the provision of high priority mental health treatment is puzzling. It is hypothesized that this relationship may be accounted for by the fact that respondents who did not concentrate in clinical social work simply defined their services in terms of mental health treatment. This may be due to the fact that these services are considered common or generic. In addition, these respondents may not be aware of or proficient in the range of other services available.

The provision of mental health oriented treatment was also oriented to the estimated length of services for the resolution of the problems identified in the case vignettes. Thus, it may be concluded that those who provide mental health oriented treatment provide them
within long-term treatment models. This appears to be consistent with a traditional mental health approach.

Those respondents with a family history of chronic mental illness may actually avoid the provision of mental health oriented treatment. This may be a result of negative personal experiences with these problems and/or with mental health treatment. It should be recalled that those who had a family history of mental health problems tended to make mental health referrals. This may indicate that this group may recognize the importance of mental health services but, because of their personal experiences, prefer that other professionals provide them.

As with the other regression analyses of treatment, mental health problem perception did not account for the variance of provision of high priority mental health treatments. Thus, it appears that respondents' case assessments did not relate to the type of treatment that they would provide for the case vignettes.

Analysis of variance indicated that generalists were most likely to provide high priority alcohol/drug abuse treatment. Alcohol/drug abuse specialists were also likely to provide this form of service. Child and youth specialists were least likely to provide this form of treatment. Thus, it appears that specialization does account for differences in the provision of high priority alcohol/drug abuse treatment. However, the regression
analysis indicated that alcohol/drug abuse specialization does not contribute to the explained variance. This is most likely due to the fact that generalists, because of their greater tendency to provide this form of treatment, confounded the analysis of this variable. Thus, there was a portion of non-alcohol/drug abuse specialists who provided a good deal of alcohol/drug abuse treatment. Group differences were therefore obscured in the regression analysis.

It is interesting to note that those who tended to provide this form of treatment also reported that they referred larger portions of their own cases to child treatment. This indicates that those who provide alcohol/drug abuse treatment tend not to provide child treatment services themselves. However, in keeping with the tendency to provide alcohol/drug oriented services, those who refer their own cases to self-help groups were also likely to provide high priority alcohol/drug abuse treatment services.

In addition, as with other portions of the analysis relating to alcohol/drug abuse, those who had a family history of alcohol/drug abuse tended to provide alcohol/drug abuse treatment services. Thus, personal experience with alcohol/drug abuse appears to exert a powerful influence in case perception and treatment.
Summary

There is partial confirmation for the hypothesis that specialization influences case perception, referral patterns, and treatment plans. However, the portion of variance accounted for by specialization is modest. It seems that specialization most influences alcohol/drug abuse variables in that those who are alcohol/drug abuse specialists tend to define their assessments and practices with regard to their specialty to a greater extent than do others.

In general, specialization seems to interact with other related variables such as family history, respondents' customary patterns of practice, and their training. Therefore, while specialization makes some independent contributions to case perception, case referrals, and to case treatment plans, it may be more fruitful to conceptualize specialization as but one important factor in influencing clinical judgments.

The fact that there is such variation in how social workers would treat the cases depicted in the vignettes may cause one to wonder if one or any of the treatments provided are valid. However, this may be an example of the system's concept of equifinality, i.e., that there are many routes to a common end. Therefore, it is possible that any or all treatment approaches would prove beneficial to the cases. Indeed, it is not unlikely that the
various case problems identified in the vignettes can be treated by most of the modalities offered. Since high priority treatment and referral services were measured, it is entirely possible that respondents provided a full range of services, but may have assigned many of them low priority. Thus, the results do not necessarily challenge the soundness of clinicians' treatment and referral plans.

The relatively modest amounts of variance explained by the regression model indicates that the formation of clinical judgments is very complex. Factors that were not measured by this study may account for the variance of dependent variables as well. Possible variables may include: the theoretical orientation of social workers, their past personal and professional experiences, personality factors, resources of agencies in which social workers practice, and the service ecology of the communities in which they practice (i.e., demands for services, the range of services provided by other agencies and service providers, etc.).

It is disconcerting to find that case perceptions do not account for treatment plans. It would stand to reason that social workers should at least be able to agree on the nature of case problems that confront them when considering common cases. In addition, the assessments made by clinicians should also have bearing on the nature
of treatment that they provide. The implications of this finding will be discussed in the next chapter.
CHAPTER 6

IMPLICATIONS

This chapter will present the broader meanings of the findings of the study and discuss their relevance to the profession of social work, to treatment, to the staffing of programs which serve these cases, and to the education and training of social workers. The chapter will conclude with a discussion of avenues for future research and a brief summary.

Implications for the Profession

This study raises the question of whether social workers need to narrow or broaden their field of vision when considering cases. The data demonstrates that insofar as clinical judgments are concerned, a broad assessment is absolutely essential. Cases involving alcohol/drug abuse, mental health problems, child behavior problems, and family problems are very prevalent. These cases are quite complex and a narrow focus on one problem or another essentially strips these problems from their contexts. Therefore, a narrow problem focus serves a retreat from complexity. This results in an artificial perception of the situations with which these clients are confronted and with which they require assistance.
While the types of cases that were studied are prevalent, and have some unique aspects, the complexity of these cases is not unique. Social workers serve cases that have myriad problems. Therefore, social workers would misserve their clients if they narrow their foci so that they merely reflect their specializations, their customary modes of practice, or their agency functions. One cannot effectively serve clients by focussing on processes and procedures of treatment if the content of case problems and resources are minimized.

Indeed, if the profession really holds to the service ideal of addressing people in their environments, then one cannot ignore or underestimate the complexity of case problems merely because they fall outside one's customary ways of perceiving, referring or treating cases. An eco-systemic perspective in social work was adopted because of the need to address case needs in their complexity. This study therefore demonstrates the need for this perspective in the practice of social work. Indeed, in an era in which a narrowing of focus and a simplification of complex social problems are fostered, the profession must assert the complex nature of the phenomena with which it deals. It will be unable to do so unless social workers base their assessments upon a broad, eco-systemic perspective.
Implications for Practice

Complicated cases such as those studied require several types of case referrals and treatment. These services could only be provided if they are based upon a broadly based assessment.

The fact that this study demonstrated that systematic biases exists in case services indicates that social workers who specialize in one area or another may miss important aspects of cases. Thus, these professionals would be wise to routinely have contact with those who have other areas of expertise so that they may be exposed to other points of view. In any case, all social workers should make referrals to colleagues who have expertise in areas in which the clinician does not. However, professionals should not end their involvement with those services to which they referred clients at the point of referral. Rather, they would be well advised to follow up with the professionals who are providing these additional services in order to integrate them. Therefore, every social worker should be a skilled case manager so that complex cases can be treated in a realistic and effective manner.

While a broad assessment is considered to be absolutely essential to the responsible practice of social work, this is not to say that there is no room in the profession for specialists. Specialists are able to
provide services to those cases that require a higher level of expertise in a particular problem area. This study did not address the levels of skills that were possessed by each group vis-à-vis particular services that were studied. However, skill levels of social workers should form part of their assessments. All responsible clinicians must be cognizant of their areas of expertise and the areas in which they need the expertise of their colleagues. Therefore, the level of skill of a particular clinician to provide a particular service, while important, is less crucial than is the ability to assess case needs and the ability to provide particular services to meet those needs.

**Implications for the Staffing of Programs**

The results of this study have some clear implications for the staffing of programs that serve cases that involve alcohol/drug abusing clients, children, families, and clients with mental health problems. It is probably beneficial to employ some staff with expertise in those areas of agency function, since these professionals will most likely have superior skills to intervene in the problems that are of import to the clients which they serve. It would be a mistake, however, to focus upon one particular area of expertise when staffing an agency or program. A service that an agency renders is only as good
as the assessments upon which this service is based. It would therefore be wise to have generalists in positions that involve assessment and treatment planning so that a sound, comprehensive service plan could be implemented. Therefore, supervisors, directors of clinical services and directors of training should be generalists (as conceptually defined in this study).

Another implication for staffing is the development of staff who act as liaisons to other community agencies along with their clinical responsibilities. Even if a program requires a large number of specialists on staff, programs and their clients would benefit from having particular staff members who are aware of the services available from other agencies. In this way clients can make use of the full range of services that are available to them. This would entail more than just the development of inter-agency contacts. It would be helpful to have the liaison staff develop secondary specialties in those areas. Such arrangements would ultimately enhance the quality of services provided by the agency. This would also provide staff members with unique areas of expertise. Staff morale would probably improve as a result since each member's status and prestige would be enhanced.
Implications for Social Work Education

This study has some clear implications for the education of social workers. If social workers must be able to address the needs of their clients in their complexity, then it is incumbent upon social work educators to devote substantial class time and attention to the analytic and practice skills that are requisites for the performance of eco-systemically based assessments. Thus, the elements of assessments, such as the clear differentiation of the case studies from actual case assessments, movement from very broad to more specific sets of case foci when making assessments, the consideration of a variety of treatment options and the development of individualized service plans that contain the appropriate mixtures of services, are necessary.

It appears that the recent focus upon practice effectiveness and outcomes, while extremely valuable, has shifted educators' attention to the processes of providing services and away from the question of which services are needed to be provided for particular types of cases. Although equifinality may explain the variation of referral and treatment plans among respondents, this is not to imply that all routes to treatment are equally effective or efficient. Thus, the issue of practice effectiveness has little meaning if it is divorced from the specific content of the cases upon which a particular practice method is
It would appear to be self-defeating to concentrate upon developing a set of practice skills without developing the necessary conceptual perspective upon which to base the application of those treatment processes.

An argument can therefore be made for redressing the balance between these two areas: the practical skills of treatment and the conceptual skills of assessment. If such a balance is developed, then effectiveness studies can be placed in their proper context. A wholesale endorsement of particular practice models would thus be less likely. In any case, if educators address the complexity of the phenomena with which social workers deal, then the profession certainly would follow. Improved social work services would result.

A second implication for social work education is the clear need to provide more content on substance abuse in curricula. The data clearly indicated that perception of alcohol/drug abuse was the key to the provision of substance abuse services. In addition, this knowledge appeared to be the domain of a relatively small group of alcohol/drug abuse experts. Given the prevalence of substance abuse disorders and the multiple effects of substance abuse upon other systems, it is important to teach substance abuse related content to all social work students. In addition, the content in substance abuse curricula should be broadened to include the relationship
of this group of disorders to the functioning of families and children. Schools of social work would be advised to help broaden the perspective of social work students with a particular interest in practice with alcohol/drug abuse so that they may redefine their practice to include those families and children who are affected by these disorders.

Last, social work educators must be able to teach the various facets of case problems across concentrations. For example, this means that educators who teach courses geared to families and children should include substance abuse content and that those who teach courses on substance abuse should teach child and family content. The interconnectedness of course content must therefore be made apparent so that students can approach cases in their complexity.

Implications for Future Research

Since this study was descriptive, causal relationships between specialization on the one hand, and case perception, referrals and treatment on the other was not explored. Thus, precise information about these relationships is lacking. A future study could thus entail an experimental analysis of how the magnitude of problems contained in case vignettes affect the judgments of social workers from various specialty areas. Such a study would help answer the question of whether certain specialists are
insensitive or overly sensitive to different case problems. For example, by testing the-threshold of the specialization groups included in this study for different magnitudes of alcohol/drug abuse problems, child behavior problems, family problems, etc., one can determine more precisely whether child and youth specialists do, indeed, miss alcohol/drug abuse problems in their assessments and treatment plans. By the same token, one could more directly assess whether alcohol/drug abuse specialists narrowly focus upon alcohol/drug abuse problems. Based upon the results of this study, further research in this area is indicated.

Another line of future research would entail a series of studies designed to determine more precisely how social worker background variables, such as family history and personality traits, training, and education, as well as theoretical orientations affect clinical judgments. The results of this study formulated some intriguing hypotheses in this regard. These hypotheses merit continued study.

The last line of research envisioned would include a study of how variations in family characteristics affect case perception and treatment with regard to the problem areas included in this study. Thus, possible independent variables might include race, ethnicity, differing family constellations, socioeconomic status, and the ages of clients contained in the case vignettes. Thus, client
family characteristics, independent from the nature and magnitude of case problems, may influence clinical judgments.

**Summary**

Several points were made concerning the larger implications of this research. The key points are clear. Cases involving substance abuse, child behavior problems, family problems, and mental health problems are very prevalent. Social workers need to recognize the complexity inherent in these cases and in others so that they can provide appropriate services. This can only be accomplished if they have the skills with which to recognize case phenomena in their complexity, and the ability to deliver and coordinate a wide range of services to address multifaceted problems. This ability rests upon social workers' abilities to formulate a broad, assessment based upon an eco-systemic framework.
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APPENDIX
*Please answer the following questions in the order in which they are presented. Please write the appropriate code number in the columns which appear in the right hand margin at the end of each question. It is important to be sure that you write one digit in each column provided.

1. What is your sex?
   1= Female
   2= Male

2. What is your age?

3. To what racial group do you belong?
   1= White
   2= Black
   3= Asian/Pacific Islander
   4= Native American
   5= Mixed Race
   8= Other (Please specify ____________________)

4. Which of the following best describes your ethnicity?
   01= Afro-American
   02= West Indian
   03= African Black
   04= Native American
   05= Caribbean Latino
   06= Mexican/Central American
   07= South American
   08= Chinese
   09= Japanese
   10= Korean
   11= Filipino
   12= South-East Asian
   13= Anglo-Saxon/Scot/Welsh
   14= Irish
   15= Dutch
   16= German
   17= Scandinavian
   18= French
   19= Italian
   20= Greek
   21= Central/East European
   22= Jewish
   23= Arab
   24= Indian Sub-Continental
   88= Other (Specify_______)
5. What is your religion?

0 = None
1 = Protestant
2 = Roman Catholic
3 = Other Christian
4 = Jewish
5 = Muslim
6 = Buddhist
7 = Hindu
8 = Other (specify _______________)

6. What is your current marital status?

1 = Single, never married
2 = Married
3 = Separated
4 = Divorced
5 = Widowed

7. How many children do you have?

____________________________________

*PLEASE CONTINUE ON NEXT PAGE
The following case materials were taken from initial interviews. They are composites of individual, couple and conjoint family sessions. As is often the case, it is not possible to obtain complete information so early in the treatment.

Please read each case summary carefully. As you do, place yourself in the role of the clinician and try to get a "feel for these clients." Following each summary are questions concerning your assessment and the type of treatment plan that you would carry out for that particular case. Please respond to each question so that it accurately reflects how you would actually intervene in the case.

Remember, there are no right or wrong responses. As a professional, you are free to provide any combination of services to any or all clients as you see fit.

CASE #1

Family Members:
Mr. M.: 35-year-old salesperson
Ms. M.: 32-year-old homemaker, part-time clerical worker
William (Bill) M.: 9 year-old 4th grader

Ms. M. contacted the agency stating that her husband of 11 years is rarely home with the family. She said that he stays out with friends after work and on weekends. Ms. M. reported that he stayed out all night recently. Mr. M. said that he can't remember what he did, but he acknowledged staying out that night. However, Mr. M. said that he didn't agree that he sees his friends excessively and stated that he sees his friends because "my wife gives me the cold shoulder." He stated that Ms. M. won't sleep with him when he comes home at night. Ms. M. acknowledged this, but stated that she "can't stand the way he acts when he comes home late" and that she is too hurt and angry at Mr. M. to sleep with him. She said that Mr. M. "acts all silly and talks on and on about nonsense-sometimes for hours." Ms. M. said that she often sleeps on the living room couch. Mr. M. sleeps in their bedroom. Ms. M. said that her husband is "like a Jekyll and Hyde:" sweet and apologetic at one time, angry and verbally abusive the next. Mr. M. attributes this to his wife's behavior-her rejection of him and her "nervous attacks," which he says occur frequently. Ms. M. stated that during these attacks, she has trouble catching her breath, feels her heart pounding, and is afraid that she is having a heart attack. However, she recently began a part-time job "to make ends meet since my husband's business has been off." Ms. M. said that she enjoys her work and has been complimented by her boss. She also became the family financial manager since Mr. M. has been away so much.
Both Mr. and Ms. M. report that their son Bill is a "model student." He reportedly gets straight A's and that "all his teachers love him." Ms. M. said "thank God I have Bill, he's the one joy in my life." She said she "needs family" and worries about being alone. Mr. M. said that she pampers Bill. He said Ms. M. recently began keeping Bill home from Little League after another child was injured during practice. Mr. M. said that it was no wonder Bill doesn't have friends. Bill said that he doesn't like to bring classmates home. He said that "they're stupid kids" and that he'd rather help out around the house. Ms. M. said that he is a big help to her around the house now that she's started working. Ms. M. says that he cleans up, sets the table, and even heats dinner up. She says that he does almost everything well, but that "he's too much of a perfectionist." Ms. M. said that he gets very upset when something in his room is out of place or when he can't find something. However, Ms. M. says that his teachers and his coach consider him a bright, conscientious child.

*The following questions (#8-16) pertain to the above case:

8. Please rate the degree of dysfunction of the following people or family subunits.

1 = Not dysfunctional
2 =
3 =
4 = Somewhat dysfunctional
5 =
6 =
7 = Severely dysfunctional

<table>
<thead>
<tr>
<th>Father</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td></td>
</tr>
<tr>
<td>Marital Couple</td>
<td></td>
</tr>
<tr>
<td>Parent Sub-system</td>
<td></td>
</tr>
<tr>
<td>Entire Family Unit</td>
<td></td>
</tr>
</tbody>
</table>
9. Please list case problem(s) which you have identified for each of these people or sub-units.

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>00</td>
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<td>01</td>
<td>Anxiety Disorder</td>
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<td>02</td>
<td>Personality Disorder</td>
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<td>Depression</td>
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<td>Other Affective Disorder</td>
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<tr>
<td>05</td>
<td>Alcohol/Drug Abuse</td>
</tr>
<tr>
<td>06</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>07</td>
<td>Other Thought Disorder</td>
</tr>
<tr>
<td>08</td>
<td>Eating Disorder</td>
</tr>
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<td>09</td>
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<td>Child Sexual Abuse</td>
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<td>Social Isolation</td>
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<td>16</td>
<td>Sexual Problem</td>
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<td>17</td>
<td>Work/School Stress</td>
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<tr>
<td>18</td>
<td>Other Problem</td>
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</table>

Father (specify if "Other")
Mother (specify if "Other")
Child (specify if "Other")
Marital Couple (specify if "Other")
Parent Sub-system (specify if "Other")
Entire Family Unit (specify if "Other")

10. Please rate the severity of each problem that you listed above.

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<td>2</td>
<td></td>
</tr>
<tr>
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<td>5</td>
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</tr>
<tr>
<td>6</td>
<td>Very severe</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

Father
Mother
Child
Marital Couple
Parent-Sub-system
Entire Family Unit
11. In order to achieve significant case improvement, how necessary would it be to resolve each problem that you identified above?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
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<tr>
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<td>Parent Sub-system</td>
<td></td>
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<tr>
<td>Entire Family Unit</td>
<td></td>
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12. For what services would you refer to other service providers or programs? (List a maximum of 6).

<table>
<thead>
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<th>Service Type</th>
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<td>Psychiatric Consultation</td>
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<td>Psychological Testing</td>
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<tr>
<td>Medical Examination</td>
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<td>Individual Treatment, Adult</td>
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<td>Individual Treatment, Child</td>
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<tr>
<td>Group Treatment, Adult</td>
<td>06</td>
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<tr>
<td>Group Treatment, Child</td>
<td>07</td>
</tr>
<tr>
<td>Group Treatment, Couple</td>
<td>08</td>
</tr>
<tr>
<td>Group Treatment, Family</td>
<td>09</td>
</tr>
<tr>
<td>Couples Treatment</td>
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<tr>
<td>Conjoint Family</td>
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</tr>
<tr>
<td>Alcohol/Drug Abuse Treatment</td>
<td>12</td>
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<tr>
<td>Child Welfare Services</td>
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<td>Community Centers</td>
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<td>Self-Help Groups</td>
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<td>Other Services</td>
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</tr>
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<td>iii (Specify if &quot;Other&quot;)</td>
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<td>v (Specify if &quot;Other&quot;)</td>
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</tr>
<tr>
<td>vi (Specify if &quot;Other&quot;)</td>
<td></td>
</tr>
</tbody>
</table>
13. What treatment services would you provide for the above case? (List a maximum of 6).
*Do not include referrals or services provided by others.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
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</thead>
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<tr>
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<td>Individual Treatment, Father</td>
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<tr>
<td>02</td>
<td>Individual Treatment, Mother</td>
</tr>
<tr>
<td>03</td>
<td>Individual Treatment, Child</td>
</tr>
<tr>
<td>11</td>
<td>Group Treatment, Father</td>
</tr>
<tr>
<td>12</td>
<td>Group Treatment, Mother</td>
</tr>
<tr>
<td>13</td>
<td>Group Treatment, Child</td>
</tr>
<tr>
<td>14</td>
<td>Group Treatment, Couple</td>
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<td>Group Treatment, Family</td>
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<td>24</td>
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<td>Conjoint Family Treatment</td>
</tr>
<tr>
<td>88</td>
<td>Other</td>
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</tbody>
</table>

Treatment i (Specify if "Other")
ii (Specify if "Other")
iii (Specify if "Other")
iv (Specify if "Other")
v (Specify if "Other")
vi (Specify if "Other")

14. Please estimate the number of months it would take to successfully treat this case.

   ____ 70

15. How likely is it that this case will substantially improve after treatment?

   1 = Not likely at all
   2 =
   3 =
   4 = Somewhat likely
   5 =
   6 =
   7 = Very likely

16. How confident are you in your assessment and treatment plan for this case?

   1 = Not confident at all
   2 =
   3 =
   4 = Somewhat confident
   5 =
   6 =
   7 = Very confident

Card #  1
       73
CASE #2

Family Members:

Mr. S.: 38 year-old construction worker
Ms. S.: 34 year-old secretary
Tim S.: 11 year-old 5th grader

Mr. and Ms. S. made an appointment with the agency on the advice of their minister. Ms. S. stated that she "feels down most of the time." She said that she has a lot of responsibility on her shoulders. Ms. S. said that she "is always arguing" with her husband. She claims that she often can't remember what started their arguments by the time they are over. Ms. S. said that they often fight over disciplining Tim. She states that her husband will often say one thing to Tim and then do another. According to Ms. S., Mr. S. reportedly "lets Tim off easy after we agreed that he'd be punished, or else he overreacts and is too hard on Tim for small things."

Mr. S. agrees that they argue, but feels that all couples do. However, upon questioning, Mr. S. admitted that he has "a lot on his mind." His foreman reportedly "has been on (his) case lately." He claims that Mr. S.'s work is sloppy and that he is careless on the job. Mr. S. said that his boss was "trying to get the goods" on him by timing his lunch hours and claiming that he misses work on Mondays in order to take three day weekends. Mr. S. says that "lots of guys take long lunch hours-it's normal for us to have lunch together and blow off some steam over a few beers." He said that he is a hard worker and needs to relax and enjoy his lunch. Mr. S. said that he had stomach problems and that his doctor said that he had gastritis. Mr. S. said that "it comes from aggravation." Ms. S. said that she is afraid that he'll lose his job and that she has pleaded with him to keep his lunch hours short. Ms. S. said that his wife 'is a worrier' and that his foreman "is full of hot air." He said that he has missed a couple of days of work during the past few months, due to the gastritis.

Ms. S. said that her husband has always been unreliable but that it has gotten worse lately. Ms. S. said that this week he forgot to pick Tim up from his Boy Scout meeting and that "Tim's Scoutmaster finally had to drive him home." Ms. S. said that Tim was "mortified." When asked how he felt about this incident, Tim just shrugged. Mr. S. said that he tries to do too much for his family and sometimes forgets some of his promises. He said that he forgot to pick Tim up because he was working with his neighbor on plans to enclose the S's back porch. Mr. S. said that he is not appreciated for the work he does for his family.
Ms. S. said that Tim's teacher called them because Tim is "defiant and disruptive" in class. She said that he was sent to the principal's office after he fought with one of his classmates. Tim said that his classmate cheated at baseball and so they got into a fight. He also was sent to the principal for kicking an aide while he was on the school yard swing. Tim said that it was an accident—that he didn't mean it, "she just got in the way." Mr. S. thought that "Tim needs to learn to stick up for himself." He said that "Tim isn't a bad kid" and that "he'll settle down as he gets older."

*The following questions (#17-25) pertain to the above case:

17. Please rate the degree of dysfunction of the following people or family sub-units.

1= Not dysfunctional
2=
3=
4= Somewhat dysfunctional
5=
6=
7= Severely dysfunctional

Father
Mother
Child
Marital Couple
Parent Sub-system
Entire Family Unit

*PLEASE CONTINUE ON NEXT PAGE
18. Please list case problem(s) which you have identified for each of these people or sub-units.

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No Problem</td>
</tr>
<tr>
<td>01</td>
<td>Anxiety Disorder</td>
</tr>
<tr>
<td>02</td>
<td>Personality Disorder</td>
</tr>
<tr>
<td>03</td>
<td>Depression</td>
</tr>
<tr>
<td>04</td>
<td>Other Affective Disorder</td>
</tr>
<tr>
<td>05</td>
<td>Alcohol/Drug Abuse</td>
</tr>
<tr>
<td>06</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>07</td>
<td>Other Thought Disorder</td>
</tr>
<tr>
<td>08</td>
<td>Eating Disorder</td>
</tr>
<tr>
<td>09</td>
<td>Child Behavior Problem</td>
</tr>
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<td>10</td>
<td>Marital Problem</td>
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<td>Parent-Child Problem</td>
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<td>Domestic Violence</td>
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<td>13</td>
<td>Child Abuse/Neglect</td>
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<td>14</td>
<td>Child Sexual Abuse</td>
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<td>15</td>
<td>Social Isolation</td>
</tr>
<tr>
<td>16</td>
<td>Sexual Problem</td>
</tr>
<tr>
<td>17</td>
<td>Work/School Stress</td>
</tr>
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<td>18</td>
<td>Other Problem</td>
</tr>
</tbody>
</table>

Father (specify if "Other")
Mother (specify if "Other")
Child (specify if "Other")
Marital Couple (specify if "Other")
Parent Sub-system (specify if "Other")
Entire Family Unit (specify if "Other")

*PLEASE CONTINUE ON NEXT PAGE*
19. Please rate the severity of each problem that you listed above.

0= Not applicable—No problem listed
1= Not at all severe
2= 
3= 
4= Somewhat severe
5= 
6= 
7= Very severe

Father
Mother
Child
Marital Couple
Parent Sub-system
Entire Family Unit

20. In order to achieve significant case improvement, how necessary would it be to resolve each problem that you identified above?

0= Not applicable—No problem listed
1= Not at all necessary
2= 
3= 
4= Somewhat necessary
5= 
6= 
7= Absolutely necessary

Father
Mother
Child
Marital Couple
Parent Sub-system
Entire Family Unit
21. For what services would you refer to other service providers or programs? (List a maximum of 6).

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>00</td>
</tr>
<tr>
<td>Psychiatric Consultation</td>
<td>01</td>
</tr>
<tr>
<td>Psychological Testing Treatment</td>
<td>02</td>
</tr>
<tr>
<td>Medical Examination</td>
<td>03</td>
</tr>
<tr>
<td>Individual Treatment, Adult</td>
<td>04</td>
</tr>
<tr>
<td>Individual Treatment, Child</td>
<td>05</td>
</tr>
<tr>
<td>Group Treatment, Adult</td>
<td>06</td>
</tr>
<tr>
<td>Group Treatment, Child</td>
<td>07</td>
</tr>
<tr>
<td>Group Treatment, Couple</td>
<td>08</td>
</tr>
<tr>
<td>Group Treatment, Family</td>
<td>09</td>
</tr>
</tbody>
</table>

Service  

i (specify if "Other")

ii (specify if "Other")

iii (specify if "Other")

iv (specify if "Other")

v (specify if "Other")

vi (specify if "Other")

22. What treatment services would you provide for the above case? (List a maximum of 6).

*Do not include referrals or services provided by others.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Treatment</td>
<td>00</td>
</tr>
<tr>
<td>Individual Treatment, Father</td>
<td>01</td>
</tr>
<tr>
<td>Individual Treatment, Mother</td>
<td>02</td>
</tr>
<tr>
<td>Individual Treatment, Child</td>
<td>03</td>
</tr>
<tr>
<td>Group Treatment, Father</td>
<td>04</td>
</tr>
<tr>
<td>Group Treatment, Mother</td>
<td>05</td>
</tr>
<tr>
<td>Group Treatment, Child</td>
<td>06</td>
</tr>
<tr>
<td>Group Treatment, Couple</td>
<td>07</td>
</tr>
<tr>
<td>Group Treatment, Family</td>
<td>08</td>
</tr>
</tbody>
</table>

Treatment  

i (specify if "Other")

ii (specify if "Other")

iii (specify if "Other")

iv (specify if "Other")

v (specify if "Other")

vi (specify if "Other")
23. Please estimate the number of months it would take to successfully treat this case.

24. How likely is it that this case will substantially improve after treatment?
   1= Not likely at all
   2=
   3=
   4= Somewhat likely
   5=
   6=
   7= Very likely

25. How confident are you in your assessment and treatment plan for this case?
   1= Not confident at all
   2=
   3=
   4= Somewhat confident
   5=
   6=
   7= Very confident

*PLEASE CONTINUE ON NEXT PAGE*
CASE #3

Family Members: Mr. J.: 32 year-old truck driver
Ms. J.: 28 year-old salesperson
Michael (Mike) J.: 8 year-old 3rd grader

Mr. J. contacted the agency after speaking with a friend, who is an ex-client. She stated that she and her husband of 9 years "never have any fun together any more." She says that when Mr. J. comes home from work, he barely speaks to her or their son, Mike. Ms. J. says that he frequently gets home late, eats left over dinner and then stays in their bedroom watching television until he falls asleep. She said that she always has their relationship on her mind and feels "hopeless about the possibility that things will get better between us." Ms. S. said that she has been "trying and trying to make things better between us but nothing I do helps." She said that she has been having difficulty falling asleep at night and that she has been waking up early lately. Ms. J. attributes this to her worries about her marriage. Mr. J. says that his wife makes no effort to spend time with him. He said that they don't go out to parties any more. Mr. J. thinks that Ms. J. makes excuses to avoid attending them. Ms. J. says that she doesn't have fun at parties any more. She said that Mr. J. "gets loud and obnoxious" at them. Mr. J. disagreed with this, saying that he is having fun, although he said that he speaks his mind when he is with friends. Ms. J. said that some of their friends aren't talking to him because of his behavior and that she doesn't want to make any more enemies. Mr. J. said that "those friends are thin skinned" and never really liked him anyway.

Mr. J. said that he is "basically a loner," but he can socialize with people he works with or with people at parties. He said that his mother died 4 1/2 months ago from liver disease. He said that he doesn't feel like being around people since she died. Ms. J. said that his mother's death was hard for him, but she thinks that their problems preceded this. Mr. J. said that he had friends through his job. He delivers beverages for a distributor. He often spends time with the restaurant and bar managers after making his deliveries. Mr. J. says that this is why he comes home late. Mr. J. stated that his boss supports this since his boss "wants to keep the customers happy."

Ms. J. said that Mike has been having problems at school. His teachers describe his school performance as inconsistent. Ms. J. says that his classmates tease him and call him names. Mike has not been doing his homework lately and has begun to wet his bed at night. Mr. J. says that Mike is lazy and thinks that he "wants attention from his mother." Ms. J. said that Mike's behavior would improve if Mr. J. "would be home more often and show a little interest in Mike." Mike stated that he "worries a lot." With some probing he said that he worries that his father will get into a car crash.
*The following questions (26-34) pertain to the above case:

26. Please rate the degree of dysfunction of the following people or family sub-units.

1 = Not dysfunctional
2 =
3 =
4 = Somewhat dysfunctional
5 =
6 =
7 = Severely dysfunctional

Father
Mother
Child
Marital Couple
Parent Sub-system
Entire Family Unit

27. Please list case problem(s) which you have identified for each of these people or sub-units.

00 = No Problem
01 = Anxiety Disorder
02 = Personality Disorder
03 = Depression
04 = Other Affective Disorder
05 = Alcohol/Drug Abuse
06 = Schizophrenia
07 = Other Thought Disorder
08 = Eating Disorder
09 = Child Behavior Problem
10 = Marital Problem
11 = Parent-Child Problem
12 = Domestic Violence
13 = Child Abuse/Neglect
14 = Child Sexual Abuse
15 = Social Isolation
16 = Sexual Problem
17 = Work/School Stress
88 = Other Problem

Father (specify if "Other"

Mother (specify if "Other"

Child (specify if "Other"

Marital Couple
(specify if "Other"

Parent Sub-system
(specify if "Other"

Entire Family Unit
(specify if "Other"

Card # 2

77
28. Please rate the severity of each problem that you listed above.

0 = Not applicable—No problem listed
1 = Not at all severe
2 = 
3 =
4 = Somewhat severe
5 =
6 =
7 = Very severe

[Begin Card 3]

29. In order to achieve significant case improvement, how necessary would it be to resolve each problem that you identified above?

0 = Not applicable—No problem listed
1 = Not at all necessary
2 =
3 =
4 = Somewhat necessary
5 =
6 =
7 = Absolutely necessary

Father
Mother
Child
Marital Couple
Parent Sub-system
Entire Family Unit
30. For what services would you refer to other service providers or programs? (List a maximum of 6).

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00= None</td>
<td></td>
</tr>
<tr>
<td>01= Psychiatric Consultation</td>
<td>10= Couples Treatment</td>
</tr>
<tr>
<td>02= Psychological Testing</td>
<td>11= Conjoint Family Treatment</td>
</tr>
<tr>
<td>03= Medical Examination</td>
<td>12= Alcohol/Drug Abuse Treatment</td>
</tr>
<tr>
<td>04= Individual Treatment, Adult</td>
<td>13= Child Welfare</td>
</tr>
<tr>
<td>05= Individual Treatment, Child</td>
<td></td>
</tr>
<tr>
<td>06= Group Treatment, Adult</td>
<td></td>
</tr>
<tr>
<td>07= Group Treatment, Child</td>
<td></td>
</tr>
<tr>
<td>08= Group Treatment, Couple</td>
<td></td>
</tr>
<tr>
<td>09= Group Treatment, Family</td>
<td>88= Other Services</td>
</tr>
</tbody>
</table>

Service i. (Specify if "Other")

ii. (Specify if "Other")

iii. (Specify if "Other")

iv. (Specify if "Other")

v. (Specify if "Other")

vi. (Specify if "Other")

31. What treatment services would you provide for the above case? (List a maximum of 6).

*Do not include referrals or services provided by others.

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00= No Treatment</td>
<td></td>
</tr>
<tr>
<td>01= Individual Treatment, Father</td>
<td>24= Couples Treatment</td>
</tr>
<tr>
<td>02= Individual Treatment, Mother</td>
<td>25= Conjoint Family Treatment</td>
</tr>
<tr>
<td>03= Individual Treatment, Child</td>
<td></td>
</tr>
<tr>
<td>11= Group Treatment, Father</td>
<td>88= Other</td>
</tr>
<tr>
<td>12= Group Treatment, Mother</td>
<td></td>
</tr>
<tr>
<td>13= Group Treatment, Child</td>
<td></td>
</tr>
<tr>
<td>14= Group Treatment, Couple</td>
<td></td>
</tr>
<tr>
<td>15= Group Treatment, Family</td>
<td></td>
</tr>
</tbody>
</table>

Treatment i. (Specify if "Other")

ii. (Specify if "Other")

iii. (Specify if "Other")

iv. (Specify if "Other")

v. (Specify if "Other")

vi. (Specify if "Other")
32. Please estimate the number of months it would take to successfully treat this case.

33. How likely is it that this case will substantially improve after treatment?
   1 = Not likely at all
   2 =
   3 =
   4 = Somewhat likely
   5 =
   6 =
   7 = Very likely

34. How confident are you in your assessment and treatment plan for this case?
   1 = Not confident at all
   2 =
   3 =
   4 = Somewhat confident
   5 =
   6 =
   7 = Very confident

*The following questions (35-52) pertain to your education, training, and clinical experience. Please select the most accurate response to each question.

35. In what year was your MSW degree granted? 1 2 __ __ __

36. What was your concentration in your masters program?
   1 = Clinical (Micro) Practice
   2 = Community Organization, Planning, Administration
   3 = Generic/Generalist Practice
   8 = Other
   (Specify if "Other" ______________________)
37. Which of the following best describes your first year field placement?

01 = Children and Youth
02 = Community Organization, Planning, Administration
03 = Family Service
04 = Corrections/Criminal Justice
05 = Group Services (Y's, Community Centers, Settlements)
06 = Medical/Health Care
07 = Mental Health
08 = Public Assistance/Welfare
09 = School Social Work
10 = Aging
11 = Alcohol and Drugs
12 = Developmental Disabilities/Retardation
13 = Other Disabilities
14 = Occupational/Industrial
88 = Other
99 = Not Applicable

(Specify if "Other")

38. Which of the above categories best describes your second year field placement?

(Specify if "Other")

39. Please estimate the frequency with which you attended seminars which addressed the following areas since graduating from your MSW program.

0 = Never
1 = Once a year or less
2 = Two to four times a year
3 = Five to seven times a year
4 = Eight to ten times a year
5 = Eleven times a year or more

- Children and Youth
- Families
- Alcohol and Drugs
- Adult Mental Health
40. Please list any other graduate/professional degrees you received and the years they were granted.

<table>
<thead>
<tr>
<th>Check if Received</th>
<th>Year Granted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masters</td>
<td>1999</td>
</tr>
<tr>
<td>(specify field)</td>
<td></td>
</tr>
<tr>
<td>Social work doctorate</td>
<td>1999</td>
</tr>
<tr>
<td>Other doctorate</td>
<td>1999</td>
</tr>
<tr>
<td>(specify field)</td>
<td></td>
</tr>
<tr>
<td>Other professional degree</td>
<td>1999</td>
</tr>
<tr>
<td>(specify field)</td>
<td></td>
</tr>
<tr>
<td>Post-masters certificate</td>
<td>1999</td>
</tr>
<tr>
<td>(specify field)</td>
<td>60</td>
</tr>
</tbody>
</table>

41. During the past year, (May 1986 - May 1987) how many seminars have you attended in the following areas?

<table>
<thead>
<tr>
<th>Area</th>
<th>Full Day Seminars (7 hours)</th>
<th>Full Semester Courses (35 hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Youth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol &amp; Drugs</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Card # 3/78

42. How many months of full-time (35-40 hours per week) or equivalent PRE-masters direct practice experience have you had in the following areas? (Do not count internships during your master's education. Volunteer experience may be included).

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Youth</td>
<td></td>
</tr>
<tr>
<td>Families</td>
<td></td>
</tr>
<tr>
<td>Alcohol &amp; Drugs</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td>10</td>
</tr>
</tbody>
</table>
43. Which of the following best describes the current nature of your practice?

01 = Children & Youth
02 = Community Organization
03 = Families
04 = Corrections/Criminal
05 = Group Services
06 = Medical/Health
07 = Mental Health
08 = Public Assistance/Welfare
09 = School Social Work
10 = Aging
11 = Alcohol & Drugs
12 = Developmental Disabilities/Retarded
13 = Other Disabilities
14 = Occupational/Industrial
15 = Other Disabilities
88 = Other
99 = Not Applicable

Primary (Specify if "Other"

Secondary (Specify if "Other"

44. How strongly do you identify yourself with your primary practice area?

1 = Not strongly
2 =
3 =
4 = Somewhat strongly
5 =
6 =
7 = Very strongly

45. How strongly do you identify yourself with your secondary practice area?

1 = Not strongly
2 =
3 =
4 = Somewhat strongly
5 =
6 =
7 = Very strongly
9 = Not applicable

46. Please estimate the percentage that the following types of cases comprised your case load during the past year. (These numbers need not add up to 100%)

<table>
<thead>
<tr>
<th>Type of Case</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; Youth</td>
<td>20%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>Family Units</td>
<td></td>
</tr>
<tr>
<td>Adults with Chronic Mental Illnesses</td>
<td>30%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td></td>
</tr>
<tr>
<td>Eating Disorders</td>
<td></td>
</tr>
</tbody>
</table>

21
47. How knowledgeable are you about the following areas?

1 = Not knowledgeable
2 =
3 =
4 = Somewhat knowledgeable
5 =
6 =
7 = Very knowledgeable

<table>
<thead>
<tr>
<th>Area</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Behavior Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol and Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Mental Illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Adult Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

48. How frequently do you screen for the following problems in your practice?

1 = Never
2 =
3 =
4 = Sometimes
5 =
6 =
7 = Always

<table>
<thead>
<tr>
<th>Area</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug Abuse (by clients or client's family members)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/Youth Behavior Problems (of child or adult client's children)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>Adult Mental Disorders (of client or client's family)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
49. How skillful are you at identifying the following problems?

1 = Not skillful
2 =
3 =
4 = Somewhat skillful
5 =
6 =
7 = Very skillful

<table>
<thead>
<tr>
<th>Problem</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Problems</td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug Abuse</td>
<td></td>
</tr>
<tr>
<td>Child/Youth Behavior Problems</td>
<td></td>
</tr>
<tr>
<td>Adults with Chronic Mental Illnesses</td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td></td>
</tr>
<tr>
<td>Eating Disorders</td>
<td></td>
</tr>
</tbody>
</table>

50. How knowledgeable are you concerning community resources for the following client groups?

1 = Not knowledgeable
2 =
3 =
4 = Somewhat knowledgeable
5 =
6 =
7 = Very knowledgeable

<table>
<thead>
<tr>
<th>Client Group</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Problems</td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug Abuse</td>
<td></td>
</tr>
<tr>
<td>Children/Youth with Behavior Problems</td>
<td>60</td>
</tr>
<tr>
<td>Adults with Chronic Mental Illnesses</td>
<td></td>
</tr>
<tr>
<td>Clients involved in Domestic Violence</td>
<td></td>
</tr>
<tr>
<td>Clients with Eating Disorders</td>
<td></td>
</tr>
</tbody>
</table>

Card # 4 65
51. For all clients that you served during the past year, approximately what percentage did you refer to the following agencies (in addition to providing treatment services or instead of providing services) [Begin Card 5]

*Percentages need not add up to 100%

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Treatment Services</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Alcohol/Drug Abuse Treatment Services</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Child Treatment Services</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Child Welfare Services</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Community Psychiatric Services</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Domestic Violence Services</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Eating Disorders Clinics</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Community Center</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Self-Help Groups</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Other (Specify________________________)</td>
<td>___ ___ %</td>
</tr>
</tbody>
</table>

*PLEASE CONTINUE ON NEXT PAGE
52. On the average, how closely would you coordinate with the above services?

1 = Not closely
2 =
3 =
4 = Somewhat closely
5 =
6 =
7 = Very closely

Family Treatment Services
Alcohol/Drug Abuse Treatment Services
Child Treatment Services
Child Welfare Services
Community Psychiatric Services
Domestic Violence Services
Eating Disorders Clinic
Community Centers
Self-Help Groups
Other (Specify_________________)

*PLEASE CONTINUE ON NEXT PAGE
*Please indicate the extent of your agreement/disagreement with the following statements (#53-61).

1= Strongly disagree
2=  
3=  
4= Neither agree nor disagree
5=  
6=  
7= Strongly agree
9= Don't know

53. Alcohol/Drug abuse is best treated by addressing stressful psychosocial conditions which underlie the abuse.  

54. Child behavior problems are best treated in conjoint family therapy.  

55. Ongoing family problems resolve themselves once an alcohol/drug abusing member becomes abstinent.  

56. The best way to help children whose parents abuse alcohol/drugs is to provide substance abuse treatment for those parents.  

57. Families with alcohol/drug abusing members are in need of family treatment.  

58. Alcohol/Drug abuse is a symptom of underlying family problems.  

59. When treating individual alcohol/drug abusing clients, their relationships with their spouses should not be directly addressed.  

60. Parenting issues should not be a major focus in the treatment of alcohol/drug abusers who have children.  

61. When treating individual children whose parents may have alcohol/drug problems, it is important to discuss their parent's alcohol/drug use in sessions.
*The following questions (#62-65) are personal. This information will be treated with respect and held in strict confidence. Please do not feel obliged to respond to them.

62. Have any members in your immediate family ever had an alcohol/drug problem?
   Yes = 1
   No = 0
   Don't know = 9

63. Have any members in your immediate family ever had a chronic mental illness?
   Yes = 1
   No = 0
   Don't know = 9

64. Have any members in your immediate family ever been involved in domestic violence?
   Yes = 1
   No = 0
   Don't know = 9

65. Have any members in your immediate family ever been sexually abused?
   Yes = 1
   No = 0
   Don't know = 9

66. Would you like to receive a summary of the results of this study?
   Yes = 1
   No = 0

*Thank you very much for completing this questionnaire. A stamped, pre-addressed envelope has been included to facilitate its return.