Social Workers' Attitudes about Psychotropic Drug Treatment with Youths

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There is considerable controversy among mental health professionals and the public about the proper role of psychotropic medications in the treatment of youths. Within social work, too, there have been sharp differences of opinion. There have been few studies, however, about the views of practicing clinical social workers on the use of psychiatric drugs in the treatment of youths. This study, a cross-sectional survey of a national sample of social workers, examines their views about medications and the role they may play in the treatment of youths. The findings suggest that social workers hold complex views that recognize both the potential benefits and harms of psychotropic medications, but overall they seem to support their use in a judicious manner.

KEY WORDS: *attitudes; psychiatric drugs; social workers; treatment; youths*

Given the precipitous rise in psychotropic drug use with youths in recent years (for example, Rushton & Whitmire, 2001; Zito et al., 2003), nearly every social worker practicing with youths has worked with a medicated child or adolescent. Despite the controversies and concerns this trend has generated (see, for example, Ingersoll, Bauer, & Burns, 2004; Moses & Kirk, 2005), we know very little about social workers' attitudes toward this trend. This is unfortunate because social workers provide the largest proportion of mental health services in the United States (Gibelman & Schervish, 1997; Knowlton, 1995), and their attitudes are likely to affect how they broker clients' access to drug treatment and the quality of supportive services that accompany drug treatment (for example, education; monitoring of side effects, adherence, and effectiveness; and collaboration with physicians). Moreover, parents often turn to social workers to ask about medication because social workers often serve as intermediaries among families, schools, and physicians in regard to referrals for medication evaluation and follow-up (Bentley & Walsh, 2001; Taylor, 2003).

Social workers' attitudes about drug treatment likely affect their behavior and communication style with clients (Bentley, Farmer, & Phillips, 1991; Taylor, 2003). Johnson and colleagues (1998) found that social workers expressing stronger beliefs that medication is helpful in treating emotionally disturbed youths were also more likely to have favorable attitudes toward collaborative work with other professionals (for example, to refer youths to other specialists) and to work more closely with families (for example, to share information with parents and to avoid attributing blame). Social workers' attitudes toward medication treatment are likely to affect medication referrals. Bradley (2003) noted that social workers' "beliefs and theoretical framework impact why, when, and how this decision [to refer for medication consultation] is made" (p. 36).

Moreover, social workers' attitudes are likely to affect clients' receptivity, satisfaction, and response to this form of treatment. A recent survey of social workers' roles in clients' psychiatric medication reported that when asked about their most important personal contribution to a successful outcome with psychiatrically medicated clients, 16 percent of respondents indicated that it was holding positive attitudes and beliefs that support medication (Bentley, Walsh, & Farmer, 2004). These social workers thought that communicating hope and sharing professional experiences of other clients' positive outcomes contributed to positive outcomes. There have been no empirical studies, however, of whether

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there is a direct relationship between social workers' attitudes toward drug treatment and treatment outcomes.

Social Workers' Views of Drug Treatment

Much of the earlier social work literature from the 1970s and 1980s depicts the profession's view of psychotropic medication treatment as suspicious and negative (for example, Berg & Wallace, 1987; Davidson & Jamison, 1983; Matorin & De Chillo, 1984). This literature, focused on adult clients, suggests that social workers are resistant to the medical model, a perspective that defines clients' problems using medical–psychopathological terms that are apolitical, decontextualized, and deficit oriented and that steers treatment toward "fixing" the individual. This literature tends to focus on the negative physical or psychosocial consequences of biological interventions and about possible drug misuse involved in inadequate screening, overmedication, and infringement on patients' rights.

More recent literature, however, has suggested that many social workers subscribe, at least to some extent, to the medical model and support as well as facilitate the use of drug treatment for adults with mental illness. Several studies of social workers' attitudes toward psychopharmacologic treatment suggest that they are more positive about drug treatment than other mental health professionals (Bentley et al., 1991; Roskin, Carsen, Rabiner, & Marell, 1988), although they seem to view it as one part of a more inclusive intervention plan. Bentley and associates' (2004) study found that the vast majority of social workers did not perceive "clashing perspectives of colleagues or personal reservations about medication" as important barriers to practice (Bentley et al., 2004, p. 10). Rather, a significant proportion of the latter study sample requested more thorough and in-depth education on psychiatric medication or called for more intensive and extensive communication with medical professionals on medication-related issues. Moreover, studies exploring social workers' emphasis on client self-determination and clients' right to refuse medication versus the value of "beneficence" (that is, facilitating patients' drug treatment by force, if necessary) have found that the majority prefer to err on the side of beneficence (Mizrahi & Abramson, 1985; Wilk, 1994).

There are, however, sharply different views on this topic between social workers concerned with the civil rights and empowerment of those with mental illness and those who are closer adherents of the medical model. On the one hand, those who view human problems within their broad social, economic, and political context perceive the medical model as simplistic, reductionist, and physically as well as psychologically harmful. These critics suggest that the medical model and its associated biological treatments are often coercive and controlling of clients and tend to delegitimize clients and their views (Cohen, 1988; Murphy, Pardeck, Chung, & Choi, 1994). Uncritical social workers are admonished as passive, unquestioning accomplices of the medical establishment, which largely uses drug treatment to promote its professional monopoly. On the other hand, other social work scholars claim that dismissing drug treatment as a viable treatment option for mental disorders ignores the substantial scientific evidence pointing to the biological contributions to mental illness (Johnson, 1989; Rosenson, 1993). Along these lines, social workers are encouraged to become better educated and assume more active roles to promote better psychopharmacologic treatment for clients (Bentley & Walsh, 2001; Dziegielewski & Leon, 2001). It is no surprise, then, that social workers, sensing these mixed messages, commonly struggle with the ethical and professional dilemmas surrounding psychiatric drugs. A recent study by Walsh and colleagues (2003) found that in a typical month, more than 60 percent of sampled social workers experience at least two types of ethical dilemmas about clients' drug treatment. Many dilemmas stem from struggles about the primacy of humanistic versus functionalist values, role confusion, and lack of confidence in one's ability or knowledge in the area of medication treatment.

If social workers' current views toward psychopharmacologic treatment with adults are somewhat unclear, there is even less information about their attitudes toward drug treatment with youths. One exception is Johnson and associates' (1998) study, which found that social workers are very much divided on this issue: Slightly more than half (177 of 334) of social workers in their study disagreed or strongly disagreed with the statement "For many psychological disorders in children and adolescents medication is necessary." However, more than two-thirds of the sample agreed that drugs are "often helpful" in treating youngsters' emotional disorders. In other words, some believe medication is helpful

but not necessary; others believe that it is neither necessary nor helpful; and still others agree that medication may be both helpful and necessary.

Factors Associated with Social Workers' Attitudes

Social workers' views about psychotropic drugs may be associated with both professional and personal factors. Of the professional factors, primary theoretical framework may be important in shaping views. Johnson and colleagues (1998) found that clinicians with a primarily cognitive–behavioral orientation or neuropsychological orientation held a more positive attitude toward the helpfulness of psychotropic drugs for treating youths. This association was replicated in another study by DeChillo (1993), examining the association between social workers' attitudes regarding the etiology of mental illness (biological versus psychological) and their collaboration with families of clients with severe mental illness. Social workers who endorsed a primarily neuropsychological theoretical frame of reference, rather than a psychodynamic, family systems, cognitive–behavioral, or existential–humanistic frame of reference, were more inclined to collaborate with families than were workers who believed in a psychogenic etiology. This suggests that a worker's theoretical framework is important not only in shaping attitudes, but also in shaping his or her general behavior toward clients and families, and, ultimately, perhaps in determining the effectiveness of drug treatment efforts (DeChillo, Koren, & Schultze, 1994; Johnson et al., 1998).

Other studies have suggested that the context of treatment, including the setting and the nature of the targeted behavior problem (for example, level of severity, dangerous behavior versus disruptive behavior), influences social workers' approach to psychotropic drugs. Johnson and colleagues' (1998) study found that social workers who viewed medication as helpful for treating young people were more likely to be working in a child mental health inpatient setting than in a school social work, family and children's outpatient services, criminal justice, or health care setting. A study by Littrell and Ashford (1994) suggested that social workers from a community mental health center (CMHC) and family service agencies were like-minded about referral of a depressed client for medication, but those from family services agencies were significantly less likely than their CMHC colleagues to feel obligated to refer a client with a less severe diagnosis (an adjustment reaction) for medication assessment. Berg and Wallace's (1987) study also corroborated the importance of work setting and the nature of the treated behavior. Social workers from inpatient and outpatient settings disagreed about the level of seriousness of disorder necessary before feeling a professional obligation to refer the client for medication assessment. Inpatient social workers were more inclined than their outpatient counterparts to refer disruptive clients for medication (75 percent compared with 35 percent) and were less likely to express various concerns about potential ethical or practical problems associated with drug treatment. This suggests that the context of practice affects attitudes: Inpatient workers were more aligned with the medical model than were outpatient social workers.

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As widespread use of drug treatment with youths is fairly recent, more experienced social workers who were trained at a time when psychopharmacology was less common may hold different opinions relative to newcomers. Only one study addressed this question, but it focused exclusively on attention deficit/hyperactivity disorder (ADHD). Pentecost and Wood (2002) found that more years of experience was related to more knowledge about ADHD and openness to a plurality of interventions but was not associated specifically with perceptions about medication for ADHD. Other professional characteristics that might be expected to shape beliefs, such as the level of training and knowledge in psychopharmacology or the proportion of a worker's caseload prescribed medication, have not been studied.

Given the limited research in this area, it is unclear whether social workers' personal characteristics are associated with attitudes about pharmacology. A study of British social workers' knowledge and perceptions about ADHD (Pentecost & Wood, 2002) found that women were significantly less

likely than men to agree with stimulant medication for ADHD and more likely to agree with alternative treatments (for example, child psychotherapy, social skills training). Similarly, Walsh and associates (2003) found that women experienced ethical dilemmas with regard to the drug treatment of adults more frequently than did men and were much more bothered by ethical struggles than were men. Among psychiatrists and psychologists, older clinicians gave more support for psychosocial treatment than for medication for clients with ADHD (Garrett, 2000). Although there is reason to expect that clinicians' ethnic differences may influence their attitudes toward medication treatment, as they do among the public (Alvidrez, 1999; Cooper et al., 2003), this has not been studied.

METHOD

Design and Sample

This report relies on data from a national cross-sectional mail survey of social workers' experiences in treating adolescents who are prescribed psychotropic medication. For the broader study, social workers were asked about their attitudes about the use of psychopharmacology with youths and their perceptions of the impact of psychopharmacology on adolescent clients' psychosocial well-being and on social work treatment (Moses, 2003). In this article, we report only on their attitudes toward medication for youths.

We wanted to reach experienced social workers who were most likely to work with children and youths. The sampling frame required that participants meet the following three criteria: (1) had MSW degrees; (2) identified themselves as practicing in either mental health or school social work; and (3) reported that their primary function was clinical or direct practice. After receiving approval from the university's human subjects protection committee, we used these criteria to select a random sample of 2,000 social workers who were members of the National Association of Social Workers (NASW). Potential participants were initially contacted in the fall of 2002 with a letter and a 12-page questionnaire; they were also provided with a postcard that they could return if unable to participate in the study (for example, if they did not have a relevant clinical case involving a medicated youth, which was required for the broader study). This was followed up with up to two reminders for those who had not responded. We received 260 returned nonparticipation postcards, 16 questionnaires that were undeliverable, and 563 usable surveys. Considering those whose mailings were delivered and who did not return nonparticipation cards, the study's response rate was 32.7 percent.

The typical respondent was a white (95 percent) woman (80 percent) of middle age (M = 52 years, SD = 7.2). We expected that our sample's demographics might differ somewhat from the overall membership of NASW. The sample's age and gender distributions were, however, comparable with the membership database statistics (last updated on May 3, 2002). NASW members' modal age is in the 50 to 55 range, and women constitute 81 percent of the membership. However, whether as a result of sampling frame criteria or self-selection bias, our sample included fewer social workers of ethnic minority status (5 percent compared with 15 percent).

Survey Instrument

An extensive 10-page questionnaire was designed for this study. A draft was used in a pilot study and revised on the basis of feedback from a convenience sample of 10 senior or supervising social workers working with youths in six different mental health agencies in Los Angeles. In the pilot study, each social worker was interviewed for feedback concerning the length of the instrument, ease of responding, comprehension, relevance to their work, and so forth. Subsequently, we clarified some instructions, eliminated items, and added new ones.

This study used two sections of the questionnaire. The first covers demographic and other personal information about respondents, as well as information about professional experiences with psychopharmacology. The second asked social workers to respond to the General Attitudes about Use of Psychotropics with Youths Scale, which consists of 14 questions eliciting respondents' judgments about the value of using psychotropic medication when treating adolescents. Specifically, social workers were asked to rate the extent to which they believe that psychotropic medication is beneficial for or detrimental to youths and to provide their opinions about the extent to which psychotropic medication is appropriately used in contemporary mental health practice. There are no appropriate standardized measures for capturing clinicians' attitudes toward drug treatment with youths. Consequently, we developed scale items on the basis of

face validity following a comprehensive literature review of studies of attitudes toward or knowledge of various forms of mental health treatment (for example, Berg & Wallace, 1987; DeChillo, 1993; Littrell & Ashford, 1994; Rosen & Livne, 1992) and a careful reading of other papers on social work and drug treatment (for example, Cordoba, Wilson, & Orten, 1983; Davidson & Jamison, 1983). Initial items were modified on the basis of the pilot study results. The final items were rated on a four-point Likert scale ranging from 1 to 4: strongly disagree, disagree, agree, and strongly agree.

Data Analysis

We used principal components analysis with varimax rotation extraction to examine the statistical clustering of items composing the General Attitudes about Use of Psychotropics with Youths Scale. This procedure yielded three clusters of items with high factor loadings and conceptual coherence. Each was subjected to a test of internal consistency using reliability analysis to check for an adequate Cronbach's alpha level. Subsequently, the items in two factors were averaged to create two composite variables that were used in all subsequent analyses (for item and scale statistics, see Table 1). The first component of the scale is referred to as Medication's Harms. It consists of six items that reflect perceptions of psychotropic medication's potential harmful effects. Higher scores on this scale indicate stronger beliefs that medication sends the wrong message to youths and others in society, that medication is often used for the wrong reasons, and that it can be detrimental to youths' well-being. Each respondent's answers to these six items were averaged, resulting in the subscale's range of 1 to 4, with a mean of 2.2 (SD = .60). The internal consistency of the six items was good (Cronbach's

Table 1: Social Workers' General Attitudes about Use of Psychotropic Medication with Youths

Scale Item	Agree[a] N	Agree[a] %	M[b]	SD
Medication's Harms (M = 2.2, SD = .60, Cronbach's α = .84)				
Psychotropic medication is often used as a substitute for other treatments.	372	67.2	2.80	.85
Psychotropic medication is often given to youths because of their parents' poor parenting skills.	222	40.6	2.33	.86
Relying on psychotropic medication for treatment takes professionals' attention away from broader problems in our society.	283	51.3	2.19	.86
Psychotropic medication sends youths the wrong message about dealing with problems.	127	22.9	2.11	.76
In the end, psychotropic medication can make youths even more disturbed.	84	15.5	1.92	.72
The primary function of psychotropic medication is to control youths.	65	11.8	1.67	.79
Medication's Benefits (M = 2.5, SD = .44, Cronbach's α = .64)				
Psychotropic medication is a necessary part of treatment for many emotional disorders.	452	81.1	3.11	.75
The benefits of psychotropic medication far outweigh any risks associated with it.	322	59.5	2.63	.70
Psychotropic medication is the treatment most likely to bring about rapid improvement.	301	54.6	2.58	.68
Taking psychotropic medication results in higher self-esteem among youths.	151	28.1	2.14	.67
Psychotropic medication is the most effective way of getting adolescents' behavior under control.	49	8.9	1.84	.58
Medication and Other Treatments[c] (M = 3.2, SD = .54, Cronbach's α = .47)				
Psychotropic medication should always be accompanied by other forms of therapy.	493	88.8	3.47	.76
Taking psychotropic medication without therapy leaves the basic problems unchanged.	444	80.6	3.11	.74
Before recommending psychotropic medication, all other treatment options should be explored.	378	67.9	2.94	.83

[a]Represents "agree" or "strongly agree."
[b]Items rated on a four-point Likert agreement scale ranging from strongly disagree (1) to strongly agree (4).
[c]Scale dropped from bivariate/regression analysis due to low Cronbach's alpha.

A substantial proportion agreed that medication is often prescribed to youths when the underlying problem is parental inadequacy.

α = .84). The second component of the scale is referred to as Medication's Benefits, which consists of five items reflecting acceptance of psychotropic medication as necessary and beneficial in the mental health treatment of youths. Higher scores on this scale represent attitudes that psychotropic medication is effective and necessary and results in better overall mental health for young clients. The respondents' averaged score on this scale had a range of 1 to 4, with a mean of 2.5 (*SD* = .44); internal consistency was acceptable (Cronbach's α = .64). A third set of three items did not meet standards for internal consistency (Cronbach's α = .47) and was dropped as a component of the scale from bivariate or regression analysis; however, these items are shown in Table 1 under Medication and Other Treatments.

We used zero-order correlations and tests of association (Pearson's *R*, *t* test, chi-square) to examine the direction and strength of relationships between respondents' personal and professional characteristics and their attitudes toward psychopharmacology with youths. Finally, we used multiple linear regression analysis to build a parsimonious model of the personal and professional attributes (significant at the bivariate level) that influence social workers' attitudes. Analyses were run as two-tailed tests, using a alpha level of.05 to determine statistical significance.

RESULTS

Sample Characteristics

The respondents were generally experienced social workers (average 20 years post–master's), typically working in adult mental health (65 percent), child mental health (24 percent), or school social work (16 percent), with many (20 percent) working in more than one field. Their primary theoretical orientations were cognitive–behavioral (50 percent), psychodynamic–ego psychology (44 percent), family systems (32 percent), problem solving (25 percent), existential–humanistic (8 percent), and neuropsychological (3 percent). On average, 46 percent of respondents' caseload was reportedly taking some sort of psychotropic medication. Most respondents (88 percent) reported having specific training or education in psychopharmacology, although this experience varied greatly in intensity and scope. Their learning came from self-teaching (for example, reading; 81 percent), workshops (74 percent), work-related in-services (69 percent), seminars (59 percent), and other (6 percent) (for example, drug representatives, work on inpatient units). Twelve percent mentioned that they learned about drug treatment through consultation with psychiatrists or other MDs. As this was not listed as a choice on the survey, it is likely that this form of "on-the-job" learning is even more common.

Attitudes toward Use of Psychopharmacology with Youths

Respondents tended to disagree that psychopharmacology is generally harmful for youths (*M* = 2.2 on the four-point Medication's Harms subscale; see Table 1). Scores on the individual items, however, indicate that a majority of participating clinical social workers agreed that medication is often used as a substitute for other treatments and that relying on psychotropic treatment offers an easy distraction from the broader social problems occurring in our society. A substantial proportion agreed that medication is often prescribed to youths when the underlying problem is parental inadequacy. Nevertheless, the vast majority disagreed that the primary motivation for prescribing medication to youths is generally for the purpose of control. Moreover, most disagreed that providing medication sends the wrong message to youths or that psychotropic drugs tend to exacerbate young clients' psychosocial disturbances.

The respondents tended to hold a midpoint position between agreement and disagreement when responding to the Medication's Benefits subscale as a whole. An item-by-item analysis suggests that a great majority of respondents (81 percent) believed that medication is a necessary component of treatment for many disorders; a majority (60 percent) agreed that medication's benefits outweigh the associated risks; and 55 percent believed that medication is the most likely to elicit rapid improvement. Nevertheless, despite its perceived benefits, only about a third (38 percent) reported believing that medication generates higher self-esteem, and few (9 percent) agreed that it is the most effective

way of getting young people's behavior under control. In short, even those who perceive that medication is often necessary or helpful may not identify medication as sufficient or the most effective way of dealing with behavioral problems.

These hesitations about medication are reflected in the responses to the items listed in the Medication and Other Treatments section (Table 1). Many social workers believed that medication should not be used in isolation or as the first line of treatment. In fact, more than half (52.4 percent) agreed with all three statements in this scale, suggesting that psychotropic treatment for youths should always be accompanied by other types of treatment, that medication without psychotherapy does not address the core problem, and that medication should be used as a last resort, after other treatments have been explored or tried. When compared with their colleagues who did not endorse all three statements, these social workers scored higher on the Medication's Harms subscale (Ms = 2.3 compared with 1.9, $t = 7.1$, $p < .001$) and lower on the Medication's Benefits subscale (Ms = 2.4 compared with 2.6, $t = -5.3$, $p < .001$).

We expected that attitudes toward medication's benefits and harms would constitute two ends of the same dimension (that is, that social workers who viewed medication as beneficial would not perceive it as harmful). This was not the case, as the principal components analysis clustered the negatively and positively worded items separately, and these two clusters (subscales) were only modestly negatively correlated ($r = -.35$, $p < .001$), sharing only 12.5 percent of their variance. In other words, respondents' perceptions of harms and benefits were relatively independent of each other, suggesting that beliefs about harms and benefits tend to be multidimensional, not one dimensional. Participants perceived psychopharmacologic treatment as both beneficial and harmful (or neither), a finding that provides some support to both sides of the debate about social workers' attitudes.

Who Favors Using Medication to Treat Youths?

What personal and professional characteristics were associated with views of the benefits and harms of psychotropic medication? Using bivariate analysis, we found that, on the one hand, social workers who perceived benefits were more likely to be male, have more direct clinical experience, practice in school social work, practice with a higher proportion of medicated clients, report having received some training or education in psychopharmacology—especially a work-related in-service—and to rate themselves as more knowledgeable about psychopharmacology (Table 2). On the other hand, participants who perceived more harms tended to be older social workers with less post-MSW direct practice experience who did not report consulting with MDs as a means of education in psychopharmacology, who had an existential–humanistic orientation, who had a caseload with a lower proportion of medicated clients, and who rated themselves as less knowledgeable about psychotropic medication. To some extent, our finding that different factors were associated with the two attitudinal subscales supports the idea that respondents' perceptions of medication's benefits and harms are independent conceptually. Using multiple linear regression analysis with the factors found to be significant at the bivariate level, we found that social workers' beliefs that psychotropic medication is harmful or beneficial remained associated with different personal characteristics (see Table 3). The only variables predicting beliefs about both benefits and harms were years of experience and self-reported level of knowledge; those more knowledgeable and experienced perceived more benefits and less harm. Respondents more likely to perceive harms (when other variables were controlled) tended to be older and have a existential–humanistic rather than a neuropsychological professional orientation and did not report consulting with physicians as a means of education about drug treatment. Those more likely to perceive benefits, with other variables controlled, were male, worked in adult mental health, and had a larger caseload of medicated clients.

DISCUSSION

This study gauged social workers' attitudes toward the use of psychiatric medication with youths, based on the assumption, supported by anecdotal data (for example, Bentley et al., 2004), that attitudes are likely to shape clinicians' communication, behavior, and, ultimately, treatment outcomes. There are limitations to our study methods that warrant caution in interpreting our results until others replicate them. For example, the sample was more experienced and less ethnically diverse than the general NASW membership, limiting generalization. Also, the study's response rate of 32.7

Table 2: Bivariate Relationships between Social Workers' Characteristics and Attitudes toward Use of Psychotropic Medication with Youths

Characteristic	Medication's Harms[a]	Medication's Benefits[a]
Gender	—	F = 2.4 (.44), M = 2.6 (.43), t = –2.7**
Age	r = .14****	—
Tenure in direct practice	r = –.09*	r = .10*
Theoretical orientation		
Existential–humanistic	Yes = 2.5 (.62), No = 2.1 (.59), t = 4.2****	Yes = 2.3 (.42), No = 2.5 (.44), t = –2.4*
Neuropsychological	Yes = 1.7 (.46), No = 2.2 (.60), t = –2.8**	Yes = 1.7 (.46), No = 2.2 (.60), t = 4.2****
Practice field		
Adult mental health		Yes = 2.4 (.44), No = 2.6 (.43), t = –3.7****
School social work		Yes = 2.6 (.45), No = 2.4 (.44), t = 2.1*
Training in psychopharmacology	—	Yes = 2.5 (.43), No = 2.3 (.48), t = 2.9**
In-service	—	Yes = 2.5 (.43), No = 2.4 (.42), t = 2.3*
Consultation with MDs	Yes = 1.9 (.44), No = 2.2 (.62), t = –3.3****	—
Knowledge: psychopharmacology	r = –.18****	r =.19****
% caseload on medication	r = –.09*	r = .13**

Note: Only significant associations are shown. Numbers in parentheses represent standard deviations; dashes indicate that there was no bivariate relationship with the dependent variable.
[a]Summary scales as shown in Table 1.
*p < .05. **p < .01. ****p ≤ .001.

percent, which is on the lower end, needs to be taken into consideration. We have no way of knowing the extent to which self-selection in the study skewed our data; it is possible that responders have significantly more or less favorable attitudes toward psychotropic medication relative to nonresponders and the broader NASW membership.

Although using a mailed questionnaire and psychometrically untested items to capture attitudes are common procedures, they also suggest caution

Table 3: Social Workers' Personal and Professional Characteristics Regressed on Attitudes toward Use of Psychotropic Medication with Youths

	Medication's Harms (R^2 = .11, Adjusted R^2 = .10, F[7, 453] = 8.2, p < .001)		Medication's Benefits (R^2 = .12, Adjusted R^2 = .10, F[9, 450] = 6.5, p < .001)	
Characteristic	B (SE)	sr	B (SE)	sr
Gender			.10 (.05)**	.09
Age	.01 (.004)***	.14		
Tenure in direct practice	–.01 (.004)***	–.14	.005 (.003)**	.09
Knowledge: psychopharmacology	–.13 (.05)**	–.11	.12 (.04)***	.14
Training in psychopharmacology			—*	—*
In-service			—*	—*
Consultation with MDs	.19 (.08)**	.10		
Theoretical orientation				
Existential–humanistic	.35 (.11)***	.14	—*	—*
Neuropsychological	–.33 (.16)**	–.09		
Practice field				
Adult mental health			–.14 (.05)***	–.12
School social work			—*	—*
% caseload on medication	—*	—*	.002 (.001)***	.12

Note: Regressions include only variables significant at the bivariate level, per model.
*p > .05. **p < .01. ***p < .001.

in interpreting the results. As little is known about what social workers believe about psychotropic medications or how their attitudes may vary by setting, demographics, client characteristics, circumstances, or different disorders, a survey using forced-choice items such as this one limits the range of responses and could create difficulty for respondents who are asked to simplify their opinions or make difficult choices. Future studies using personal interviews with professionals who are encouraged to elaborate on their beliefs would undoubtedly capture even more complexity in their attitudes. Similarly, experimental designs, for instance, using clinical vignettes (manipulating severity, type of disorder, and so forth), would also advance understanding of the factors that mediate beliefs.

Social workers' attitudes about psychotropic medication factored into distinct dimensions along broadly framed positive and negative dimensions (harms and benefits). At first glance, one might view the two factors as reflecting polar opposites, as suggested by some of the vigorous debates in the literature (Cohen, 1988; Johnson, 1989). However, the weak correlation between these two clusters of items suggests they tap separate dimensions of social workers' complex views. Social workers simultaneously hold views that medication is helpful and necessary, and at the same time, they also recognize the potentially iatrogenic effects. Judging by respondents' written comments, they struggle with this tension on a case-by-case basis, taking into consideration various factors such as type and seriousness of disorder. This process likely mirrors the cost-benefit analysis that individual consumers of medication conduct on an ongoing basis (Walkup, 1995).

Respondents tended to neither agree nor disagree about the benefits of medication for youths, such as its ability to bring about effective or fast relief of symptoms. This is in concert with other findings, suggesting that social workers hold mixed or ambivalent attitudes toward medication treatment (Bentley et al., 1991; Johnson et al., 1998). For example, Bentley and associates found that many social workers responding to an attitudes survey used the "no-opinion" category but offered strong approval for items referring specifically to medication treatment of serious mental illness. In our study, respondents were not offered a "no-opinion" option, but a substantial number of respondents left some items blank, circled more than one response choice, or wrote notes in the margins referring to their difficulty in responding without knowing specific information about the case (for example, disorder type and severity, case circumstances). A typical written comment was the following: "Many of these questions would be answered one way if I assume a diagnosis that clearly calls for medication and differently if medication is not so strongly indicated." Some respondents felt the answer choices were too limiting ("Too strong for me to agree" or "Sorry, I generally do not think in black–white"). Apparently, for severe mental disorders among adolescents, medication was viewed as necessary and effective, as other researchers have found with respect to adults (for example, Bentley et al.; Berg & Wallace, 1987). This suggests that social workers are not opposed to the idea of medication treatment for youths, as was speculated by writers in the 1970s and 1980s (for example, Davidson & Jamison, 1983; Kane, 1982; Matorin & DeChillo, 1984), nor do they enthusiastically accept medication (Cohen, 1988). Instead, their opinions reflect more complex thinking about the value of medication in given contexts and for specific problems.

Overall, social workers did not express beliefs that medication is inherently detrimental to youths. Although some observers have expressed concerns that medications prescribed to children are used as agents of social control or misused as a remedy for frustrated parents (Cordoba et al., 1983), in the present study the majority of social workers disagreed. At the same time, substantial portions of our sample agreed that medication is often used when other treatments would be appropriate and that the ease of medication prescription serves to distract professionals from societal problems that are far more elusive or difficult to address. Social workers tended to agree that medication should be tried after other options have been exhausted or only in conjunction with other forms of treatment. Furthermore, they seemed reluctant to view medication as the "first line of treatment," at least if the client is not severely mentally ill.

These results are fairly consistent with the professional stance toward drug treatment advocated by some scholars in the field (for example, Cohen, 2002; Lacasse & Gomory, 2003), who call on social workers to maintain an informed but critical stance. This stance involves developing adequate knowledge about various drugs, their potential to

improve functional status, and their side effects while also being aware of the political, economic, and social context in which contemporary pharmaceutical treatment is thriving, where clients' best interests sometimes compete with other interests.

According to these data, older social workers are more concerned about psychotropic medication's potential harmfulness to youths. Studying psychiatrists and psychologists, Garrett (2000) also found that older clinicians were more supportive of psychosocial treatment than medication treatment of youths diagnosed with ADHD. This suggests that distrust or reluctance to accept psychopharmacologic treatment may be generational. In our study, men were more inclined to view medication as beneficial than were women; this mirrors another study's findings among European social workers referring to medication for childhood ADHD (Pentecost & Wood, 2002). Reasons for this gender difference are unclear and warrant further investigation. In terms of professional characteristics, social workers with more exposure to drug treatment (for example, more training, knowledge, and work experience) were more likely to believe in the benefits of psychotropic medication for youths. The causal direction of these relationships cannot be inferred from these cross-sectional data. There are several different possibilities. On the one hand, those with more positive attitudes toward medications may seek out more training, become more knowledgeable, stay in clinical practice longer, and encourage medication for their young clients. Preexisting attitudes, in this case, could shape professional behavior. On the other hand, the data are consistent with an alternative interpretation. Those in clinical practice settings where medications are frequently used may, of necessity, become better trained and more knowledgeable and may over time align their views and attitudes to be consistent with what they are expected to do as part of their agency's standard practice. Attitudes, in this case, would be the product of careers, not of their progenitors.

CONCLUSION

Drug treatment increasingly accompanies psychosocial services for clients of all ages (Olfson, Marcus, Druss, & Pincus, 2002; Olfson et al., 1998), and this has affected most social workers' work (Moses, 2003). Understanding clinicians' beliefs about psychopharmacology, how these beliefs may be expressed in practice settings and with specific types of clients, and how attitudes are related to treatment outcomes is critical to improving social work education and training. One of this study's most consistent findings suggests that clinicians who have had more exposure to drug treatment and who have more knowledge of its goals and consequences have more favorable attitudes toward it. More exposure to and training with psychopharmacologic drugs, which may need to take place within a medical setting and be provided by medical practitioners, may yield more positive attitudes toward this ubiquitous form of treatment. It may also encourage social workers to play an active role in interacting with physicians and ensuring that clients' interests are protected. Moreover, more knowledge may serve to balance the views of "true believers," who may tend to perceive their clients as benefiting from medication even when they do not. Others, too, have advocated for the expansion of the curriculum in psychopharmacology in social work educational programs (Bentley & Reeves, 1992; Johnson et al., 1990; Lacasse & Gomory, 2003).

There are many important questions that require further study. For example, to what extent do social workers' views of drug treatment diverge from the public's views? How knowledgeable are they about the controversies surrounding medication and youths? Do attitudes toward drug treatment predict treatment outcomes? At the very least, respondents' comments suggest that their attitudes are mediated by case-related information (for example, type of disorder, severity) in ways that were not adequately captured in this study. Undoubtedly, social workers' attitudes, knowledge, and behaviors with clients regarding pharmacological interventions are likely to be very complex and consequential. If attitudes influence behavior toward clients and treatment, it would be important to understand how attitudes either promote or impede effective and ethical intervention with clients. Although we found that attitudes and knowledge are related, it is unclear whether these are merely correlated or if one affects the other. If more knowledge leads to more balanced attitudes and more active involvement in ensuring clients' needs are met, it would have implications for educational programs. As a backdrop to these questions, there are major scientific debates taking place in the medical journals and in Congress about whether pharmaceutical companies, which control and fund

most drug studies, have deliberately distorted scientific reports about their effectiveness (Angell, 2004; Meier, 2004) and whether certain antidepressant drugs promote suicidality among youths (Goode, 2003; Wessely & Kerwin, 2004). Perhaps more than ever, social workers need to stay informed, vigilant, and critically minded. SW

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