

Professional Dissonance: Colliding Values and Job Tasks in Mental Health Practice

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ABSTRACT: This study investigated the relationship between individual and job characteristics of mental health social workers and professional dissonance—an experienced conflict between values and job tasks. A 33-item questionnaire, designed specifically for the study's purposes was utilized. A total of 320 usable study questionnaires were returned (44.5% response rate). The primary study hypothesis, that professional dissonance is related to individual and job characteristics, was partially supported by the data. While job characteristics appeared to have little influence on dissonance, several individual characteristics of the respondents were statistically related to level of dissonance. Specifically, men with the most years of experience and with lower reported attachment to self-determination reported higher levels of dissonance. Study participants affirmed the importance of life-long supervision in managing dissonance in practice.

KEY WORDS: mental health practice; values; dissonance; involuntary treatment.

Excellent mental health practice can often be difficult and complex. Indeed, mental health practitioners frequently face seemingly “no-win” situations when they are required to negotiate workable solutions between client and practitioner goals that may not be compatible, or when interventions result in value dilemmas, or what Victor Frankl (1988) has termed a “value collision.” For example, the current mental health

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practice context increasingly requires mental health practitioners to engage in involuntary treatment interventions leading to a practice climate rife with potential value collisions. Such potential value collisions can include: providing mandated or involuntary treatment, intervening in a consumer's decision-making about medication, breaching confidentiality to communicate with family members, and making decisions about a consumer's ability to direct his or her own life, such as advocating for outpatient commitment, or court orders allowing forced medication.

Opinions in the literature about involuntary interventions vary with some authors (Bentley, 1993; Bentley & Taylor, 2002; Dewees, 2002; Kutchins & Kirk, 1997; Taylor & Bentley, 2004) pointing out the incongruity—and perhaps, incompatibility—between involuntary treatment interventions and professional value positions especially pertaining to self-determination. Other writers strongly disagree with this perceived incompatibility (Murdach, 1996; Rosenson, 1993) and cite the consumers' *right to treatment* as an important area for social work support, not just the *right to refuse treatment* (Mizrahi, 1992). Still others suggest that taking for and against positions in this debate distracts the mental health community from more important questions about the state of service delivery in the mental health arena (Saks, 2002). Involuntary interventions are just one area of practice where the tension between evolving mental health interventions and longstanding helping profession values places practitioners in mental health settings at potential risk for what is being called here "professional dissonance."

PROFESSIONAL DISSONANCE DEFINED

Professional dissonance is conceptualized as a feeling of discomfort arising from the conflict between professional values and expected or required job tasks. The conceptualization of professional dissonance as a researchable topic for practice, as well as the generation of the study's dissonance-reducing cognitions, owes a large debt to Leon Festinger and colleagues' previous work on cognitive dissonance (Festinger, 1962, 1964; Festinger & Carlsmith 1959; Harmon-Jones & Mills, 1999). The current research specifically focused on social workers and the social work value of self-determination and its potential for generating dissonance within mental health settings, especially amid increased controversy around involuntary outpatient commitment in particular,

and the call for more assertive community mental health programs in general (Bentley & Taylor, 2002; Dennis & Monahan, 1996; Moran, 2000; Torrey & Zdanowicz, 2002).

The primary purpose of the research was to refine the concept of professional dissonance and to draw attention to and stimulate dialogue about its existence, and its impact on individual practitioners working in the mental health arena with the vision of adding to the ongoing dialogue in social work and related professions around negotiating a satisfactory, sustainable balance between consumer rights and needs and professional or societal requirements, rights and duties. A more specific aim of the study was the exploration and description of the types of individual characteristics and job tasks that most contribute to professional dissonance in daily practice. It was also hoped that the proposed research would yield insight into the ways practitioners in mental health “live with” and manage professional dissonance. In this way, professional longevity and job efficacy of individual practitioners is ultimately protected, and excellence in mental health practice is promoted.

PROFESSIONAL DISSONANCE IN AN HISTORICAL CONTEXT

Examining the larger environment of mental health service delivery in this country involves taking into account the forces and events that have shaped the development of pervasive cultural beliefs about individual versus societal rights. In this way, professional dissonance can be understood as a problem that is part of the tapestry of contemporary mental health practice and policy. For example, since the beginnings of the country, Americans have struggled with the emphasis and protection that individual liberties could and should have while simultaneously maximizing the general welfare. Self-determination as a concept is similar to the ideas of liberty and the pursuit of happiness that appear in the Declaration of Independence, one of the first American documents. This early emergence of self-determination is consistent with Freedberg's (1989) assertion that the roots of the concept reach back to the Enlightenment. As perennial as the ideas of self-determination, freedom and liberty are themselves, so is the *competition* and *tension* surrounding them in a society that equally values social welfare, general safety, protection and maintenance of the community. In other words, the struggle to work out an acceptable balance between the sometimes mutually exclusive goals of personal

liberty and societal well-being is a source of dissonance for our legal system and, indeed, society at large. This same struggle is played out in mental health between the rights of individual consumers to refuse or accept treatment and the rights of communities to feel safe physically, psychologically and aesthetically. The task of negotiating about this larger struggle falls to mental health practitioners, in our often multiple (and sometimes mutually exclusive) roles as consumer advocate, family advocate, risk manager, agency employee, and community citizen.

In trying to negotiate the struggle between consumer rights and liberties and societal rights and interests, as well as juggle their multiple roles, practitioners may feel they have a daunting assignment. They are regularly asked and often required, to formulate practice decisions that both protect society *and* maximize the rights of the individual—perhaps an impossible task. When the two aims are incompatible, practitioners find themselves in the position of making a practice decision that may be unwanted and/or directly opposed by the consumer. An example of such a decision would be requiring a consumer who is actively psychotic and handing out leaflets in the park but not currently dangerous, to be hospitalized against his/her will. The decision to hospitalize may conflict with the value of self-determination. In these situations, practitioners have to deal with layers upon layers of competing values at the personal, group and societal levels (Loewenberg, Dolgoff, & Harrington, 2000). This research project was influenced by key concepts in cognitive dissonance theory as well as existential theory. Existential theory, especially, speaks to the internal, spiritual struggle to live an authentic life and is therefore instructive in developing professional dissonance as a problem for social workers.

PROFESSIONAL DISSONANCE AND EXISTENTIALISM

The core ideas of existential theory are important to the present research because the key existential issues of “authenticity” vs. “bad faith” and “ontological guilt” vs. “ontological anxiety,” speak to the current struggle in the mental health practice context to negotiate a practice position that simultaneously protects a consumer’s rights (even to fail) and ensures the practitioners’ ability to make professional, caring and sometimes unpopular decisions about what should happen in an intervention. The discussion of professional dissonance highlights the notion of the dissonance process as one filled with confusion, angst

and, hopefully in the end, professional and personal growth. Rollo May (1983), a prominent existential author wrote that the German word that Freud and Kierkegaard among others use for anxiety is "angst." While it has no English equivalent, angst has been translated as "dread" as well as "anxiety" and captures the experience of being "torn" or in a dilemma.

Quite simply, ontological anxiety is the price of living authentically. By contrast, choosing the more comfortable, non-anxiety provoking course of action will result short-term in feeling safer but long-term leads to the more malignant state of "ontological guilt." Ontological anxiety, while uncomfortable is more a pain of risk or a growing pain, while ontological guilt is the pain of not accessing one's potential and the ache of regret about "what might have been." Series of bad faith actions result in heavy ontological guilt which envelopes the individual in shame and regret, paralyzing their process of becoming (Maddi, 1996).

Existential psychology, with its focus on authenticity and responsibility, speaks directly to the cost of bad-faith actions. In this way, it answers the question of what happens to practitioners who consistently act in a way that conflicts with their ideas of what they should be doing or as Margolin (1997) calls it, living in contradiction. It also changes the negative cast of anxiety to encompass anxiety as a potential growing experience. In this way, existential psychology balances the prevailing view of anxiety as burn-out or pathological, by casting it as a growing pain. This recasting is appropriate for the current research study, which combined the views of anxiety as problematic (as seen in cognitive psychology and ego psychology) with the idea of anxiety as a possible vehicle to excellent practice in the crafting of the concept of professional dissonance.

METHODS

This study utilized a cross-sectional, survey design. The design was appropriate given the priority of collecting data from a large group of social work practitioners in this exploratory study. A 33-item questionnaire, designed specifically for the study's purposes was utilized (copies are available from the 1st author). It combined Likert-type items, several open-ended questions and three case vignettes that portrayed hypothetical practitioners intervening in practice "gray areas" constructed to stimulate dissonance in the participants. Study vignettes were created by the author and utilized both expert consultation as well as pilot-testing to insure applicability to real-life practice situations. Professional dissonance as a variable was measured both directly and indirectly in an effort to maximize construct validity in this new instrument.

In other words, participants were asked directly about professional dissonance in an open-ended question and their responses to the vignette situations were calculated to produce a dissonance score.

Specifically, participants were asked to respond to 10 Likert-type items for each vignette. Each vignette was followed by an item regarding comfort with the intervention, an item about anxiety in similar situations, and a list of eight dissonance-reducing cognitions that the practitioner might have when making a decision about how to intervene in the case. In designing the instrument, each of the eight statements was related to a specific dissonance reducing cognition represented by cognitive distortions or defenses since resorting to defenses is often the way people reduce dissonance. For example, "Telling her (the consumer's mother) about the session isn't that big of a deal" related to the distortion of minimization. Participants endorsed each thought on a Likert-scale of 1-5, with five meaning they would be "very likely" to have that thought when deciding how to intervene. These scores were totaled and a "dissonance score" was calculated for each vignette. These were then summed across each participant's responses to the three vignettes to create a Total Dissonance Score. Summing scores for corresponding cognitions also created subscale scores for each of the eight cognitive distortions/defenses across each of the three vignettes. In this way, scores were calculated for minimization, rationalization, denial/mind reading, projection, displacement, emotional reasoning, labeling and overgeneralization. Additionally, the three "comfort" questions, and three "anxiety" questions were summed to develop a total comfort and total anxiety score. Attitudes and experiences in involuntary treatment as well as opinions and experiences of self-determination in practice were included in the instrument.

Seven hundred and fifty prospective participants were selected from the *Register of clinical social workers, 11th Ed*, a published document maintained by the National Association of Social Workers. This source was utilized primarily because of the high likelihood of accessing participants with a long practice history since one assumption of the study was that dissonance in practitioners might wax and wane over the course of their careers. Appropriate univariate, bivariate and multivariate data analysis methods were performed on the closed-ended data. Open-ended data was analyzed using a content analysis method at the word level that combined both qualitative and quantitative methods, in that similar responses were coded into categories and counted.

HYPOTHESES

The implicit research question associated with this study was the exploration of whether or not professional dissonance truly exists as a problem in mental health. Following from this, it was hypothesized that *individual characteristics* (gender, age, years in practice and self-reported commitment to the value of self determination) and *job characteristics* (frequency of involuntary intervention and associated comfort level, job setting, consumer population and primary job function) would account for some of the variance in reported levels of professional dissonance. Several secondary hypotheses were also formulated. Specifically, it was expected that a positive association between stated levels of self-determination with levels of professional

dissonance would exist, since a high commitment to self-determination should result in more opportunities for dissonance when encountering paternalistic practice interventions. A similar positive association between amount of involuntary treatment experience and professional dissonance was expected for the same reason. A negative association was expected between years of practice experience and professional dissonance since it was expected that in order to remain in the field, dissonance would have to be resolved in some fashion.

FINDINGS

A total of 320 usable study questionnaires were returned (44.5% response rate). The responding participants had an average of approximately 25 years in the field and a mean age of 56 years. A large majority of participants identified themselves as White/Caucasian (293, 91.6%). Gender was fairly representative at 62.8% female ($N = 201$) and 36.8% male ($N = 117$). The majority of participants described their primary job setting as private practice 50.6% ($N = 162$).

The vignettes portion of this new instrument yielded a Cronbach's alpha of .80. Despite this indication of high internal consistency, issues of content validity emerged with regard to the study vignettes portion of the instrument. Specifically, while participants indicated experiencing dissonance in the form of conflict, discomfort, anxiety, anger and ambivalence, they did not endorse the related "dissonance-reducing" cognitions that followed each vignette. These results suggest taking a closer look at the structure of the vignettes or, on a broader level, reconsidering the study methodology from a survey method to a structured interview method in future studies.

Responses to the vignettes included the endorsement of eight dissonance-reducing cognitions as well as Likert-type questions related to anxiety and discomfort with the hypothetical intervention. Table 1 displays average vignette scores. The primary study hypothesis, that professional dissonance is related to individual and job characteristics, was partially supported by the data in that job characteristics did not appear to influence dissonance scores but gender, length in the field, and reported level of commitment to self-determination were statistically related to level of dissonance (Total Dissonance Score). Specifically, men with the most years of experience and with lower reported attachment to self-determination reported higher levels of dissonance ($F = 4.945, p < .027$). Importantly, responses to open-ended

TABLE 1
Vignette Results

<i>Variable</i>	<i>Average Score (SD)</i>			<i>Total</i>
	<i>Vignette 1 Confidentiality</i>	<i>Vignette 2 Hospitalization</i>	<i>Vignette 3 Forced Medication</i>	
<i>Range (1–5)</i> Comfort	4.22 (1.08)	3.36 (1.35)	3.52 (1.33)	<i>Range (3–15)</i> 11.10 (2.78)
<i>Range (1–5)</i> Anxiety	2.74 (1.09)	2.88 (1.04)	2.94 (1.14)	<i>Range (3–15)</i> 8.58 (2.62)
<i>Range (1–5)</i> Minimization	1.35 (.81)	1.49 (.91)	1.95 (.99)	<i>Range (3–15)</i> 4.78 (1.82)
Rationalization	1.85 (1.0)	2.89 (1.34)	3.14 (1.19)	7.86 (2.52)
Denial/Mind reading	1.51 (.90)	2.26 (1.11)	2.25 (1.10)	6.02 (2.20)
Projections	2.48 (1.22)	1.88 (.92)	1.84 (1.44)	6.19 (2.47)
Displacement	2.0 (1.04)	2.18 (1.17)	1.40 (.74)	5.57 (2.12)
Emotional Reasoning	1.74 (1.0)	3.25 (1.24)	2.01 (1.20)	6.96 (2.42)
Labeling	2.93 (1.11)	3.09 (1.21)	2.05 (1.19)	8.62 (2.55)
Overgeneralization	1.57 (.92)	1.60 (.87)	2.05 (1.25)	5.23 (2.08)
<i>Range (8–40)</i> Dissonance Score	15.31 (4.23)	18.62 (5.47)	17.23 (4.58)	<i>Range (24–120)</i> 51.24 (12.08)

questions affirmed the experience of dissonance in practice and respondents described the rich and diverse ways that they deal with this issue, emphasizing consultation and supervision. Specifically, participants were asked to describe *how they feel* and *what they do* when their professional values seem to be in conflict with a practice situation. Interestingly, "feeling" responses made up only 27.1% ($N = 73$) of the 273 responses. The feeling responses affirmed the qualitative experience of dissonance as "conflict," feeling "torn" and "ambivalent."

Additional study findings noted a surprisingly high level of support among participants for involuntary treatment interventions in general, especially emergency hospitalization and mandated outpatient counseling. Participants most often cited situations of imminent danger as the necessity for involuntary interventions and, consequently, had the most experience with emergency psychiatric hospitalizations as well as mandated outpatient counseling.

DISCUSSION

Study Limitations

As a "first-generation," exploratory study, the current research has several limitations that are especially evident in the areas of instrument design and sampling frame. The study vignettes, by far, appeared the most problematic of the instrument components. A full 20% of all participants wrote in unsolicited feedback, much relating to the fact that *they would not* in reality intervene in the manner of the hypothetical practitioner the vignette portrayed. While apparently troubled by the events depicted in the vignettes, participants had relatively low levels of endorsement of dissonance-reducing cognitions. Indicating that either they did not identify with the listed strategies, or did not feel *dissonant* in that what they read did not cause conflict. These results indicate a failure of the vignettes to do what they were designed to do in producing dissonant feelings in participants. Another explanation is that social-desirability bias prevented participants from endorsing cognitions that seemed insensitive, such as "Tom's really not that opposed to medication," or "Sherry doesn't know what she's saying."

Problems related to the instrument design are closely associated with possible study design issues. For example, the projective design of the instrument (utilizing a hypothetical practitioner in a case vignette)

may have set up a situation in which the interventions could be intensely criticized without being "owned" by respondents. In other words, instead of choosing to intervene in a delicate situation and dealing with the resulting dissonance, study respondents could comment on the problems with the intervention from a safe "moral high ground." A remedy for both the instrument design limitations as well as the study design issues could involve a structured interview design for future studies that would allow more detail and process dimensions involved in intervention decisions. Specifically, allowing a participant the space to take the researcher through their decision-making process with all of the "but-on-the-other-hands" that are involved in real practice interventions should provide richer information on professional dissonance in mental health practice.

An additional limitation that was expected from the beginning of the study was with the sample. The researcher made an informed choice to err on the side of experience in the field for this first exploratory dissonance study. The strategy worked in that participants had an average of 25 years of experience, however, in choosing this more seasoned population, "front-line" practitioners in case management positions were not extensively sampled. These newer workers may have a different understanding of dissonance than their more mature colleagues. Future studies should target this group of workers.

Study Contributions and Implications

Possibly one of the strongest contributions of this study is the actual subject matter. Research on practice issues relating to involuntary treatment with people who have serious mental illness, and research on operationalizing values for practice is underrepresented in the social work and allied literature. Studying professional dissonance affirms the importance of dealing with these critical issues in mental health practice by illuminating the complexities of practice where coercive elements exist and practitioner and consumer wants and needs are often at odds.

The research described was motivated primarily by a desire to better practice with persons who have serious mental illness as well as to protect the longevity and emotional well-being of the practitioners who everyday engage in sorting out practice situations the best way they can. The study results are applicable to practice issues along several dimensions. First, through the open-ended data regarding involuntary treatment, self-determination and professional dissonance,

participants affirmed their reliance upon their colleagues both in and adjacent to the profession to sort out difficult situations. In these days of cut-backs in social service and burgeoning case-loads, the affirmation of the place of *peer support and quality supervision* is a very important one in real world practice.

Study respondents also pointed to their process of deciding what was most important as a guide to managing anxiety about practice decisions. Many respondents cited the necessity of curbing the pursuit of other treatment goals when the goal of safety becomes the most important. Other participants pointed to their practice of referring to values espoused by their agency, their Code of Ethics or their licensing board. The idea of *rank-ordering ethical principles* has been offered by Loewenberg et al. (2000) as a way to help resolve ethical and value dilemmas and may be instrumental in dissonance resolution for practitioners in tough clinical situations.

The current research focused a great deal on the experience of conflict, ambivalence and anxiety among social workers when trying to decide what is the next right thing in practice interventions amid the "gray areas" of mental health. One of the major contributions of existential theory, however, is to *recast anxiety* from a negative hobgoblin of burn-out and attrition in practice into a state of potentiality. This spirit of "becoming" can enliven the concept of professional dissonance in a way that moves it from a pathological problem needing a cure to a practice process that signals avenues of change.

Along this line, respondents affirmed their willingness to "sit with" dilemmas in order to work them through. One reported seeing dilemmas as "A golden opportunity to review what is really important." Another agreed, "Life is full of conflicts. Things are not simple." The practice wisdom of the sample population was evident in this area. Respondents also spoke to the importance of simply doing the best they could as practitioners: "Make a decision, move on, let go," "Pray I'm doing the right thing." It would seem that perhaps the idea of "*good enough practice*" especially when partnering with consumers has potential for mental health practice and may go a long way in helping to prevent burn-out from unresolved professional dissonance. This dimension of living with dissonance and doing the best you can has implications for education of future mental health practitioners to help them learn to expect dissonance and dilemmas and normalize the process while underlining the importance of life-long supervision and collegial support.

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