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PROMOTING WHOLENESS PROGRAMS
IN
HEALTH-RELATED GRADUATE EDUCATION

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Introduction

Opportunities exist to design professional education programs that not only prepare individuals for the realities and demands of their chosen careers, but provide prescription for receiving eternal life blessings. This process begins by developing a clearer understanding of the multiple factors that may negatively impact students' strive for wholeness during their graduate education experience. The basis for examining these factors relies on the theoretical foundations of diffusion research as a means of examining the individual, organizational, and innovation components that may influence students' participation in programs promoting wholeness. As such, the objectives guiding this examination are: (a) to describe the impinging issues and factors of graduate students in health-related professions that make wholeness programs timely, (b) to present conceptual explanations for the issues affecting the ability of graduate students to achieve spiritual wholeness during their educational experience, and (c) to propose a program promoting spiritual wholeness during students' graduate education experience. The result of the examination should support the development of a co-curricular program for promoting responsible self-care behaviors and subsequently reducing the potential impairment of future professionals that can occur during their graduate education. It is also hoped that this examination will have implications for evaluating and modifying the academic environments of related-health professions.

Diffusion theory: A conceptual framework for viewing the potential factors influencing the change process toward wholeness

The complex interplay of the variables associated with the introduction of programs promoting wholeness in graduate education for health-related professions draws on the explanatory elements of diffusion paradigm¹ as the most complete conceptual framework for understanding and identifying variables which influence individuals' intraorganizational behaviors and capacities for change (Corwin, 1972; National Science Foundation [NSF], 1983).

Factors thought to influence human behavior in an organizational context have been grouped into three categories; individuals' personal demographics and behaviors, organizational (often referred to as contextual or system effects), and knowledge and attitudes toward new ideas. As such, differences in the behaviors of individuals being

¹The diffusion theories which provide the conceptual orientation of diffusion research pull together the commonalities of classical organizational theory, human relations theory, contingency theory, systems theory (NSF, 1983), communications theory ("The Adelphi Study Group", 1982), social change theories, and principles of the learning theories (Rogers & Shoemaker, 1971).

introduced to programs promoting professional and personal wholeness can be better understood by gaining insight into these three dimensions. This multivariate approach is consistent with trends in organizational and communications research (Baldrige & Burnham, 1975; Van de Ven & Ferry, 1980, as cited in Svenning, 1982).²

The innovation decision process. As individuals become aware of a new idea (from this point forward referred to as an innovation), they begin to develop attitudes (predispositions or inclinations) toward it and start a process of decision-making with regard to the use of that innovation; the consequence of which may be its implementation or rejection. This process, referred to as the innovation-decision process, represents the diffusion of an innovation whereby information about an innovation over time spreads to members of a social system leading to its eventual implementation or rejection (Rogers & Shoemaker, 1971).

Traditionally the diffusion process is examined from the viewpoint of the innovation's origin (typically the organization) or as provided to the unit (members of the organization) that adopts or rejects the innovation (Rogers & Shoemaker, 1971). Change that occurs regarding the innovation at the individual level, where the individual is the implementor or rejector of the innovation, is referred to as diffusion (other terms include adoption, modernization, acculturation, learning, or socialization).³ A traditional individual oriented model of the diffusion of an innovation, referred to as the innovation-decision process (also called the adoption process), consists of the following stages:

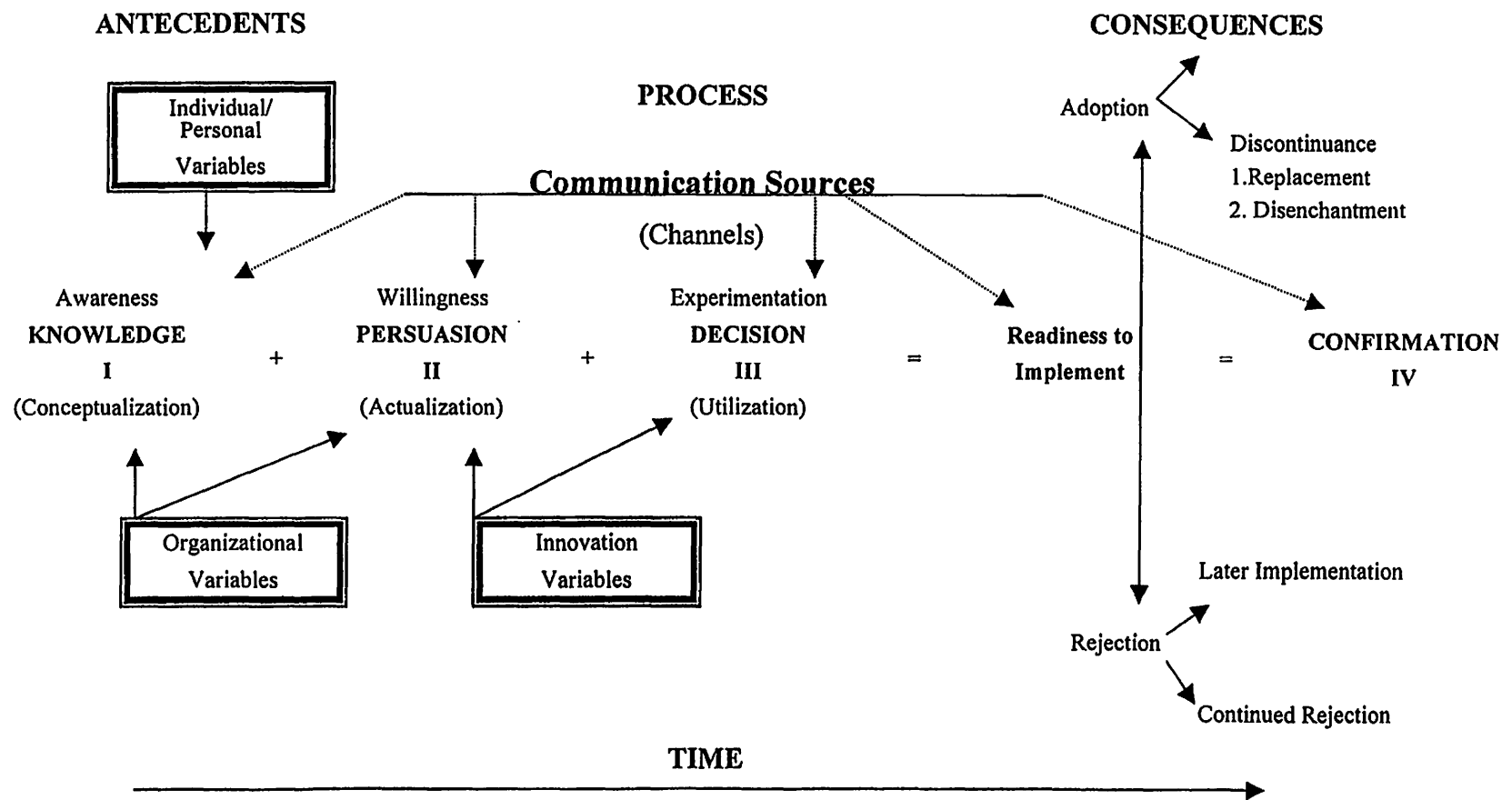
1. Knowledge Stage. Individuals are exposed to the innovation's existence and gain some awareness and understanding of its functions.
2. Persuasion Stage. Individuals form favorable or unfavorable attitudes toward the innovation and consequently a willingness to further explore (or not explore) the

²The central theme of diffusion studies is, "communication is essential for social change" (Rogers & Shoemaker, 1971). As such, the process of change centers around communication, information processes and those factors which influence the effect of these processes. The differentiation of diffusion research from other studies that combine change and communication is that in diffusion studies direct emphasis is placed on identifying barriers affecting the adoption or rejection of innovations. Adoption and rejection are considered intermediate steps to overt behavior change in the decision-making process of the individual (or social system) rather than just changes in knowledge and attitudes. This distinction is important as we know that knowledge, change, and persuasion do not always lead directly and immediately to behavior change (Rogers & Shoemaker, 1971).

³Typically this is referred to as the microanalytic approach to implementation (the approach followed by this study), as it focuses on individual change of behavior (Rogers & Shoemaker, 1971).

In contrast, organizational implementation is conceptualized as change that occurs at the social system level. This type of change has been diversely termed development, specialization, integration, or adaptation. Here attention focuses on the innovation as it effects structural and functional conditions of the organization. This is referred to as a macroanalytic approach to implementation of an innovation (Rogers & Shoemaker, 1971). These two levels of implementation are closely interrelated. Implementation at the system level can eventually lead to individual member implementation. Similarly, the aggregation of individuals' implementation of an innovation can produce system level alterations (Rogers & Shoemaker, 1971).

FIGURE 1
PARADIGM OF DIFFUSION: THE INNOVATION
DECISION PROCESS



(Rogers & Shoemaker, 1971) →

applicability to their present and anticipated future situations.

3. Decision Stage. Individuals engage in activities (including small scale experimentation) which lead to a decision to adopt or reject the innovation (Readiness-to-Implement).

4. Confirmation (Implementation) Stage. Individuals seek reinforcement for the innovation-decision they make through implementation of the innovation.

This model of the individual innovation-decision process is depicted in Figure 1. This model demonstrates the existence of three major divisions in the individual innovation-decision process: (a) antecedents, (b) process, and (c) consequences. Antecedents in this paradigm consist of those variables present in the situation prior to the introduction of the innovation. Antecedents include: (a) personal characteristics of the individuals, (b) contextual issues in the individuals' environment; and (c) perceptions about the innovation. All of these variables are viewed as affecting the initial outcome of the innovation-decision process (Rogers & Shoemaker, 1971).

As such, this paradigm illustrates the process by which information collected concerning the innovation are systematically evaluated. This information represents the compilation of products of the knowledge, persuasion, and decision stages. As indicated, upon becoming aware of the innovation individuals make an initial assessment and consequently form attitudes that are manifested into a degree of willingness to utilize the innovation. This points the way to experimentation which leads the individuals to reach a decision regarding the initial implementation or rejection of the innovation. This point in the innovation decision process can be quantified and represented by a score referred to as "readiness-to-implement" (Buckles, 1989).

Application of diffusion as a conceptual framework understanding students' participation in programs promoting wholeness

Individual demographics and behaviors. In the hundreds of diffusion studies that have been conducted over the span of the last 50 years which focused on identifying the influence of personal demographics on the acceptance of organizationally sponsored innovations results have almost without exception, found personal demographics to have no significant effect on implementation behavior (Rogers & Shoemaker, 1971). Multivariate studies, which jointly considered individual, contextual, and innovation factors as possible categories of variables explaining the variance in individual implementation behaviors, have repeatedly arrived at the same conclusions (Adams, Laker, & Hulin, 1977; Roussau, 1978; Baldrige & Burnham, 1975; Svenning, 1982). However, Herman, Dunham, and Hulin (1975) assert, that the individual factors that do reveal some influence on individuals' implementation behaviors. These include: (a) individuals' perceptions of their importance in the host organization or their overall attitudes about the organization, (b) coping styles and perceived organizational influences on individuals' levels of stress affecting the rate to which behaviors can be observed to change (Svenning, 1982), and (c) work-related psychopathologies (Neff, cited in Purvine, 1972).

Each of these factors give meaning to the degree to which graduate students conceptualize and subsequently demonstrate a willingness to participate in programs

promoting wholeness. Each also clearly interdigitate with the organizational context of the academic environment. The first seems only logical (i.e., that individuals are more open to change in environments where they believe they are perceived positively). As such, the foundation for program participation is the prior existence of positive relationships with faculty, staff, and peers. With regard to the second item, students' participation will be influenced by their perception of the degree to which faculty have designed academic requirements to accurately represent bonafide knowledge and skill needs, and not unnecessarily added undue stress. The third condition, the presence of individual psychopathologies, presents a more complex set of conditions for faculty review and consideration of students' needs for therapeutic intervention or dismissal. Neff (cited in Purvine, 1972) postulates five possible psychopathologies which require some form of intervention as follow:

1. Type I: Individuals who appear to have major lacks in work motivation as they have a negative conception of the perceived role expectations.
2. Type II: Individuals whose predominating response to the demand to be productive is to manifest fear and anxiety.
3. Type III: Individuals who are predominantly characterized by open hostility and aggression.
4. Type IV: Individuals who are characterized by marked dependency.
5. Type V: Individuals who consistently demonstrate work maladaptation and who display a marked degree of social naivete.

Organization system effects. This category of factors recognizes that implementation behavior is associated with social structure of the organizational environment, often referred to as contextual or environmental influencing factors (Zaltman, Duncan, & Holbek, 1973; Rice et al., 1984). Baldrige and Burnham (1975) emphasize the merits of organizational factors as they found that patterns of communication, system structure, and administration's role in support of innovations had more influence in deterring or enhancing the behavior than individuals personal demographics or attitudes. Delineation of these as they apply to the implementation of programs promoting wholeness point to three broad areas: (a) academic system effects, (b) peer group processes, and (c) faculty modeling.

1. Academic system effects

In this context attention needs to be given to understanding the reality of demands being placed on the graduate students in health-related professions. Many health-related professions struggles with the challenge of producing graduates that can meet the increasing demands of contemporary practice. Academic programs attempt to meet this challenge by continuously examining ways of incorporating more content into the graduate education experience. Thus, for most full-time graduate students in health-related professions this results in two-four years of concurrent didactic and practica experiences. Throughout these processes students are expected to demonstrate increasing abilities to dynamically integrate (i.e., make horizontal and vertical linkages) knowledge, values and skills into practice and emerge capable of becoming leaders in a complex multi cultural society.

A significant component of this professional growth process is the practice experience. In most health-related professions graduate students are typically placed multiple or extended experiences where they are to demonstrate the capacity for burgeoning competence and autonomy with increasingly difficult cases. This requirement is designed to simulate, as much as is legally and ethically possible, the responsibilities of graduates post graduation.

However, the result of this type of program of study does more than simulate the roles of health-related professionals post graduation. It provides an early introduction to the real environmental issues that students will one day encounter. More specifically, there is a growing body of both scientific and anecdotal evidence that supports the contention that individuals working in the health-related professions are particularly prone to stress because of the complexity of the emotion-laden biopsychosocial issues that these professionals address with patients (Freudenberger, 1986). Pines (1986) suggests that intense involvement with large caseloads of patients or clients in situations that are emotionally demanding is the precursor to burnout, and if such involvement is characteristic of most health-related professionals, then it should not be surprising that burnout is prevalent among such professionals.⁴ In a study by Deutsch (cited in Reamer, 1992) which examined the symptoms of burnout in social workers, psychologists, and master's level counselors, over 50% of the respondents reported significant problems with depression, 80% reported problems with relationships, approximately 11% reported substance abuse with problems, and 2% reported past suicide attempts.

Role definition appears to offer substantial explanation for the onset of professional impairment. As such, health-related professionals are expected to be unwavering in their kind, caring, patient and respectful comportment (Maslach, 1982). This client-centered orientation of health-related professions defines an asymmetry in the therapeutic relationship, where the reward is giving with no or little regard to self (Cherniss, 1980). In this view professionals believe that they are not suppose to feel, share, or respond emotionally to the pain of patients or their families. Here professionals

⁴Burnout is defined as "subjectively experienced as a state of physical, emotional and mental exhaustion caused by long-term involvement in situations that are emotionally demanding" (Pines & Aronson, 1988). According to these authors burnout may be accompanied by symptoms including, "physical depletion, feelings of helplessness, hopelessness, disillusionment and the development of a negative self-concept and negative attitudes towards work, people involved in the work, and life itself."

The exploration of stress and burnout began with Freudenberger (1975) through his examination of issues of health professionals. According to Freudenberger (1986), health professionals are at-risk of experiencing emotional and physical problems and burnout arising out of the demands of caring for people. His observations sought to unravel the individual paradigms that contributed to the on-set of burnout. As such, his approach was largely clinical and psychoanalytic, utilizing case studies and clinical observations of professionals in treatment programs.

Over-time these research efforts were broadened to understand the dynamics of the burned out professional, by examining how an individual perceives stress (Lazarus, 1991). Focus shifted to understand how cognitive appraisal mediates stress and burnout and what objective factors need to be present in the environment of the individual in order for burnout to occur.

interpret that there is no place in the health care arena for their personal needs, and that a competent professional must submerge all needs except the abstract desire to be helpful (Jaffe, 1986). For some these emotional responses are interpreted as evidence of potential boundary problems with patients and clients and dredge up the terrifying stories of countertransference. This perception may arise from a distorted interpretation of curricular and behavioral emphases introduced during graduate education or from individuals' personal needs to protect themselves against the effects of repeated contact with distressing situations. Jaffe (1986) notes that, regardless of the source, the result of this type of processing may produce cynical detachment and ineffectual self-care.

Studies regarding the impairment of health professional have offered little insight into solutions to the problem or assessed the problem prior to the need for intervention (Graham, 1986). Still fewer studies have considered the affects of the professional educational process on the future burnout and emotional well-being of students. Even more startling is the contention that these findings appear to mirror the experience of the professional graduate students during their practicum experiences. A study by Wodarski et al., (1988) expressed that a primary concern for students with symptoms of burnout prior to graduation was their capacity to function in a competent and ethical manner with their first cohort of clients post graduation. The results of this study pointed to the growing national sentiment that the structure of graduate education for health-related professions may need to be revisited.

Further complicating this situation is the increasing emphasis being placed on professional comportment of the developing professional. This added element attempts to operationalize, through a number of maturing processes, the capacity for ethical and competent judgement, problem-solving integrity, professional fidelity to one's peers and numerous other behavioral outcomes. The emphasis placed on this later element has required accredited health-related graduate programs to move to articulating professional performance policies with measurable outcomes for assessing the degree to which graduates achieve (or are unable to achieve) professional and personal growth and maturity into each of these areas. This added dimension has unquestionably become one the most difficult aspects of the professional graduate education experience for both students and faculty to address.

2. Peer group processes

Whereas group processes in graduate education that promote the development of positive mutual aid and peer support are broadly encouraged, the possibility does exist for groups to develop which have a counterproductive effect on students' academic experience. Relying on the contributions from field theory (Lewin, Lippitt, & White, 1939) and social exchange theory (Homan, 1961) we need to understand that peer interactions among students are influenced by forces internal and external to the immediate academic environment. As such, students may bring to the academic environment maladaptive patterns of interacting along with personal histories and agendas that negatively influence what might otherwise be positive group processes. In this context healthy, yet naive students may be drawn into subgroups that they perceive as supportive only to find themselves unwittingly involved in group contagion, unable to

correct or move away from situations that threaten their well-being and positive interactions with other members of the academic environment (i.e., other students, faculty, and staff). The presence of group processes of this type within an academic environment can serve to undermine the efforts of faculty and administration from all sides. Often this phenomenon creates an "us" versus "them" mentality in which faculty and students retreat to their respective corners to plan defense strategies. Environmental warfare of this type takes many casualties, not the least of which are the students who receive little attention (positive or negative) from war fatigued faculty. Academic environments experiencing this phenomenon find implementation of new ideas extremely difficult.

3. Faculty modeling

Faculty modeling is a primary force in motivating students to adopt new behaviors and a key factor in implementing programs promoting wholeness. According to Lantos (1996) faculty members considered the most effective in modeling are ones that demonstrate a pragmatic, problem-solving, and participation-provoking attitude. Faculty of this type illustrate that which they purport to be good in both their professional and personal lives. Further, these individuals influence changes in students' behavior through consciousness raising illustrations in which they clearly articulate how academic expectations can meet students' aspirations for professional and personal growth.

Innovation variables. Diffusion research is rich with suggestions about factors associated with innovations that influence adoption behavior (Svenning, 1982). Below is a list of the factors most commonly considered when designing and implementing new programs. These have merit for recognizing the diversity of students' needs when promoting wholeness programs.

1. Complexity is defined as the degree to which the knowledge or skill is perceived as difficult to obtain or use (Zaltman et al., 1973). It may occur at the levels of conceptual complexity and also at the level of complex implementation (Zaltman et al., 1973).

2. Compatibility is a major factor influencing behavior and is defined as the degree to which the knowledge or skill is perceived as consistent with the existing values, past experiences, needs of the individual, and the degree to which adjustments must be made in the work environment before the knowledge or skill can be used (Zaltman, 1973).

3. Relative advantage influences the choice of behavioral strategies and is defined as the perceived advantage of an innovation over other innovations or the status quo in terms of economic and social costs, return on investment, efficiency, risk and uncertainty (Rogers & Shoemaker, 1971). Zaltman (1973) says that the greater the number and magnitude of perceived advantages, and the more visible these advantages are to the implementor, the more likely the innovation will be implemented.

4. Trialability also influences implementation of an innovation and is defined as the degree to which an innovation is perceived as divisible by the individual (Rogers & Shoemaker, 1971). Divisibility means the innovation can be experimented with starting at the most elementary applications and then progressing to the more difficult ones. Zaltman (1973) defines trialability further, as the degree to which the status quo can be

maintained, and the innovation broken down and implemented in gradual states, producing a positive effect on individual implementation behavior. Rogers and Shoemaker (1971) feel that the results of experimentation creates the alteration in individuals' sense of willingness to alter their commitment to the implementation of the innovation. Kiresuk, Davis, and Lund (1980) assert that the significance of trialability is that the innovation can be safely and easily discarded if it does not achieve its objectives.

5. Observability influences behavior in that resistance to innovation is thought to result often times from confusion and uncertainty in conceptualizing concrete utility (Kiresuk et al., 1980) and is defined as the degree to which the results of the innovation are visible and their effectiveness is easily communicated to the individual (Rogers & Shoemaker, 1971). Thus, when individuals see the innovation as working, fears are reduced and recognizing potential utility is eased (Kiresuk, Davis, & Lund, 1980).

The Program

Incorporating wholeness into the training of health care professionals is the essence of being committed to the maturation of the professional and personal selves of students. Within this commitment is the desire that health professionals are professionally effective and personally balanced. These individuals use God's power in their lives as their guiding force. As such, health professionals understand their dependence on God, their interdependence on humans, and the need to care for themselves.

Goals:

- 1) To develop a broader understanding of the appreciation of the bio-psycho-social spiritual issues of life.
- 2) To develop effective coping strategies for dealing with life's problems.
- 3) To develop values, attitudes and behaviors (in addition to knowledge and skills) to properly carry out comprehensive practice in a health-related profession.
- 4) To create an environment, provide professional activities, and encourage personal choices that promote students' growth toward wholeness (Buckles, Dyer & Hooker, 1996).

Objectives:

- 1) Promote students' knowledge and awareness of:
 - a) the implications of normal life cycle events on their lives and on the lives of those they will serve;
 - b) the stages of faith and self awareness of their own faith maturity;
 - c) professional and personal limitations and vulnerabilities; and
 - d) the benefits of the need for life-long consultation.
- 2) Build students' skills in:
 - a) leadership;
 - b) interpersonal communication (verbal and nonverbal); and

- c) professional communication for appropriate assertiveness, conflict resolution, positive boundary maintenance, and effective collegial and patient interactions.
- 3) Promote students' values and attitudes which:
- a) engender self-awareness that acknowledges that life is difficult, filled with both pain and joy;
 - b) acknowledge need to engage self-care in each of four human dimensions (i.e., physical, mental/cognitive, social/cognitive, and spiritual); and
 - c) engenders values and attitudes toward mutual assistance (helping others) through:
 1. competent compassionate service to others by reflecting the Christ's gracious character;
 2. promoting the self-worth of others in each of the four dimensions of wholeness;
 3. participating in community service and outreach programs;
 4. acknowledging and maintaining healthy boundaries in working with others; and
 5. trust in others by developing a trusting relationship with God (Buckles, Dyer & Hooker, 1996). This requires that students develop an understanding that growth in this relationship comes from surrender, "becoming real with God." "Those who have grown the most spiritually are experts in living" (Peck, 1978).

Co-curricular strategies for developing wholeness programs in health-related graduate education:

- As students enter professional health-related graduate programs they would develop a portfolio in which they create goals in each of the four dimensions of professional/personal wholeness (i.e., physical, social/emotional, mental/cognitive, and spiritual).
- Students would begin this process during the orientation to new students and continue its development through a series of colloquia.
- Monitoring would be supported by the program's mentoring processes which are continuous with one week each quarter specifically set aside in faculty schedules to assure that all students have an opportunity to meet with someone.

Examples of professional/personal goals:

| | |
|-------------------------|--|
| Physical | Develop individualized realistic nutrition/exercise program. Establish plan for study, work, and rest for optimal success. |
| Social/Emotional | Incorporate into schedule protected time for family, friend, and play. |
| Mental/Cognitive | Take advantage of counseling needs to address individual and familial issues. |
| Spirituality | Develop activities to support spiritual renewal (i.e., daily worship, meditation, and activities that encourage the joy of spiritual celebration). |

Examination of existing mechanisms to support wholeness:

Prior to initiating significant change academic programs should evaluate existing co-curricular activities and offerings that support the development of wholeness programs. Examples of co-curricular offerings found in graduate health-related education that promote wholeness include:

- Orientation of new students by department/school.
- Orientation of new students by University to all student services including the health fitness center/s and health screening/planning activities.
- Professional colloquia offered by the department/school.
- Departmental colloquia series on spirituality in professional practice.
- Seminars that include content on burnout, stress, and professional impairment.
- Confidential support groups ran by a qualified licensed practitioners.
- Student mentoring by faculty.
- Use of University-based student assistance programs and student counseling centers.
- Financial support for expanded counseling services for identified students.

Expanded co-curricular strategies to support wholeness:

Following are example of how existing co-curricular offerings can be expanded to promote wholeness programs:

- Orientation of new students expanded to include introduction to the Wholeness Portfolio.
- Increase the promotion of the use of the University fitness facilities and health screening/planning services.
- Professional colloquia offered by the department expanded to operationalize and set the foundation for the Wholeness Portfolio.
- Expanded curricular and co-curricular opportunities for personal growth (e.g., course work in conflict resolution and spirituality in professional practice; and content specific colloquia on burnout, stress, and emotional impairment--including the symptoms, causes, prevention and intervention strategies).

- Sponsor-co-sponsor health and nutrition colloquia to assist students in maintaining good nutrition during their studies.
- Student mentoring by faculty expanded to use the Wholeness Portfolio as the guiding instrument for interactions.
- Expand use of University's student assistance programs and student counseling centers.
- Continue and work to expand financial support of counseling services for identified students.

Conclusion

Essential to the implementation of wholeness programs in health-related graduate education is an understanding of the multiple individual, organization (contextual or systemic), and innovation factors which may facilitate or impede its acceptance or rejection. Applicable to a wide variety of settings, the analytical framework presented in this illustration should enable faculties not only to identify inhibitors but develop strategies toward the implementation and continued utilization of programs promoting wholeness. Finally, the process of analysis proposed should better equip faculty to engage in multiple activities that will improve their knowledge of students' needs and ultimately enhance their roles as educators.

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