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A pilot study of fieldwork rotations vs.
year long placements for social work students in a public hospital

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Abstract

A comparison of two types of fieldwork was undertaken with 26 social work students in a large urban hospital. The first group was assigned to a traditional, year long placement. The second group was assigned to three successive placements of approximately 10 weeks each. The impact of these two types of placement on students' general sense of self-efficacy, self-efficacy regarding specific hospital social work activities and perceptions of the work environment, was assessed. Initial results suggest that both groups produce virtually no change in students' general sense of self-efficacy, yet produce positive changes in students' self-efficacy regarding hospital social work. In addition, results suggest that the fieldwork rotation used in the second group may produce somewhat more positive views of the work environment.

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Introduction

Social work field education has grown over the years from a simple apprenticeship model to an integrated educational approach with a sustained focus on 'learning by doing'. Kadushin asserts and probably many would agree, that field instruction is "the most significant, most productive, most memorable" component of social work education (1992, p. 11). It is in the field work experience that students, utilizing theory and knowledge acquired in the classroom, test out skills toward developing professional competence and identity.

Experiential learning has been included as an integral part of social work education since the founding of the first professional school of social work in 1898 with the intensive one to one teaching relationship predominating in field work education for many years (Hollis & Taylor, 1951). Given its importance in professional development, it is surprising to note that there has been limited development of alternative models of field education. Graduate field education continues to be characterized by a single, year long assignment under the mentorship of an individual field instructor. The apprenticeship approach has given way to more sophisticated models of instruction that increasingly emphasize reflective and conceptual activities, integrate knowledge about adult learners (androgogy), and promote integration of theory and practice. There has been little attention paid to alternative structures and their potential influence on the development of professional competence. Marshack

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and Glassman state that although the “incorporation of andragogical principles into field teaching has greatly enhanced its effectiveness, it does not change the essential structure of one to one field instruction” (1991, p. 88). These authors also note that innovations in the structure of field education have emerged, including group field instruction (e.g., Kaplan, 1988, Shulman, 1992), primary and secondary field assignments (e.g., Lurie & Pinsky, 1973, Rehr & Caroff, 1986), as well as task and secondary supervision (e.g., Marshack, 1986). Although primary and secondary assignments were first employed in the 1970’s, social work has not traveled further down this road away from the single instructor/single placement model.

One notable exception to the lack of alternative structures for field education was a rotation model implemented at the University of Utah Medical Center. Responding to the evolution of the medical social worker as a “full member of the health team”, the authors describe a model in which first year graduate MSW students rotated through three distinct services exposing them to a “variety of paces, workloads, medical problems and definitions of health related concerns” (Dalglish, Kane & McNamara 1976, p. 168). Project participants who were surveyed after the rotation experience noted concern over the “loss of field instructors after brief periods, limits on opportunities for intensive involvement with clients and the erosion of student confidence because of the need for continuous fresh starts” (Dalglish, Kane & McNamara 1976, p. 169). Identified advantages of the rotation structure included

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exposure to a range of services, as well as the breadth of policies and practices encountered in the field work setting.

Paralleling the relative lack of change in field education, are very dramatic changes in some field education settings. Hospital service provision for instance, is changing at a dizzying pace, driven by factors such as DRG's, cost containment, managed care and consumer preference. Institutions have built in mechanisms to measure quality and involve workers from top to bottom to provide input. Regulations increase and change frequently. Institutions are faced with using creative approaches or losing out to other organizations that are more sensitive to the changing times. Social work fieldwork in hospitals has been greatly influenced by many of these forces, through their reduction in patients' length of stay. Traditional long term work has shifted to short term or crisis intervention. The AIDS epidemic, continuing substance abuse, homelessness, child abuse, sexual assault, and the changing structure of the family have through necessity redefined social work practice. Workers face both larger and more diverse caseloads, especially in major urban settings. Their students' cases reflect these changes (Marshack & Rosenfeld, 1986). In that social workers are expected to be equipped with the sufficient knowledge and skills to assist the majority of those on their caseloads, the profession is faced with the need for expert generic social work practitioners.

Social work, with its traditional year long field assignment, stands in marked contrast to allied health fields such as psychology and medicine, which incorporate a

rotating clinical practicum as a central feature in their professional education programs. The clerkship model has been the primary clinical experience for medical students since the late nineteenth century (Butterfield & Libertin, 1993). Students in clinical psychology programs, residency training in podiatry and osteopathy (among others) routinely rotate from one setting to another, thereby experiencing a range of practice arenas, service delivery systems and clinic/patient populations. The goal of this pilot study was to compare the traditional models' single, year long field placement with a fieldwork rotation model where students experienced three successive, ten week long, field placements.

Method

The Setting

This study was conducted at a major tertiary health care provider in New York City with 615 inpatient beds with an average occupancy rate of 90%. There are over 115,000 emergency room visits and an additional 335,000 patient visits annually to both Primary Care and subspecialty outpatient clinics. The hospital is located in what has been described as the most ethnically diverse county in the United States (Edmondson, 1991). The provision of social work services is complicated by the fact that it is estimated that over 100 languages are spoken in New York City. The area has experienced significant immigration from a host of countries in South and Central America, and Asia. A large proportion of this population is comprised of undocumented immigrants. Table 1 provides additional socioeconomic details

regarding New York City. It is obvious after reviewing this data, that the social work students in our study faced a broad array of clients and client problems.

Insert Table 1 about here

Intervention

The department of Social Work Services in this hospital has been involved in field instruction since 1970. It has established relationships with the Adelphi, Columbia, Fordham, Hunter, New York University, SUNY Stony Brook and Yeshiva schools of social work. In 1993-94, students were distributed among the general medicine and surgery, pediatric, psychiatry, maternal/child health, rehabilitation, and substance abuse services. The field instruction model employed here has been described elsewhere (Showers & Cuzzi, 1991). The standard fieldwork group (SFW) was trained using this model during their year long placement. Students had one primary supervisor and one task supervisor throughout the year. Students in the fieldwork rotation (FWR) had three separate placements that were each approximately ten weeks in length. Rotation students had three different primary supervisors, a new one during each rotation.

Sample

Participants were 26 masters level social work students who had been assigned to the hospital. To reduce the practical difficulties of carrying out the study, 8 students from a single school were assigned to the experimental intervention (FWR) and 18

students were assigned to the comparison group (SFW). One participant in the comparison group was dropped from the analyses presented here due to a withdrawal from school for medical reasons.

Measures

To assess the potential impact of fieldwork rotations a variety of measures were employed. Data from the following measures will be discussed here:

- ❑ Work Environment Scale - Real [WESR]
- ❑ Self-Efficacy Scale[SES]
- ❑ Hospital Social Work Self-Efficacy [HSWSE]

Work Environment.

No evaluation of social work field placements in health settings as work environments for the student, were found in the literature. For non-student, health workers, Moos (1985) has noted:

Health care settings provide a work environment for staff as well as a treatment or living environment for patients. Although these two facets of the environment serve different functions, they are closely related. For instance, staff who feel little support from peers or supervisors and who are unclear about their job and role performance expectations may find it difficult to establish a supportive clear treatment environment (p. 451).

Moos' (1986) Work Environment Scale Real Form [WESR] - is a 90 item self-report measure that assesses perceptions of work environments. The form typically takes 15-20 minutes to complete. The WESR contains ten subscales which form three

dimensions: 1) Relationship; 2) Personal Growth; and 3) System Maintenance and System Change. These measures have undergone extensive psychometric evaluation (Moos, 1986). In order to ensure that all students were referring to precisely the same time period in their assessments of the work environment, they were told at each administration to answer the questions referring to the past 10 weeks. Moos and Schaefer (1987) compared scores on the WESR for 1607 employees in various health care settings, with scores 1442 employees in business settings. They note:

health care employees report less job involvement and less co-worker cohesion and supervisor support. Moreover, health care settings are seen as lacking in autonomy and clarity, as less physically comfortable, and as placing more emphasis on work demands and supervisor control. . .

Following the sociotechnical perspective, these differences probably reflect both the stressful and emotionally difficult nature of health care tasks and the problem of working in large, highly structured organizations (p. 102-03).

Given that differences have been observed between employees in health care settings and employees in other work environments the authors believed that it would be important to assess whether similar perceptions of health care settings were shared by social work students who were present in a health care setting for a circumscribed time period. In addition, the authors wanted to assess the impact of fieldwork rotations on both student perceptions of the educational experience and the work environment.

Self-efficacy.

Both the previously developed Self-Efficacy Scale [SES] and the Hospital Social Work Self-Efficacy Scale [HSWSE] which was developed in this study, are based on Bandura's [Social Cognitive Theory] construct of self-efficacy. Bandura states that "perceived self-efficacy is defined as people's judgments of their capacities to organize and execute courses of action required to attain designated types of performances. It is concerned not with the skills one has but with judgments of what one can do with whatever skills one possesses" (Bandura, 1986, p. 391; c.f. Bandura, 1977, 1982, 1988). Perceptions of self-efficacy have shown a consistent positive relationship to subsequent health related and non-health related behaviors (e.g., Holden, Moncher, Schinke, & Barker, 1990; Holden, 1991; O'Leary, 1985; Strecher, DeVellis, Becker, & Rosenstock, 1986). In other words, the more confident individuals are in their ability to perform a behavior in the future, the more likely it is that they will perform that behavior successfully.

Although self-efficacy was conceived as referring to very specific behaviors, Sherer and his colleagues perceived the need for a broader measure of self-efficacy (Sherer, et al., 1982; Sherer & Adams, 1983). A number of scale development studies resulted in the SES, a two factor scale with evidence of reliability, as well as criterion and construct validity. Kahn and Long (1988) used the General Self-Efficacy subscale from the SES in a cross-sectional study of female clerical workers. In multivariate analyses, self-efficacy was the strongest predictor of both workers' trait anxiety and self-perceived work impairment. Keane and Morgan (1991) recently used the General Self-Efficacy subscale to provide an explanation for the exam performance of nursing

students. Sherer and Adams note that the SES is not intended to replace more specific self-efficacy scales. It was employed in this study to gain a more detailed view of students self-perceptions, as well to assess the construct validity of the HSWSE.

There has been considerable work on the role of self-efficacy in one's career. Hackett, Betz, Casas, and Rocha-Singh (1992) note the following regarding research done by a variety of investigators between 1981 and 1991.

Career self-efficacy, or expectations of one's confidence in career related pursuits, has been found to be related to vocational interests . . . academic achievement and persistence in college majors . . . and career choice processes such as career indecision Career self-efficacy appears to be particularly useful in understanding the educational and career choices of high school and college students (p. 527).

As others have noted (Lent & Hackett, 1987) there has been less research on the role of self-efficacy in ones career outside of that done with students. Jex and Gudanowski (1992) found that self-efficacy regarding one's job was moderately correlated with work related anxiety and correlated to a lesser degree with work related frustration. In both instances the relationship was in the expected direction - higher levels of self-efficacy were related to lower levels of anxiety and frustration. Self-efficacy failed to show a significant relationship with job satisfaction, intentions to quit or organizational stressors such as role ambiguity in this cross-sectional study.

We thought it would be important to assess the impact of the two types of fieldwork on students' self-efficacy regarding hospital social work. Although there are

measures of self-efficacy regarding one's ability to pursue particular occupations or self-efficacy regarding job performance in general terms, no measures of self-efficacy regarding hospital social work tasks could be found. Therefore we developed our own, the HSWSE. While the details of this process are described elsewhere, it should be noted that evidence supporting the reliability and validity of the HSWSE was found (Holden, Cuzzi, Rutter, Rosenberg & Chernack, in press).

Procedure

In order to maintain anonymity and decrease the press for socially desirable responding (Paulhus, 1991), the following procedure was employed during the group administration of the student measures. At the first administration, each participant entered a unique identifier on their measurement package. This number consisted of 14 numbers and letters selected by the subject in response to four questions. The questions were designed so that even if a participant could not recognize their identification number on a subsequent measurement occasion, they could simply answer the questions a second time and then match their answers to the list of identification codes. In addition, a list of names and the unique identification numbers was made and kept by one of the participants, in case this process failed. In this way the evaluators could match responses on the various administrations, and participants could be assured that they would remain anonymous.

The student forms typically took approximately 45 minutes each, to complete. Table 2 details the array of observations over time.

Insert Table 2 about here

Results

A multivariate approach to the analysis of these data was not used because there were fewer participants than dependent variables in the smallest group (Tabachnick & Fidell, 1989). As an alternative, we first compared the mean ratings of the two groups at pretest and again at posttest using, independent groups t-tests for both of the self-efficacy measures and the work environment scale. The second comparison focused on the question of whether field work in this setting increases students' self-efficacy regardless of the type of fieldwork. When multiple tests are used in this manner there is an increased probability of making a Type 1 error (concluding that that there is a significant difference between the groups in the population when in reality there is not). To guard against increasing the probability of Type 1 errors, a Bonferroni approach was employed.¹

Inspection of Table 3 reveals that students' reports of their more general sense of self-efficacy were quite similar in the two groups at both pretest and posttest. The results of the t-tests bear this out in that none of the comparisons reached significance.

Insert Table 3 about here

¹ To keep the overall alpha for each set of comparisons at .05 the alpha level was divided by the number of comparisons, to arrive at a more conservative alpha level for each comparison (Cliff, 1987). In Table 3 for instance, four t-tests were performed. The alpha level that was used for each individual test in this table was $\alpha = .0125$.

None of the comparisons on the Hospital Social Work Self-Efficacy scale were significant either, despite the fact that the differences between the groups on the means detailed in Table 4 appear to be larger.

Insert Table 4 about here

The comparisons of the two groups on the Work Environment Scale did reveal two significant differences between the groups. At both the initial and final administration of the WESR, the SFW group reported significantly more work pressure than the FWR group.

Insert Table 5 about here

Finally, we had designed the HSWSE as a measure that would be sufficiently sensitive to assess the impact of fieldwork on students. We expected that self-efficacy regarding hospital social work would be increased more than students' general sense of self-efficacy. To test this prediction we analyzed the change in self-efficacy over the nine months, for the two groups of students combined, using a paired sample t-test. As was expected, no significant change occurred in students' general sense of self-efficacy.

On the other hand, students' self-efficacy regarding hospital social work increased significantly on three of the five HSWSE subscales as noted in Table 6.

Insert Table 6 about here

Discussion

There are a number of caveats to conclusions that might be arrived at from the results of this study. In that the study was quasi-experimental - lacking random assignment to groups - a number of threats to internal validity may have been operating in addition to the threats to internal validity that randomization does not rule out (Cook & Campbell, 1978). For example, the significant changes on the HSWSE in the combined groups analysis presented in Table 6, may simply reflect maturation that is independent of any impact produced by the field placement. Also, the study was carried out with a single group of students in a single organization in a unique locale, at a single point in time and therefore external validity is questionable. Finally, although we think self-efficacy is an important variable to monitor, we continue to search for alternative measurement possibilities that more directly reflect the acquisition of professional skills and the delivery of high quality services. The task for a third year replication and extension, which is currently being planned, is to begin to address these threats to internal and external validity.

Despite these concerns this research has informed our practice in a variety of ways. First, the measures employed with students provide us with a picture of how

fieldwork impacts upon them. Regarding global self-efficacy (SES), the two groups of students were relatively similar at the beginning of the year and remained so at the end of the year. What was conceptualized as a more general and more stable measure of self-efficacy behaved that way in this study. In terms of hospital social work self-efficacy (HSWSE), both groups of students began with what we would consider a very high level of confidence in their abilities. Despite this both groups of students increased their confidence a small amount in each of the areas tapped by the subscales of the HSWSE. The high initial levels of confidence are intriguing. Was this an unusual group of students? Do most social work students enter their placement with such confidence in their abilities? Are these high levels of confidence reflective of actual skill levels, or are they 'over'ratings? One possible explanation for the pattern of ratings observed in this study (*response shift bias*) is addressed elsewhere (Holden, et al., 1994). This bias may occur when a self-report measure is used in a pretest - posttest intervention study. Response shift means that individuals change their understanding of the construct being measured, as a result of the intervention. For instance, students might enter fieldwork in a hospital 'very confident' in their ability to work with terminally ill patients. They gain skills and confidence during the year, yet their experiences with these patients leads them to understand how difficult such work really is. When asked at the end of the year how confident they are in their ability to work with such patients, they again answer 'very confident'. In such an instance, response shift masks the positive effects of the intervention (c.f., Riley & Greene, 1993; Robinson & Doueck, 1994; Sprangers, 1988).

We will focus here on the one significant result, as well as some of the other results from Time 4 on the Work Environment Scale. This was probably the students' most informed point regarding their work setting. In terms of the relationship aspects of the environment we saw that the standard field work group saw their co-workers as less concerned about their jobs, as well as less friendly and supportive. They also perceived management as less supportive. Regarding the personal growth aspects of the setting the standard field work group reported a similar level of perceived autonomy (to the rotation group) and the thought there was slightly more emphasis on task orientation. The standard field work group perceived a much higher degree of work pressure. In terms of the system maintenance and change aspects of the work environment, the standard field work group thought that rules and policies were less clearly communicated and they viewed the work setting as less innovative. Conversely the rotation group, viewed management as somewhat more control oriented and they also thought the physical surroundings were somewhat less comfortable.

In that our research team believes that it is important to communicate the results of studies to respondents and to listen to their reactions to the findings, we did a formal presentation of the results at a luncheon that was held for the students. Only 56% of the students (evenly split between rotation and non-rotation) attended the luncheon, in part due to scheduling difficulties. The primary themes that emerged from the discussion were ones that would be expected given the design of the study. All of the students reported that they were pleased with the learning that took place at the hospital, regardless of the group to which they were assigned. Rotation students noted that they

had received knowledge in each placement which built upon the prior one. They emphasized the advantage of the exposure to three separate placements in making career decisions. In addition, they thought that working with three separate supervisors provided them with unique learning experiences. They also remarked on the strong investment of the supervisors and the excitement of being part of the development of a new model (it will be interesting to see how many years this novelty effect remains). While the rotation students felt special, none of the non-rotation students reported feeling short changed. Although not verbalized directly at the luncheon, we noted that the non-rotation students reacted more negatively to the extra work entailed in completing research questionnaires and that they were more suspicious of our promise to provide feedback about the study at the end of the year. The non-rotation students did spend more time during the luncheon questioning rotation students about their experience, than they did talking about their own. It appeared as if there had been very little discussion regarding the differences between the two groups during the year. It was suggested by the non-rotation students that first year students would benefit from rotating field placements, allowing second year students to specialize. Rotation students disagreed, stating that their first year experience prepared them for a difficult second year experience. Overall, all students expressed a belief that the model used to teach them fieldwork was effective - a result that is consistent with our quantitative findings. Among second year students applying for jobs, 87.5% of rotation students and 50% of non-rotation students applied for jobs at the hospital.

Conclusion

We are currently engaged in refinements of the model. During the 1994-95 academic year a direct replication of the study described here will be undertaken. Simultaneously, both work on the educational modules and organizational development to expand the size of future studies will be carried out. If the findings of this pilot study are replicated in the future, we believe that field work educators will have an additional option available to them when they consider the design of their programs.

References.

- Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavior change. Psychological Review, 84, 191-215.
- Bandura, A. (1982). Self-efficacy mechanism in human agency. American Psychologist, 37, 2, 122-47.
- Bandura, A. (1986). Social foundations of thought and action: a social cognitive theory. Englewood Cliffs: Prentice-Hall.
- Bandura, A. (1988). Self-efficacy mechanism in physiological activation and health-promoting behavior. In J. Madden IV, S. Matthyse, & J. Barchas (Eds.), Adaptation, learning and affect. New York: Raven Press.
- Butterfield, P. S., & Libertin, A. G. (1993). Learning outcomes of an ambulatory care rotation in internal medicine for junior medical students. Journal of General Internal Medicine, 8, 189-92.
- Cliff, N. (1987). Analyzing Multivariate Data. New York: Harcourt Brace Jovanovich.
- Cook, T. D., & Campbell, D. T. (1978). Quasi Experimentation: Design and Analysis Issues for Field Settings. Boston: Houghton Mifflin.
- Dagleish, K. B., Kane, R. A., & McNamara, J. J. (1976). Rotating social work students within a medical center. Health and Social Work, 1, 166-71.
- Edmondson, B. (1991). American diversity. American Demographics Desk Reference Series, 1, 20-21.

- Hackett, G., Betz, N. E., Casas, J. M., & Rocha-Singh, I. A. (1992). Gender, ethnicity, and social cognitive factors predicting the academic achievement of students in engineering. Journal of Counseling Psychology, *39*, 527-38.
- Holden, G., Moncher, M. S., Schinke, S. P., & Barker, K. M. (1990). Self-efficacy of children, and adolescents: A meta-analysis. Psychological Reports, *66*, 1044-46.
- Holden, G. (1991). The relationship of self-efficacy appraisals to subsequent health related outcomes: A meta-analysis. Social Work and Health Care, *16*, 53-93.
- Holden, G., Cuzzi, L. C., Rutter, S. Rosenberg, G., & Chernack, P. (in press). The Hospital Social Work Self-Efficacy Scale: Initial development. Research on Social Work Practice.
- Hollis, E., & Taylor, A. (1951). Social Work Education in the United States. New York, Columbia University Press.
- Jex, S. M., & Gudanowski, D. M. (1992). Efficacy beliefs and work stress: An exploratory study. Journal of Organizational Behavior, *13*, 509-17.
- Kadushin, A. E. (1992). Field education in social work: An introduction. In D. Schneck, B. Grossman, and U. Glassman (Eds.) Field Education in Social Work: Contemporary Issues and Trends. Dubuque: IA: Kendall/Hunt Publishing Company.
- Kahn, S. E., & Long, B. C. (1988). Work-related stress, self-efficacy, and well-being of female clerical workers. Counseling Psychology Quarterly, *1*, 145-53.
- Kaplan, T. (1988). Group field instruction: Rationale and practical application. Social Work with Groups, *11*, 125-43.

Keane, M. C., & Morgan, B. S. (1991). Perceived self-efficacy and language differences.

Psychological Reports, 69, 291-98.

Lent, R. W., & Hackett, G. (1987). Career self-efficacy: Empirical status and future

directions. Journal of Vocational Behavior, 30, 347-82.

Lurie, A., & Pinsky, S. (1973). Queens Field Instruction Center: A field instruction center

for multilevel education in social work. Journal of Education for Social Work, 9, 3,

39-44.

Marshack, E., (1986). Task supervision: A quiet revolution in field teaching of MSW

students. ARETE, 11, 45-50.

Marshack, E., & Glassman, U. (1991). Innovative models for field instruction: Departing

from traditional methods. In D. Schneck, B. Grossman, and U. Glassman (Eds.)

Field Education in Social Work: Contemporary Issues and Trends. Dubuque: IA:

Kendall/Hunt Publishing Company.

Marshack, E., & Rosenfeld, D. (1986). Agency perspectives on current practice:

Implications for education. Paper presented at the Annual Program Meeting of the

Council on Social Work Education in Miami.

Moos, R. (1985). Evaluating social resources in community and health care contexts. In

P. Karoly (Ed.), Measurement Strategies in Health Psychology. New York: John

Wiley.

Moos, R. (1986). Work Environment Scale Manual. Palo Alto, CA: Consulting

Psychologists Press.

- Moos, R., & Schaefer, J. A. (1987). Evaluating health care work settings: A holistic conceptual framework. Psychology and Health, 1, 97-122.
- Paulhus, D. L. (1991). Measurement and control of response bias. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), Measures of Personality and Social Psychological Attitudes, New York: Academic Press.
- NYCPPD (1992). Demographic Profiles: A Portrait of New York City's Community Districts from the 1980 and 1990 Censuses of Population and Housing. New York: New York City Department of Planning's Population Division.
- NYCPPD (1993). Socioeconomic Profiles: A Portrait of New York City's Community Districts from the 1980 and 1990 Censuses of Population and Housing. New York: New York City Department of Planning's Population Division.
- O'Leary, A. (1985). Self-efficacy and health. Behavioral Research and Therapy, 23, 437-51.
- Riley, J. L., & Greene, R. R. (1993). Influence of education on self-perceived attitudes about HIV/AIDS among human service providers. Social Work, 396-401.
- Robinson, E. A. R., & Doueck, H. J. (1994). Implications of the pre/post/then design for evaluating social group work. Research on Social Work Practice, 4, 224-39.
- Rehr, H., & Caroff, P. (1986). A New Model in Academic-Practice Partnership: Multi-instructor and Institutional Collaboration in Social Work. Lexington, MA: Ginn Press.

- Sherer, M., Maddux, J. E., Mercandante, B., Prentice-Dunn, S. Jacobs, B., & Rogers, R.W. (1982). The self-efficacy scale: Construction and validation. Psychological Reports, 51, 663-71.
- Sherer, M., & Adams, C. H. (1983). Construct validation of the self-efficacy scale. Psychological Reports, 53, 899-902.
- Showers, N., & Cuzzi, L. (1991). What field instructors of social work students need from hospital field work programs. Social Work in Health Care, 16, 39-52.
- Shulman, L. (1992). Interactional Supervision. Washington, DC: NASW Press.
- Sprangers, M. (1988). Response Shift and the Retrospective Pretest: On the Usefulness of Retrospective Pretest-Posttest Designs in Detecting Training Related Response Shifts. het Institute voor Onderzoek van het Onderwijs S.V.O. 's Gravenhage.
- Strecher, V. J., DeVellis, B. M., Becker, M. H., & Rosenstock, I. M. (1986). The role of self-efficacy in achieving health behavior change. Health Education Quarterly, 13,
- Tabachnick, B. G., & Fidell, L. S. (1989). Using Multivariate Statistics, 2nd Edition. New York: Harper Collins.

Table 1. Selected 1990 socioeconomic data for New York City, Manhattan and Queens.

Factor	NYC %	Manhattan %	Queens %
Race/ethnicity			
White nonhispanic	43.2	48.9	48.0
Black nonhispanic	25.2	17.6	20.0
Hispanic origin or descent	24.4	26.0	19.5
Asian & Pacific Islander nonhispanic	6.7	7.1	11.8
Nativity			
Percent of total population: foreign-born	28.4	25.8	36.2
Not a citizen among foreign-born	58.5	60.1	57.7
Language spoken at home			
Percent of total population of persons 5 yrs old or older who speak a language other than English at home	41.0	39.0	43.9
Percent of total population of persons 5 yrs old or older who do not speak English 'very well'	20.0	19.3	22.1
Selected sources of household income [multiple sources possible]:			
Wage & salary	73.6	74.2	77.3
Nonfarm self-employed	9.5	15.6	8.9
Social security	24.6	20.3	28.2
Public assistance	13.6	10.9	7.5
Retirement income	12.6	9.4	15.1
Educational Attainment (persons 25 and older)			
Less than 9 years	14.1	12.4	12.7
High school graduate (only)	26.3	15.9	29.8
Some college	19.0	17.2	20.8
Bachelor's, graduate or prof. degree	23.0	42.2	20.6
Proportion of families, with the following characteristics, who fell below the poverty level			
Families with related children under 18	24.8	29.4	12.7
Female householder, no spouse	35.3	37.6	18.9
Female householder, no spouse and children under 18	48.1	52.2	30.0
Marital Status of Persons 15 or older			
Married	42.5	34.1	49.5
Never married	37.2	44.7	31.9
Separated, widowed, divorced	20.3	21.3	18.7
Age of Households			
Households w/ persons under 18	31.6	19.1	31.8
Households w/ persons 65 and over	25.5	22.0	29.4
Housing			
Persons over 5 who lived in same housing 5 years prior to census	63.1	60.2	63.1
Crowding: 1 person or less per room	87.7	89.9	88.2

Note. Table adapted from NYCPPD (1992) & NYCPPD (1993).

Table 2. Array of measures and measurement points.

10/4/93	12/6/93	2/28/94	5/2/94	
SES	SES	SES	SES	SES
HSWSE	HSWSE	HSWSE	HSWSE	HSWSE
	WESR	WESR	WESR	WESR

Table 3. Mean scale scores and (SD) on Sherer et al's. Self-Efficacy Scale subscales (n=25).

Subscale	Baseline		Rotation 1		Rotation 2		Rotation 3	
	SFW	FWR	SFW	FWR	SFW	FWR	SFW	FWR
General Self-efficacy	4.03 (.42)	4.32 (.35)	4.19 (.60)	4.07 (.42)	4.27 (.45)	4.20 (.56)	4.28 (.47)	4.29 (.55)
Social Self-efficacy	3.83 (.53)	3.27 (.58)	3.91 (.55)	3.40 (.67)	3.88 (.64)	3.52 (.44)	3.78 (.64)	3.31 (.51)

Note. The number for the rotation indicates that the measure was obtained after rotation x. SFW = standard field work; FWR = field work rotation.

Table 4. Mean scale scores and (SD) on Hospital Social Work Self-Efficacy Scale subscales (n=25).

Subscale	Baseline		Rotation 1		Rotation 2		Rotation 3	
	SFW	FWR	SFW	FWR	SFW	FWR	SFW	FWR
Self-efficacy re: patient groups	6.23 (1.3)	5.64 (1.1)	6.11 (1.1)	6.02 (1.1)	6.63 (1.1)	6.37 (1.2)	6.89 (.76)	6.69 (.66)
Self-efficacy re: written communications	6.21 (1.9)	7.31 (1.6)	6.94 (1.3)	7.81 (1.1)	7.53 (1.4)	7.75 (1.3)	8.15 (.81)	7.63 (1.9)
Self-efficacy re: performance on team	7.37 (1.3)	7.88 (1.1)	7.62 (1.2)	7.96 (1.0)	7.64 (.97)	7.75 (1.2)	7.71 (.83)	8.14 (.86)
Self-efficacy re: critical case tasks	6.69 (1.7)	6.48 (1.4)	7.29 (1.2)	6.68 (1.3)	7.34 (.82)	6.98 (1.3)	7.54 (.80)	7.35 (1.3)
Self-efficacy re: stress management	5.68 (1.5)	6.35 (1.8)	6.17 (1.6)	6.23 (1.6)	6.91 (1.3)	6.60 (1.2)	6.89 (1.2)	7.13 (1.0)
Total Scale Score	6.40 (1.1)	6.34 (1.1)	6.58 (1.0)	6.58 (1.1)	6.99 (.87)	6.80 (1.0)	7.18 (.72)	7.15 (.64)

Note. The number for the rotation indicates that the measure was obtained after rotation x. SFW = standard field work; FWR = field work rotation.

Table 5. Mean scale scores and (SD) on the WESR by occasion (n=25).

Dimension/ Subscale & Description ¹	Health Care Norm ¹	Time 2		Time 3		Time 4	
		SFW	FWR	SFW	FWR	SFW	FWR
Relationship							
<i>Involvement</i> - the extent to which employees are concerned about and committed to their jobs	5.56 (1.54)	6.00 (1.9)	6.25 (2.4)	5.12 (2.1)	7.25 (.71)	5.53 (1.7)	6.63 (2.1)
<i>Peer Cohesion</i> - the extent to which employees are friendly and supportive of one another	5.22 (1.40)	3.82 (2.1)	4.63 (2.3)	3.41 (2.6)	5.38 (1.8)	3.35 (2.1)	4.88 (1.8)
<i>Supervisor Support</i> - the extent to which management is supportive of employees and encourages employees to be supportive of one another	4.99 (1.40)	4.88 (1.7)	6.25 (1.0)	4.77 (2.5)	5.88 (.99)	4.41 (1.8)	6.25 (.89)
Personal Growth Dimension							
<i>Autonomy</i> - the extent to which employees are encouraged to be self-sufficient and to make their own decisions	4.98 (1.46)	6.00 (1.7)	5.25 (1.4)	5.59 (1.9)	6.00 (2.2)	5.35 (1.9)	5.38 (1.8)
<i>Task Orientation</i> - the degree of emphasis on good planning, efficiency, and getting the job done	5.63 (1.31)	7.00 (2.0)	7.00 (1.7)	6.35 (2.3)	6.63 (1.9)	7.06 (1.8)	6.88 (1.6)
<i>Work Pressure</i> - the degree to which the press of work and time urgency dominate the job milieu	4.87 (1.57)	7.65 ^a (1.6)	4.00 (2.7)	7.00 (1.8)	4.25 (3.2)	7.18 ^a (1.7)	4.13 (2.6)
System Maintenance and System Change Dimensions							
<i>Clarity</i> - the extent to which employees know what to expect in their daily routine and how explicitly rules and policies are communicated	4.44 (1.41)	5.41 (2.0)	5.88 (1.8)	5.00 (2.4)	6.13 (1.7)	4.88 (2.5)	5.88 (2.6)
<i>Control</i> - the extent to which management uses rules and pressures to keep employees under control	5.43 (1.42)	6.24 (1.7)	5.13 (1.7)	6.18 (2.1)	5.13 (2.2)	6.00 (1.5)	6.38 (1.2)
<i>Innovation</i> - the degree of emphasis on variety, change, and new approaches	4.37 (1.82)	1.00 (1.5)	3.38 (2.9)	1.41 (1.42)	3.25 (2.8)	1.65 (1.0)	2.88 (3.1)
<i>Physical Comfort</i> - the extent to which the physical surroundings contribute to a pleasant work environment	3.72 (1.28)	2.59 (1.8)	3.25 (2.1)	2.47 (1.8)	2.88 (1.4)	2.71 (2.3)	2.38 (2.6)

Note. The number for the rotation indicates that the measure was obtained after rotation x. SFW = standard field work; FWR = field work rotation.

Mean scores in the SFW column with the superscript ^a are significantly different than the corresponding FWR mean score.

1 The descriptions of the subscales are a direct quote from Moos (1986), p. 2, Table 1. The health care norms based on 1607 employees in a various health care settings are transcribed from the same publication p.4 Table 2.

Table 6. Changes in self-efficacy for the entire sample over the nine month placement ($n = 25$).

Scale & Subscale	Posttest - Pretest	
	M	SD
<i>Self-Efficacy Scale</i> ¹		
General Self-efficacy	.19	.46
Social Self-efficacy	-.01	.54
<i>Hospital Social Work Self-Efficacy Scale</i>		
Patient Groups	.79 ^a	1.1
Written Communications	1.42 ^a	2.1
Team Relations	.32	1.3
Critical Case Tasks	.86	1.5
Intrapersonal	1.07 ^a	1.4
Total Scale	.79 ^a	1.0

Note. The entries in the cells are the mean difference scores for each variable, which are obtained by subtracting the pretest score from the posttest score. Mean difference scores with the superscript ^a are significant.