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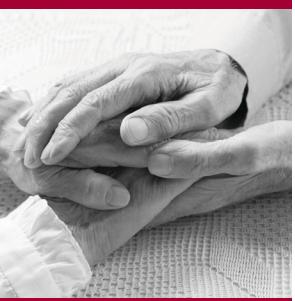


SPECIAL SECTION: CONGREGATIONAL & SOCIAL WORK CONTRIBUTIONS TO HUMAN THRIVING AMONG PERSONS 55+

ARTICLES

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Introduction to Special Section: Congregational & Social Work Contributions to Human Thriving among Persons 55+

Dennis R. Myers & Terry A. Wolfer

I have come that you may life and have it more abundantly (John 10:10).

This special section of *Social Work and Christianity (SWC)* is devoted to congregational and social work contributions to human thriving among persons 55+. We believe that Jesus' intention to offer abundant living for humankind resonates with the positive psychological construct of human thriving. We think that a deep longing for abundant living and human thriving among marginalized persons 55+ in our communities explains why the contributing authors offer these contributions to social work-informed and congregationally-based responses to their challenges. Based on a definition authored by Benson and Scales (2009), human thriving represents a dynamic and reciprocal interplay of an older person intrinsically animated and energized by overcoming personal and environmental challenges to discover his/her specialness, and the developmental, relational, and institutional contexts (people, places, organizations) that know, affirm, celebrate, encourage, and guide its expression (p. 90). The articles in this special section highlight the responses of social work researchers and practitioners to the growing number of persons 55+ who daily encounter poverty; gender, racial and economic injustice; social isolation; invisibility; and life-threatening illness. Each article addresses one or both fundamental

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questions: What are the personal and environmental assets and challenges that sustain and discourage human thriving? How can congregations and social work professionals contribute to this outcome among the 55+ population?

SWC has a long history of response to the implications of the longevity revolution for social work, particularly at the intersection of social work practice, congregations, and religiously-affiliated organizations. In1983, *SWC* published the first special issue on aging, edited out of a conference at the University of Chicago. Since that time, the journal has consistently provided a forum for authors to deliver articles, practice notes, and book reviews informing colleagues committed to abundant living of the 55+ population. Thirty years later, in 2013, *SWC* published a second special issue on *Congregational & Social Work Responses to Older Adult Vulnerability,* featuring articles, practice notes, and a book review that offered guidance for social workers and religious leaders committed to collaborative approaches for enriching the lives of persons 55+. The special issue highlighted innovative responses of congregations and assets and vulnerabilities of the 55+ population and the role of social work in the design, delivery, and/or evaluation of these congregational programs. This special section is a five-year update on research and congregationally-based innovations since the 2013 issue. Congregationally-affiliated social workers have much to offer congregations in their mutual quest to nurture personal and spiritual thriving, the central theme across the thirty-five years of *SWC* commitment to informing social work practice with the 55+ population. The synergy at this intersect between the two is a potent place to disseminate research on human thriving in this population group and build congregationally-based innovations like the ones selected for this special section as well as the ones that will be needed in the future.

According to the Benson and Scales (2009) definition above, human thriving is an outcome of a reciprocal relationship between the internal needs and aspirations of the person and an external context that can activate and sustain the person's "specialness." Persons 55+ cannot thrive in isolation. The opportunity to realize their "specialness" is impossible without personal and contextual enablers. According to Brown, Arnold, Fletcher, and Standage (2017), personal enablers are "attitudes, cognitions, and behaviors that help him or her to thrive" (p. 171). Examples include religious beliefs and spirituality (Park, 1968), resilience, (Gan, Xie, Wang, Rodriguez, & Tang, 2013), and motivation (Benson & Scales, 2009). Contextual enablers, such as supportive family (Weine et al., 2013) and work environments (Paterson et al., 2014), are external facets of the person's relational and organizational environment that also foster human thriving (Carver, 1998). The articles in this special section demonstrate how congregations are also contextual enablers of thriving among persons 55+ who struggle with challenges to their sense of specialness.

In this special section, you will find five articles that offer guidance for social workers and congregations committed to collaborative approaches for activating and sustaining human thriving in lives of persons 55+. Three articles focus on the threats to thriving created by loneliness, dementia, and human and natural disasters. One article examines the extent to which hope is a personal enabler of thriving through its impact on resilience. The special section also offers an innovation in social work field education that prepares social workers for competency in strengthening congregations' contribution to thriving among the 55+ population marginalized by economic and health challenges. All the articles prescribe initiatives that congregations can activate, and interventions that social workers can implement to increase the efficacy of congregations as contextual enablers of human thriving.

In *Loneliness and Congregational Social Work,* Victoria A. Charles and Terry A. Wolfer address social isolation in later life, one of social work's Grand Challenges. In concert with local congregations, the authors demonstrate how congregationally-affiliated social workers can use community development, community organizing, and direct practice skills to foster human thriving by nurturing personal relationships and socially cohesive communities.

In *Remembering Faith: Rural Faith Communities' Outreach to Members with Dementia,* Kenneth Flanagan focuses on how congregations can become more dementia-friendly. Based on qualitative interviews with twelve pastoral staff in seventeen rural congregations in North Dakota, the researcher identified four characteristics of congregations that were welcoming to persons living with dementia. This article offers guidance to congregationally-affiliated social workers interested in addressing the challenges of promoting human thriving in this population group.

In *Congregational and Social Work Responses to Older Survivors of Natural/Human Disasters,* James W. Ellor and Margaret Mayo draw attention to the impact of natural or human disasters on older survivors and the responses of congregations and congregationally-affiliated social workers to these devastating and unanticipated events. This father-daughter author team offers a current perspective on how congregations can promote human survival and even thriving across each phase of the disaster cycle—pre-event preparation, post-event/acute phase, and post-event/long-term phase. Micro and macro prescriptions for congregational and social work engagement that support resilient outcomes for older survivors are included.

In *Hope and Resilience among Vulnerable, Community-Dwelling Older Persons,* Edward C. Polson, Rachel Gillespie, and Dennis R. Myers investigate how community-dwelling older adults experiencing poverty, social isolation, and deteriorating health and daily functioning remain resilient. Based on research with other population groups, the researchers tested the

proposition that hopefulness may help explain resilience in older, vulnerable persons. Based on survey data drawn from a sample of 64 persons 55+ experiencing devastating physical and psychosocial marginality, hope was a significant predictor of resilience among these older adults and mediated the effect of spiritual experience on resilience. Recommendations to social workers and congregational leaders for promoting hope in congregational and community contexts are provided.

Finally, in *The Congregational Social Work Education Initiative: A New Pathway in Field Education and Community Partnership,* Fran Pearson, Kelly J. Poole, Wayne R. Moore, Lelia Moore, John Rife, & Antonia Reaves Richburg follow an article in the 2013 special section with an update on a nationally-recognized field education model for equipping future social workers for competent practice with congregational and religiously-affiliated organizations aimed at vulnerable community members to include persons 55+. Based on sustained delivery of the model, the authors present the history, goals, programs, outcomes, strengths, and limitations of Congregational Social Work Education Initiative (CSWEI). This unique field education program, which partners with a local congregational nurse program, provides an array of services aimed at human thriving. The authors encourage replication of the CSWEI model and development of strategic interdisciplinary and religious organizational affiliations.

Our authors present evidence that congregations provide an enabling context for personal and spiritual thriving and abundant living among persons 55+ and that social workers committed to congregational affiliation have much to offer congregations in this mission. The longevity revolution will continue to offer new opportunities and challenges for persons 55+ facing marginalization. As never before, congregations and congregationally-attentive social work practitioners, educators, and researchers will have opportunities to build on the contributions of these authors and collaboratively create, promote, deliver, and evaluate innovative public policy and programmatic contexts for those facing seemingly insurmountable barriers to human thriving. ❖

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Loneliness and Congregational Social Work

Victoria A. Charles & Terry A. Wolfer

By 2030, one in five people will be at least sixty-five years old. Socio-demographic changes pose challenges for the wellbeing of older adults. Among these is social isolation. Because of its impact on health, eradication of social isolation has recently been named one of social work's Grand Challenges. The size and diversity of close support networks have declined in the United States increasing the risk of social isolation. Interventions involving older adults in meaningful social activities within their communities may build and enhance social networks. Socially cohesive communities present opportunities for shared social support. Leveraging support resources within a congregation may promote wellbeing for those experiencing social isolation and loneliness, and congregational social workers are well positioned to lead these efforts. Social workers can use community development, community organizing, and direct practice skills to facilitate supports and relationships, as either volunteers or employees in congregations.

As life expectancy increases and the Baby Boomer cohort ages, an unprecedented shift in the United States population will occur. By 2030, as many as one in five people will be at least sixty-five years old (U.S. Census Bureau, 2014). Socio-demographic changes over the next 20 years will create distinctive challenges in addressing health and wellbeing of older adults that future social workers will be called to address. Among those challenges is social isolation, which has been identified in a body of epidemiological literature as being closely linked to health (Berkman, 1995; Berkman et al., 2000; Cohen, 2004; Cohen, 2001; House, 2001). Recently, Dr. James Lubben and colleagues have identified social isolation as one of social work's Grand Challenges (Lubben et al., 2015).

As Baby Boomers revolutionize the meaning of older adulthood, changes occurring within the social context of aging hint that social isolation may pose a rising challenge to the maintenance and enhancement of quality of life in the coming years. American research spanning the past

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several decades demonstrates that the size and diversity of close support networks have declined (McPherson, Smith-Lovin & Brashears, 2006, 2008). This decline highlights the potential for increased social isolation.

Social Isolation

In a theoretical paper, Nicholson (2009) reviewed definitions of social isolation and provided a summary definition which synthesizes previous definitions of the construct. Previous definitions of social isolation did not address the number of social contacts needed for adequate socialization or the quality of those relationships (i.e., belonging or engagement with others). Nicholson's (2009) proposed definition was, "a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling and quality relationships" (p. 1346).

Subjective and objective components of social isolation can be measured both separately and in tandem. As Nicholson's (2009) definition implies, social isolation can be conceptualized subjectively by looking at both quantity and quality of social contacts, and the concept can be operationalized by measuring an individual's perceptions of support, sense of belonging, and quality contacts with others who meet his/her social desires. In contrast, it can be conceptualized more objectively using structural analyses by identifying the number of people within a person's network and/or the frequency of a person's social contact.

Social isolation has been linked to loneliness and psychological distress which have been empirically linked to poorer health outcomes (Krause, Herzog & Baker, 1992) and increasing future risk for long-term health problems such as chronic illness and disability (Lin, Ye & Ensel, 1999; Thoits, 1995). Social isolation has been linked to serious threats to wellbeing in aging (Berkman, 1995) such as loneliness, depression, and all-cause mortality (Berkman, 1983, 1984, 1986; Berkman & Syme, 1979; Blazer, 1982; Ceria et al., 2001; Cohen, 2004; Ell, 1984; House, Landis & Umberson, 1988; Rook, 1994; Berkman, Glass, Brisette & Seeman, 2000; House, 2001; Shor & Roelfs, 2015; Uchino, 2006). Social isolation has been found to be a risk factor for dementia (Cooney, Howard & Lawlor, 2006) and may also increase the likelihood of elder abuse (Acierno et al., 2010).

Bronfenbrenner's (1979) ecological systems theory provides a conceptual framework through which the problem of social isolation can be contextualized to highlight both risks and points of intervention at different levels of an individual's social system. Developing an understanding of the mechanisms that increase the risk for social isolation at the individual, community, and societal levels can help with identifying older adults who are at risk and can guide the development of specific interventions to foster

resilience. The next sections explore social isolation at the individual and community levels.

Social Isolation at the Individual Level

Loneliness is the subjective experience of social isolation. Someone who is lonely perceives fewer intimate, personal relationships with others than they desire (Perlman & Peplau, 1981). Loneliness is an existential phenomenon common within human experience. Because humans are social beings, we all want to belong, particularly with people we understand and who understand us. Loneliness has been defined as a condition under which a person experiences distress and discomfort from a lack of relationships to meet that person's social needs (Weiss, 1975; Young, 1982). Some people can live alone or have few relationships, and not experience loneliness, while others can be surrounded by a crowd of people, even regular caregivers, and feel lonely. This difference reflects a discrepancy between the expectations people hold for relationships and their actual relationships (Sermat, 1978; Perlman & Peplau, 1981).

Weiss (1973) developed several explanations for why people might experience loneliness. He discussed "emotional loneliness" which was defined as an absence or loss of a close, personal attachment figure in an individual's life. In contrast, he discussed "social loneliness" as having fewer social contacts as well as lacking access to people with whom to build connections. The following sections elaborate on each conceptualization.

Emotional Loneliness

Attachment figures are those people with whom individuals share the closest intimate bonds (Bowlby, 1969). Significant changes and loss of relationships, such as the death of a spouse, create deficits in an older adult's social environment, potentially presenting them with challenges not previously encountered without the comfort and security of having a close confidant. The loss of close supportive relationships, which once made the world a safe and secure place, may leave an individual feeling alone and alienated from others. The impact felt in the loss of a spouse, longtime partner, companion, close friend or confidant cannot be simply filled by another person so easily (Bowlby, 1969; Weiss, 1975). Emotional loneliness is often associated with such a personal loss. Older adults may feel emotional pain associated with close personal loss.

Continuity theory suggests that individual behavior within social environments remains consistent (Atchley, 1989; Hooyman & Kiyak, 2011), meaning that the way social ties are developed and maintained is fairly stable, and older adults typically want to maintain the social roles and

activities that they are familiar with even during life transitions (Rowe & Kahn, 1998; Thoits, 1992). People who develop or maintain fewer ties over their lifetimes may suffer greater social loss when existing ties diminish. As people age, they are more likely to lose close social ties among age mates, typically spouses and friends, and are more likely to experience changes in health that impact daily functioning and/or mobility. Older adults living in poverty are disproportionately at risk for isolation because members of this population are more likely to lose a close tie or a greater number of network ties in general due to lower average life expectancy and disparities in health care access.

Loss of close relationships and a broader social network can be a reminder of an older adult's own mortality. Gerotranscendence theory suggests that older adults transition toward putting less focus on external sources of support, and focus their attention inward and start thinking more about what might happen beyond their current existence, seeking sources of meaning, hope, strength, and solace (Tornstam, 1989). O'Reilly (2004) has suggested that the search for meaning, hope, and transcendence is often associated with spirituality, and an essential component of wellbeing (Mohr, 2006). As close social connections diminish, older adults may seek to renew, develop, or strengthen their spirituality.

Social Loneliness

Social loneliness stems from social isolation, i.e., lacking a sufficient social network from which to draw critical social support, and lacking a group of people with whom to share a social identity or sense of belonging (Weiss, 1973). Social loneliness contains structural elements as well as a subjective assessment of the quality of those connections. Rolelessness may contribute to a sense of social loneliness as an individual may no longer feel a sense of connection to others through the support roles. Social loneliness can influence how older adults feel about their own lives and how they see themselves in the world around them (Baumeister & Leary, 1995).

This shift may impact older adults disproportionately due to changes within an individual's social environment over the life course. Older adults experience disengagement from social lives that once provided opportunities to regain network members, support, and ultimately social integration. Opportunities for social integration that existed in previous life stages diminish, such as participating in a workplace, gaining social contacts while raising children, and participating in other community and social activities. While it is true that older adults may continue working, volunteer, raise grandchildren, and remain engaged within their communities, older cohorts experience general life stage changes due to aging which introduce disproportionate loss of social network members, potentially impacting

their levels of social integration. This becomes more pronounced when older adults experience a loss in mobility or declining health, poor mental health, or cognitive impairment (Wethington et al., 2000; AARP, 2012).

General Impact of Loneliness

Cacioppo and colleagues (2002) have suggested that being socially connected to others is a basic physiological need. Thus, humans feel lonely as a warning signal that we are in danger of being socially isolated, just as we feel hunger and thirst when we are in need of food and water. The loneliness signal is complex. While it signals potential danger due to lacking social connections and close, satisfying relationships, social needs that go unmet can actually provide a different message in the brain. Neuro-psychological research over the past decade suggests that when humans are unable to connect with others and experience prolonged social isolation, the brain responds by triggering a fear response when an individual has opportunities to connect with others (Cacioppo & Patrick, 2008). An individual may view potential connections with other people as dangerous, threatening, or critical (Cacioppo & Patrick, 2008). Once stress and anxiety develop from the fear response, a person may become less likely to acknowledge the perspectives of others or understand others' intentions. This behavior can lead to self-isolation and/or socially awkward behaviors, removing the individual farther away from developing social connections and meaningful relationships. This perspective highlights complications in intervening with people who may be lonely due to the barriers associated with the stigma of loneliness and the strength of reinforced patterns of isolation.

Similar to the findings with social isolation, loneliness has been connected to poor health outcomes as well. Findlay (2003) found that loneliness significantly impacted quality of life in older adults and led to a need for more acute inpatient stays in hospitals (Windle, Francis & Coomber, 2011). Loneliness both affects and is affected by depressive symptoms and functional limitations, making it a risk factor for mortality (Luo, Hawkley, Waite, & Cacioppo, 2012). The effects of aging and the progression of chronic and terminal illnesses accelerate in those who experience prolonged loneliness (Thurston & Kubzansky, 2009; Wilson, Krueger, Arnold, et. al., 2007). Loneliness leads to poorer self-care (Cacioppo & Patrick, 2008), has been linked to alcoholism (Akerlind & Hornquist, 1992), and increases risk of suicide in the older adult population (Goldsmith, Pellmar, Kleinnman & Bunney, 2002). These associations demonstrate that unmet social and emotional needs are linked to a decline in health and wellbeing in older adults. Those who are at a greater risk for experiencing loneliness are women, those with low socioeconomic status, and those who are experiencing cognitive impairment (Pinquart & Sorensen, 2001).

Social Isolation at the Community Level

Social network and community level factors also contribute to social isolation of older adults. Older adults are increasingly choosing to remain within community settings for as long as possible. As health and functioning decline, many still choose to live in their own homes with supports rather than entering an institutional setting. Among community-dwelling older adults, as many as one-half of those age 85 and older live alone (Kaplan & Berkman, 2016), and living alone is a well-known risk factor for social isolation. Additionally, older adults who live in rural areas and those who perceive their neighborhoods as unsafe are at a greater risk of experiencing social isolation (AARP, 2012).

The place where an older adult lives can impact the size, diversity, and quality of social networks. For those who live alone, their mobility, access to safe and reliable transportation, walkability of a neighborhood, and distance to meaningful social activities all play a role in their level of social integration within social networks (AARP, 2012). Additionally, social cohesion within one's physically accessible environment can also impact levels of isolation. The opportunities to develop new relationships are impacted not only by the quality of the existing relationships that older adults have but also by the relationships that they might be able to build with others. The more opportunities that older adults have to participate in meaningful social activities within their communities, the greater the opportunity for developing social ties or connections to build their network.

Social cohesion indicates a shared sense of community amongst members of that community, reflecting trust, mutuality, and solidarity (Friedkin, 2004). In socially cohesive communities, people work together providing resources and support to one another. Because socially cohesive communities provide various opportunities for developing connections with others, even older adults who are experiencing loneliness or social withdrawal due to prolonged social isolation may have the opportunity to develop bonds with others for reasons besides strictly social activities. For example, a social tie might be built because a community member volunteers to help an older adult with repairs or other chores around the house. A new connection can be built over time because an individual is willing to provide a needed resource. Building on the idea of using resources that inhere within a socially cohesive network (i.e., social capital), social connection with others may be an area of intervention to address social isolation and loneliness.

Social Connection

Social connectedness is defined as interacting with others in a community or group, through which understanding oneself occurs through the

process of self-reflection and deepening spirituality (Register & Scharer, 2010). Social connectedness is being embedded with a group of people who provide opportunities for socialization and from whom one can also gain an understanding of one's self and develop self-efficacy through social interactions with others.

Ashida and Heaney (2008) found that social connectedness is important to maintaining health and wellbeing of older adults. One potential solution to combating social isolation and loneliness is by promoting prevention and intervention through social support and social connectedness within communities. Previous studies have examined concepts of social support and social connectedness as being critical to wellbeing for older adults (Cornwell, Laumann & Schumm, 2008; Register & Scharer, 2010; Ashida & Heaney, 2008). Social connectedness has also been linked to increased quality of life (Register & Herman, 2010).

Socially cohesive communities in which social connectedness thrives contain opportunities for the provision of different forms of social support amongst members. Social supports are the actualized resources provided within social networks. The support that an individual gives and receives is typically categorized as affective or emotional, informational, and instrumental (Cohen, 2004; Wills, 1985; House, Landis, & Umberson, 1988). Affective support is usually provided by those in closely bonded relationships; it is the provision of empathy and care. For example, a close friend or family member may comfort an older adult during a time of loss, listening to them, and being present with them through a stressful time. Informational and instrumental support can be provided by those who are closely bonded as well as those who share weaker bonds. Informational support is providing knowledge or guidance to assist with a particular problem or issue at hand, while instrumental support is the provision of a needed resource, such as making a repair at someone's home or helping them eat. Supportive others may provide informational support about healthcare or making decisions about important matters. The number of different people providing social support is not as important to wellbeing as is the quality of support that individuals actually receive and the frequency with which they receive it.

Relationships with Congregants

As Cnaan, Boddie, and Kang (2005) suggested, older adults tend to rate religion as important, and social engagement for older adults most commonly occurs through religious participation. Thus, congregations are significant natural communities for many older adults. Congregation-based social support could be a particularly effective method of addressing social isolation, staving off loneliness with older adults. As Krause (2008) described in his book Aging in the Church, support provided from

congregation members is distinctive from other types of social support. The support that older adults access through congregations may be more naturally occurring and more familiar to many, as this support is provided within a long-term, socially cohesive community.

Reaching out to fellow congregation members may be less stigmatizing for an older adult who is experiencing loneliness because the social norms of mutually supportive behavior exist and are reinforced by religious teachings (Coward, 1986). Furthermore, relationships among people with similar religious beliefs and values may provide emotional or tangible forms of support as well, thereby strengthening both hope and faith rooted in the religion. The congregation as a community can encourage the development and maintenance of relationships among congregation members, and those relationships may in turn reinforce their relationships with God, potentially providing two sources of connection for the older adult (Krause, 2004).

Relationships within a congregation may provide opportunities for older adults to both give and receive several types of support including emotional, spiritual, tangible, and anticipated support (Krause, 2008). The types of support identified by Krause (2008) parallel definitions of social support discussed earlier (i.e., affective, instrumental, and informational). However, two important distinctions can be made with regard to congregational support. First, fellow congregants can offer spiritual support to one another, a distinctively different type of support. For example, two people from the same congregation might pray for and with one another or study religious teachings together. This type of relationship has the potential to provide reciprocal support between the two people involved, and also serves as a source of connection to faith. Second, congregations are groups based on shared values and beliefs among members, on which a foundation of trust and a sense of solidarity has developed among group members over time.

Spiritual support is provided among people of a shared faith who assist one another in further developing religious beliefs and behaviors to manage stressors (Krause, 2002). Fellow congregants can provide support to older adults by talking about their own spiritual experiences and how the older adult can draw on their faith during times of stress. Similarly, an older adult can articulate their own spiritual experiences, including their past efforts to make sense of loss and change. The provision of spiritual support fosters a sense of understanding between the older adult and the supportive other and simultaneously builds coping skills that the older adult can implement when he or she is faced with coping with a stressor on one's own.

Spiritual support can connect older adults to supportive others who share their faith, which may also help with strengthening their sense of control. People who are left alone to manage the stress of loneliness may also be in need of establishing some sense of control over their own lives.

Berrenberg (1987) introduced the concept of God-mediated control, which is loosely defined as a perception of control from believing God will play a role in intervening with stressful life events. God-mediated control is developed through a relationship with God and can be strengthened through relationships with supportive others within a congregation (Krause, 2007). As members from the congregation support one another, they can also collectively draw on religious teachings and their spiritual practices in managing life stressors. Social connections developed among fellow congregants might provide needed social support to otherwise socially isolated older adults while providing opportunities to further develop both people's relationships with God. While fellow congregants might provide more tangible forms of support, older adults might also look to God for guidance in balancing stressors in their lives.

Emotional support can aid in maintaining a sense of self-worth and closeness with others. This can be particularly helpful in addressing emotional loneliness through building friendships and regular social interaction. Having unconditional support from others who are willing to listen empathically develops a support system through which older adults can respond to stressors and receive feedback from trusted others. These relationships can be some of the closest of relationships that older adults build. Because relationships formed with age-mates within the church may be long term, they may also pose significant loss when someone becomes ill or dies. This risk points to the importance of facilitating bonds and linkages between older adults and younger generations within the church as well. Cross-generational relationships might also be developed into close, trusted social ties which provide an opportunity to maintain or regain companionship within the lives of older adults. In building close personal relationships with others within the church, older adults might also find ways to provide support, wisdom, and a listening ear for others.

Receiving emotional support is important, but being able to give emotional support to others also has a lasting impact on an older adult's self-esteem and quality of life. Providing support to others is so important to wellbeing that Rowe and Kahn (1998) included helping others in their concept of successful aging. Congregations present a unique opportunity for older adults to be incorporated into a family-like network of people who both receive and provide support for others over time (Krause, 2006).

Tangible support is the type of assistance provided to meet needs that occur when a person lacks resources. Tangible support might include having someone come to the home to clean or prepare a meal for an isolated older adult. This type of support alone is not likely to decrease significant social loneliness. However, when paired with spiritual and/or emotional support it may decrease loneliness in an older adult's life and serve as a concrete reminder that the older adult is not alone and not forgotten. Because someone

is actually coming to actively do something for the older adult, this may also increase the older adult's anticipated support. They will believe that others might be likely to come help them during a time of need. Additionally, within a diverse group of people such as a congregation, many different types of people, including older adults themselves, may seek to volunteer time to provide tangible support and outreach to other older adults.

Anticipated support is associated with the belief that certain supports will be available when an individual needs them (Wethington & Kessler, 1986). Because individuals with anticipated support believe that they have a source of support available when they need it most, this provides opportunities for the older adult to try to manage a stressor independently and then call on the supportive others when necessary. This means that an older adult with higher levels of anticipated support may be more likely to attempt to self-regulate negative emotions experienced when alone. Having a supportive network from which to develop anticipated support can also sustain older adults with the hope that their situation can and will be different in the future. Even if they are alone, they may be less likely to feel isolated and lonely when they develop anticipated support in the context of a cohesive network of supportive others. Anticipated support is the feeling of reassurance that if life becomes overwhelmingly stressful, someone is available and willing to provide support. In this way, people who are socially isolated may be less likely to feel lonely because they feel connected to a community in which they belong. Anticipated support has been shown to impact older adults more positively over time than enacted support (Krause, 2006) because they have both a sense of belonging and also are able to develop some autonomy in managing stressors. Congregations may be especially good sources of increasing anticipated support.

Because fellow congregation members can provide the specific types of support that older adults need, congregations hold resources that could significantly impact the lives of older adults within congregational communities. However, the issue of how to organize and mobilize such support remains. Although a significant body of research has been generated about the deleterious effects of social isolation and loneliness, little progress has been made toward identifying effective interventions (Rubin, 2017).

Congregational Social Work

For social workers, addressing social isolation and loneliness to improve quality of life of older adults is paramount. As noted earlier, Lubben et al. (2015) identified social isolation as a grand challenge for social work, and issued a call for social workers and social work scholars to focus efforts in this area. Because congregations tend to be socially cohesive communities where support for older adults can be leveraged, social workers using community

development and community organizing skills within a congregation as a practice setting can aide in linking older adults to critical supports. Congregational social workers are well positioned to promote various types of support among congregational members that address needs of lonely older adults. For social workers volunteering or employed by their own congregations, the opportunity to build connections among fellow congregants is ever present.

Using information about different types of social support that congregation-based ties can provide for isolated older adults, congregational social workers may develop both formal and informal programs to reduce loneliness. Congregational social workers can conduct needs assessments within the congregation, identifying those who are socially isolated or at risk for social isolation or loneliness based on factors discussed earlier in this paper, such as experiencing the loss or absence of close relationships, living alone, lacking transportation, or living with a cognitive impairment. Social workers could also engage the broader congregation about how to reach out to those who are isolated while also asking those who are isolated how they would like to be involved in their congregation. Social workers could develop initiatives along with the congregation members to promote the health and wellbeing of all members. Working from a community development framework, social workers can coordinate volunteer efforts to connect with isolated members by developing outreach, visitation, Meals-on-Wheels, and other volunteer programs. They could also design methods to evaluate the services provided.

Congregational social workers might also be able to provide various activities in order to build different types of support including tangible, emotional, spiritual, and anticipated support. Social workers can provide education sessions to members about the different types of activities that volunteers might do with isolated older adults and develop a call to action along with those who are interested in volunteering. When recruiting volunteers, the congregational social worker can discuss the benefits for volunteers who would like to provide support to older adults and also for older adults who would like to volunteer in some capacity themselves.

A congregational social worker might coordinate activities to provide tangible support for older adults who are in need of specific resources. One example might be arranging transportation for older adults no longer able to attend worship services or other congregational activities on their own. They also might be able to enlist the help of people within the congregation to make repairs or modifications to an older adult's home to better support them in their living environment. This could also build older adults' anticipated support, as seeing people within the church mobilize to provide them with needed repairs or transportation would provide evidence that a group of people are available to them and willing to help them meet their needs.

Activities can be designed to promote engagement of those who are isolated, and reconnect former members with their congregation family (e.g., by visits, telephone, other technology). This will provide an opportunity for lonely and isolated older adults to interact with fellow congregants, and it will also present an opportunity for volunteers within the congregation to experience the reciprocal benefits associated with providing support to others. Indeed, congregational social workers may be able to work with older adults to rebuild and practice social skills within the congregation as well. They can promote intergenerational activities involving children, adolescents, and young adults. In addition, congregational social workers can make regular visits to home-bound older adults to assess what support is needed and how to orchestrate it. Such activities can bolster emotional and anticipated support.

Congregational social workers may also ensure that older adults remain connected with the congregation in other ways. For home-bound older adults, social workers may provide bulletins, audio recordings of services, or other information. Social workers may help them stay connected by serving communion in their homes. They may also include isolated older adults on visitation lists so that church members might visit with older adults to provide and receive spiritual support. This might give older adults an opportunity to share their experiences with others and give them a sense of belonging and purpose.

On limited occasions, congregational social workers may themselves provide various types of support directly, but their efforts will be most sustainable and long-lasting if they can activate and monitor the efforts of other members to provide support. Given their theologies and relationship networks, congregations may be primed to assist lonely older adults. As naturally occurring communities, congregations have great potential for providing sustained and multi-dimensional support. However, congregations may fail to respond, or lack organization in responding to social isolation in older adults, without the leadership provided by congregational social workers. ❖

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Remembering Faith: Rural Faith Communities' Outreach to Members with Dementia

Kenneth Flanagan

Dementia affects an increasing number of individuals, families, and communities, a trend that is expected to rise significantly during the coming decades. This increase in the number of people coping with dementia will continue to challenge family caregivers, churches, and other groups these individuals belonged to prior to the onset of dementia. The faith community of a person and family can serve as an anchor and source of social support during these life transitions. The study deepens our understanding of how rural congregations respond to dementia-related issues when other formal service resources are not readily available or accessible.

DEMENTIA AND THE RESOURCES NEEDED FOR ITS TREATMENT ARE receiving increased attention in the literature, as the anticipated number of individuals who will be diagnosed with a dementia-related condition increases in the coming decades. Over 5 million people in the United States have dementia, and 15 million people are providing unpaid care for those with the disease (Alzheimer's Association, 2013). The number of people with dementia is expected to climb to 16 million by 2050 (Alzheimer's Association, 2013). Globally, approximately 37 million people have dementia; this number is expected to double during the next 20 years (World Health Organization, 2012).

According to the Alzheimer's Association Fact Sheet (2013), 450,000 people will die this year in the United States as the result of the condition, and this number is on the rise. The cost for providing care to people with Alzheimer's in the United States was expected to exceed $206 billion in 2013.

In North Dakota, 18,000 individuals were diagnosed with Alzheimer's in 2010, up from 16,000 in 2000. By 2020 this number is expected to increase to 19,000 (Alzheimer's Association, 2013). This number does

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not include those diagnosed with other forms of dementia. In 2010 there were 361 deaths in North Dakota due to Alzheimer's disease, making it the state with the highest death rate from Alzheimer's in the United States (Alzheimer's Association, 2013).

Overview of Dementia

Dementia is a term that describes a range of symptoms associated with a decline in memory or other thinking skills. In addition, dementia can affect emotions and a person's personality over time (Jolley et al., 2010). Dementia can become so severe that it reduces a person's ability to perform everyday activities (Alzheimer's Association, 2013).

The most prevalent form of dementia is Alzheimer's disease; 60–80% of individuals with dementia have this condition (Alzheimer's Association, 2015). Alzheimer's disease is a degenerative disease of the brain that can gradually result in loss of memory and judgment and impair activities of daily living.

Sometimes there is confusion between dementia and Alzheimer's disease. Dementia is a symptom of Alzheimer's disease; however, dementia can be diagnosed and experienced without a diagnosis of Alzheimer's disease.

Besides Alzheimer's disease, there are a number of conditions that can lead to the development of symptoms associated with dementia. One is vascular dementia, which develops as the result of strokes. An estimated 10% of individuals with dementia have this condition. Others develop dementia as the result of Lewy bodies. In this condition, there is a buildup of protein alpha-synuclein in the cortex of the brain, leading to dementia symptoms. Individuals with Parkinson's can experience dementia as that disease progresses (Alzheimer's Association, 2013). People can also develop dementia because of a drug interaction, a vitamin deficiency, a chemical imbalance, and a wide range of other situations. In these cases, when dementia is caused by other pathologies, dementia can be reversed (Jolley et al., 2010).

There are a number of common signs and symptoms associated with dementia. They include problems with attention, episodic memory deficits and/or short-term memory deficits, common reasoning function limitations, a decrease in perceptual abilities and language functioning, along with social behavior challenges (American Speech Language Hearing Association, 2015). These symptoms can lead to challenges with communication and activities of daily living.

While all these symptoms are associated with dementia in general, certain types of diagnoses result in symptoms common for those conditions. For example, people with Alzheimer's disease have difficulty with short-term memory during the early course of the disease, with later symptoms including

impaired communication, confusion, and difficulty with speaking, swallowing, and walking. In contrast, those who experience dementia as the result of vascular problems will often experience impaired judgment and difficulty with planning and decision making rather than memory loss (American Speech Language Hearing Association, 2015).

One of the consequences of Alzheimer's disease and other types of dementia is the loss of social connectedness that occurs over time (Svanstrom & Dahlberg, 2004). Social connectedness is defined as the degree to which a person is socially close, interrelated, or shares resources with other people (CDC, 2011). Social connectedness can become a challenge for older adults in general because of a number of factors, including a decrease in the size of the social network, physical health issues, role changes, and fewer opportunities to engage with others (Cornwell & Waite, 2009). Older adults with dementia encounter even more challenges in maintaining social connectedness because of dementia-related changes that create barriers to relational development and maintenance.

This loss of social connectedness is often related to the cognitive and behavioral changes experienced by those with dementia. These include

- inappropriate behavior outside of a socially acceptable range
- inability to read facial expressions and other social cues
- loss of empathy
- mood fluctuations, including agitation and crying
- restlessness
- depression
- negative reaction to questioning
- combativeness/hostility/aggressiveness
- compulsive or obsessive behaviors
- erratic or strange behaviors
- loss of initiative/motivation
- paranoia and delusions of persecution
  (American Speech Language Association, 2015)

Maintaining social contact is important because people with mild dementia who have higher levels of social connectedness are more likely to be able to remain in their own homes and communities (Nikmat, Hawthorne, & Al-Mashoor, 2013), and thus a significant challenge for older adults with dementia is to maintain social relationships. Friendship is an important form of social relationship and provides meaning to the human experience (Harris, 2012). Recent research has demonstrated that friendships, whether short term or long term, can serve a protective function against some of the effects of dementia (Bennet, Schneider, Tang, Arnold, & Wilson, 2006; Harris, 2012; Van Dijkhuizen, Clare, & Pearce, 2006). As dementia becomes more pronounced, however, the person experiences

a decline in the number of friendships, as others become uncomfortable with the disease progression and are at a loss as to how to maintain the friendship (Harris, 2012). One of the reasons for the decline in these social relationships is the difficulty maintaining conversation with the affected person, and conversation is the vehicle by which we verbally communicate with others. Those individuals with dementia experience difficulty with the cognition and verbalization skills needed to engage with others in conversation (Mok & Müller, 2014).

However, conversation allows the person with dementia to remain connected to others, as well as maintain a connection with a familiar external environment. One familiar social institution that provides this connection is the church. During recent years there has been increased attention on the effect of spirituality and religion in the lives of those with dementia (Dakin, 2009; MacKinlay, 2011). In rural communities, older adults often turn to pastors for assistance (Campbell, Gordon, & Chandler, 2002). The church can provide a link between a person's past and their currently blurred present; the church, with its rituals and traditions, can be an anchor for those coping with this condition.

For some older adults, the church has always been, and can continue to be, a source of social connectedness and thus prevent premature placement in more restrictive levels of care. In a study by Conner and Nemeth (2010), religious and social supports provided at the church site and in the home were identified as key to providing assistance to people with dementia and their caregivers, resulting in delays in moving to more restrictive levels of care. In rural areas in particular, churches take on a role that extends beyond the personal experience of rituals and traditions to a role of providing cohesiveness and a symbol of history in rural communities (Neitz, 2005). This role is due to the nature and dynamics associated with rural communities.

Although a consensus of what constitutes a rural community does not exist, some common characteristics are associated with rural communities (Ginsberg, 2005), such as a low population, scarcer resources leading to use of an informal network to respond to needs, and an emphasis on community (Flanagan, Heitkamp, Nedegaard, & Jayasundara, 2014). In rural communities, there is an emphasis on the reliance upon personal and informal relationships to respond to needs, both material and emotional (Greenfield, 2009). The term gemeinshaft describes this social and cultural orientation of rural communities (Greenfield, 2009).

Rural life is grounded in place, and institutions such as the church emerge as an important focus within rural communities (Neitz, 2005). The Scandinavian farm families that settled much of North Dakota "preserved their cultures and forged communities" in the church, according to a New York Times article (Brown, 2002) regarding the increasing number of abandoned

churches in North Dakota. One of the people quoted in the article, North Dakota resident Dale Bentley, said, "The little churches speak of the human connection to the land." Another resident, Kim Nesvig, said, "When I was growing up, often the only occasion during the week where farm people got to socialize was at the church. It was a place to shoot the breeze." The church provides connections that give meaning to life experiences.

In North Dakota, involvement with faith communities is an important aspect of life for many residents. In a recent survey of states by the Association of Religious Data Archives (2010), North Dakota ranked fifth in the nation in terms of the number of congregations per 10,000 people. In 2000, North Dakota ranked first in the nation. These rankings highlight the importance that faith communities have for many North Dakotans and the potential effect the churches can have in providing care and outreach to members coping with dementia-related conditions. Because congregations have significant numbers of individuals who are older than 65, they reflect a population that needs to address the issue of dementia (McFadden, 2012). About 10% of congregation members nationwide suffer with dementia, according to a report from the Alabama Dementia Education and Training Program (2006).

Theoretical Framework

This study is exploratory in nature; it is an initial attempt to gain understanding of the relationship between a person with dementia and his or her faith community. A theoretical framework that is of use in this exploration is that of personhood. This framework was developed by Tom Kitwood (1997) and has provided the foundation for the development of person-centered care, which is increasingly being used to provide care to those with dementia. According to Kitwood in his seminal work, Dementia Reconsidered, the person is to be put first and not to be minimized by others, particularly by care providers. Kitwood also stresses the influence interpersonal relationships have on one's sense of personhood, as reflected in his statement, "The standing or status that is bestowed upon one human being, by others, is in the context of relationship and social being" (p. 8). Kitwood's framework fits well with the scope of this study, which is focused on the importance and significance of interpersonal relationships that are formed within faith communities.

Some have referred to dementia as "the theological disease," as it fundamentally challenges one's sense of selfhood as the reflection of God (McFadden, 2012). The concepts associated with the personhood framework provide the basis for theological as well as sociological reflection around the issues of dementia, personhood, and relationships, both human and divine.

Method

This exploratory study focused on how rural faith communities in North Dakota reach out to members of their congregations who are experiencing dementia, and how they plan to respond as members age and may in the future experience dementia. The study identified strategies that faith communities use to keep members connected to their spiritual homes and experience less social isolation, and sought to gain an understanding of how rural congregations respond to dementia-related issues when other formal service resources are not readily available or accessible.

The congregations targeted for participation were Roman Catholic parishes and Evangelical Lutheran Church in America congregations. North Dakotans belong to these two denominations more than any others. According to the U.S. Religion Census for 2010, conducted by the Association of Statisticians of American Religious Bodies (2012), 167,000 North Dakota residents belong to the Roman Catholic Church and 163,000 are members of the Evangelical Lutheran Church in America, out of a total population of 673,000.

The focus of the study was on rural faith communities, so congregations in the cities of Bismarck, Fargo, and Grand Forks were excluded. These larger cities have resources and services not available in more rural communities. In order to have representation from all areas of the state, congregations from the eastern and western sides of North Dakota were included. Since this was an exploratory study, the sample size consisted of 12 individuals. These individuals were pastors or pastoral associates within the congregations contacted. A snowball sampling approach was used to identify participants. The researcher conducted a semi-structured face-to-face interview at the congregational site. Some of the pastors had responsibility for more than one congregation, which increased the number of congregations reviewed beyond the expected 12. The study assessed 17 rural congregations covering all areas of North Dakota. The interviews were tape-recorded with permission of the participants, who completed the necessary consent forms prior to the interviews as required by the Institutional Review Board. No remuneration was given for participation. Upon completion of the interviews the data was reviewed, transcribed, and coded using content analysis that systematically identifies and categorizes themes in qualitative analysis.

Results

The analysis of the interviews revealed a number of common themes. These common themes are a respect for the individual with dementia, a respect for the disease and its impact, the use of a binary care delivery system,

and an awareness that, in the end, it's about community. The faith communities that were included in this study displayed all of these characteristics.

Theme 1: A Respect for the Individual With Dementia

A constant theme throughout the interviews was a respect for the individual regardless of the degree of limitations due to dementia. Pastors referred numerous times to the fact that the individual is created in the image of God and needs to be responded to as such. This approach is consistent with the Christian scriptures, as well as with the personhood framework identified earlier in this article. This separating of the person from the disease suggests that those involved with pastoral care of people with dementia see beyond the challenges, limitations, and difficulties currently being dealt with. Referring back to the personhood framework, this orientation allows for the development and maintenance of interpersonal relationships where personhood is recognized, even though the person with dementia might not recognize his or her own personhood. As shared by the pastors,

> *People are the image of God, the Imago Dei.*
>
> *We want to be respectful. We remember what was done in their younger days for the church and community.*

Theme 2: A Respect for the Condition of Dementia and Its Effects

The interviews revealed a respect for the condition and its effect on the individual. The pastors expressed a desire to "work with" rather than against the dementia, not ignoring or minimizing its reality and effect on the person and other family members. There seems to be a willingness to tolerate how the disease is manifested and to work toward maintaining the relationship.

> *I correct people who are saying, "They are having hallucinations and seeing things that aren't there." I say, "No, they are not. They are seeing things you can't see; there's a big difference."*
>
> *You encounter different levels of memory issues. Sometimes it's a weird conversation to be able to make, to be comfortable with the discomfort. A person in our congregation brings up people's names and events but we have no clue of who these people are or these events.*
>
> *A member of our congregation brings us a lot of joy and she'll say things that are funny and often times will joke and laugh*

> *with us. One day she said something, and we laughed. She said, "Oh, now you're making fun of me," and she was serious. We really felt bad so we're very careful about that, but we share this story with our volunteers because we want to be careful.*
>
> *I work really hard just to be with them where they're at. If they're getting ready to cook for company from Norway, we just talk about cooking for company from Norway. Just kind of go back to whatever point in their life, that is where they're at that day.*
>
> *I had this woman who would repeat a traumatic life event that occurred in her young adulthood. Every time I saw her, she would share this story with me, which meant that clearly it was something that not only was important to her, but it hurt. She went from having a smile to this very serious look when she told me this story. Then she'd come out of it. Clearly something very important was being worked out.*

The pastors' responses reflect a ministry of presence. A faith presence has been described as accompanying a person on the journey of life (Monahan & Renehan, 1998). Some qualities associated with this approach are being open, inviting, and accepting (Covington, 2003). The comments reflect this approach and demonstrate the difference between pastoral care and care provided by other professionals. The ethics of pastoral care encourage being there for the person as an end in itself, whereas care provided by social workers and other care providers may incorporate a presence-based approach but for a different end, a professional intervention based on assessment, and, at times, diagnosis. In other words, presence is an approach used to implement other goals.

Theme 3: A Binary Care Delivery System

A consistent comment made in the interviews was that individuals with dementia tend to remain in their homes for as long as possible, using family and other support services. Once a person's condition reaches the point when that is not enough, he or she moves into a nursing home facility. This reflects the reality of a care delivery system that does not have the ability to provide mid-range services in the home or other environments. It suggests the either/or type of care delivery system that exists within rural communities.

Partnership. There seems to be not only awareness but also desire to work in partnership with other community care providers in order to meet the multiple needs of the person with dementia.

> *We always recognize our role in partnership with everyone else, whether that be the hospital or nurses or at the care center and other service providers.*

> *One of the first things I do when I come to a community is to get a list of resources and providers, because you never know when you are going to need them.*

Use of church informal networks and community-based services. The pastors are aware of the limitations of the current availability of services to meet the needs of those with moderate and severe levels of dementia and the need for a more expansive care delivery system that can provide services in the mid-level range to rural communities.

> *Some older members with dementia can remain somewhat active if they retain some physical abilities. But those who experience physical limitations are likely to end up in the nursing home.*

> *By and large, outreach is informal. We don't have anything, officially, kind of organized, but it's a small town. Neighbors helping neighbors. So often it's members of the congregation helping out, keeping an eye on, providing rides and doing those types of things. Sometimes there may be some family connections.*

Limited availability of more advanced services. However, once care moves beyond being informal or of a maintenance level, the options are more limited.

> *I would like to see us do more work on alternatives for dealing with dementia and helping people to do that.*

> *There doesn't seem to be a lot of services available to sort of meet the demands.*

> *One of my concerns is for people living alone. They really pride themselves on this: They want to stay in their homes. That can be a good thing up to a point, but when it gets to create isolation, that is a problem.*

Distance can be an issue, particularly if the individual is placed in a protective environment. This becomes an issue because memory care units are concentrated only in certain areas.

> *When people get to a point where they need memory care, which we do not have around here, they get moved and fall off the radar a little bit.*

A member of the congregation fell and was living by himself here in town, but eventually had to be placed in a home away from the community. When that distance happens then the faith community over time becomes disconnected. I try to visit but it becomes tough.

Theme 4: In the End, It's About Community

The theme of community was mentioned by all the pastors. It seems that their desire is to bring together people and have them remain connected. This notion of community is a distinguishing characteristic of the Christian faith and allows people, even those with dementia, a "place" to experience God and relationships. Creating this "place" or this "space" becomes a challenge for the pastors. How do they maintain community in the midst of the personal disintegration experienced by those with dementia, particularly in the later stages?

It's the loss of community that brings the loss of being. There are people like Dietrich Bonhoeffer, in particular, who really argued that. That's why people say I can worship God out on the boat and stuff, but are missing the point that God gathers together people to this imperfect and frustrating thing called community. We are only fully alive when we are in community. So, do those people lose being? Yes, not because of their disease, but because of the isolation.

The people are pretty faithful with one another. I knew some folks who would visit a person over and over, even when they are in tough shape, and it's heartbreaking. I think that duty and obligation to this person and their relationship with them make them continue to try to stay connected in spite of the difficulty.

God is here. God is here in community. I really believe that.

We have challenges in moving away from this thinking that it is the pastor's job to do this. This is the body of Christ's job. This is our church's job. This is our call. We are not a glorified country club. We cannot serve because it is safe and is easy or it makes me feel good.

It's all tied to community. I mean, that's what it really is tied into is a sense of community regardless of your age. Because if you just hang around long enough, you're going to get older.

> *So, if you're in a community, that community should support you through it.*

Use of rituals. A means to maintain connection within the context of community with this population is through the use of rituals. The two Christian denominations involved with this study are strongly liturgical, which means members have experienced a spirituality that has a repetitive dimension to it and is used to relate to members as they advance through the stages of dementia.

> *So, I am visiting with somebody at the bedside. They can't talk, they can't do anything, but as soon as I make a sign of the cross, they are right there. Certain prayers, music seem like it's engrained. It doesn't quite leave, which I guess is a gift.*

> *I mean she could say every damn word of the Lord's Prayer. It's the only time she ever spoke or made a sound, so the power of that kind of repetition is an advantage.*

> *I'm amazed when people have been completely nonresponsive and how many times we go into the Lord's Prayer and they pray with us. This happens with "Amazing Grace," all of a sudden, they start singing "Amazing Grace."*

> *What is interesting is how praying the Lord's Prayer or maybe Psalm 23 stays longer than anything else. You can see their mouths moving with yours.*

Theological issues. Connected to this notion of community is how to theologically ponder the condition of dementia and the struggle members of the faith community have when reconciling faith with the reality of personal disintegration by those experiencing dementia. The pastors expressed a sense that as a faith community, there is a need to develop a theology of dementia. Such a theology could situate this condition within the experience of faith.

> *I visited with congregation members and wondered how coherent do you need to be to receive communion? The most basic care as a pastor that I can give you is the word and sacrament. Well, if you can't come to a service or through a visit hear the word and receive the sacrament, what can I do for you other than these things and to pray for you?*

> *At some level, if we recover the mystery of the church, where it's a healing body of Christ, then miracles happen.*

> *A number of people have talked about that there is almost a theological dimension to it, of trying to understand God's working in the midst of people who don't have that awareness of even who they are. There just doesn't seem to be the theological perspective of still being able to see this as being valuable.*

> *I always try to give communion. I think it is a gift from God. So, in my mind it doesn't matter if the person doesn't quite grasp anymore what communion is about. I still feel God is communicating his love and grace to them.*

Training to assist with building community. The pastors consistently identified the need for training for all individuals working with this population. Training assists both the ordained and lay members of the faith community to develop the ability to relate to members with dementia and provide a potentially mutually beneficial experience of community connectedness.

> *Good to have training about Alzheimer's disease and dementia, that would be something for us to be a little more aware of, not just the physical needs but also mental needs, too.*

> *I think we could use training, to understand their plight and learn how to relate to these individuals with dementia better.*

> *We do training of lay leaders around this issue. We'll talk about Alzheimer's and kind of how it's okay to just be with people. You don't have to correct people, just be with them where they are. If they're in a place with pictures, pick up the pictures and say, "Well, who is this?" Talk about the people in the picture, just some touch points so they have something to talk about.*

> *Give people some kind of time to go do some of this work out there and then give them a chance to talk about it. Was it scary or what did you notice? I think that's good. Provide the support on the back end. Let's come back and process what we've seen.*

Discussion

The study provides some insight into how those who exercise pastoral responsibility relate to members of their congregations who are dealing with dementia. All of the pastors who participated in the study demonstrated genuine concern and respect for the affected members and their families as they journey through the progression of this condition. In addition, the pastors were able to see the person independently of their condition. This most

likely is due to their theological training and personal faith experiences. The person takes precedence over the disease. In this respect, those of us in the "helping professions" can learn something from the pastors regarding how to incorporate this differentiation of the person from their condition. Social workers sometimes see the two aspects together, leading to assumptions and approaches that can be counterproductive to healthy interventions.

The study also highlights the importance of community and the responsibility church leaders have in developing a sense of togetherness among members of the congregation. This togetherness is what allows the faith community to accompany those coping with dementia-related conditions. At the same time, the faith community requires its members to deal with the mystery of faith, particularly in the midst of suffering. This raises theological and existential questions that need to be explored. What is the meaning of suffering? How do suffering and loss influence faith perspectives, and are there meanings associated with these experiences? The pastors allowed themselves to delve into these existential questions and areas, working with them rather than denying them. These issues need to be placed within a theological framework, particularly in light of advances in medical technology and other health care developments. The social work field also needs to explore these issues and develop a framework that incorporates these existential questions. These issues of respect, community, meaning within a personhood perspective and a person-centered approach are what social work as a profession needs to delineate.

Implications

Rural communities face numerous challenges, including issues related to decreasing membership in faith communities. This decrease in membership is often tied to decreases in population in rural communities (USDA, 2014). In the United States, there has been a decrease in the percentage of the population residing in rural areas (USDA, 2014). In North Dakota, for example, there was a 26% decrease in the overall rural population between 1960 and 2010 (Larson, 2015). This decrease creates challenges for faith congregations in enlisting new members to sustain their congregations, leading to challenges in terms of having the fiscal and personnel resources to create pastoral activities to create dynamic faith environments.

Although there are certainly challenges for rural faith communities in their ability to reach out and support members with dementia, there are also opportunities. These opportunities are rooted in the relationships that can develop in rural communities. As was mentioned previously, rural communities have been referred to as having a *gemeinschaft* orientation, that is, a focus on the personal and informal networks that provide support (Harris, 2001). This type of orientation can provide the opportunity for

rural faith congregations to build upon those personal relationships and grow their communities.

Social workers are trained to intervene at the micro and macro levels. Practitioners have a number of intervention modalities available to improve the quality of life of those coping with dementia-related conditions. At the micro or direct service level, social workers can use their skills to work with pastoral care staff and congregations to develop and maintain the informal and formal approaches to care. They can serve as a resource for congregations, family members, and individuals by referring and coordinating care services and using case management strategies.

Social workers can work directly with individuals and provide counseling-related services. Research has demonstrated that individuals with dementia can engage with and benefit from a range of psychological and talk-orientated counseling services (Minghella & Schneider, 2012). Consideration should be given to the use of existential approaches. As the interview narratives reveal, individuals with dementia can work through emotional issues related to earlier life experiences and have memories that create discomfort for them. Some counseling approaches, including reminiscing and life review, can be helpful (Lantz & Walsh, 2007). Social workers' unwillingness or inability to craft approaches that permit movement toward resolution of emotional conflicts can limit and compromise the quality of life of people with dementia.

This study reveals a need for professional social workers and other care providers to experience an attitudinal change in their work with this population. The personhood perspective and framework for intervention challenges us to view each individual with dementia as a person with a history and current existence that has worth beyond the challenges associated with dementia. The pastors' approaches reflect some of the characteristics consistent with a personhood perspective. The narratives reveal that for the most part, individuals responded to this approach with ease, contributing to relational development between members of the faith community and people dealing with dementia.

It would be beneficial for social workers to intervene also at the macro level. A number of pastors highlighted the need for a wider range of services for individuals with moderate to severe levels of dementia. Creating this range of services would involve partnering with other service providers, congregations, and political leaders to advocate for policies, services, and funding to allow for the development of a more intensive level of services in rural communities. This partnering could change the paradigm of a binary care service delivery system that leads to increased institutionalization of people with dementia. Here, too, an attitudinal change is needed. There is a prevailing attitude that individuals with moderate to severe levels of dementia are in need of more restrictive levels of care, such as nursing homes. In our

nation's social welfare history, individuals with moderate to severe levels of intellectual disabilities were once viewed as needing a level of care requiring institutionalization, which led to a significant number of individuals being institutionalized. People with dementia may be headed in the same direction unless we change our conceptualization of dementia and its service needs. One of the contributing factors that led to a change from an institutionalization mind-set for individuals with intellectual disabilities was a move away from an emphasis on the medical model to a functional approach to service delivery. The movement to this functional approach allowed for services and service sites to be based on a person's functional skill level, rather than on a diagnosis. Thus, an individual in the moderate to severe level of intellectual disability could remain at home in the community rather than experience institutionalization. A shift to this approach for people with dementia would permit a redesign of the current binary care service delivery system.

Finally, social workers possess a skill set and expertise to be of service to congregations as they develop and maintain outreach to members with dementia. Social workers can assist pastoral staff and other congregational volunteers to increase their knowledge and skills in working with individuals with dementia. Social workers can also become involved with various psycho-educational workshops open to members of the congregation and the general public. One of the congregations involved with this study conducted a well-received community-wide workshop in conjunction with the Alzheimer's Association.

Another area of involvement for social workers is organizing various support groups for individuals with dementia and their caregivers and family members. Ideally, lay leaders within the congregation would provide leadership and maintain these groups. The development of resource materials is another valuable contribution social workers can make in this realm.

Limitations

This study explored how rural faith communities in North Dakota reach out to members of their congregations who are experiencing dementia or how they plan to respond as members age and may, in the future, experience dementia. The study involved one primarily rural state located in the upper Midwest. It would be beneficial in future research to expand to rural areas in states other than those that are primarily rural to determine if some of the findings of this study turn out to be similar to the experiences of other states. Also, the study limited itself to two Christian denominations. Future studies that incorporate various other faith communities would be beneficial for detecting similarities or differences among them. This study consisted of only 12 pastors, and future studies expanding upon that number would allow for greater generalizability.

Conclusion

This study attempted to assess the current or planned outreach of rural faith communities to congregation members who are coping with dementia. The study involved interviewing 12 pastors who provided insight into the faith life of their congregations and their outreach to members with dementia. One of the major takeaways of this study is an increased awareness of how pastors are genuinely concerned about the needs of this segment of their congregations and their desire to effectively engage others in partnership in order to improve the quality of life of members with dementia. The personhood perspective is a foundational element of the pastors' involvement with this population. Social workers are challenged to offer their skills and expertise in order to assist pastoral staff and congregations in this endeavor. ❖

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Keywords: Dementia, Faith Communities, Social Support; Older adults

Congregational and Social Work Responses to Older Survivors of Natural/ Human Disasters

James W. Ellor & Margaret Mayo

Abstract

Older adults suffer chaos and loss along with others in any community impacted by a disaster. Whether the disaster is caused by human actions such as a mass shooting or by the forces of nature such as a hurricane or tornado, all disasters challenge the capacity of older persons to survive the encounter and adapt to the new reality they face. Unfortunately, the fragility of this age group makes them significantly more vulnerable than younger persons. Depending on the extent to which they are directly affected, congregations are in a unique position to provide material, emotional, and spiritual resources for long-term recovery as well as offer a context for social work practice aimed at disaster relief. This article focuses on the impact of natural or human disasters on the older population and the responses of congregations and congregationally-affiliated social workers to these devastating and unanticipated events.

Current evidence informs understanding of the physical and psychosocial impact of natural/human disasters on vulnerable older survivors. Factors that contribute to resilience, including spirituality and religious involvement, are addressed. Within each phase of the disaster cycle—pre-event preparation, post-event/acute phase, and post-event/long-term phase—prescriptions for congregational and social work engagement that support resilient outcomes for older survivors are provided. Emphasis is placed on emotional and spiritual support throughout the process. Unique contributions of micro and macro social work practice are highlighted.

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Introduction

When the community is impacted by a hurricane or church shooting, the entire community is affected and all suffer, regardless of age. For example, Moran (2017) reported that the 2017 California wild fires killed forty-two people; the youngest was fourteen and the oldest was one hundred. While the recovery process is a shared journey for younger and older adults, the older population, like other vulnerable groups, suffers disproportionally. A review of death tolls linked to disasters documents that older adults are more likely to die as the result of a significant disaster than are younger persons. Johnson, Ling, and McBee (2015) found that "while older adults comprised only 15% of the population of New Orleans (USA) prior to Hurricane Katrina, 71% of those who died because of the hurricane were elderly" (p. 72). These mortality differentials, while alarming enough, also draw attention to the physical and psychosocial trauma suffered by older survivors.

One of the challenges in understanding age disparity in the impact of natural/human disasters is the lack of evidence about the consequences of these events for older persons. For example, the American Association of Geriatric Psychiatry (AAGP) noted in its introduction to a position statement on Disaster Preparedness for Older Americans that "little is known about…the psychosocial impact of disaster on the elderly" (Sakauye, Steim, Kennedy, Kirwin, Llorente, Schultz & Srinivasan, 2009, p. 917). Researchers' capacity to plan well-designed studies and procure adequate funding is further challenged by the unpredictability of disasters. Consequently, the information that is available is often found in newsletters, informal training documents, and anecdotal experiences. When documentation is available, it focuses on events that attract national attention, such as the Charleston church shooting, Hurricane Matthew, or, more recently, Hurricane Harvey. Although significant, this results in minimal examination of the effects of most disaster events on older persons (Sakauye et al., 2009). In this article, the authors systematically present the most relevant observations and evidence on the impact of natural and human disasters on older persons as well as the current and potential responses of congregations and affiliated social workers to these devastating, life-altering occurrences. Our focus is on the contribution of social work practice to the response of congregations committed to the well-being of vulnerable older survivors.

In this article, congregation refers to a single, locally-based religious organization or to its collaboration with denominational governance structures, religiously-affiliated organizations, and/or public and private disaster relief agencies. Congregational or congregationally-affiliated social work includes practitioners as paid ministers, volunteers, or staff of a community organization that values the contribution of congregations.

We begin by identifying the physical, cognitive, and emotional vulnerabilities for older persons as well as how relocation increases them. We also highlight factors that bolster and diminish resilience. We offer an overview of the ways that congregations respond to these consequences, with a focus on the ministries that address this population in particular. We then propose the unique contribution that social work practioners, working in the congregational context, make during each phase of the disaster recovery cycle as they relate to older survivors, their families, and the community.

Physical, Cognitive, and Emotional Challenges

According to the AAGP position statement (Sakauye et al., 2009), physical, cognitive, and emotional challenges uniquely affect the resilience of older persons traumatized by natural/human disasters.

Physical and Cognitive Challenges

First, and possibly foremost, physical and cognitive health challenges are more common among older adults (Johnson et al., 2015). Health providers commonly note that multiplicity and chronicity are the two distinctives of geriatric medicine (Guralnik, 2004). Pervasive health challenges, such as vision and hearing impairment, set preconditions for vulnerability. Dementia and pre-dementia, and especially Alzheimer Type Dementia, obviously impact older adults and their caregivers more than younger populations (Marcantonio, 2004).

Older adults are more likely to have co-occurring, multiple health challenges and these are complicated by having more than one chronic condition. Depending on what these conditions are, they can combine to exacerbate the traumatizing effect. For example, when the fertilizer plant exploded in the Texas community of West in 2013, older persons experienced more disabling chronic hearing loss. When this hearing challenge was combined with high blood pressure from stress, physical health and emotional health were immediately marginalized (Ellor & Dolan, 2016). For any person, blood pressure can increase due to stress (Dorn, Yzermans, Guijt, & van der Zee, 2006), but when the person also cannot hear well enough to understand what is happening, it makes the event even more stressful.

Emotional Challenges

The AAGP position statement (Sakauye et al., 2009) notes concern for older persons with past histories of psychiatric diagnoses as well as

older persons who are challenged as they cope with a current disaster. The observation by Ellor and Dolan (2016) that there are three groups of responses to disasters among adults can be applied to understanding how older adults react emotionally to disasters. Their typology is based on the intersect between the traumatic event and the presence or absence of current and past predisposing factors. The first group of older persons experience relative emotional wellness prior to the disaster event and accommodates the losses with emotional reactions within boundaries appropriate for the magnitude of the event. Emotional equilibrium is reestablished in a way that promotes productive adaptation. A second group struggles with physical and emotional vulnerabilities prior to the event. Older persons in this group experience the physical and cognitive challenges described earlier and/or the loss of a spouse, adaptation to retirement, or other psychosocial difficulty. When the stress of the event is added to these prior concerns, a multiplier effect may produce longer term maladaptive emotional reactivity. Holleran (2015), in her discussion of trauma and older adults, points to the second group that combines both physical and emotional concerns as most representative of the responses of older adults. Finally, a third group is older persons with previously established psychiatric illness. Liang (2016) found that "psychological problems, such as depression and anxiety, are prevalent at high levels among earthquake survivors" (p. 1869). Depression at times of a disaster can reflect the multiple losses and significant anxiety that characterize the responses of older persons in the second group, pre-existing anxiety and depression diagnoses, or both. Each of these three groups requires different responses from clergy, social workers, and other mental health professionals (Ellor & Dolan, 2016) wanting to bolster the resilience of older persons and particularly those suffering from stress-related to relocation.

Relocation Effects

Physical relocation intersects with health challenges to further complicate the traumatizing effects. The AAGP report notes that older persons seeking to replace a home after a disaster encounter a barrier to financing even a fifteen-year mortgage due to assumptions about their mortality. Medications are an essential element in health care for older persons living with chronic illness, and seniors who are rapidly evacuated from coastal areas are uprooted from a variety of resources—social, medical, and especially pharmaceutical (Patterson, 2005). After the fertilizer plant explosion demolished a local nursing home, one of the survivors was moved to another nursing home in the next town during the night (Ellor & Dolan, 2016). Unfortunately, she was evacuated so quickly that her hearing aid and glasses were not sent with her, nor was her medical

record. The new nursing home staff observed her as unwilling to talk and barely responsive to the new staff. They also observed her blood pressure going up. One observant nurse practitioner asked, "Where are your glasses and hearing aid?" The patient did not know where these items were. When replacement hearing aids and glasses were obtained a day later, her blood pressure settled down and she became communicative with staff and other residents (Ellor & Dolan, 2016).

Relocation also has a significant impact on older persons living with cognitive impairment and is another one of the significant disaster impact areas for older adults reported by the AAGP (Sakauye et al., 2009). If individuals are in early stages of the dementia, they could be quite functional at home. However, after a disaster and a move to a new environment, they may no longer function in the same way they did prior to the disaster. When this happens, family members often must step in and find alternate permanent housing for people who might have remained independent much longer but for the disaster.

Disasters disrupt both the older person living with dementia as well as their caregivers (Hawkins & Manne, 2004), making an unanticipated and sudden transition to a new living environment very stressful. Hikichi, Aida, Kondo, Tsuboya, Matsuyama, Subramanian and Kawachi (2016), in their study of the Great East Japan Earthquake and Tsunami, examined risk factors for dementia before and after the disaster. They observed the reciprocal stressful effects of relocation on both the person living with dementia and the caregiver, with the personal stress on the caregiver adding to the stress of the person living with dementia. This finding is significant for this discussion because of the critical role that support systems play in one's recovery. The AAGP Position Statement notes that the "absence of family or other supports to assist an older adult during an emergency is perhaps the single most critical risk factor for adverse outcomes" (Sakauye et al., 2009, p. 919). Social support is understood as emotionally critical for older adults in numerous contexts, but particularly after a traumatic event.

Resilience

The concept of resilience is important for understanding the emotional impact of a disaster. Walsh (2015) defines it as "the ability to withstand and rebound from adversity" (p. 427). Research has suggested that the effects of future trauma may be moderated by productive adaptation to initial trauma (Weisaeth, 1998). Older persons have faced a lifetime of potential traumas. The current older cohort faced World War II and the Korean War, which were often major loss events, early in their lives. However, even if the older person did not lose anyone that they knew, they experienced numerous tragedies, including 9/11 and other natural

and human-caused disasters, along with the rest of the nation. Depending on their age, they also may have suffered the loss of parents, spouse, or even children and grandchildren. Unfortunately, life is filled with the potential for many traumatic times. Resilience suggests that a combination of previous experiences of trauma as well as a healthy attitude toward their own aging process can offer the older adult the potential to get through new traumatic events. Mancini and Bonanno (2008) posit that the concept of resilience does not suggest that the older person is not impacted at all by the untoward event. Instead, they highlight the capacity of the older person to successfully navigate the event and remain functional and forward-thinking as they move beyond the tragedy (p. 585).

The literature on emotional impacts and resilience of older survivors offers a mixed picture (e.g., Knight, Gatz, Heiller & Bengston, 2000; North, 2007 Yan, 2010; Yeung & Fung, 2007). Yan (2010) asserted that "despite frequent physical frailty and lack of resources, older adults are often more mentally resilient in coping with disaster than younger people" (p. 1). In contrast, Goenjian, Najarian, Pynoos, Steinberg, Manoukian, Tavosian and Fairbanks (1994) offer a rare comparison study between younger and older adults in terms of Post-Traumatic Stress Disorder (PTSD) and found that both groups were significantly and equally impacted.

One older, evidence-based article on this topic examined the Northridge Earthquake in 1994 (Knight et al., 2000). This study examined two explanations for resilience and older adults, the maturation hypothesis and the inoculation hypothesis. The maturation hypothesis argues that "psychological maturation, including more mature coping styles, protect older adults against stressors" (p. 627). The inoculation hypothesis suggests that "prior experience with disaster provides an inoculation against strong emotional reaction to repeat experiences with disasters" (p. 628). These models were developed to explain the incidence of depression among older adult survivors. Knight et al. (2000) found very little support for the maturation hypothesis, and modest support was found for the inoculation hypothesis. Whatever the mechanism for increased coping, prior experience with stressful events seems to strengthen resilience in later life.

Religious beliefs and spirituality may be an important variable in explaining the resilience of older survivors. Pargament (1997) noted that religion can be employed as both a positive or a negative coping mechanism. Some persons of faith turn to God for help, often reframing a human trauma as a reflection of God's will, thereby bringing God into the event. This belief affirms that the older person is no longer alone and can rely on a powerful partner in moving forward despite the tragedy that has impacted them. On the other hand, there are those who blame God for the event, feel abandoned by God, and generally feel separated from their understanding of and relationship with God. These negative feelings can

build up with other factors to impact the older person negatively.

Religious congregations may be a source of coping as well. Krause (2008) concluded that having a healthy support group, such as a church or senior center, will also facilitate the individual's ability to cope with adversity. Since older survivors are likely to attend a church, synagogue, or temple, the fellowship and instrumental aid provided during a disaster is often a major support system to get through a tragedy (Krause, 2008).

Congregations and Disaster Recovery with Older Survivors

Congregations deeply embedded geographically, relationally, and missionally within neighborhoods are present in every disaster. Whether working as a community-based member of a disaster relief team or in a congregationally-affiliated role, social workers must be prepared to understand and activate the recovery resources of congregations. When natural/human disasters strike, congregational members and their sanctuaries suffer equally, and sometimes disproportionally, the aftermath of storms, like Superstorm Sandy, or human-caused disasters, such as the mass church shooting in Sutherland Springs, Texas. To the extent they can overcome their own losses, congregations have historically been central to the provision of recovery and resilience-promoting resources primarily through informal community services and volunteer-driven initiatives (Tobin, Ellor & Anderson-Ray, 1986). They also have access to larger denominational assets needed to restore losses caused by disasters.

Congregations have traditionally provided a core of informal psychosocial services that benefit vulnerable older persons seeking to cope day by day and constitute a platform for resources specifically aimed at dealing with their recovery needs in the aftermath of a disaster. Most significantly, congregations anchor, encourage, and inform spiritual beliefs and practices, offering meaning and hope in the context of incomprehensible devastation. Clergy and congregations are key providers of spiritual support, both one-on-one and through worship and community grief rituals. Clergy, as well as congregational social workers and other community mental health providers, provide mental health counseling services during this same time. Although recent data suggests that clergy are no longer in the lead as emotional support responders, the pastoral care they provide continues to be a substantive and trusted source of mental health guidance for older persons in recovery (Vermaas, Green, Haley & Haddock, 2017).

Congregations also directly provide services for vulnerable older adults such as food, transportation, assistance with the activities of daily living, and hosting community and social services (i.e., offering space in their buildings). During the disaster recovery phase, congregations often

provide space in their buildings for meetings as well as office space for recovery staff. Congregations, working alone or sometimes with other churches, may even permanently create human service organizations to fill a gap in available eldercare services or temporarily in response to the recovery needs of the community. Occasionally, these organizations become independent of the congregation even though they continue to reside there (Tobin et al., 1986). Congregations can also be critical in the recruitment, development, deployment, and retention of volunteers to provide the vital human resources for supporting the recovery and resilience of older survivors.

The challenge for congregations is that, while they are formal organizations that can address the needs of survivors of a disaster, they face the challenge of all informal service providers: they can deliver only the services that their volunteers and resources can provide (Davey, Famin, Zarit, Shea, Sundstrom, Berg & Savla, 2005). If they run out of either financial or human resources, they need to limit their activities. Unfortunately, this becomes a difficult challenge when communities face significant needs such as those found after wide-encompassing events, like the Thomas, Creek, Rye, Skirball, Lilac, and Liberty fires in southern California. Whatever the cause, each event sets in motion a disaster cycle that offers opportunities for congregations and congregationally-affiliated social workers to step into the aftermath, overcome their organizational and financial limitations, and make a meaningful and sustainable contribution to recovery.

The Disaster Cycle, Congregations, and the Role of Congregationally-Affiliated Social Work

The phases of disaster recovery or the disaster cycle—pre-event planning phase, post-event-acute phase, and post-event, long-term recovery phase—offer an organizing frame for communicating the wide variety of recovery roles and responses available to congregations and the social workers working alongside of them to help older survivors (Franklin, 2017). Throughout the process, local congregations as well as their denominations play critical roles, particularly in post-event recovery after natural disasters.

Pre-Event Planning Phase

Congregations. Based on Federal Emergency Management Agency (FEMA) standards, a person designated as the Community Emergency Manager takes the lead on pre-event planning. This process involves evaluating the most likely threats and then determining how to respond.

Preplanning is not an activity that most communities consider, but resources are available from FEMA to help. For example, communities in Kansas will not need to plan for a hurricane, but they will need to be ready for a tornado. Also, communities with chemical plants, railroads, or pipelines need to be prepared for chemical spills.

Congregations can advocate for the development of a plan for natural/human disasters and also help implement the plan. Unfortunately, few do. Many congregations believe that if they periodically take up a collection for their denominational group, they have done their part. However, if the disaster happens in the local community, then churches are suddenly thrust into leadership. Congregations need to have a plan for an active-shooter incident as this can happen even in rural areas. Congregations that are in areas where hurricanes occur need to be prepared to cover their windows or install sprinkler systems in case of fire, and then they need to prepare to assist formal public agencies should such events take place. In urban and rural areas alike, congregations can plan for cold weather emergencies in which older adults may lose electricity and heat and require service from Meals on Wheels and access to medical care and medication. Congregations are also critical as local agencies to help Area Agencies on Aging and other senior groups assist the frail members of their community to evacuate or find shelters as needed. Local congregations and their denominational support agencies are key potential supporters of local, state, and federal emergency management.

Opportunities for social work practice. In congregations, members with social work training can play critical roles in many of the congregational activities noted above. Indeed, these social workers may initiate, design, and provide leadership for these activities. Diversity of people and professional skills is a significant source of congregational strength and contribution, but it may not be activated without such leadership. Beyond these general contributions, however, there are ways for social workers to specifically address the needs of older adults.

Congregationally-affiliated social workers are critical in the pre-event planning phase, particularly in preparation for emotional and spiritual trauma to older survivors. Before any disaster occurs, social workers can be organizing emotional and spiritual support teams uniquely equipped to address the recovery needs of older adults. These can be done through local emergency management, the Red Cross, and denominational resources. Whether the event is a significant auto accident or a major hurricane, training persons who can offer emotional and spiritual support for older trauma survivors is an important supplement to the primary emergency responders in the community.

Congregationally-affiliated social workers involved in eldercare after a disaster need to be aware of the roles that most major denominations

play in crisis management and long-term recovery of older persons and their communities, particularly when it is declared a disaster by FEMA. To coordinate their responses, state and/or local Volunteer Organizations Active in Disasters (VOAD) groups combine to coordinate the various denominations. However, most denominational groups specialize in a few areas of the disaster rather than trying to address all the needs presented. For example, one of the best-known groups is the Southern Baptist Men, which generally has a group with chain saws and other equipment to help clean up after the disaster. Other groups include the United Methodist Committee on Relief (UMCOR), which often offers case management during long-term recovery, along with St. Vincent DePaul, which also offers case management. The Presbyterian Disaster Assistance (PDA) provides emotional and spiritual care resources along with other groups. While the methods each group uses may be different, each group is committed to serve communities at times of disaster.

In the case of a hurricane or tornado, social workers can assist congregations as they offer preparatory guidance to vulnerable older persons and their caregivers. In areas prone to such events, FEMA offers advice regarding preparation of resources for either sheltering in place or evacuating the area. Such a resource may be a list of an individual's important medications and/or medical appliances kept in a location that can be accessed quickly in case of an emergency. Some religious communities have developed plastic envelopes that can be attached to a refrigerator or other accessible location for containing both diagnoses and prescription information for the seniors who live there. This preparation can be helpful to Emergency Medical Technicians (EMTs) as well as other disaster first responders should they be needed. This ministry of preparation should be part of every congregation's outreach to vulnerable older persons among its membership and within the community at large.

Post-event/Acute Phase

Congregations. Ideally, religious communities join with other nongovernmental and governmental organizations to respond after the disaster has just happened. Immediately after the event, congregations can offer their buildings or parking lots to support community emergency response agencies. At this point, congregations can also become monitors of their community to identify persons or portions of the community who may be in pain, in need of emergency assistance, or missing. As members of the community, congregants will know when there are persons in special need and they can provide that information to Long Term Response groups. This can be very helpful in providing support that may be missed.

Congregations can also be critical sources of communication for members of the community who have returned as well as those who are still staying with family or friends (Franklin, 2017). Congregations generally have directories of members both in print and online. These lists of persons can be helpful to disaster managers immediately after the event to find impaired older persons and even long after the event to locate a senior to understand the disposition of their property. Church newsletters, listserves, and websites can further help push out accurate information regarding important community events and concerns.

Sometimes congregations can offer their buildings for other groups to set up locations for filling out forms and other response activities or to provide temporary lodging and meals for older survivors or for out-of-town recovery volunteers. These volunteer villages are critical to reduce the costs of disaster reconstruction. As congregations enact their hospitality gifts (Tobin et al., 1986), active engagement from their own parishioners is essential to offer adequate inventories of meals, blankets, and other comfort materials for both the older survivors and the volunteers who serve them.

Congregations concerned about vulnerable older persons in long-term need must be aware of the post-event, acute-state issue of evacuating or not evacuating. There has been a lot of discussion over the question of whether to shelter in place or to evacuate when a major storm is headed toward the local area. In some ways, the choice seems simple: hunker down at home where you can protect your belongings or run away to be sure that what you can take with you is safe. For vulnerable older adults, particularly those in nursing homes, this is not quite as simple as one might think. Older adults suffer the impact of the stress of a disaster more than younger persons, particularly when morbidity is examined (Holleran, 2015).

Gerontologists have known for many years that unwanted transition increases morbidity among seniors, particularly those with some form of dementia. Persons who are frail and need a consistent environment often find the stress of transition to be significant, thus creating an impact of the event particularly on the cardiovascular system (Dosa, Grossman, Wetle, & Mor, 2007). In a retrospective examination of the Ohio Trauma Registry, Caterino, Valasek and Werman (2010) reported that "patients 70-74 years of age have significantly greater mortality than all younger age groups" in the aftermath of trauma (p. 157). In a similar study, Holleran (2015) separated persons 60 to 70 years old from those 70 plus and noted that the older group was "more likely to die while in the hospital from traumatic injury" (p. 299). This is particularly significant for vulnerable elders in long-term care facilities.

A mistake that is commonly made by administrators and social workers in long-term care is to assume that evacuations can take place by

rolling the individual down the hall and out the door with a wheel chair or other conveyance. When the fertilizer plant exploded in West, Texas, the roof completely collapsed on the local nursing home. One of the authors observed that most of the residents had to be handed out windows or even through walls.

Dosa et al. (2007) used epidemiological methods to track morbidity of older adults in long-term care facilities during Hurricane Katrina. The average nursing home administrator must weigh the morbidity of a mass move against the hazards of sheltering in place. Dosa et al. (2007) suggested that unless the facility is directly in the path of the disaster, fewer people will die by staying than by moving to a safe location. Many nursing homes in coastal areas have other facilities within their ownership group where they can move residents, but the risk of movement even to a facility down the street is significant.

Opportunities for social work practice. Moving persons in the community can also be significant. However, when the individual can move with their family, the morbidity rate seems to be less impacted. With the encouragement of congregationally-affiliated social workers, long-term care staff should also account for the items needed by the older and vulnerable survivor, such as medications and health care appliances (Sakauye et al., 2009). While medications can be replaced, they need to be prescribed by a physician. If the senior does not know which medications he or she is on or has dementia, this becomes more complex for the prescribing doctor. When the congregation's ministry of preparation is effectively disseminated in a community, the medication and appliance list will be readily accessible.

In the post-event, acute state, congregationally-affiliated social workers can play an important role in both the areas of emotional support and logistical planning for vulnerable congregants and noncongregants. When older adults need to be moved, insuring communication with family members as well as other caregivers is critical. Obtaining appropriate transportation is equally important. Not every recovering older person needs an ambulance, but buses with bathrooms, for example, as well as vehicles with enough room for some freedom of movement can also be helpful. These older adults, particularly those with some dementia, will need to be prepared emotionally for the move. Explaining where they are going and, if needed, who will take care of them will help in this transition. While there may not be a way of reducing the stress of an evacuation for elders, their having knowledge of what is happening and having supportive persons with them can be critical. Finally, the congregationally-affiliated social worker concerned about older congregants or even noncongregants in a nursing care facility should consult with the in-house nursing facility social worker or administrator, advocating for the emotional needs of the residents to ensure that they are considered equally with the logistical concerns.

Post-event/Long-Term Recovery Phase

Congregations. In many states, facets of the post-event/acute phase, such as emergency response, search and rescue, and disaster management, are the responsibility of local government (including support from county, state, and national assets). However, post-event, long term recovery is largely turned over to nongovernmental, often religious groups (McGeehan & Baker, 2017). After any event, the world presents a strange and "new normal" for older survivors. Even where all the buildings have been restored and the community is functional once more, nothing is quite the same again. Religious congregations and their affiliated social workers continue to play important roles during this last and longest phase in the disaster recovery cycle. Their primary role is as emotional/spiritual encouragers. While some pastors and social workers will provide formal counseling, the unique asset of the congregation is its capacity to sense the emotional and spiritual needs of the community and respond to them. At some point after the event, some will begin to ask questions as to why this had to happen, why here and why now. This most human of queries is best understood in the context of the beliefs of the congregation. However, one common answer is, "We don't know why, but we do believe that God is walking with us." This may or may not be comforting to every individual, but it can be helpful to many at times of recovery.

Congregations, pastors, and social workers who are conscious of the flow of the long-term recovery need to be able to take stock of older survivors in the congregation to identify who is emotionally hurting and find assistance for them. This monitoring function includes emergency management staff, such as fire and police department personnel, city officials, and any others involved in response. Particularly when lives have been lost, first responders often feel the emotional impact almost as much as family members, and they also need support. Congregations, as monitors of the community, need to remember that few disasters lend themselves to full physical recovery in less than two or three years, and in many incidents the emotional recovery will take longer.

Regardless of the age of the survivor, denial is often a factor in trauma response (Horowitz, 2008). Many first responders and independent, older survivors are sure that they are tougher than any given situation they might encounter and that they can get through it. This may or may not be functional for congregational and community members. Immediately after a disaster, members of the community will all be highly engaged in the restoration process—busy cleaning up, busy getting rid of the refuse, busy helping each other out. Then there is the phase where homes and other buildings need to be rebuilt. While the individual homeowner is unlikely to be the carpenter, the stress of working with insurance companies or not

knowing where the money will come from is significant. This stressor is particularly true for older adults. After the fertilizer plant destroyed his home in West, Texas, one older owner noted that many years ago he had built his home with the help of his son, who had died in Vietnam. The man was now over eighty. The building itself held memories for him right down to the last nail, in addition to the contents that were important to his family. In this incident, most of the valuables in the home could be salvaged, but the house itself also had irreplaceable significance. Older adults are often left out of the housing repair or replacement phase because it may be easier for families to move the older adult closer to them and to simply sell the land if the home is destroyed.

If a community has a significant portion of their members who are older and impacted by a hurricane or other major incident, the average age of the community may drop after the event and the tax revenue as well as wealth of knowledge and experience reflected in the older population may move away. In a coastal area, older persons may be owners of summer homes, or as they are called in Texas, Winter Texans. Seniors or families who come to the coast for warmer weather in the winter, have homes somewhere else to go to and thus may not make any effort to rebuild. The loss of the snow birds or Winter Texans for seniors who live in the communities reflects the absence of friendships and sometimes family members. When this happens, this loss greatly impacts the older persons who remain as well as the economic base of the community in terms of stores, restaurants, and other public facilities that may rely on the tourist trade. These second homes generally are unable to receive FEMA or other funding for recovery which will also affect the decision of whether to rebuild.

It should be noted that not every disaster has a "Bang!" In other words, there may not be one incident to which one can point that creates the event, yet it is clearly a disaster (e.g., the water crisis in Flint, Michigan). Unlike a tornado, where a specific start date can be identified, the water crisis in this case seems to have emerged from a series of bad decisions that had significant impact on the community. In a smaller such case, one of the authors had a personal dialogue with local officials in an upstate New York Community, and they indicated that the water crisis in their community was created by many years of a local chemical plant's discharging chemicals into a local river, contaminating the community's drinking water and creating a pattern of unusual cancers in the area. In such cases where there is no single event, it is harder to know how to manage the disaster cycle process, to decide when long-term recovery can or should start, and, even more difficult, simply to identify how to best serve older persons adversely affected by the incipient disaster. These communities and their older citizens continue to need long-term recovery, and the religious community may be the only social institution with the capacity to

advocate for sustained recovery initiatives, even though the disaster lacks a clear post event/acute phase. Interestingly, one of the authors discovered in conversation with residents of Hoosick, New York that older persons were choosing to remain in their homes as they are nearer to the ends of their lives and don't see moving as a viable option.

Opportunities for social work practice. In addition to the intervention paths identified, congregationally-affiliated social workers have macro-level knowledge and skill sets well-suited for helping older survivors and their community navigate the post-event/long term recovery phase. We illustrate some specific ways they can lead and contribute to this process so that the resources at the local, state, and national level are activated, resulting in improved outcomes for older survivors. While we focus on the role possibilities for congregational social workers, these observations are applicable for any community-based social worker committed to restoration for older survivors. One prominent point of difference-making is leadership on long-term recovery committees. This role draws on planning and community organization skills. Even if the administrator of a long-term recovery committee is a retired first responder or even a realtor, the social worker, as a committee member should look for opportunities to enact macro social work practice skills to keep the committee focused on emotional and social dynamics within the community.

Congregational social workers also need to ensure that every cultural group with older members is included in the recovery. Some minority communities may be slow to surface in recovery or they may feel that they need to do their own recovery, but inclusion in the larger community effort both enhances their resources and favorably impacts the entire community's resilience and solidarity. Social workers, particularly those in congregations and private practice, can offer emotional and spiritual support for members of the community often forgotten in the recovery process, including first responders and family and paid caregivers with vulnerable older survivors. In this last phase, the congregation social workers can lead out in memorial and remembrance initiatives. Anniversary recognitions and the creation of memorials are healing for older survivors as well as congregational and community members. These markers of disaster restoration affirm the resilience and resolve of all affected persons and serve as a source of hope for future generations.

Conclusion

Congregations and older adults are never just the recipients of outside help at times of a disaster. As they are able, they can be part of the solution. Guided by the knowledge and practices of a culturally sensitive social worker, congregations are uniquely equipped to provide support for older

survivors and their families and community at every phase of the disaster cycle. Whatever the source of congregational social work expertise—whether as a paid staff member, volunteer, or staff member of a community partner—congregations with social work assistance may be better able to contribute to the mix of public and private community resources needed to respond to the human suffering caused by disasters. At the same time, they may uniquely provide spiritual support unavailable from nonreligious providers. As a result, congregations and community partners can work together to reconstruct and restore lives and communities.

As we have noted, social workers can employ practice skills to assist congregations during each phase of the disaster cycle. For example, they can use community organizing skills to advocate and guide program planning for older adults and the broader community. They can also use clinical skills, especially with older adults who need assistance as they struggle to make sense of the event, and address emotional needs. While other professions exhibit some of these skills, social workers often implement them with greater cultural sensitivity. Older adults and their communities benefit when social work practice and congregational resources intersect before, during, and after any type of natural/human disaster. ❖

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Hope and Resilience among Vulnerable, Community-Dwelling Older Persons

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Abstract

Community-dwelling older adults in the U.S. are at risk for experiencing a number of physical, emotional, and social issues including poverty, social isolation, and deteriorating health and daily functioning. Despite such challenges, research indicates that many older adults remain resilient and that factors such as social support, spirituality, and self-esteem contribute to resilience and improved outcomes. One factor that has been found to be particularly important for resilience among older adults is a sense of hopefulness. However, research has not looked specifically at the effects of hope on older adults experiencing severe economic and psychosocial challenges. Utilizing survey data drawn from a unique sample (n = 64), we explore the relationship between hope and resilience among a group of at-risk, community-dwelling older adults in one central Texas community. We find that hope is a strong and significant predictor of resilience among older adults and that hope tends to mediate the effect of spiritual experience on resilience. Drawing on these findings, we discuss potential implications for social workers and congregational leaders working with older adults and for future scholarship on hope and resilience.

Introduction

When the community is impacteTo contribute to the understanding of FBCFWAs and the Christians they license to help "the children God has graciously given" (Genesis 33:5), this study focuses on two research questions: (a) what are the motivations among Christians to become foster parents for Christian FBCFWAs; and, (b) what personality characteristics are associated

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with a Christian foster parent's desire to remain a foster parent? Because there is little knowledge in the professional literature about Christian foster parents licensed through Christian FBCFWAs, this study focuses on the motivations and personality characteristics of this specific population. The results of this study can help to inform the child welfare research and practice community in engaging, recruiting, and retaining foster parents for Christian FBCFWAs.

Literature Review

Pervasive poverty and devastating cut-backs in health and human services deepen the vulnerabilities of isolated, at-risk older adults in our congregations and communities. According to Cassidy, Coverdale, Kunik, Naik, and Nair (2010), vulnerability is "the failure to engage in acts of self-care that adequately regulate safe and independent living, or to take actions to prevent conditions or situations that adversely affect personal health and safety" (p. 615). Inconsistency in performing activities of daily living (ADLs), self-neglect, erratic medication management, and unsafe living environments threaten the capacity of many older adults to age in place. Environmental factors such as a lack of running water, air conditioning or heating, and, in some instances, inadequate flooring increase the risk they face. All of these significant challenges are compounded by the social invisibility they encounter on a daily basis.

Vulnerabilities take their toll on physical and mental health and contribute to hospital admissions and readmissions as well as placement in long-term care facilities (Hardy, Concato, & Gill, 2004; Montross et al., 2006; Lamond et al., 2008). Nevertheless, significant levels of resilience and effective adaptation are also documented in this population by researchers (e.g., Hardy, Concato, & Gill, 2004; Lamond et.al. 2008; Wells, 2010). Initiatives to understand resilience among this population yield a range of correlates that include health status and quality of life (Connor, Davidson, & Lee, 2003) and social support (Lubben & Gironda, 2003).

Among the range of possible correlates, researchers are finding that positive psychological factors such as hope (Ong, Edwards, & Bergeman, 2006), thriving (Tremethick, 1997), and self-esteem and optimism (Lee, Brown, Mitchell, & Schiraldi, 2008) may contribute to understanding resilience among older persons. Likewise, religion and spirituality have been identified as a significant correlate of resilience (Weaver et al., 2005). In this study, we seek to clarify the unique relationship between hope and resilience among impoverished and vulnerable older adults. This relationship has not previously been examined in a sample solely comprised of older persons who encounter severe economic and psychosocial challenges.

Our aspiration is to equip social workers and congregations with evidence about how hope, as a positive psychological factor (PPF), may

bolster resilience among older persons who are at-risk due to impoverishment and isolation. If hope is a modifiable construct (Johnstone, 2014), understanding how it relates to resilience may provide an empirical basis for assessment and intervention by social workers, other professionals, volunteers, and congregational leaders. We think that paying attention to hope and related assets in this population increases the likelihood of thriving in spite of challenging personal, relational, and environmental contexts. We emphasize the important role that social workers play in fostering hope as they create and mediate transactions between the needs of at-risk elders and congregational and community resources. We also provide practical guidelines and practices intended to demonstrate how energizing hope can strengthen resiliency among older persons on the margins of community life.

Research Questions

After a brief review of extant literature on the challenges faced by older adults as well as correlates of resilience among this population, we analyze data drawn from a unique data set to address the following research questions:

1. To what extent does hope contribute to resilience among at-risk, community-dwelling older persons?
2. How is this contribution affected by social support, spiritual experience, health (ADL), and ethnicity?.

Fostering Characteristics

Community dwelling older adults in the U.S. face a number of significant physical, social, and emotional challenges. In recent decades, an interdisciplinary body of research has emerged documenting these challenges and examining the effects they have on outcomes related to older adults' health and well-being. Nevertheless, scholars have also recognized that many older adults are resilient and that factors such as hope, social support, and spirituality can contribute to resilience and improved outcomes in the lives of older persons. This study focuses on the relationship between hope and resilience.

Challenges Faced by At-Risk Older Adults

Poverty. Despite social programs that have improved the lives of older adults in the U.S., many still experience hardship and poverty. According to the U.S. Census Bureau (Proctor, Semega, & Kollar, 2016), 8.8% of adults age 65 and over fell below the poverty line in 2015. Poverty was even more prevalent among some groups. Women age 65 and older experienced higher

rates of poverty (10.3%) than men (7%), while older adults of color experienced higher rates of poverty than whites. Poverty was most prevalent among black older adults (19.2%). However, Hispanic (18.1%) and Asian (14.7%) older adults also experienced higher rates of poverty than whites (7.8%) (Administration on Aging, 2016).

Social isolation. In addition to economic hardship, older adults often experience increasing social isolation as a result of major life changes and losses at this stage in life. Research suggests that such isolation can take a significant physical toll on older adults' well-being (McMaster University, 2016). In a 2013 study of the link between social isolation, loneliness and mortality among older adults, Steptoe, Shankar, Demakakos, and Wardle (2013) found that social isolation was significantly associated with mortality. Social isolation and loneliness were correlated with risky behaviors such as being inactive and smoking. Social isolation has also been found to be correlated with health indicators such as high blood pressure, C-reactive protein, and fibrinogen levels (Shankar et al., 2011). Researchers concluded that social isolation may contribute to the development of cardiovascular disease (Shankar et al., 2011). Importantly, findings also suggest that healthy behaviors, which reduce social isolation, may lead to more positive outcomes (Steptoe et al., 2013).

Activities of daily living and the older person. Many adults also face the loss of functional capacity and independence as they grow older. With changes in physical and cognitive ability, some daily tasks may become more difficult for older adults to complete without assistance. These changes can have a significant impact on older persons' quality of life. Activities of Daily Living (ADL) is a measure of older adults' functional capacity. ADL tasks include basic self-care such as bathing and eating and even meal preparation, keeping up with bills, cleaning, and other activities pertinent to running a household (Caskie, Sutton, & Margrett, 2010). Previous research indicates a correlation between older adults' ADL and their overall health status. Loss of ADL skills tends to result in a greater likelihood of transitioning to assisted-living and is related to higher mortality rates (Caskie, Sutton, & Margrett, 2010). Related to ADL, housing is another critical indicator and predictor for older adults in maintaining health and daily functioning. Older adults who cannot maintain their homes to fit their changing physical needs are at risk for "declining health, function and independence, and even premature or avoidable nursing home placement" (Spillman, Biess, & MacDonald, 2012, p. 1).

There are many challenges faced by older adults and these challenges have very real consequences on both the physical and emotional dimensions of older adults' lives. Despite these challenges, research also finds that many older adults are resilient. Research has identified a number of adaptive factors that may contribute to higher levels of resilience among this population.

Resilience and Vulnerable Older Persons

Resilience in older adults is defined as an individual's capacity to accommodate life hardships and engage a new pattern of living (Klaver & May, 2006). While it is widely recognized that resilience can be an important asset for older adults, little is known about what contributes to this valuable characteristic. In previous studies, self-esteem, optimism, social support, spirituality, and other environmental factors have been found to predict higher levels of resiliency (Lee, Brown, Mitchell, & Schiraldi, 2008; Lubben & Gironda, 2003; Tremethick 1997; & Weaver, Flannelly, Markowitz, & Flannelly, 2005).

Interestingly, some researchers also contend that adversity itself promotes resilience in older adults (Richardson, 2002). Some researchers posit that compared with younger persons, older adults have a greater potential for resilience in response to difficult life experiences because they can maintain healthy adaptive patterns more effectively than young adults (Zeiss, Cook, & Cantor, 2007). Wells (2010) reported that geography did not affect resilience levels of older adults living in either rural, suburban, or urban areas, but instead strong social ties and mental and physical health contributed to resilience. Wells also noted that a decline in health did not always mean a decline in resilience. A process called resilient reintegration helps older adults to draw on good health, social networks, and self-reliance when they experience stress or disruption. Interestingly, no socio-demographic factors were correlated with resilience except for income where higher income actually tended to indicate lower resilience (Hardy et al., 2004). Luthar and Ciccheti (2000) believe that resilience is shaped by life stressors and experience, and therefore resilience can be grown and enhanced through specific intervention strategies, which can be beneficial and useful for building resilience in individuals and in communities.

While resilience is an important concept, there is little agreement on the best way to measure it. Currently there are at least 15 resilience scales, none of which have been identified as an exemplary measure (Wild et al., 2013). Often used, the Wagnild and Young Resilience Scale is a 25-item questionnaire measuring resilience on 5 components, equanimity, perseverance, self-reliance, meaningfulness, and existential loneliness (Wagnild & Young, 1993). Others include the Connor-Davidson Resilience Scale, which is an intervention-oriented measure, as well as the Psychological Resilience Scale that measures self-esteem, personal competence, and interpersonal control (Connor & Davidson, 2003).

Adaptive Factors

Spirituality. Spirituality and religion are two interrelated terms used to define faith and a person's set of attitudes, beliefs, and values relating to God or a higher power. Spirituality is an important aspect of many individuals' lives, providing such resources as hope, trust, and meaning (Bassett, Lloyd, & Tse, 2008). Involvement in spirituality may also draw individuals into community and help them maintain meaningful social ties. Research by Fry (2000) has shown that spirituality and faith may explain more variety in a person's well-being than demographic and health characteristics. Spirituality may even help older adults to understand their meaning and purpose later in life (Fry, 2000).

Researchers suggest that religiousness and spirituality build resilience and adaptability, especially in older adults. June, Segal, Coolidge, and Klebe (2009) studied the relationship between religiousness, social support, and reasons for living with European Americans and African Americans over 65. Findings revealed that the correlation between social support and reasons for living were more significant among European Americans, whereas the correlation between religiousness and reasons for living were more significant for African Americans (June et al., 2009). For both groups, high religiousness was predictive of more reasons for living. They also found that religiousness at a higher level protects individuals, especially in the older adult population, from suicidal risk. For the African American respondents, religious faith was a strong factor in dealing with problems of aging. Faith and spirituality are important facets of older adults adapting to the physical and environmental changes of aging.

Social support. Social support may also have a significant bearing on the ability of older adults to adapt to their changing life circumstances and environments. Tomoika, Kurumatani, and Hosoi (2015) studied associations between social participation and decline in effectance with community-dwelling older adults age 65 and older. Five different types of social participation were measured: neighborhood association, hobby groups, local event groups, senior citizen clubs, and volunteer groups. At the three-year study follow-up, 17.8% of study participants had experienced a decline in effectance. Social participation in neighborhood associations, hobby groups, local event groups, and volunteer groups was found to be inversely related to decline in effectance among women in the study (Tomoika, Kurumatani, & Hosoi, 2015). With men, however, positive effects were only reported when older men were involved with hobby groups and volunteer groups (Tomoika, Kurumatani, & Hosoi, 2015). These findings suggest that encouraging older adults to participate in social groups may contribute to positive outcomes that improve health and well-being in older age.

Hope. One factor that scholars find to be particularly important for improved outcomes and resilience among older adults is hope or hopefulness. For example, in one study of 100 community-dwelling older adults, researchers found that higher levels of hope predicted greater life satisfaction and better perception of their physical health (Wrobleski & Snyder, 2005). Hope has also been linked to improved mental and physical health (Barnett, 2014) and lower levels of depression (Hirsch et al., 2011) among older populations.

Interestingly, Wrobleski & Snyder (2005) also reported that hope did not correlate to the number of illnesses or disabilities experienced by study participants; rather it related to older adults' feeling of confidence in goal attainment. Further, Rustoen, Cooper, and Miaskowski (2010) have found that hope mediates the relationship between physical health and psychological distress. Hopeful older adults may not be inoculated from the physical and emotional challenges that come with aging. However, hope appears to provide internal resources that assist older adults in coping with such challenges.

Hope is often described in the midst of adversity and has been defined in a number of ways. Farran, Salloway, and Clark (1990) describe hope as having four main characteristics: suffering or trial, transcendence, rational thought, and inspiration. Wrobleski and Snyder (2005) describe hope as being "goal-directed thinking in which a person has the perceived capacity to produce routes to desired goals" as well as the "motivation to initiate and sustain the use of those routes" (pg. 217). Herth (1996) describes hope as the power of the self to mobilize and move beyond present to tomorrow and envision that future. What these definitions have in common is a sense of expectancy that allows one to look beyond the present condition to see a potential future where new goals can still be set and meaning can still be made. This is a valuable asset for sustaining resilience among at-risk older adults.

Explaining the presence of hope in the midst of struggle is one of the central questions addressed by scholars. Bergin and Walsh (2005) trace the roots of hope to infancy where children learn hopefulness when they can balance trust and mistrust and this process plays out through the lifespan. Snyder (1991,1995) observed that agency and pathway are two dimensions of hope, related to the person's assumptions about their capacity and opportunity to attain hoped-for goals, creating the Adult Hope Trait Scale to measure these dimensions. Agency relates to the person's perception of capacity for goal-attainment and pathways refers to the means or method (way finding) activated in pursuing the intended goal. In their sample of 259 older persons, Ferguson, Taylor, & McMahon (2017) were not able to validate the two dimensions (agency and pathway) of the Adult Trait Hope Scale, finding empirical support for a six-item, unidimensional version of this scale. Bays (2001) found that hope requires effort and determination as well as family connections and spiritual connections. Further, Benzein and Saveman (1998)

note that hope is a human phenomenon and that it can be connected to an array of other emotions such as joy, enthusiasm, or expectation.

Clearer specification of how hope intersects with desirable outcomes such positive affect and meaning in life may contribute to understanding how it thrives in the midst of difficult individual and contextual challenges. Ferguson, Taylor, & McMahon (2017) examined the relationships among hope, experiential avoidance, affect, and meaning in life and found that hope was associated with positive affect and meaning in life whereas experiential avoidance was associated the negative affect and lower meaning in life. Experiential avoidance in older adults involves suppressing unpleasant or unacceptable thoughts about the future in ways that have longer term detrimental effects such as lowering quality of life (Butler, et al., 2007) and anxiety and depression (Andrew and Dulin, 2007).

According to Hayes, et al. (2006), experiential avoidance is the opposite of acceptance and is a misdirected strategy for emotional regulation. Older persons who report higher levels of hope and lower levels of experiential avoidance experience enhanced meaning in life as well as a sense of well-being (Ferguson, Taylor, & McMahon, 2017). Wrobleski and Snyder (2005) observed that hope facilitates desired outcomes in later life through drawing attention to their personal assets and minimizing their limitations, a proposition based on Baltes and Baltes' (1990) selective optimization with compensation model. Whatever the paths through which it operates, hope appears to be an important resource in energizing resilience among at-risk older adults

Summary

Community-dwelling older adults are at risk for a myriad of physical, emotional, and social issues, experiencing greater levels of poverty, greater levels of social isolation, and deteriorating levels of health and daily functioning. Hope and resilience are both associated with adaptation of older adults to these contextual realities and are often used interchangeably. However, Ong, Edwards, and Bergeman (2006) conclude that "hope is an important source for resilience in later adulthood: Both within and across individuals, hope appears to shape the meaning of daily stressors in ways that reduce their intensity and hinder their proliferation" (p. 1271).

In this study, we describe the relationships between hope and resilience in at-risk community-dwelling older adults, aspiring to encourage further research into this relationship and to inform social work practioners and congregational leaders committed to hope-promotion within this population.

Methodology

To examine the relationship between hope and resilience among at-risk, community-dwelling older adults, we analyzed survey data drawn from a unique study conducted in 2011 by social work researchers at Baylor University. In partnership with Meals on Wheels, a nonprofit organization serving older adults in central Texas, researchers and agency staff designed and conducted a cross-sectional, mixed-method study examining resilience among the organization's clients. The original study included the collection of both survey and interview data. For the current study, we utilize data drawn from the survey phase of the project.

Study Sample

A random sample of participants was drawn from a population of 255 Meals on Wheels clients that met specific inclusion criteria. To be eligible for the study, individuals had to be age 60 or older, be receiving agency services, have income falling below the federal poverty level, reside in substandard urban housing, and had to be living alone. Each client selected to participate was initially contacted by Meals on Wheels staff, provided information on the purpose of the study, and invited to take part in the study. Clients were informed that participation was voluntary and would have no impact on receipt of services provided by Meals on Wheels. A total of 64 Meals on Wheels clients agreed to participate in the project.

Survey Administration

Meals on Wheels staff members and volunteers administered survey questionnaires during in-person visits in participants' homes. During research visits, interviewers read survey questions out loud to participants and recorded their responses on survey forms. To ensure standardization of survey administration and data collection throughout the study, social work researchers conducted several training sessions with all interviewers prior to data collection.

Instrumentation

The interviewer-administered questionnaire included a battery of basic demographic items, several inventories dealing with respondents' physical and mental health, and a number of previously validated scales which are described below. These measures make it possible to examine the relationship between resilience and other important factors that may affect the well-being of at-risk, community-dwelling older adults.

Dependent Variable

The dependent variable under analysis, resilience, represents respondents' scores on a refined Resilience Scale developed by Wagnild & Young (1993). The refined Resilience Scale is comprised of 14 Likert-style survey items that tap into several important dimensions of resiliency among older adults – dimensions such as self-reliance, meaning, equanimity, perseverance, and existential aloneness. Respondents' scores on the Resilience Scale could range from 14 to 98 (alpha = 0.89). Higher scores on the Resilience Scale suggest clients are more resilient.

Independent Variable

The primary independent variable of interest in our analyses, hope, derives from respondents' scores on the Herth Hope Scale (Herth, 1996). Participants were asked to respond to 30 Likert-style questions measuring several dimensions of hope: temporality and future, positive readiness and expectancy, and interconnectedness. The scale taps into participants' tendency to look forward to the future with anticipation. Respondents' scores could range from 30 to 120 with higher scores representing higher levels of hopefulness (alpha = 0.87). Higher scores indicate more hopefulness.

Control Variables

We also control for a number of important physical, social, emotional, and cognitive factors that may have some bearing on at-risk, older adults' resilience. First, we include a composite measure for daily living impairment. The original questionnaire included an inventory of 6 activities of daily living (ADL). ADLs represent activities that people commonly do to take care of themselves and live independently in daily life. ADL measures typically include items such as the ability to bathe, dress, and feed oneself. The interviewers asked participants to indicate their level of impairment for each of 6 ADLs included in the survey. Responses for each item ranged from 0 (able to conduct activities without difficulty and has no need for assistance) to 3 (completely unable to carry out any part of the activity). Scores for the composite inventory could range from 0 to 18, with higher scores representing higher levels of impairment.

Next, we include a composite measure of participants' mental health status constructed from a series of five survey items. Respondents were asked to report whether they had recently experienced any of five common indicators of mental health impairment (e.g., feeling hopeless, problems sleeping, loss of enjoyment, feeling of little value, changes in appetite). Respondents' responses to these five items were summed to construct a

mental health status score. Scores could range from 0 to 5 with higher scores indicating that respondents experienced more indicators of mental health impairment.

The interviewer-administered survey also included a series of three items that provide a simple composite measure of participants' cognitive status. The first of the three items asked respondents to report whether they had any trouble concentrating or making decisions in the last two weeks. Responses ranged from 0 (not at all) to 3 (every day). This self-report item was accompanied by two additional items requiring the interviewer to make an assessment of the respondent's cognitive status based on interactions with them. One item asked the interviewer to indicate whether the participant had the ability to make decisions independently. Responses ranged from 0 (makes consistent and reasonable decisions independently) to 3 (severely impaired, rarely makes own decisions). The final item asked whether the respondent appeared to have short-term memory impairment. Responses ranged from 0 (no) to 3 (has memory lapses resulting in inability to perform routine tasks on a daily basis). Responses to these three questions were summed for each respondent creating a cognitive status score that could range from 0 to 9. Higher scores suggest higher levels of cognitive impairment.

Because research suggests that social support is an important resource for many older persons, we also included a variable measuring the strength of respondents' social networks. Participants were asked to respond to six Likert-style items comprising the Lubben Social Network Scale-6 (LSNS-6) (Lubben et al., 2006). The LSNS-6 assesses the nature and strength of respondents' relationships with family and friends. Scores could range from 0 to 30 with higher scores representing stronger social networks (alpha = 0.76).

Spirituality and religion are other important resources that may contribute to resilience. Therefore, we included a measure of respondents' spiritual experience in our analyses. The Daily Spiritual Experience Scale is a 15-item measure examining respondents' perceptions of the spiritual or transcendent and their interaction with it (Underwood & Teresi, 2002). Respondents' scores could range from 15 to 90 (alpha = 0.90).

Finally, we included controls for respondents' age (in years), sex (female = 1, male = 0), and race (white = 1, non-white = 0).

Results

Table 1 presents a descriptive profile of the at-risk, community-dwelling older adults who participated in the study. The average age of participants was 72.7 years (SD = 9.98). A majority of participants were female (67%), and just over half identified as white (56%). Despite being

identified as at-risk older adults, survey data suggest that most participants experienced high levels of mental health and cognitive functioning. The average participant reported very few mental health indicators (mean = 1.92, SD = 1.26) and low incidence of cognitive impairment indicators (mean = 2.32, SD = 1.78). Likewise, respondents' scores on indicators such as the spiritual experience scale (mean = 68.89, SD = 14.80), the social network scale (mean = 13.84, SD = 5.99) and the hope scale (mean = 99.92, SD = 14.07) suggest that many of the participants possessed important personal and social resources to cope with the ups and downs of life and that contribute to resilience. Indeed, resilience itself appeared to be fairly high among participants (mean = 79.42, SD = 15.90). However, the average respondent also reported a score of 9.56 (SD = 3.08) on the ADL inventory, suggesting that many study participants experienced at least some daily living impairments.

Table 1. Descriptive Statistics

VARIABLES	DESCRIPTION	N	MEAN	SD
Dependent variable				
Resilience	Resilience Scale score (range = 14 – 98)	64	79.42	15.90
Independent variables				
Age	Respondent's age (in years)	59	72.71	9.98
Female	Respondent's sex (male = 0, female = 1)	61	0.67	0.47
White	Respondent's race (nonwhite = 0, white = 1)	59	0.56	0.50
Mental health status	Mental health indicators (range = 0 – 5)	59	1.92	1.26
Cognitive impairment	Cognitive status indicators (range = 0 – 9)	59	2.31	1.78
Daily living impairment	ADL inventory score (range = 0 – 18)	59	9.56	3.08
Spiritual experience	Daily Spiritual Experience Scale score (range = 15 – 90)	63	68.89	14.80
Social network	Lubben Social Network Scale score (range = 0 – 30)	64	13.84	5.99
Hope	Herth Hope Scale score (range = 30 – 120)	63	99.92	14.07

How are these various factors related to resilience among older adults? Does hope help to predict resiliency among this group as previous research suggests? We now turn to the results of multivariate analyses to examine more closely the relationship between resilience, hope, and our other independent variables. Table 2 presents standardized coefficients from a series of OLS regressions predicting study participants' scores on the refined Resilience Scale. Model 1 includes a number of control variables representing physical, social, cognitive, and emotional characteristics that may be related to at-risk, community-dwelling older adults' resiliency. Interestingly, none of the control variables included in Model 1 were found to be significantly related to resilience. These factors appear not to be particularly helpful for predicting whether an at-risk older person in the sample will also demonstrate resilience.

In Model 2, we introduce two additional variables representing respondents' spiritual experience and the strength of their social networks. Standardized regression coefficients indicate that spiritual experience has a fairly strong and positive relationship with resilience among the older adults in the sample (0.374, $p < 0.01$). Further, the results indicate that when controlling for spiritual experience and the strength of social networks, participants' age, and daily living impairment also become significant and are negatively related to the dependent variable. In other words, when the significant effect of spiritual experience is factored into the model, age and diminished daily functioning both have a negative effect on older adults' resiliency. This supports the notion that religion and spirituality are important sources of support for many older adults and may help foster resilience.

Table 2. Standardized OLS Coefficients Predicting Resilience in At-Risk Older Adults

DESCRIPTION	MODEL 1	MODEL 2	MODEL 3
Age	-0.207	-0.282*	-0.266*
Female	0.039	-0.047	0.066
White	0.064	0.114	0.025
Mental health status	0.048	0.068	0.086
Cognitive impairment	-0.046	0.067	0.025
Daily living impairment	-0.270	-0.347**	-0.304*
Spiritual experience		0.374**	0.116
Social network		0.135	0.003
Hope			0.479**

DESCRIPTION	MODEL 1	MODEL 2	MODEL 3
Intercept	110.687***	90.695***	56.104**
R2	0.12	0.28	0.41
N	56	56	56

Note: *p < 0.05. **p < 0.01. ***p < 0.001.

In model 3, we add our primary variable of interest, hope. Tests for multicollinearity indicated very low levels (i.e., VIF scores less than 2) for all variables. The standardized coefficients reported in this model indicate that hope is a strong and significant predictor of older adults' resilience (0.479, p < 0.01). Indeed, the standardized coefficient for hope appears to be stronger than any other variable in the model. As older adults' hopefulness increases, so too does their ability to cope with the ups and downs of life. This appears to be an important resource for at-risk older persons. The results in model 3 also reveal, however, that the effects of hopefulness mediate the positive effects of spiritual experience that were found in the previous model. When controlling for hope, spiritual experience no longer has a significant effect on the dependent variable. This suggests that the positive effect of spiritual experience on older adults' resilience may be a result of the hope offered by such spiritual experiences, beliefs, and activities. Both increased age and daily living impairments continue to be negatively related to resilience. Additionally, model 3 explains a larger amount of the variation in our dependent variable than the previous two models (R2 = 0.41).

Discussion and Implications

Discussion

Our intention was to contribute to current understanding of how at-risk, community-dwelling older adults remain resilient as they encounter adaptational challenges. All of the older persons in our sample were exposed to challenges to resilience due to personal and environmental stressors such as age, poverty, social isolation, living environment hazards, and health deficits. Rather than assuming these structural factors diminish positive adaptation to stress, we empirically assessed how positive psychological factors such as spirituality and hope significantly alter the presumed impact of risk factors associated with personal and environment distress. Consistent with other studies of older populations (Chang & DeSimone, 2001), our study provides evidence that the significant presence of personal and environmental risk factors is not a sufficient basis for predicting diminished resilience in this population.

Previous research has suggested that hope is an important resource for coping with many of life's challenges (Johnstone, 2014) and may be particularly relevant for older adults (Ong, Edwards, & Bergeman, 2006; Ferguson, Taylor, & McMahon, 2017). Our findings extend knowledge in this area by looking specifically at the effect that hope has on resilience among especially vulnerable older adults – those living alone in urban communities and falling below the federal poverty line. The results of our analyses suggest that for this group of older persons, hope is a strong and significant predictor of resilience or the ability to cope with the challenges of life. Older adults in our sample who demonstrated a higher level of hopefulness (e.g., looking to the future with a sense of optimism and anticipation) also tended to be more resilient. In fact, hope was the strongest predictor of resilience in any of our models. More than social connection or physical ability, hope predicted whether at-risk, older adults exhibited resilience.

Empirically explaining the interrelationship between hope and resilience in our sample is beyond the scope of this study. Our data do, however provide a basis for suggesting a possible linkage. We reported that the spiritual experience and resilience relationship in Model 2 was not present when we entered hope in Model 3. Supported by the findings of Ong, Edwards, and Bergeman (2006), we speculated that the salience of positive spiritual experience for resilience may be linked to the hope that these beliefs and experiences offer to the vulnerable older person.

Bussema and Bussema (2000) observe that spirituality is a source of hope and provides a reason to choose life. Mednick et al. (2007) and Seligman and Gillham (2000) suggest an interactive relationship between the two concepts, pointing out that hope increases resilience and resilience, in turn, increases hope.

Snyder's (1995) conceptualization of hope highlighted the relevance of goals (what the person is expecting) and the person's perception of capacity (agency) and opportunity (pathway) to attain the desired ends. In our sample, agency and pathway do not appear to be diminished by either personal or environmental hazards. When viewed through the spiritual experiences lens, hope can flourish in the context of a viable sense of agency such as being faithful to or serving God and available pathways such as adherence to faith practices (prayer, worship, and/or service).

Hope may also be influenced by religious and spiritual beliefs that are reinforced and sustained by faith practices. The impact of spiritual beliefs and practices may be explained through the lens of the selective optimization with compensation model proposed by Baltes and Baltes (1990). These beliefs may be accounted as personal assets and also a basis upon which to reduce the salience of economic, health, and environmental hazards. Finally, the finding that hope and meaning in life are reciprocally related (Ferguson,

Taylor, & McMahon, 2017) may also prove to be important in explaining how hope contributes to resilience among economically and socially vulnerable older persons. Rigorous survey research and in-depth, qualitative studies are needed to test these ideas as well as sort out other possible explanations for the impact of hope on thecounterintuitive finding that resilience thrives in the context of oppressive social and economic challenges.

Implications

One of the primary questions this study raises for social workers and congregational leaders who work with older adults is whether hope is a modifiable construct and whether hope-building and hope-sustaining assessment and interventions, particularly those that engage the spiritual experiences of the older person, may be effective approaches for strengthening and sustaining resilience. If so, effective practitioners should be aware of and comfortable with utilizing hope-building interventions.

Recent scholarship has sought to identify clinical interventions and applications that help to create and sustain hope in individuals' lives (Bassett, Lloyd, & Tse, 2008). For example, Weingarten (2010) stresses the importance of helping persons practice "reasonable hope," focusing family clinicians on goals and expectations that are, in the perception of the client, attainable. In this model, practioners are reminded that hope is dialogical rather than one-way. It is co-created in conversation and cannot be instilled. It is relational and a process rather than an end in itself. In this approach, social workers will be most effective when tuning in and bearing witness to the source(s) of hope, deeply listening for the sense of agency and pathway revealed in the narrative, seeking to honor and strengthen these dimensions of hope. In addition to the micro-level intervention possibilities, case management and macro interventions are needed to address factors that may interfere with agency and pathway such as access to health care, isolation, and living environment challenges. The current initiative to eliminate the relational aspect of the Meals on Wheels program is an example of the importance of macro work. For many older persons like those in our sample, this nutrition program offers meals through personal delivery. In some cases, this may be the only human contact available for the recipient. State legislatures are considering a plan for bulk delivery of frozen meals by package delivery services. In a recent pilot study, Thomas and Dosa (2015) found evidence for the benefits of the personal delivery approach. In this case, social work advocacy is needed to retain the relational aspects of the program that may be perceived by the older person as hope-promoting. Similar social policy and organizational advocacy opportunities are all too available in the context of scarce resources that are increasing vulnerability in this older population.

Our findings on the relevance of spiritual experiences for hope-promotion, suggest that the relational partner may be God with reasonable hope co-created in this attainable and sustained relationship. When agency and pathway are spiritually energized, social workers, mindful of the ethical integration of faith and practice, may engage the vulnerable older person in at least two roles-counselor and facilitator. Assuming cultural competence in understanding spiritual experiences, the social worker as counselor engages the co-creation process described by Weingarten (2010) and thereby strengthens client perception of agency and pathway. If the older person's hopefulness is embedded in faith practices and relationships with a congregation, the social work as facilitator could activate a more supportive and enriching spiritual experience for both the older person and the congregation. Guidelines for this work are provided in Myers, Lawrence, and Jones (2013).

Limitations

There are several limitations of the current study that must be taken in to consideration. First, our sample is relatively small (n = 64). A larger sample is preferable for multivariate analyses and will generally lead to more reliable results. A larger sample size would also make it possible to look more closely at the relationship between resilience and separate dimensions of hope. While it is not always possible to draw a large sample in community- and agency-based research due to overall size of the population, in the future researchers should seek to expand sample size based on desired effect sizes and significance levels when possible. Power analysis prior to data collection can be a helpful way to ensure adequate data is gathered for obtaining robust results from multivariate analyses.

Second, it should be noted that our findings are not generalizable to the experience of older adults across the U.S. or even to older adults in central Texas. Rather, our findings provide important insight into the experiences of a particular group of older adults in one community – at-risk, community-dwelling older persons receiving services from Meals on Wheels. Our findings reveal an important link between hope and resilience for this group of older adults, even in the face of other social, physical, and emotional challenges they experience. However, future research can explore whether this link persists among other groups of older adults and in other communities or regions.

A third limitation of the current study relates to measurement. While the initial interviewer-administered survey included several well-known and previously validated scales (e.g., hope, spiritual experiences, social networks), we also utilized data from indexes included on the survey that were relatively untested and had not been previously validated (i.e., cogni-

tive impairment, mental health status). Future research should continue to test the validity of these items as well as their utility for predicting resilience and their correlation with hope. Despite these limitations, we believe our analyses point to an important finding with significant implications for practice and for future scholarship on resilience among older adults. Hope is an important resource for many older adults. Finding ways to help them foster, strengthen, and maintain hopefulness in the face of challenges may be an effective way of improving their health and well-being.

Conclusion

Recent major public policy and administrative changes, such as the growth of Medicaid-waiver long-term care options, signal a transformational shift away from institutional care to in-home and community care options. These innovations are driven by concerns over rising long-term care costs, aging of the Baby Boomer population, and growing commitments to promotion of resilience and well-being of older persons. Fostering resilience is a key component in preventing removal from the home environment and placement in a long-term care setting, a central facet of current long-term care health care policy. Our study provided evidence that hope has a positive and substantial relationship with resilience among a population of older adults encircled by challenging personal and environmental hazards. We note that spiritual experiences may illumine the linkage between the two concepts and we encourage future investigations aimed at fuller understanding of this relationship. We conclude that the intention of vulnerable older persons in our communities and congregations to embrace and sustain hope is a sacred opportunity for social workers to walk along side of them in ways that honor and strengthen this virtue. ❖

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The Congregational Social Work Education Initiative: A New Pathway in Field Education and Community Partnership

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Abstract

Unique community challenges require unique and creative solutions so that the local human service delivery network can effectively bridge service gaps. Congregations and other religiously-affiliated organizations represent a community resource, largely untapped in both traditional and nontraditional ways. Congregants and the larger underserved community may require specialized skills and services that the organization is ill-equipped to manage, while social work educators are always seeking dynamic and enriching field experiences for student learners. The Congregational Social Work Education Initiative (CSWEI) is a unique field education program, which partners with a local congregational nurse program to provide an array of services within faith-based and religiously-affiliated organizations. This article will outline the CSWEI's history, structure, and outcomes, as well as offer a brief discussion of the history of social work within congregations.

Introduction

Burgeoning social service needs can create numerous opportunities for social work field education, which in turn can simultaneously provide communities with high quality, no-cost services. Ten years ago, during the fragmented dismantling and privatization of North Carolina's mental health system, and only months before the onset of the Great Recession, the Congregational Social Work Education Initiative (CSWEI) commenced

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services. Its goal was to erode barriers to medical and behavioral health care, develop an enriching field education experience for both graduate and undergraduate social work student learners, and partner with the Congregational Nurse Program (or CNP) to create a holistic, multidisciplinary team working within local congregations, faith-based agencies, and other religiously-affiliated organizations (RAO's).

Complex problems require new and creative solution-focused pathways. Placing social work students in religious congregational settings represents a significant shift from traditional social work placements, especially for educators working within a public university system. CSWEI thus serves as an innovative program model that has broad implications for social work educators, student learners, congregants, underserved community members, and RAO's. We describe the program's creation, as well as the model's benefits and challenges, briefly discuss congregational social work within the context of faith-based settings, and outline implications for future programmatic innovations.

Social work field education has been designated the signature pedagogy which represents "the central form of instruction and learning in which a profession socializes its students to perform the role of practitioner" (Council on Social Work Education, 2012, p. 8). Researchers support CSWE's assertion that field instruction is one of the most critical elements of social work education given its robust correlation to the development of strong practitioner skills (Fortune, McCarthy, & Abrahamson, 2001; Wiebe, 2010; Deal & BrintzenhofeSzoc, 2004).

Traditionally, social work interns have been located in secular community placements, most frequently in public sector agencies or private, non-profit organizations. Despite the church's long history of acting as a social service delivery system, schools of social work education have purposefully distanced themselves from churches or other faith-based organizations. Cnaan, Wineburg, and Boddie (1999) write extensively about the longstanding tension between religion and the profession of social work, yet note how faith-based initiatives have been touted as an important community service support by prominent political figures. Conversely, the importance of spirituality and religion within social work education programs is well supported in the literature (Barker, 2013; Furman, Benson, Canda, & Grimwood, 2005). Furthermore, the field of social work has long been a professional interest for many Christian students since it promotes the religious doctrines of service to others and of promoting social justice (Barker, 2013). While the social work profession often rejected the notion of faith-based or religiously-affiliated institutions, Barker (2007) notes, "The inclusion of spirituality and religion within social work is supported by the profession, including mandates from the National Association of Social Workers (NASW) and the Council on Social Work Education (CSWE)"

(p. 147). Other researchers have noted the emerging trend of congregationally based social work internships. "Congregational social work as a career path as well as internships in congregations serving older adults are signs on the horizon of the growing attention to the social work and congregation relationship" (Myers & Ellor, 2013, p. 369).

Just the word "congregational" can impact students' perceptions of social work practice. In its earliest years, CSWEI found its program name both a recruiting draw during the program's annual recruitment efforts for students interested in affiliating with a faith named internship, and a recruiting barrier for other students who wrongly perceived it to be a social work program for proselytizers. As the social work profession slowly accepted, if not embraced, congregational social work, new opportunities arose for beleaguered field education directors as they struggled to identify fresh placement sites for an increasingly competitive social work field education landscape. Similarly, students have a new field path and an opportunity to immerse themselves within a newly developing social work subspecialty.

Against the backdrop of discussions surrounding religion and its place, if any, within social work, congregations slowly emerged as viable field education placement sites. Poole, Rife, Pearson, and Moore (2009) clearly demonstrate the unique and untapped opportunities for collaboration between social workers and RAO's. In addition to the rich learning experience for students, the community benefits as a new (and some researchers note), more embracing service portal emerges for community members. Noting their work with older adults, Myers, Lawrence, and Jones (2013) opine, "Congregations are uniquely equipped to offer a range of potential services" (p. 466). Also, the stereotypical institutional chill to social services provided by a governmental agency is the antithesis to the perceived warm, welcoming environment provided by a faith entity. Smidt (2009) found that services provided by congregations are "often viewed as more personal and less bureaucratic, more holistic and less narrowly materialistic, than those provided by secular social service agencies" (p. 49). He also found that those services were offered with an efficiency, speed, and customization not found in public sector organizations. However, other studies dispute these findings, especially in rural congregations where social workers are perceived much more negatively.

CSWEI was the first and is still the sole social work internship program in our community which partners with congregations for field education placements. As noted by congregational social work research pioneers, Yancey and Garland (2014), "Social work within a congregational context is still a developing field of practice" (p. 279). Given its status as an evolving field of research and education, congregational social work has had little guidance and too few resources in the development of curriculum and resources to ensure practitioner competencies in this nontraditional

setting (Sherr & Wolfer, 2003). However, bereft of any national model or programmatic blueprint to follow, CSWEI has benefitted from the innovative program opportunity offered thereby. Since CSWEI was not encumbered at its inception by a well-researched and nationally adopted prototype, the opportunity offered the program greater creativity and flexibility to design a collaborative model which best met the needs of this community.

Community Profile

To fully comprehend the CSWEI Program, it is important to understand the two communities, one urban and one rural, wherein it operates. CSWEI operates across diverse and socio-economically challenged sub-communities. As service gaps have been identified, CSWEI has shifted its services to more targeted population groups, specifically immigrants, refugees, and persons experiencing homelessness. Older adults 64 years of age and younger have also been identified as an underserved group by the Initiative's funder.

CSWEI primarily serves the residents of Greensboro, NC. Part of a Metropolitan Statistical Area (MSA), as of 2013, Greensboro's population was 279,651 with a countywide population of 506,610 (Planning Department, 2015). Guilford County is 52% female and 47% male, 57% white and 33% African-American. Almost one-fifth (19.8%) of its residents are uninsured. One demographic, which greatly impacts the community and CSWEI's service outreach is that more than 12% of Guilford County's residents are born outside of the United States (U.S. Census Bureau, 2013). This is due to Guilford County's identification as a refugee resettlement hub. Immigrants and refugees are primarily from Latin America, with Burmese- and Nepali-speaking Bhutanese also well represented. According to the Center for New North Carolinians (2014), over one hundred twenty-five languages and one hundred forty countries of origin are represented in the Guilford County Schools. The top five languages spoken are Spanish, Vietnamese, Arabic, Jarai (a Montagnard language from Vietnam), and Urdu (Center for New North Carolinians, 2014). Refugees from Burma and Bhutan also constitute a large resettled population group in this county. This rich diversity offers an outstanding opportunity for CSWEI interns to enhance their cultural competency skills; however, the language barriers, cultural differences, and lack of health literacy create an additional hurdle when attempting to effectively serve these consumers. Despite these ongoing challenges, the Initiative successfully serves racially, ethnically, and economically diverse service areas.

In 2012, CSWEI, in partnership with CNP, was asked to expand its services immediately north of the program's primary service area, to Rockingham County, a rural county numbering approximately 94,000. When compared to that of Guilford County, the population of Rockingham County is, on average, older and far less racially diverse. Seventy-three percent of

its residents are white, 19% are African-American, and 5.5% are Latino. It is an economically distressed county with a high poverty rate. Like Guilford County, it has substantial health access challenges, since 20% of residents are uninsured (Rockingham County Public Health, 2012). Given that Greensboro remains CSWEI's primary service base, however, we maintain the focus here on activities in that geographic area.

Greensboro is an ethnically rich and diverse community, yet it faces challenges concerning poverty, food insecurity, a depressed socioeconomic base, and unmet health and behavioral needs. The recent Point-In-Time Count found 662 individuals experiencing homelessness (Partners Ending Homelessness, 2015), although most professionals in the community believe this is a woeful underestimation of the actual total. In April 2015, the Greensboro-High Point area received a dubious distinction from the Food Research and Action Center, designating the area's food hardship as the most severe in the nation. In short, this means CSWEI's geographic service area is plagued by food deserts and food insecurity (Food Research and Action Council, 2015). These community issues all impact CSWEI's service strategy and program targets.

Creation and Support of CSWEI

The original catalyst for the creation of CSWEI was the leadership of the Congregational Nurse Program (CNP). Eleven years older than CSWEI, the CNP team is comprised of seasoned, mostly semi-retired public health nurses, with a mix of paid and volunteer nurse staff. CNP's practice settings parallel those of CSWEI because CSWEI was created to partner with the CNP in churches and RAO's. The CNP serves more than 40 community partners and CSWEI ranges from 15 to 20, all within the walls of those congregations and faith-based agencies. Both programs are embedded within organizations that target vulnerable individuals. The populations served span the racial, ethnic, economic, and age spectra and include well-known entities, such as the Salvation Army, as well as local partners, including the Interactive Resource Center, the Center for New North Carolinians, and Greensboro Urban Ministry. Access to care - linking underserved individuals to a primary care provider - remains the primary goal of CSWEI and the CNP.

Cone Health Foundation, a local foundation loosely affiliated with Cone Health Systems, the tri-county's primary health care system, underwrites both CSWEI and the CNP. It is well documented that many uninsured individuals access their local emergency departments (ED) for physical health problems. However, it may be less well-known that these same patterns are also true for behavioral health concerns. With limited options for the uninsured, Guilford County mental health patients also often have to

seek treatment in emergency rooms (Guilford County Department of Public Health, 2013). Consequently, the health system is highly vested in identifying community-based programs to deter uninsured tertiary care ED visits.

Grant Support

CSWEI is 100% funded through the generous support of Cone Health Foundation. As part of their Access to Care funding focus, both CSWEI and the CNP endeavor to link underserved groups to primary medical homes, as well as offer an array of other services. For students, taking part in a grant-funded program creates both opportunities and challenges. On the one hand, it creates an additional documentation burden on CSWEI interns since the latter must collect, collapse, and submit client data on a weekly basis in order to document client outcomes and sustain grant funding. Conversely, it provides interns with extensive experience in grant-based programs, which benefits them after graduation, since most human service programs have a grant-funded component. A CSWEI graduate assistant also handles collection of the data under the guidance of the program director. In a study of challenges facing the county, underwritten by Cone Health Foundation and entitled, Meta-Analysis of Reports on Substance Abuse and Health, the authors recommended that the foundation continue funding the CSWEI/CNP model as a best practice and to "continue to support co-location of faith-based communities" (NPH Consulting, 2010, p. 9).

Mental Health

The provision of mental health services may be particularly apt for a faith community setting. Both CSWEI and CNP service programs are community-based service providers, purposefully embedded in nontraditional settings to increase individuals' and families' access to care. Providing services in non-governmental, congregational and RAO's decreases the most common barriers to care: cost, availability, and accessibility—all within a non-stigmatizing environment. The latter characteristic may be the most significant. Research is replete with the effects of stigma and shame upon individuals deciding to seek mental health care. Such concerns are still common for those considering accessing behavioral health services (Kessler et al., 2001; Corrigan, Watson, Byrne, & Davis, 2005; Arboleda-Flórez & Stuart, 2012). Rather than disclosing to an interested friend or neighbor plans to visit the local mental health center, the congregant can merely respond that she or he is heading to church. Furthermore, co-location may eliminate a common barrier of care—transportation—since many churches already offer vans and volunteers to ferry homebound congregants to church for other church-related activities.

Congregational Nurse Program

The Congregational Nurse Program nurses are considered service providers under Faith Community Nursing (FCN). Faith Community Nursing is a nursing specialty focused on health promotion and advocacy in the context of faith communities and with an intentional focus on spiritual aspects of care (North Carolina Nurses Association, 2015). The term "Parish Nursing" was changed to "Faith Community Nursing" on a national basis to be more inclusive of all faith traditions. According to van Loon (2001), a Faith Community Nurse typically provides services consisting of wellness education, advocacy, health counseling and care management to members of the faith community.

> These educational functions of a parish nurse intersect the various aspects of the church's life through the nurses' role as a wholistic [sic] health educator, personal health counselor, and advocate for health ministries…The parish nurse is a person who serves the congregation, neighborhood, and community by providing an intentional emphasis on wellness, wholeness, and prevention of disease. This teaching function is carried out in planning and organizing seminars, workshops, and classes on a wide range of health and wellness topics (Matthaei & Stern, 1994, p. 236-237).

Without the FCN designation, CNP nurses would be considered community health nurses; therefore, every CNP nurse placement must have a faith affiliation or connection. Since CSWEI and the CNP nurses are embedded together, this determines CSWEI field placements' co-location within faith-connected entities. Congregational nurses are also the primary referral source for clients referred to CSWEI. Since they are based at their assigned locations throughout the year, they have already established the trust necessary to be effective and highly-utilized service providers within congregations. Additionally, the embedded nurse can also serve as a faith-based cultural guide. "For social workers who are not part of the congregation's life, working with a congregation requires cultural competence, much like working in other cross-cultural settings" (Garland, Myers, & Wolfer, 2008, p. 262). Given the contrast between religious placements, and the historical secularization in social work practice, FCN's intentional care of the spirit has elicited some passionate ethical and boundary debates amongst CSWEI interns.

Interdisciplinary Partnerships

Although CNP's and CSWEI's faith-based, interdisciplinary partnership is unique to the field, the needs and benefits of working within an inter-

disciplinary model are well-documented. Social work's multi-collaborative practice requirements merit the need for students to acquire interdisciplinary practice skills. "Arguably social work is the joined-up profession – a profession that seeks to liaise, to mediate, and to negotiate between professions and between the professions and the children and their families" (Frost, Robinson, & Anning, 2005, p. 195).

> Any intervention must be organized in consideration of various fields of practice such as mental health, criminal justice, child welfare, and health care. As part of their education, social workers become adept at understanding the influence of factors associated with physical, mental, and social functioning. Thus, they learn to appreciate the need for interdisciplinary collaboration (Linleya, Mendoza, & Resko, 2014, p. 642).

Berg-Weger and Schneider (1998) found numerous benefits of interdisciplinary partnerships, including the transfer of knowledge, skills, and values, resource development, and cross- disciplinary communication. However, Bonifas and Gray (2013) showed that social work students evidenced "significant gains in their attitudes and values toward interdisciplinary collaboration but not in their understanding of the roles and training of other disciplines" (p. 476). Thus, CSWEI and CNP role distinction and differentiation begins the first day of pre-service, starting with the CNP presentation by CNP's coordinator, who is always a guest speaker on the first day of training. The delineation of service roles continues throughout pre-service.

Organization

CSWEI operates as a joint field program between NC A&T State University, a historically black university, and the University of NC at Greensboro, a former women's college. At the master's level, the Joint Master of Social Work Program (JMSW) is one, fully-integrated program, with students taking requisite classes on both campuses, in addition to its joint field efforts. At the undergraduate level, only the field programs are partnered, with each program functioning independently in regard to academics. This rich partnership broadens the diversity of the learning experience for CSWEI students.

With the hiring and orientation of its program director, CSWEI's sole paid staff member, CSWEI became operational on August 1, 2007. Its administrative and leadership structure is flat, with the program director reporting directly to the principal investigator, who reports to the department Chair. This administrative model is both purposeful and practical.

The lack of bureaucracy and its flat organizational chart allows CSWEI to be programmatically nimble and adaptive so that it can easily respond to community conditions. It also enhances program communication and coordination. In practical terms, CSWEI's grant award only funds the program director position and supplies; therefore, administrative oversight has had to be absorbed by existing faculty. The remainder of the CSWEI program team is comprised of its 14 student learners, seven undergraduate and seven graduate students, all of whom report directly to the program director. Nurturing leadership and administrative skill, except for the initial charter team, every subsequent CSWEI team member has been interviewed and selected by the program director, in conjunction with a panel of current CSWEI students. CSWEI is committed to diversity and this extends beyond its community placement partners. Every academic year, CSWEI's team is chosen with diversity in mind including, but not limited to, race, ethnicity, gender, sexual orientation, and age.

As the only staff member, CSWEI's program director has broad oversight and responsibility for the CSWEI Program. Usefully, the program director has dual competencies—she is both a licensed clinical social worker and has worked as a registered nurse—in order to clearly understand each discipline and the discrete service roles of both social workers and nurses. This includes direct support and direction of all student activities, including clinical supervision, all curriculum development, and teaching both field seminar classes. Additional administrative responsibilities include grant writing, completing the funder's quarterly reports, liaising with the funder and CSWEI community partners, and maintaining fiscal management of the program.

In the Field – Pre-Service

CSWEI core services are consistent with those offered in most social work field education internships. All CSWEI interns conduct comprehensive bio-psycho-social assessments, including treatment planning, crisis intervention, case management, education, advocacy, and therapy or supportive counseling, depending on whether a graduate or undergraduate student conducts the assessment. Interns benefit greatly from the flexibility of the CSWEI program because its service parameters offer broad experiential learning opportunities, as well as other community engagement activities. All of CSWEI's services are free, due to the generosity of its funder, Cone Health Foundation, so interns learn about regulatory standards through other activities. To train them for agency practice post-graduation, their productivity is loosely tracked, and the entire team is required to attend monthly 'staff' meetings. They are taught Medicaid audit criteria and professional social work documentation standards, in accordance with state and

federal regulations. During the monthly meetings, students are divided into seven two-person teams comprised of one master's and one bachelor's level student who audit each other's files. In addition to regulatory accountability, individual students learn how to accurately document client activities and to mentor one another, all of which enhances relationships between students from each class, which creates a stronger, more cohesive team.

The foundation of CSWEI's success begins with its annual fall pre-service training. CSWEI's funder mandated a 48-hour pre-service training course in order to increase the skills of team members to address the unique challenges of serving in congregational settings. At the time the program began, little available research addressed this service area, nor was there much identified supplementary training materials; hence, the curriculum of pre-service has been under the purview of the program director (Sherr & Wolfer, 2003). Beyond skill development, the primary goals of pre-service are to increase student confidence and team building. All 14 members are required to successfully complete pre-service prior to entering their field placements. Pre-service covers a host of topics and has, over time, evolved to incorporate additional materials and topics in response to community needs. A detailed list of pre-service content may be found in Appendix A.

Ethical Considerations

A strong educational focus is on ethics, boundaries, and roles since congregational settings are unique placements with unique challenges. Prior to their field placement assignment, CSWEI students are asked to inform the program director (PD) of any local faith affiliation that may conflict with CSWEI's field education placement sites to ensure students are not placed within their personal faith home. Given the profession's ethical mandate regarding the inherent complications of dual relationships, Justice and Garland (2010) caution, "Assuming clinical roles with fellow congregants with whom the social worker has other roles is another matter, however, and fraught with complications that the social worker can neither control nor foresee" (p. 439). Northern (2009) echoes the additional complications of congregational practice adding, "Church social workers do face additional issues more frequently than social workers in other contexts: dual relationships, administrative issues" (p. 283). Students are instructed in HIPAA standards to ensure confidentiality and record storage regulatory compliance. Once assigned to their field placement locations, every student is assigned a lock box to store client records, a necessity, because the interns are community-based in multiple locations. (They also need their lock boxes for general storage since they must carry all of their folders, pens, pads, assessments, blank forms, office supplies, and any other service supply needs with them). Students may frequently be

reminded of the need for boundary maintenance, given that they must also use their own vehicles and often their personal cell phones for fieldwork.

Unique Practice Skills

Social work interns must learn some foundational skills as to how to navigate the complex internal structure of congregations, which includes clergy, volunteers, and lay persons who may have informal leadership roles. CSWEI students must also navigate role differentiation with their CNP nurse partners. Sherwood (2003) listed many common issues that congregational social workers must address, including "professional role and identity; 2) competent handling of personal beliefs, values, and social work ethics; [and] 3) confidentiality and multiple relationships" (p. 1). These new and evolving partnerships present unique challenges for social workers that must also be explored. "Social work responses to faith-based initiatives must consider complex relationships between religion, culture, practice, and policy" (Tangenberg, 2005, p. 197). Tangenberg (2004) also addresses the role of the social worker and how social workers are perceived within the faith community, writing, "Some providers viewed social work and social service ministry as fairly synonymous… Others lacked knowledge of professional social work, and most associated social work with the state and public service bureaucracies" (p. 18). Congregational social work intern placements within rural faith communities offer even greater challenges. Trust is critical to becoming an effective practitioner and community program partner, but even more so with rural congregational practice. Following their literature review of how social workers can gain greater understanding of congregational social work through a rural lens, Harr and Gaynor (2014) conclude, "building trust within the community is a critical first step and should remain as an ongoing priority" (p. 150).

Ethical Integration of Faith and Practice

Professional boundaries and guidelines addressing confidentiality, boundaries, and other professional codes of ethical conduct, so much clearer against the backdrop of a sterile public service entity, become much more opaque within a congregation (Yancey & Garland, 2014). For example, a family unit as an identified 'client' differs greatly from the outpouring of care from a congregational faith family, who may share the same concerns for its members, yet eagerly asks a newly assigned intern, "We are going to prayer group; how is Bob doing?" Given the social work profession's own internal conflict with the issue, a pre-service topic that elicits vigorous debate is the question of prayer with persons served. In-depth discussion and role-plays sensitize students to these questions and help students develop

their scripts around the unique challenges they may face. The development of their scripts regarding this and numerous other situations increases their confidence and inoculates them somewhat against new-practitioner anxiety, since they feel more prepared. According to Tangenberg (2005), "Increased awareness of the diversity and complexity of faith-related services is vital to critically-informed social work practice" (p. 205). Furthermore, social workers must take time to reflect on both their roles and their beliefs when considering congregational practice. "Social workers need to be sensitive to how their own beliefs, values, and attitudes are or are not congruent with those of the congregation and its potential volunteers" (Garland et al., 2008, p. 262).

Pre-service Curriculum

An apt description of pre-service came from an MSW student who reflected that it was akin to "social work boot-camp." Pre-service is critical to determining field placements since it affords the PD an opportunity for in-depth evaluation and observation to evaluate an individual student's skills, fears, experience, and personality. The same pre-service curriculum is taught to both the graduate and undergraduate students, although undergraduates are clearly instructed about their range and scope of practice boundaries. Due to differing university field schedules, the two classes are combined only one day per week. MSW interns have 24 hours of field per week and BSW interns 16 hours per week. This provides an incredible opportunity for the MSW class to cement their roles as class leaders, educators, and mentors since they are responsible for teaching the undergraduates the material they learned the prior day. Additionally, on a rotating basis, the MSWs are assigned a project leader to direct the class as they design their teaching strategies. This increases their leadership skills and confidence, and aids in forming the team since they are forced to work together towards a common goal. Similarly, the following class period, BSWs teach the MSWs a section of material that they have learned. Not only does this create the same benefits as previously outlined, it helps mold MSW perceptions that the BSWs are not just followers, but also have knowledge and skills to contribute to the entire team, thus fostering an equal learning partner dynamic. Both classes have demonstrated their pedagogical creativity with teaching methods that included skits, songs, games, poems, and dance routines.

This team-building is a critical dynamic because, whenever possible, once in field, MSWs and BSWs are placed together so they must learn to trust and rely on one another to maximize client outcomes. Every activity in pre-service is designed to encourage relationships between students from different classes and schools, either in small work groups or two-student teams. In pre-service class, an MSW and a BSW are paired together for the

day so that by the end of pre-service, they have all worked together on a learning activity. The same format is used on days when only the BSW class is together since the BSWs are selected from two different schools.

Program Director (PD) Role

In addition to forging strong bonds amongst the student team, the intensive multi-week training also helps create trust and relationship with CSWEI's PD. A notable difference in organizational structure from most field education designs is that the PD serves in multiple roles and capacities. Coordination and communication is vitally important in CSWEI since the Initiative's 14-person team can serve up to 25 agencies in any given year. In CSWEI, the PD conducts all of the individual student supervision and is the clinical supervisor and faculty liaison, as well as the field instructor for both seminar classes. Combining the clinical supervision and field instruction roles has proven incredibly beneficial since it allows the PD to accurately assess students' skill growth and affords students an opportunity to have a trusted learning partner and mentor that they feel increasingly comfortable with and trusting of over time.

The unusually lengthy amount of time that the PD spends with each student strengthens the relationship and creates greater safety for the student learner, who can then challenge him- or herself to take greater learning risks with close support and supervision without putting the people served at risk. An individualized learning and skill plan is possible with this model, and its theoretical concepts learned in seminar can be reinforced in individual supervision. CSWEI's administrative model of collapsing the roles into one greatly enhances this process as it eliminates role confusion, and increases program coordination, communication, and collaboration. In end-of-year surveys, students consistently rate both the program and the model highly. On a 5-point Likert scale from 1 to 5, with 5 representing the highest level of satisfaction, over the course of the program, CSWEI participants, on average, rate their overall satisfaction as 4.9. Moreover, CSWEI's pre-service model has been so successful in boosting student confidence and skill acquisition that, two years ago, UNCG's JMSW Program implemented a pre-service for the remaining, non-CSWEI MSW class.

Module Project

In consultation with the congregational nurse and congregants, students develop mental wellness, behavioral health, community resource, or health literacy education modules. Harris and Myers (2013) recognize that, "the integrative field seminar is the bridge insuring learning exchanges between field and classroom, between concept and practice" (p. 53). As

noted, the PD teaches both field education courses. Except for one assignment, an educational module, most seminar assignments are similar to other programs with case presentations, logs, and process recordings. The module project increases their group presentation skills, helps them gain experience in developing wellness educational programming (with a required interactive activity), provides experience in the facilitation of psycho-educational groups, and ensures that students acquire experience in the development and administration of outcome tools by developing individual pre- and post-tests. Although almost uniformly dreaded by the team, invariably by the end of the academic year, following five to ten presentations, they report satisfaction with the learning experience. Education topics have included Deal or No Deal: Bipolar Style (Bipolar Disorder), Dysfunctional Family Feud, Wheel of Misfortune, Tic Tac Oh No (Anxiety), Get High on Life (Substance Use), Bounce Back Bingo (Depression), Who Wants to Be a Millionaire (financial literacy/budgeting), Bowl Away Your Anger (Anger Management), Do You See What I See (Schizophrenia), He Loves Me-He Loves Me Not (domestic violence), Healthy Aging Bingo, and Grief and Loss Jeopardy.

Congregations are effective venues for health, behavioral health, substance use, and health literacy education. Congregations already convene many small groups, so adding a 30- to 40-minute interactive workshop to a pre-existing group is a non-stigmatizing way to ensure that an affected congregational member learns more about a particular topic. Since the student chooses topics based on either a congregation-wide interest survey (a skill acquisition activity for interns) or in consultation with the trusted congregational nurse, the subject matter has relevance for participants. Students benefit because they learn to develop client-driven curricula, and gain presentation and facilitation experience in a supportive environment. Finally, the activity creates opportunities to greatly increase student confidence.

In the Field—Community Partnerships

Having successfully completed pre-service, CSWEI students are then assigned to their field placements. Every CSWEI intern has a minimum of two different placements per week. CSWEI uses a multi-agency split time rotation design (Gough & Wilks, 2012), chosen for its numerous learning benefits. CSWEI's rotational model encompasses many of the benefits of a rotational system while limiting many of its challenges. Gough and Wilks' (2012) comprehensive literature review discusses the benefits and shortfalls of each. Benefits include increased confidence, increased self-efficacy, greater community resource knowledge, broader depth of experience and context of learning, increased cross-collaboration skills, and increased

exposure to different population groups. CSWEI's administrative model, and the multiple roles under which the PD operates, seems to mitigate many of the concerns outlined in their literature review. Students maintain the supervisory relationship since the PD is the clinical supervisor for the team for the entire academic year. According to Maynard, Mertz, and Fortune (2015), programs should use the same pair of off-site MSW instructors or task supervisors over time. Having the same off-site MSW instructor and task supervisor work together over multiple years can help create stability, constant communication, and understanding between the off-site MSW instructor and the task supervisor (p. 532).

Administrative protocols and CSWEI's overarching program expectations, roles, and assignments remain the same as well. This configuration of the model also eliminates the change-of-semester placement anxiety, given that students remain in these same placements for the entire academic year. Additionally, the interns' primary service partner, the congregational nurse, is unchanged, so students have multiple relationships to anchor them, despite the initial anxiety that a multi-agency schedule can evoke. Students are placed with a congregational nurse, another CSWEI student, or both.

Unique Features of the Model

CSWEI adds many unique components to the traditional field education model. As noted, whenever possible, MSW and BSW students are placed together in pairs. This affords the MSW student the opportunity to undertake some task supervision activities, as well as to mentor the undergraduates, both of which enhance leadership skills. Additionally, with shared placements, every MSW has some supervisory accountability over an undergraduate, even though they may not be in the placement on the same day. On field days when only BSWs are in field, there is also a designated leader within each placement. MSW students serve essentially as middle management within the CSWEI model. Such activities develop MSW leadership skills and allow the students from different classes to maintain strong relationships throughout the year, thus forging strong bonds and feelings of being part of a team. Anecdotally, this mentorship also illuminates why such a high percentage of CSWEI BSWs continue their academic training to obtain their MSW. Some of the most frequent written feedback is that CSWEI student participants report feeling like a "team" and "family."

Placements

CSWEI field education placements reflect the diversity of the community. As noted, all CSWEI placement sites have some religious affiliation or faith connection. A shift in funding interest and community needs

has caused a change in CSWEI's placement solely within congregational settings. CSWEI/CNP placements include organizations that serve immigrants - primarily Latinos, refugees (Montagnards, Burmese, Bhutanese, Congolese), older adults, and persons experiencing homelessness (PEH). Community placement partners include Faith Action International House, Greensboro Urban Ministry, Center for New North Carolinians, Salvation Army Center of Hope, New Arrivals Institute, and the Interactive Resource Center. Each partner offers interns a unique learning experience, but the Interactive Resource Center (IRC) has evolved into CSWEI's most robust program partner.

The IRC is a day center for individuals at risk of or currently experiencing homelessness. The Center provides services to almost 200 "guests" a day. Created through community grassroots efforts, CSWEI became its sole social work guest services arm when the program became affiliated with the agency within two weeks of its opening. CSWEI's presence is so large and the needs are so great that the organization built and designated five intern offices. CSWEI's PD also conducts individual supervision there and convenes field seminar in designated space within the agency. The generous community office accommodation also allows the PD to be community-based, which is critical when students contact the PD regarding an at-risk client. With this central location, the PD can arrive at any local placement within 10 minutes. Initially located within a local Methodist church, the IRC's size and scope of services quickly warranted a larger site.

Internship Learning Opportunities

CSWEI student learners are trained in CSWEI's core services array: bio-psycho-social assessments, including treatment planning, crisis intervention, case management, education, advocacy, and therapy or supportive counseling, depending on class designation. These practice skills are well-honed during the pre-service training, especially risk assessments. Each service is available at every placement location, although the rate and frequency of utilization varies for individual service settings. For example, risk assessments are conducted daily at the IRC, who serve PEH with complex behavioral health and substance abuse issues, while therapy, education modules, and case management may be accessed more often at other sites, especially congregational settings. All of CSWEI's services are low-barrier services without regards to cost, insurance status, or documentation status. The congregational nurse, clergy, and agency staff can refer individuals, or individuals may self-refer.

Mental health. CSWEI's mental health therapy services have also been a frequently-utilized service since the program's inception, especially following the global financial crisis. In its 2009-2010 report, NCDHHS found

that Guilford County's public mental health system provided services to less than half (43%) of individuals with mental health needs, and even more dismal, only 10% of the estimated adults needing substance abuse services. Members of faith communities experience similar unmet needs. In Rogers, Stanford, and Garland's (2012) study of the impact of mental illness on families within faith communities, they concluded that mental illness was present in 27% of congregant families, and that those families reported double the stressors. Despite the identified need, Frenk's (2014) study found only 8% of congregations sponsor social services for people with mental disorders, and that sponsorship was greatly influenced by the religious tradition of that church. He also determined that few churches sponsor any programming for those with mental health disorders specifically, and that, if provided, these services are provided by clergy who very often do not have the skills to identify and treat those congregants requesting services. This conflicts with a therapeutic reality wherein "one quarter of the people who ever sought care for mental disorders sought it from clergy" (Wang, Berglund, & Kessler, 2003, p. 653).

The importance of mental health needs of congregants is supported by Carroll (2006) who found "clergy report spending more hours per week engaging in counseling than engaging in evangelism or being involved in community affairs" (p. 107). This denotes a pastoral conundrum for clergy who may feel ill-equipped to provide services effectively and who were called to religious service to become spiritual leaders rather than clerical therapists. The confluence of need and expertise may explain the success of CSWEI's congregationally-based therapeutic service efforts to fill this service void. It offers opportunities for CSWEI interns to flex their clinical muscle, meet congregant needs, and assist overburdened clergy, all within a welcoming environment.

Case coordination. The most frequently accessed service across all service domains is case management/case coordination. Case management has long been a fundamental service of the social work profession, linking individuals in need with appropriate community services. Its core components include assessment, resource coordination, treatment planning, education, and client advocacy. With CSWEI's service focus on the underserved—immigrants, refugees, older adults, and persons experiencing homelessness—client requests for case management services is understandable. For students, case management is more of a hybrid service because many individuals initially enter CSWEI services seeking some basic human needs, housing, food, medical care, or employment. Once engaged, and trust is established, it very frequently evolves into a traditional therapy service relationship. This is very important to highlight, especially to CSWEI's MSW program participants, as they often cite their career goal as that of a "therapist," and they may initially bemoan this aspect of their field experi-

ence as "not clinical." This response is a common occurrence as Xenakis and Primack (2013) note: "Many MSW students become disillusioned if their field placement does not provide the clinical experience they envision as necessary to becoming mental health professionals" They conclude that, "ideally, the field experience should emphasize integrated case management, incorporating the two broad functions…as a clinical social work function that can optimally serve the needs of clients if practiced correctly" (p. 686).

Administrative learning. Once CSWEI MSW interns experience the broad clinical opportunities case management can bring, the initial concerns quickly dampen. In order to replicate agency practice post-graduation, CSWEI MSWs rotate in the role of 'clinical director'. CSWEI team members who encounter an individual experiencing safety issues of harm to self or others, the team member—under the supervision of the PD, an LCSW—must 'staff' the case with the designated MSW student clinical director to determine the treatment plan. This provides real world experience, and an opportunity for clinical critical thinking skills for the MSWs. It also, again, forces the team to rely on one another and maintain the team-spirited ethos of the Initiative. Texting is a major method of contact for both the interns and PD, and it enables the intern to quickly alert the PD in case of immediate clinical consultation.

Another non-clinical activity that helps mold CSWEI MSWs into future leaders is the rotation of the administrator on duty (AOD). The large contingent of interns at the Interactive Resource Center necessitates an administrative role to coordinate the daily activities of the team. The AOD makes room assignments, tasks individual team roles and duties, manages client flow, coordinates breaks, liaises with IRC staff, and essentially serves as a program director for the day. Where MSWs and BSWs are placed together in congregational settings, the MSW assumes the role of both AOD and clinical director.

Advocacy. Lastly, CSWEI interns serve as advocates. Advocacy as a social work core value is represented in both a field seminar assignment and a field education responsibility. The CSWEI syllabus reads as follows;

> Advocacy is a core value of social work practice as reflected in both our NASW Code of Ethics and CSWE's Core Competencies. Students will engage in one advocacy activity consistent with social work's core values. This may include, numerous activities, such as a rally, petition, 'walk' for any cause advancing social justice or supporting a specific human service organization, voting, etc. (Pearson, 2015, p. 12).

With CSWEI's unique administrative model, and the flexibility afforded by its funder, as the field supervisor, the PD can approve field time

for community advocacy activities. Interns learn the value of advocacy on a larger scale and have an opportunity to network with other organizations. Advocacy activities have included The Human Race (fundraising walk for numerous local nonprofits), IRC's -A Night of Remembrance (honoring the deaths of PEH), March of Dimes Walk, Lobby Day at the NC General Assembly, Deaf Awareness, NC General Assembly Social Work Advocacy Day, BRAVE (sexual assault and domestic violence), Winter Walk for HIV/AIDS, and Rally for Recovery. The core values of social justice and advocacy correlate with many congregations' own community advocacy efforts. CSWEI interns, serving in a faith-affiliated institution, have more opportunities to capitalize on the pre-existing energy and efforts of their congregations. This opportunity highlights the broader social work learning opportunities within these nontraditional, faith-based field placements. Maynard (2015) states, "many nontraditional organizations offer superb learning opportunities, especially for students interested in macro practice, management, vulnerable populations, and social justice" (p. 532).

Innovations and New Directions

As previously noted, CSWEI has proven itself to be a programmatically nimble model. It has quickly responded to changing community service needs, adopted the latest evidence-based practices, and incorporated new technologies into its program design. Although CSWEI was originally developed from an interdisciplinary, collaborative program model, it is continuing to refine this design and further evolve. With the advent of newer evidence-based treatment models, CSWEI is currently, as of this writing, moving from a co-located, interdisciplinary model to a multidisciplinary, Integrated Care model. Integrated Care is the "systematic coordination of general and behavioral healthcare" (SAMHSA, 2017). According to SAMHSA (2017), "Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs" (para 3). With Cone Health Foundation's generous support, CSWEI is being guided in this effort by the Center of Excellence for Integrated Care, which has provided training and technical assistance to ensure that CSWEI adheres to the fidelity of the model.

Currently, CSWEI is actively transitioning to a partnership with a local nonprofit integrated care clinic that operates within the Interactive Resource Center, to provide Integrated Care services to uninsured individuals experiencing homelessness. The CSWEI MSW works directly alongside a nurse practitioner and provides behavioral health screenings and brief interventions, while the nurse practitioner simultaneously provides medical services. Not only has this been proven to be a highly effective model, it

greatly enhances the skills of the participating CSWEI interns and provides employment advantages at graduation as this is the latest trend in care. The students will continue to closely partner with the Congregational Nurse Program because they are involved in this new care continuum.

Another innovation that CSWEI has added is the incorporation of more technology into the student learning process. According to McGovern, Luna-Nevarez, and Baruca (2017), "as more students organize and align their everyday activities around mobile apps, it is essential for business educators to experiment with such tools and make the classroom experience more relatable to the new norm of students' lifestyles" (p. 95). The authors found that tablets were the preferred mobile device for students. At every high client volume agency, interns have access to a tablet provided by the Initiative.

Every CSWEI student is also required to download MedScape, a common medication application used by many medical providers. This provides both an instant resource for learning about medications and their purposes, including both medical and mental health medications, since CSWEI will operate in an Integrated Care setting, but it also adopts the preferred learning modality—technology—of student learners. Interns have also been required to download one of the common group communication applications, such as GroupMe. Initially, this was required for coordination and communication amongst the student team, although it never included client data. As students relied on the app, it quickly morphed into a way for the students to motivate, support, and encourage one another. The unintended consequence was that use of the application strengthened the CSWEI interns' bond and sense of team and belonging, especially among those who did not see one another routinely across various placements (Poole, Pearson, Rife, & Moore, 2017).

Conclusion

To date, CSWEI has provided direct and indirect services to 18,109 individuals. This includes 16,248 client contacts and 594 risk assessments for persons served in acute psychological distress, who were at risk of harm to self or others. Crisis intervention services is a service outcome that has only been tracked for the last five program years, since January, 2012, so actual crisis service outcomes are much higher. Since it commenced services, the Initiative has expanded to 2 counties and grown to 14 student team participants. To date, it has graduated 131 students, with one returning to the university as an adjunct professor. Over the course of the program, it has affiliated with several different faiths across the religious spectrum and it is connected with every major religiously-affiliated organization in the area.

With CSWEI's successes also come numerous challenges. With only one funder, program sustainability is an ongoing issue. As a permanent

program staff of one, CSWEI has also reached program capacity in regard to its ability to expand services to other agencies and its ability to expand the student team. Every year, the PD must decline requests to place an intern within an organization or expand within an existing partner placement. Of the 131 graduates from the CSWEI Program, one student raised concerns about the administrative model. The administrative structure of key leadership holding multiple roles creating, for this student, a sense that there was not a person outside of the Initiative to whom she could voice concerns. We did not change the structure, but did create and incorporate a process through which students can express concerns to academic department leadership not directly involved in delivery of the model.

Competition for MSW students throughout the human service community is high, so recruitment at the MSW level can be difficult, especially with the previously discussed "congregational" moniker of the Initiative. CSWEI competes with other placements that may offer a large stipend, although this has been eased with a recent university grant award from the Health Resources and Services Administration (HRSA). Contingent upon funding, CSWEI has offered small stipends intermittently to offset student out-of-pocket costs.

RAOs and other faith-based entities offer a unique, diverse, and enriching learning environment for student learners, yet historically it is a setting avoided by field educators. The CSWEI model demonstrates how creative collaborations can enhance student skill development while simultaneously bridging community gaps in care. A primary goal of this article is to encourage other communities to expand programs beyond traditional field partners and replicate the model. There exists an intersection of community health needs and a need for dynamic field education placements. Capturing this programmatic potential requires identifying new pathways and engaging new partners.

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Appendix A

CSWEI Pre-Service Curriculum

1) What is the Congregational Social Worker Educational Initiative [CSWEI]
2) What is the purpose of the Initiative and why is it so important
   a. ACCESS to CARE
   b. Description of project
   c. Areas of need and funder priorities
3) How has CSWEI grown?
   a. Partnership to Address Mental Health, Substance Abuse, and Co-Occurring Disorders in Vulnerable Populations
   b. Rockingham County Project
   c. HOPES
4) How is CSWEI related to the Congregational Nurse Program
5) How is CSWEI different/similar from other internships/field instruction experiences
6) What challenges and strengths/benefits would you anticipate encountering in this unique setting
7) How will success be defined [by]
   a. Students
   b. Consumers

c. Funders
d. Community and community partners
e. Relationship, relationship, relationship
f. CSWE Core Competencies

8) What do you need to know now
   a. Intern safety protocol
   b. Evidence-Based Practice [EBP]
      i. Principles of Recovery and Person First/Centered Language
      ii. Motivational Interviewing
      iii. Health literacy, "Ask Me 3" campaign
      iv. Patient navigators [community health worker]
      v. Incentive Contingency Management

c. Diagnostic overview of mental illness [MI] and substance abuse [SA]
      i. Prevalence
      ii. Overview of symptoms
      iii. Mental status exam [MSE]
      iv. DSM-IV-TR vs. DSM V and what's a WHODAS?

d. Help, my client said suicide!
      i. Conducting a thorough crisis/risk assessment
      ii. Developing a safety plan
      iii. Risk factors

e. Confidentiality and its limits
f. Brief overview of psychotropic medications [antipsychotics, antidepressants, mood stabilizers, and anti-anxiety meds]
g. Bio-psychosocial issues associated with aging and related g erontological concerns
h. Cultural sensitivity and cross-cultural competence
i. Immigrants and refugees
      i. How to work effectively with an interpreter
      ii. Interpreter versus translation services

j. Documentation: Initial assessment and ongoing documentation
      i. Developing a treatment plan [follow up, follow up, follow up]
      ii. Principles of case management
      iii. Case management, supportive counseling, or therapy oh my
      iv. S.O.A.P.

k. Administration of screening tools
      i. Screening instruments: The good, the bad, and the funded
      ii. Introduction of a screening instrument into the therapeutic process
      iii. The GAIN-SS [Global Appraisal of Individual Needs-Short Screener]
      iv. Depression screening

l. Resource development: Information and referral [See attachment]
m. De-escalation: The art of the calm
n. IRB & Data collection, data, data, data: Why, why, why? [Direct/indirect service data]
    i. The GRID
    ii. Pre- and post-test ["On a scale of 1 to 5…"]
    iii. Stories of impact [SOI]
    iv. Person Served Questionnaire
    v. The GAF Scale [Global Assessment of Functioning] vs. DSM-5

9) What other topics will be addressed
    a. Safety first-again
    b. Boundaries [intern-client, intern-nurse, intern-clergy or congregation, intern-agency]
    c. NASW Code of Ethics and ethical dilemmas: Is a brownie just a brownie?
    d. Direct practice skills
    e. Is acknowledging spirituality ok?
    f. Role conflict or difficulty with role differentiation
    g. Working within an interdisciplinary team
    h. Client record management
    i. Client termination
    j. Mental Health Reform: The privatization of MH/SA services
    k. Challenges of implementing a pilot program underwritten by an external funder
    l. What does 'professionalism' mean and what responsibilities does it entail; a.k.a. Also, see NASW Code of Ethics
        i. Punctuality
        ii. Productivity [Quality versus quantity]
        iii. Responsibility [to clients, your team members, your supervisor, your placement, your funder]
        iv. Social media

Spiritual but not Religious: The Fine Line Between the Sacred and Secular on the Camino de Santiago

Buetta Warkentin

O God, who brought your servant Abraham out of the land of the Chaldeans, protecting him in his wanderings, who guided the Hebrew people across the desert, we ask that you watch over us, your servants, as we walk in the love of your name to Santiago de Compostela.

Be for us our companion on the walk,
Our guide at the crossroads,
Our breath in our weariness,
Our protection in danger,
Our refuge on the Camino,
Our shade in the heat,
Our light in the darkness,
Our consolation in our discouragements,
And our strength in our intentions.

So that with your guidance we may arrive safe and sound at the end of the Road and enriched with grace and virtue we return safely to our homes filled with joy.

In the name of Jesus Christ our Lord, Amen.
Apostle Santiago, pray for us.
Santa Maria, pray for us.
(Pilgrim's Prayer found in the 12th Century Codex Calixtinus).

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In the spring of 2016, while on sabbatical as an educator from a faith-based social work program, I completed 700 kilometers of the Camino de Santiago pilgrimage in Northern Spain. My sabbatical goal was to explore the intersection of spirituality and social work, to look at theological connections between faith and social work practice both historically and currently, and after ten years in academia, to experience a time of spiritual renewal that was offered on the Camino journey. In the following article I will review literature on the intersection between spirituality and religion in society, and their corresponding emergence in social work. I use autoethnographic research methods (Witkin, 2014) to explore and engage in this discourse of the spiritual and religious within my own personal experience of the Camino pilgrimage. Insights and implications for social work practice are further discussed.

Spiritual But Not Religious

Harvey Cox (2009), a theologian who writes on the topics of faith and secularism, recounts a story by Miguel Unamuno, a Spanish writer from the early 1900s. The story tells the experience of a young man who is brought to his mother's bedside in a small Spanish village. As she is dying, she asks him to pray for her. He says nothing to her, but as he leaves the room he tells the priest that he does not believe in God, and therefore cannot pray. The priest says, "That's nonsense, you don't need to believe in God to pray" (p. 3). This sense of paradox seems to be an evocation of the renewed emphasis of the spiritual as opposed to religious. We find ourselves in a world that has sought meaning and truth first in dogmatic religious absolutes, then in secular, scientific reasoning, and now we find ourselves reaching for a deeper connection to the spiritual as we make meaning of our world (Taylor, 2007; Cox, 2009).

The Modern Era emerged from the Enlightenment and sparked a world to be studied and explained with science and reason rather than religion, tradition and authority (Caputo, Epstein, Stoezs & Thyer, 2015; Taylor, 2007). It marked a shift from earlier times when "religious life was more 'embodied,' where the presence of the sacred could be enacted in ritual, or seen, felt, touched, walked towards (in pilgrimage)" (Taylor, 2007, p. 554). Yet there was dissatisfaction with the modern, progressive understandings of the world and our part in it. As we became less certain about the universal truth of the Enlightenment and the Modern Era, we moved into postmodernism, which was suspicious of objectivity, and questioned authority whether from religion or from science. It identified the role of power in the creation of knowledge, and emphasized personal experience, pluralism, and multiplicity of truth (Caputo et. al, 2015). Cox (2009) tracks adjustments in our understanding of faith, noting that as we move

through postmodernity, we live into the Age of the Spirit with a renewed interest in direct individual experience of the Holy Spirit. While society has seen a decrease in religious participation over the last number of years, this has not translated into a straight forgoing of religion for secularism. Wilkins-LaFlamme (2015) looks at the increase in those individuals who identify as "religious nones" (p. 478) and discovers that while fewer people are identifying with institutional religion, within this group there remains a complex interest in religious and spiritual beliefs. While disenchanted with religion, people are still seeking ways to find deeper meaning in their experiences and their lives (Taylor, 2007; Wilkins-LaFlamme, 2015; Ammerman, 2013; Coates, 2007). We find an increase of those who would identify as spiritual but not religious.

In recent years we have also witnessed a parallel resurgence in the interest in spirituality in social work practice. While social workers have expressed suspicions of religion and uncertainty about spirituality and their appropriateness or inappropriateness in the work we do, in the last 25 years we have begun acknowledging and exploring the significance of spirituality in the lives of our clients and ourselves as social workers (Canda & Furman, 2010; Dudley, 2016, Coates, 2007; McKernan, 2007). We have found that while our clients may be less connected to religious institutions, they still yearn for spiritual connection and experience (Canda & Furman, 2010; Dudley, 2016). We have begun to acknowledge the spiritual space that is created in the work that happens with our clients, and the work of meaning-making that is at its core (Coholic, 2007).

The Camino de Santiago pilgrimage has also echoed this shift to the spiritual, with a turn from being a clearly religious ritual to a spiritual path that verges on cultural tourism. There is a greater number of pilgrims who identify as not religious, but spiritual at heart, seeking insight, healing and strength in their journeys both on and off the Camino. The pilgrimage is an opportunity for meaning-making that moves through and beyond religious ritual to spiritual expression.

The History of the Camino de Santiago Pilgrimage

The Way of St. James or the Camino de Santiago, is a group of ancient Christian pilgrimage routes through Northern Spain that lead to the city of Santiago de Compostela, where the relics of St. James are said to lie. Legend states that St. James travelled to Spain to preach but returned to Jerusalem where he was martyred. The legend continues that his body was miraculously taken to Galicia where it was buried and forgotten until 813 AD when a shepherd followed a bright light or star to a field with a burial site with a body that was declared to be St. James. The location came to be known as Santiago de Compostela–St. James of the Field of Stars, and St.

James became the patron saint of Spain (Brierley, 2016; Giles, 2001; Mullen, 2010). By the year 950 AD, the first pilgrims, or peregrinos, began travelling to Santiago de Compostela, with tens of thousands of pilgrims walking the journey each year in the Middle Ages, making it as popular as the pilgrimage routes to Rome or Jerusalem (Brierley, 2016). At its peak in the 12th to 14th centuries, 150,000 to 500,000 pilgrims journeyed annually (Giles, 2001; Mullen, 2010). Historically, some pilgrims walked for themselves, some walked in the place of loved ones, and still others were criminals and forced to walk as punishment (Brierley, 2016; Giles, 2001; Mullen, 2010).

Traditionally, for religious Catholics, completion of the pilgrimage results in the intercession of St. James and forgiveness of one-third of the pilgrim's sins, while attendance at various shrines along the way increases this, and a pilgrimage in a Holy Year, as declared by the Pope or when St. James' birthday falls on a Sunday, results in full remission of sins. Walking pilgrims who have completed at least the last 100 kilometers on foot receive a certificate or Compostela, which accredits their pilgrimage (Pilgrim's Reception Office, 2016; Mullen, 2010). While the popularity of the Camino diminished over the centuries, there has been a resurgence in recent decades, with the Pilgrim's Reception Office (2017) and the Confraternity of St. James (2016) noting statistics of pilgrims receiving the Compostela rising from around 2,500 in 1986, to 100,000 in 2006 and just over 277,000 in 2016. The four main Camino de Santiago pilgrimage routes in Spain and France were inscribed as UNESCO World Heritage Sites in 1993 (United Nations Educational, Scientific and Cultural Organization, 2016).

Religion and Spirituality on the Camino

The shift in pilgrim traffic on the Camino de Santiago provides evidence of a changing worldview and emergence of the "spiritual but not religious" perspective. Few pilgrims who journey today do so to receive indulgence and forgiveness of sins, and indeed there is evidence that the rise in pilgrims on the Camino de Santiago is more closely related to tourists than religious pilgrims (Aviva, 1998; Herrero, 2008). Frey (1998, cited in Herrero, 2008) notes that the recovery of the pilgrimage route has not been connected to faith, but to an increased interest in tourism, tradition and syncretic spirituality. Aviva (1998) speaks of the 'McDonaldization' of the Camino. The secularization of the route meant that religious symbols and legends were shifted into cultural capital and historical heritage. Various Pilgrim's Way Friends Associations have emerged that promote tolerance of diverse motivations for pilgrimage, while the Catholic Church maintains a more orthodox religious motivation focused on devotion to the Apostle St James as opposed to connection with the cultural or historical significance of the route (Herrero, 2008). Luik (2012) notes that pilgrims may fall

somewhere on a continuum between those who journey as pilgrims with clear religious purposes, to those who seek personal reflection and more general spiritual development, and those who journey as tourists. Winsberg (1993) shares his story as a Jewish man choosing to complete this Christian pilgrimage in 1990, and starts by stating that it is not an account of a major religious experience. He notes that while most of the walking companions he joined up with were Catholic, they fit a description that a local priest gave as "cultural tourists" and not true believers. Artress (2006) identifies the difference between pilgrims and tourists: "The pilgrim participates. The tourist observes" (p. 35).

When pilgrims begin the journey in St. Jean-Pied-de-Port and again when they complete their Camino in the city of Santiago de Compostela, they are asked to identify their reasons for doing the Camino. In 2015, the Pilgrim's Office found that 38% of pilgrims listed solely religious reasons as their motivation, eight percent listed cultural reasons, and 54% noted a combination of religious and cultural reasons as their motivation for completing the Camino (Pilgrim's Reception Office, 2017). Many people, whether religious or not, choose to list religious or spiritual reasons for their Camino knowing that only in doing this will they receive the Compostela certificate of completion of the Camino that links them with the history of the route (Herrero, 2008). For this reason, pilgrims may overreport religious and spiritual motivations.

Oviedo, de Courcier and Farias (2014) looked more closely at the rise in pilgrim traffic over the last number of years, particularly at a time when there seems to be a decrease in religiosity in Europe and North America. They surveyed 470 pilgrims to discern whether this increase in pilgrims related to a secular expression of nature travel, alternative spirituality or a religious revival. Their sample of pilgrims included 66% Christians and they found that participants in the sample were no more or less religious than the average in the general population of Europe and tended to identify themselves more with spirituality than religiosity. In terms of motivation and experience of the Camino, most pilgrims were not interested in traditional religiosity, but did present with various forms of spirituality that some framed in religious terms and symbols. Most pilgrims were seeking personal experiences and feelings to help them shape their identities, with meaning and references constructed individually. Their motivations spoke to a shift from modernism to postmodernism. They were looking for escape from the "logic of consumerism…An avoidance of the impoverishing logic of disenchantment…looking to redefine their flexible identities" (Oviedo, de Courcier & Farias, 2014, p. 441).

Aziz (1987), in her research on pilgrims across various religions, identifies that while we see great numbers of people congregating at sacred shines, their motivations for and experiences of pilgrimage are particular

and unique to each individual. She highlights the ideal of the heroic as a framework for understanding these motivations and experiences, with the pilgrim facing trials and tribulations in pursuit of 'becoming the hero' (p. 12) to find connection with the divine. Regardless of one's motivation for beginning the Camino, beliefs and values related to religion and spirituality shift and evolve throughout the journey, as pilgrims move through that sense of "becoming" (Aziz, 1987; Luik, 2012). In his anthropological study of the implications of walking on the pilgrim experience, Slavin (2003) notes as well that the motivations of pilgrims are rarely phrased in religious terms, but are often more spiritual in nature. He reflects that the act of walking allows pilgrims to fall into a rhythm that opens them up to the present, in both time and place, allowing a deeply spiritual experience to emerge. In a book about the Camino, German comedian Hape Kerkeling (2006) provides his memoir which involves seeking personal change and spiritual growth outside of a religious experience. His final words in the book sum up his thoughts on God and speak to this juxtaposition of the religious and the spiritual:

> The way I see it, 'God' is a unique liberating spark that fans out infinitely to foster and embrace self-realization. By contrast those who get swept up in any group aimed at robbing us of our individuality and dousing the liberating spark wind up crushing themselves in the process….When I think back on all that has happened along the way, I realize that God kept tossing me into the air and catching me again. We encountered each other every single day (p. 331-332).

The Camino offers a liminal space that is a point of transition where one is between past and future with potentialities for changed categories and meaning of one's life and experiences (Turner, 1969 cited in Herrero, 2008). Pilgrims are in a suspended space where they are opened to new meanings for themselves. Religious or not, through the ritual of the walk, the physical demands of the body, and the imperative of being present on the journey, pilgrims are opened to this sense of possibility. The sacred enters to provide new insights, healing, and meaning-making, and through the emergence and evolution of identity.

My Own Camino Journey

My own experience of the Camino echoed this postmodern tug and pull of the religious and the spiritual. While I did not take on the Camino for religious indulgence and forgiveness of sins, I did have a strong sense of connection to the religious tradition and ritual of pilgrimage as a way to seek a spiritual connection with God and with myself. My own as-

sumptions of religiosity and spirituality were challenged for myself, in my understandings of fellow pilgrims on the road, and in the experience of the sacred on the journey.

I began the Camino having prepared physically, mentally, and spiritually, and I had strong intentions to incorporate the religious and spiritual into my journey. I planned to begin each day with the Pilgrim's Prayer. Recognizing the impact of the Buddhist spiritual practice of mindfulness in social work (Hick, 2009), I brought along Buddhist monk Thích Nhất Hạnh's (2013) tiny book, *How to Walk*, as inspiration for a daily walking meditation. I intended to stop in as many cathedrals as I could along the way, to both take time for prayer and appreciate their beauty, and to take part in regular services of Mass. But, with all my intentions, I did not live up to my own expectations of personal religiosity or spirituality. Aside from the first morning, I did not read the Pilgrim's Prayer, I did not regularly read Scripture and set aside time for prayer, and I attended Mass only a few times. I did not open Thích Nhất Hạnh's tiny book to guide my walking. And yet the Camino still worked itself in me and the spirituality that was integral to the pilgrimage itself took hold. My days took on a rhythm and ritual—rising in the pre-dawn with the rustling of other pilgrims preparing to leave, putting on my boots, hoisting my pack to my back and fitting my hands into the straps of my walking poles. In the stillness of the mornings, my prayer emerged without words. I can easily identify with Slavin's (2003) note of rhythm where the walk takes you beyond and within time and place to the simplicity and fullness of the present. I found that without planning it, I could not help but be mindful in my walk. As social work academic Laura Beres (2012) notes of Iona, an island in the Scottish Hebrides steeped in Celtic spirituality, the Camino was also a 'thin place' where the boundaries between physical space and spiritual space are diffuse.

As I settled into the journey and into myself, I found a luxuriousness in the ability to be present. My senses were heightened as I felt the ground rise up to meet my feet, the sun warm my back and the breeze cool my face. I took the time to pause and revel in the nature around me—the bright red poppies against the yellow-green wheat fields and the azure sky. I could relate to a colony of snails nestled in the safety of the green grass those mornings when I simply wanted to curl up in my bunk, and the bravery of the lone snail venturing across the busy pilgrim path uncertain of his fate. I could appreciate my newfound strength in body—as my feet hit the ground and my body carried my pack. My body made itself known through aches and pains, but these did not consume me, and the blessings of the walk allowed me to set aside the pains and carried me forward. The stamina I developed saw me hike to the highest peak and appreciate the views along the way rather than simply pushing through the pain to reach the summit. I was a part of the beauty that sur-

rounded me, that unfolded like a birthday present waiting to be opened as I crested each hill and rounded each bend.

The varied topography of the journey was a gift in itself as I drew in the ancient vineyards and olive groves alongside the red clay roofs of villages rising on the dusty hills of the Rioja region, the vast blue skies and flat, green fields of the Meseta, the lushness of the Valcarce valley and the stunning vistas of the Galician mountains with its ethereal, misty woods and farms. The sacred within the Camino itself created a space where it demanded that you be in the moment—taking note of the natural world around you and the varied people you interact with. It was truly a deeply spiritual experience for me connecting with God, with nature, with myself, and with my walking companions. Yet to reach this sense of spiritual connectedness, I needed to let go of my preconceived notions of what I understood religion and spirituality to be. God was so much more than the institutions of ritualized prayer and worship, and spirituality was deeper than pious devotion. In opening myself to being fully present and aware within each moment, the sacred reached in to meet me. My experience of the Camino was intrinsically personal and in many ways echoed the individualism of postmodernity. One of the phrases that I heard early on was "It's your Camino." Rooted in that postmodern emphasis of finding your own truth, the intent of the speaker (a four-time Camino pilgrim) was to ensure I did not feel judged by others for taking a bus or taxi to skip over portions of the Camino, or choosing to send my backpack forward by a paid service or staying in hotels as opposed to the bare bones albergues (i.e., hostels) with common rooms and bunk beds. While I appreciated this sentiment, it raised some questions for me related to being a religious or spiritual pilgrim versus a tourist. Was the physical challenge and hardship of the pilgrimage supposed to be part of the cost for spiritual renewal? If I focused on doing the pilgrimage 'my way,' did I risk losing the significance of the shared history of walking with others in the footsteps of the ancients? Do we lose something of the spiritual if we divorce it from the religious?

Each day I was witness to a great diversity in motivations and means of completing the Camino. I walked alongside individuals who were deeply committed to the religious aspects of the Camino, taking time to pray at the many cathedrals and other religiously significant sites, and attending Mass regularly. Many of these individuals were committed to walk every inch of the Camino, to the point that these pilgrims would take a taxi back to their last stopping point if, for instance, they were forced to taxi ahead to find an empty bed in the next town. This religious commitment to walking every step means I also saw pilgrims racing ahead to make up necessary time to meet scheduling commitments, and in the process losing sight of the experience of the sacred in the moment of the journey. Some individuals identified more as tourists than pilgrims and readily acknowledged a lack

of spiritual or religious motivation, instead looking for the next physical challenge to tick off a bucket list as part of an adventure tour, or a way to see the culture of Northern Spain. They might be more inclined to cherry-pick certain iconic sections of the Camino to complete, stay in fancy hotels, have their bags carried forward, and take part in fine dining rather than the basic pilgrim's meals. This, however, begs the question of how participation on the Camino differs from a really long walk or a nice vacation. Without having a sense of the religious or spiritual challenge that aligns with the physical demand, are these people really meeting the intended spiritual or religious purpose of the Camino? Finally, there were others who, whether acknowledged or not, sought the peace of the Camino to help them through a challenging time. These pilgrims often came at transition points in their lives—the gap between the end of college and the beginning of a career, the ending or potential ending of a relationship, the shift into retirement, the death of a loved one, or as response to a personal health crisis. They seemed to fall in line with Luik (2012) and Aziz (1987) in their understandings of the emergence of identity and spirituality in the experience of the pilgrim.

At times, I struggled with the level of traffic on the Camino and with the intentions of some of my fellow pilgrims. I worried about finding a bed at the end of the day, and longed for a deeper experience of solitude in the walking. As I journeyed, my body strengthened, as did my mind and my soul. I was open to hearing the stories and appreciating those varied ways that individuals completed the Camino. On my second last day, I sat with a group of young 20-somethings with whom I had maintained some connection throughout my journey. Most of them seemed to be doing the Camino as a stop-gap between finishing school and entering the 'real world.' As we sat and chatted over ice cream, we talked about the meaning of the word "pilgrimage" and I discovered that while many didn't have a clear understanding of the terminology, they were each in their own way on a spiritual pilgrimage whether they named it that or not. They may have begun their Camino as a fun way to see the world and avoid the responsibility of finding a job, but seeing their faces later in the square outside the Cathedral in Santiago, I knew that the liminal nature of the Camino worked on each of them as it did on me. They were changed as a result of their experiences during this time in between. Who they were at the beginning of the journey is not the sum of who they are now. They were changed by the physical challenge of the walk, the community of albergue life, the beauty of nature, shared conversations, and insights with which they grappled. The end of their Camino is really just another beginning, an opportunity to re-enter life with a re-imagined sense of self that incorporates the meaning they have internalized from their journey. The division between the sacred (whether religious or spiritual) and the secular is a fine line. My Camino journey opened me to a nuanced understanding of religiosity and spirituality, the

presence of the sacred within the secular, and the belief that in some ways these distinctions do not matter. As Luik (2012) notes, quoting a Catholic priest who had been involved in the Camino for years, "There is all that talk about tourism and indulgences and all that. But it does not matter. Once you are there and you actually experience it all, it affects you, it changes you, and it happens to everyone" (p. 29). As Cox (2010) reminds us, we do not need to believe in order to pray.

Religion and Spirituality in Social Work

As social workers, rather than getting caught up in distinctions between religiosity and spirituality or sacred and secular, and worrying about whether it's appropriate to reach for religious and spiritual concerns and strengths, perhaps we can learn from the Camino how to be a fellow pilgrim on the journey, bear witness to the stories we hear and the changes that happen, and reach into liminal spaces as our clients develop their identities and make meaning of their lives. Coholic (2007) reminds us that spirituality is inherently connected with meaning-making, which is core to our practice as social workers. As social workers, by opening ourselves to meaning- making, from the language and worldview of our clients, we move beyond distinctions between religious, spiritual, and secular and meet clients where they are (Canda & Furman, 2010; Dudley, 2016).

Practices like pilgrimage can be therapeutic for clients and social workers alike, and can be understood in religious, spiritual, or secular ways (Canda & Furman, 2010; Dudley, 2016). While taking the time to complete the entire Camino de Santiago Pilgrimage is not realistic for most people, pilgrims often choose the more manageable final 100 kilometers to earn the Compostela certificate. Still others take several years, completing a section of the journey each year. Barush (2016) writes of someone who for health reasons had to forego plans to walk the Camino and instead created a pilgrimage route on his acreage, slowly walking to his own "Santiago."

Pilgrimage can also move beyond personal to a communal spiritual exercise grounded in social justice. A group of Canadian Mennonites is completing a pilgrimage in solidarity with indigenous rights, journeying 600 kilometers in spring 2017 to the Canadian capital in Ottawa to raise awareness and work towards reconciliation and healing of broken relationships between indigenous and settler people (Epp, 2017).

The labyrinth is an ancient spiritual exercise also finding renewed interest in our time. Some suggest the development of this practice by the Catholic church in the Middle Ages was rooted in the desire to create a surrogate pilgrimage experience at a time when travel to traditional Holy sites in Jerusalem, Rome, and Spain was difficult for reasons such as expense, safety related to the Crusades, being tied to the land, or ill health (Artress,

2006; Barush, 2016). A labyrinth is a circuitous walking path that leads the walker to a center and then back out to return to the world. They give the walker the opportunity to reflect, to question, to open, and to receive. They are metaphors for journey and offer us the chance to quiet our minds and open our souls (Artress, 2006). Offering the labyrinth as an exercise can be meaningful for clients struggling with transitions, with grief, with identity. Like pilgrimage, they incorporate the body into a holistic exercise that helps with making meaning of our experiences.

Pilgrimage can be an important spiritual tool not only for clients, but also for social workers. We know that care of self is significant for helpers (Dudley, 2016), and taking time to invest in one's own spirituality is important. Pilgrimage can be as significant as travelling to Northern Spain, but can also involve intentional time for journey to a particularly meaningful place in one's own life. Taking the opportunity to walk a labyrinth in a local park, or simply becoming intentional in a regular mindfulness practice of walking meditation are other ways that we can feed our souls and nourish ourselves for the journey with our clients.

Limitations

Autoethnography grounds itself in the postmodern tradition of social construction. It does not seek to claim universal truth, but uses personal narrative to enlighten and engage in building connections from others' experiences (Witkin, 2014). The experiences that I share are my own attempt at building connections between my experience of the Camino pilgrimage and my awareness of the growing interest in spirituality both in society and in social work. My Camino experiences, while fitting with much of the literature, are my own and while I hope they may spark insight and engagement for readers I recognize that others who walk the journey may take away a different meaning from their own experiences.

Conclusion

In our society, we have seen a shift away from institutionalized religion but heightened awareness of and reaching towards the spiritual (Taylor, 2007; Wilkins-LaFlamme, 2015; Ammerman, 2013; Coates, 2007; Cox, 2009). We have also seen a parallel interest in exploring the role of spirituality in social work practice to provide holistic service to our clients and recognition that spiritual awareness and self-care on the part of the social worker is a part of ethical practice (Canda & Furman, 2010; Dudley, 2016, Coates, 2007; McKernan, 2007). My own participation in the Camino de Santiago pilgrimage was in part to develop my own spiritual practice and awareness, and in doing so my sense of religion and spirituality shifted to

become more open and acknowledging of the spiritual act of meaning-making that occurs on the Camino regardless of whether one walks as a pilgrim or a tourist, with a religious, spiritual or cultural motivation. In the same way, in working with our clients, we do not need to worry about labeling religion or spirituality, but simply need to be open to the journey of helping the client make meaning of their experiences. For both clients and social workers, participation in exercises like a pilgrimage or walking a labyrinth can be life-enhancing regardless of whether the client identifies as religious, spiritual, or neither. ❖

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Testing Faith: An Investigation of the Relationship Between Prayer and Test Anxiety

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Abstract

College student test anxiety is currently a problematic phenomenon that has been shown to impact scholastic performance. The current study explored the use of Christian prayer to lessen college student test anxiety. It was hypothesized that Christian prayer would significantly reduce physiological test anxiety biomarkers of heart rate (HR), salivary cortisol (SC), and salivary alpha amylase (SAA). Biomarker measurements were taken four times over two separate meetings. Forty-eight undergraduate students were given the Westside Test Anxiety Scale (WTAS), as well a question about their perceived valuing of prayer. Three experimental groups of students were given 20 minutes to meditate (14), follow a study guide (16), or pray (18) after being told they were going to take a IQ test that would have the results publicly displayed. ANCOVA was used to determine whether prayer displayed significant biomarker differences when compared to guided meditation or studying after a test anxiety stressor. The current study did not find a significant difference in biomarkers of test anxiety between prayer, guided meditation, and studying. Additional descriptive data, however, suggested that students who valued Christian prayer experienced overall lowered biomarkers of test anxiety. The findings provide insight to social workers who work with students and those who suffer from test anxiety. More studies on the phenomena of prayer and test anxiety are necessary.

Introduction

Test anxiety is a pervasive problem on college campuses that affects a substantial number of college students (Chappell et al., 2005; Spielberger et al, 2015). Two meta-analyses (Hembree, 1988; Seipp 1991) of nearly

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700 studies found that student test anxiety affected academic performance from college to grade school. In most exam situations students may feel discomfort and want to avoid testing, but are expected to attend and use coping methods for anxiety (Kondo, 1997).

Test Anxiety in Students

Test anxiety is a psychological and physiological phenomenon (Zeidner, 1998). As early as the 1950's, it was recognized that Americans live in a test-conscious/test-giving society wherein people's lives are partly determined by their performance on exams (Sarason, 1959). America has continued this trend with more standards and accountability in the educational environment, implementing nationwide Common Core State Standards in 1996 (Achieve, 2015). College students that have been educated in testing-heavy classrooms have been shown to have poorer academic success and lower GPAs (Chappell et al., 2005; Rana & Mahmood, 2010; Talib & Sansgiry, 2012). In the current academic environment, students are suffering from test anxiety and want assistance learning how to cope with it (Atik & Yalçın, 2010; Gallagher, Golin & Kelleher, 1992; Zeidner & Nevo, 1992). A meta-analysis completed by Saunders et al. (1996) examined 37 different studies and found that training to cope with stress is an effective way to reduce anxiety and enhance performance.

Prayer as a Method for Anxiety Reduction

Prayer is a method people use to cope with anxiety while concentrating on God and staying spiritually connected (Dehghani et al., 2012). The word "pray" originates from the word precari in Latin, which means "to entreat or to ask" (Das & Anand, 2012, p. 143). Prayer has been defined in many ways, and it is a term that can be used across different contexts and cultures (Ladd & Spilka, 2013). James (1902) gave a generalized and historically well-accepted definition of prayer, defining it as every kind of internal communication with a power recognized as divine. Christian prayer is a type of prayer that believers of Jesus Christ use to stay in communication with God, who shows Himself and speaks to humans through Jesus and the books in the Holy Bible (Constable, 2003). In addition, Christians believe prayer to be a form of concentrated communication with God that can be used by followers of Jesus Christ during times of stress and anxiety (Weld & Eriksen, 2007).

Because a relationship with God through prayer can be a buffer for some aspects of anxiety (Ellison, Burdette, & Hill, 2009), many researchers have studied the relationship between prayer and anxiety (Das & Anand, 2012; Harris, Schoneman, & Carrera, 2002; Koenig, George, Blazer, &

Pritchett, 1993; Meany, McNamara, & Burks, 1984; Zeng, 1996). Some studies have found prayer to be a key coping resource for persons facing elevated levels of emotional suffering; this is particularly the case when other possible coping responses are unreachable or unsuccessful (Das & Anand, 2012; Ellison, Burdette, & Hill, 2009).

Test Anxiety Biomarkers

Psychological stress can produce physiological effects (Takai et al., 2004) and affect student's biological stress levels, which impacts student cognitive functioning (Lupien et al., 2007; Martinek et al., 2003; Spangler et al., 2002). Two main systems are involved in producing biomarkers related to psychological stress: the hypothalamus-pituitary-adrenocortical (HPA) axis and the Sympathomedullary (SAM) system (Takai et al., 2004; Chen et al., 2014). Two primary biomarkers that are used to determine the stress levels in clinical research participants are cortisol and alpha-amylase (Allwood et al., 2011). Kirschbaum and Hellhammer (2000) posit that the hormone cortisol is the primary hormone responsible for stress responses in humans and animals, and according to Smyth et al. (2013), cortisol is the primary stress hormone in the human body. The enzyme salivary alpha amylase (SAA) has been studied as a biomarker for stress over the last 30 years (Allen, 2014) and is a useful biomarker for measuring the response of biological stress systems (Chen et al., 2014; Walsch et al., 1999; Skosnik et al., 2000).

Study Purpose

A review of the research literature found no previous studies measuring the effect of Christian prayer on test anxiety. More generally, Harris, Schoneman, and Carrera (2002) suggest that the nature of the relationship between prayer and anxiety is unclear. Because test anxiety can negatively affect student outcomes (Chappell et al., 2005) and greater spiritual wellbeing can lower stress (Fabbris et al., 2106; Waghmare, 2015), the purpose of this study was to determine whether there was a difference in the physiological biomarker responses to test anxiety of students who use Christian prayer compared to students who meditated or used a study guide.

Methodology

Research Design

According to Zeidner (1998), "Experimental design serves to guide the test anxiety researcher in the process of collecting, analyzing, and

interpreting observations in order to answer critical questions at the heart of the research as validly and accurately as possible" (p. 101). The quasi-experimental design chosen for this study was an alternative treatment design (Rubin & Babbie, 2009)

Hypotheses

The independent variable for the study was test anxiety coping mechanisms, defined as Christian prayer, guided meditation, or a study guide. The dependent variables were heart rate, salivary cortisol, and salivary alpha amylase. There were three hypotheses for the study.

H1: Christian prayer will be related to lower heart rate (HR, a biomarker of test anxiety) more than a study guide or guided meditation when a person is presented with a testing stressor.

H2: Christian prayer will be related to lower levels of salivary cortisol (SC, a biomarker of test anxiety) when compared to a study guide or guided meditation when a person is presented with a testing stressor.

H3: Christian prayer will be related to lower levels of salivary alpha amylase (SAA, a biomarker of test anxiety) when compared to a study guide or guided meditation when a person is presented with a testing stressor.

Participants

Convenience sampling was used to obtain 52 college students from a Christian university in the Northwest United States who volunteered for initial participation. The 52 participants from different class levels were recruited by the lead researcher from four different disciplines—psychology, biology, history, and kinesiology—none of which were taught by the lead researcher. Four students did not complete the study, thus making the sample of participants 48. Seventeen participants were male and the mean age with 20.2 years.

Data Collection

Permission to conduct the research was granted from the college research board and college biosafety committees. Students were informed that participation was voluntary and if they signed up to help, they could leave the research process at any time. All participants in the study signed an informed consent form before participating in the research.

According to Zeidner (1998), experiments in test anxiety research need to be carried out in realistic situations. To do this, students were offered the opportunity to participate in a test-like scenario in a science lab

on campus. Students were informed there would be two meetings; a script was used during each meeting.

Student volunteers were then asked to attend an initial meeting to learn about and participate in research. Students were told that they could not eat one hour prior to attending the meeting, as well as not consume alcohol 12 hours before the meeting—since those factors had the potential to affect salivary biomarkers. Salivary cortisol, salivary alpha amylase, and heart rate were chosen as test anxiety biomarkers for the study due to their accuracy, non-invasive nature and continued successful use in anxiety research (Allen, 2014; Granger et al., 2012; Kirschbuam & Hellhammer, 2000; Ng, et al., 2003; Smyth et al., 2013; Spangler et al., 2002). Students had their heart rate (HR) and saliva collected at the first meeting. HR was taken with fingertip monitors, and saliva was collected with kits obtained from Salimetrics. Along with the biological data being collected, students completed the Westside Test Anxiety Scale (WTAS; Driscoll, 2007). The WTAS is a brief 10 item questionnaire created to determine students who had impairments from anxiety and could benefit from an intervention to reduce anxiety (Driscoll, 2007). The scale categorizes students on a 1-5 scale ranging from comfortably low test anxiety to extremely high test anxiety. The WTAS was examined for reliability and scale validity based on two correlational measures, and was found to be reliable and have high validity at r =.44 (Dricoll, 2007).

The researcher used participants' scores on the WTAS to separate participants into one of four groups based on test anxiety levels (Low (1-1.9), Low Normal (2-2.9), Moderately High/High (3-3.9), and Extremely high (4-5). The respondents in each group were then equally split by the lead researcher and randomly assigned into one of the three test conditions. The conditions were a Christian prayer group, a guided meditation group, and a study guide group. The goal of creating the groups based on the WTAS categories was to have an equal amount of Low, Low Normal, Moderately High/High and Extremely High test takers in each experimental group.

Students were informed that the second meeting would take place one week later in the same lab. The second meeting was unique for each test condition group. The time of second meeting was within two hours of the original meeting time as not to disrupt any diurnal readings of SC or SAA. Saliva and HR samples were taken three times with 20 minutes between each collection. The researcher made sure to take saliva samples 20 minutes after the stressor because biomarkers show changes in this time period (Smyth et al., 2013). For clarity, the timeline for each group was: initial HR/saliva collected first time, seven days passed, HR/saliva collected second time, 20 minutes passed, a test anxiety stressor was introduced, HR/saliva collected a third time, Christian prayer/guided meditation/study guide time (20 min), HR/saliva collected a final time.

The Christian prayer section of the intervention included a recitation of the Lord's prayer (Matthew 6:9–13, ESV), an improvised silent personal prayer time, and a prayer based on research by Harris et al. (2005) and written by the lead researcher that focused on asking Jesus for help in the current testing situation. The guided meditation section included a 20-minute guided meditation. The study guide section was created by using two practice IQ exams.

To create test anxiety, a minimal level of deception was used. Students were informed that they would be taking an "IQ test" and that scores were going to be published in a public area on campus. Dickerson and Kemeny (2004) found that studies that have participants actively engage in tasks (i.e., testing), experience some loss of control, and have a socially evaluative threat are more reliable in producing biologically measurable stressful responses. Research on test anxiety has shown that fear of negative reaction to poor test results is associated with higher levels of testing anxiety (DeCaro et al., 2011). The deception lasted only 20 minutes; participants were informed after the last collection by the lead researcher that no test would be taken. Students were then debriefed on the purpose of the deception, the study, and given resources to seek assistance if anxiety levels stayed elevated.

Results

The researcher sought to determine through three hypotheses whether there was a significant difference in the physiological responses (HR, SC, SAA) to test anxiety of students who used Christian prayer compared to students who meditated or used a study guide. SPSS v.22 (2014) was used to analyze the data. The researcher chose to use analyses of covariance (ANCOVA) to look at HR, SC, and SAA between groups who prayed, meditated, and studied before a test. ANCOVA tests were conducted on the differences between each experimental group at time four when controlling for time 3 (identified as pre-test scores).

The researcher measured the test anxiety biomarkers of three different experimental groups (prayer, meditation, study guide) at four times. The first two times served as a baseline for all three biomarkers. Time three served as a standard pretest and time four as a post test. The three test anxiety biomarkers were heart rate (HR), salivary cortisol (SC), and salivary alpha amylase (SAA). Figures 1-3 below depict the mean HR, SC, and SAA levels of students in the three experimental groups at times 1-4.

Figure 1: HR of Experimental Groups at Times 1-4

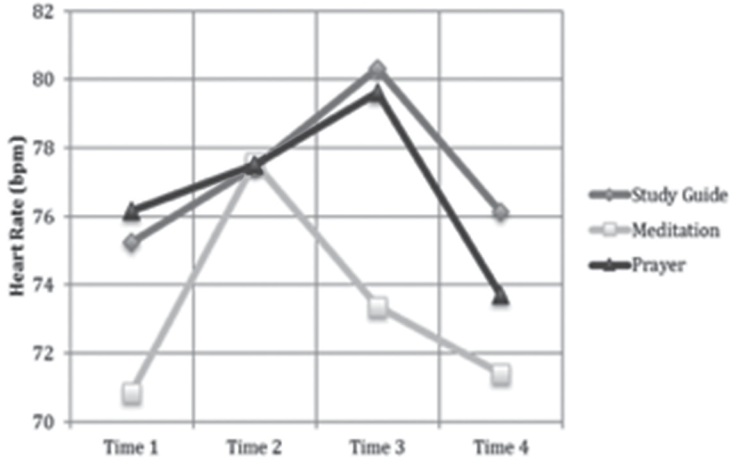


Figure 2: SC Levels of Experimental Groups at Times 1-4

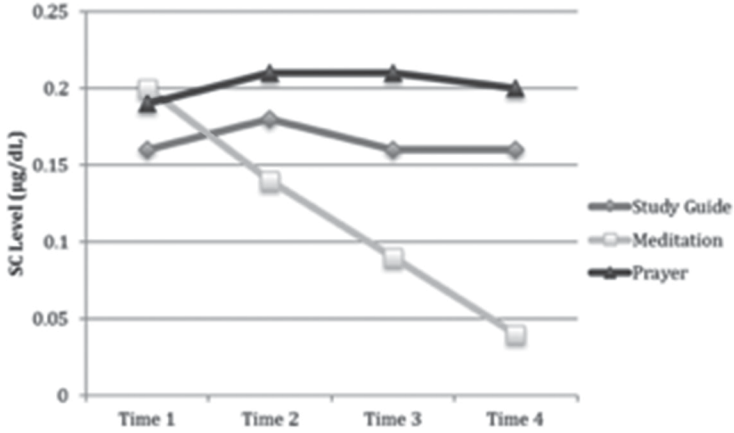
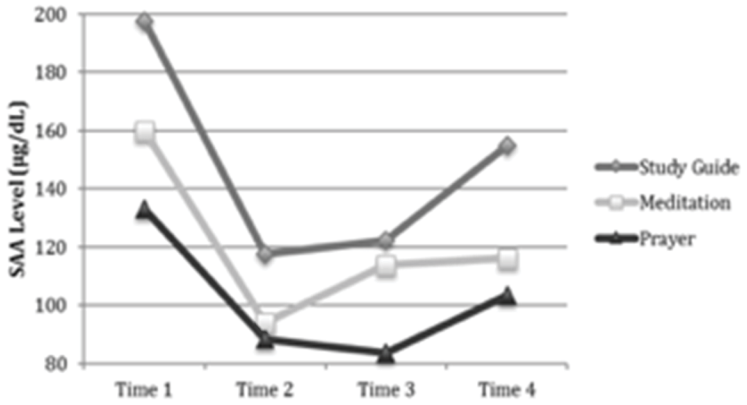


Figure 3: SAA Levels of Experimental Groups at Times 1-4



The focus of the three hypotheses was to determine whether Christian prayer was more effective at alleviating test anxiety after a stressor was presented. For each biomarker, there was no significant change from time three to time four.

The results of the ANCOVA comparing Christian prayer, guided meditation, and study guide use on biomarkers of test anxiety did not provide evidence of a pattern of significant findings to affirm that Christian prayer is a better method for lowering biomarkers of test anxiety than guided meditation or study guide usage. When assessed overall, there were no significant differences found between baseline and pretest for HR and SC. However, there was a significant increase between baseline and pretest for alpha amylase. This is shown in the table below.

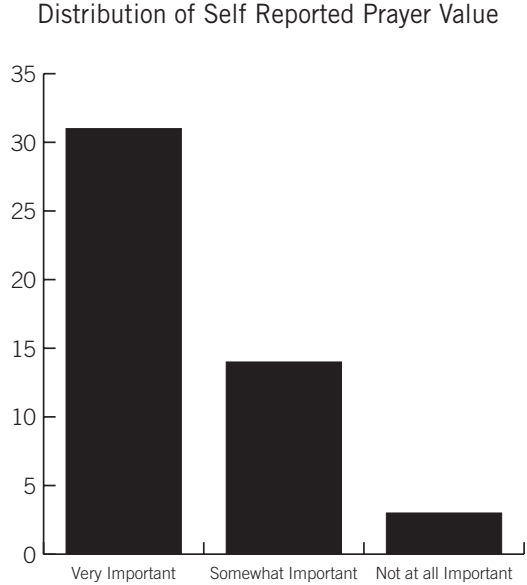
Table 1. Baseline to Pretest Comparison

Measure	Baseline Mean	Pretest Mean	Sig
Heart Rate	75.9	78	.195
S. Cortisol	.196	.186	.491
S. Alpha Amylase	131	105.3	.01*

As a whole, the results do not suggest that Christian prayer was significantly more effective at reducing the measured biomarkers of test anxiety than the other two methods. This finding resulted in none of the study's three hypotheses being supported.

In addition to the hypothesis testing, the variable of Christian prayer value was used to compare student outcomes to better understand how subjective prayer impacts test anxiety in students. Students were asked about the subjective value of prayer in their lives, with prayer values being very important (VI, 31), Somewhat Important (SI, 15), or Not Important at All (NI, 3). This is shown in the following figure.

Figure 4: Self-Reported Values of Prayer for Students



Students who ranked prayer as very important (VI) had the lowest HR, SAA levels and SC levels across each of the four times when compared to students who valued prayer as somewhat important and/or not important at all. The values were averaged and are shown in the following table.

Table 2. Prayer Value Biomarkers

Prayer Value	Heart Rate	Salivary Cortisol	Salivary Alpha Amylase
Not Important	80.1	22.8	256.3
Somewhat Important	77.4	22	123.5
Very Important	74.8	17.3	109.6

Note. Biomarker measures for each prayer value averaged over 4 collection times

Discussion

This is the first study on the interaction of Christian prayer and test anxiety. The aim of the study was to determine whether Christian prayer was more effective in lowering test anxiety among college students than the use of guided meditation or a study guide. The three hypotheses for the study were not supported, as the study's results suggest that Christian prayer is not significantly more effective at reducing test anxiety for college students than a guided meditation or study guide. However, the study's findings indicate that Christian prayer was equally efficacious in reducing test anxiety when compared to guided meditation and studying.

Two biological systems involved in producing biomarkers related to psychological stress are the hypothalamus-pituitary-adrenocortical axis (HPA) and the Sympathomedullary (SAM) system (Takai et al., 2004; Chen et al., 2014). The current study showed that the HPA axis, as measured by the cortisol level differences for students, was not significantly responsive to the test anxiety stressor that was presented. Cortisol levels were generally unchanged over the four measurements. The SAM system however, as measured by differences of SAA levels, did show a significant change ($p = .01$). Contrary to other research findings (Allwood et al., 2011; McGraw et al., 2013; Ponzi et al., 2015), salivary alpha amylase (SAA) decreased significantly from baseline to the presence of a stressor in this study. This may have been due fact that students potentially became calmer as the interactions with the researcher in the lab progressed.

The findings also suggest that the stressor was potentially not "stressful enough" to activate the HPA and/or SAM systems. Considering prior research by Graeff and Junior (2010), it may be that the test anxiety stressor was enough to elicit a SAM response but not a HPA axis response. According to Nater et al. (2005), SAA, although quite responsive to physical stress, can be an inconsistent indicator of psychological stress. Nater et al (2005) stated that this could be due to the nature of the psychological stressors.

The descriptive data about subjective prayer value lends some interesting insight and hope for future research. Across the board, those who found prayer to be very important (VI) had lower HR, SC, and SAA levels than those who valued prayer as somewhat important (SI) or not important at all (NI). This may align with research by Harris et al. (2002) that shows students who are active in their relationship with God (i.e., pray more) had lower levels of anxiety.

These data may indicate that the subjective value a student places on prayer is related to the effectiveness of prayer as a strategy for reducing test anxiety. Considering this, studying the subjective value a student places on any form of test anxiety reduction strategy may be a key aspect of future research.

Limitations

The most important limitation to note is that a control group would have been helpful to determine whether Christian prayer, guided meditation, or a study guide influenced the biomarkers of test anxiety. The supportive atmosphere of a small Christian college could have potentially muted the physiological response to stress, since fear of negative evaluation in a supposedly supportive environment may be less likely.

The study having taken place on a Christian campus may be related to an additional limitation. Students may have felt pressure to pray or to report that prayer was important, from the researcher and/or other students, because they were being analyzed. This may have been why only three of the students indicated prayer was not important. Students with different belief systems may have also actively not prayed to object to the cultural themes at the college they attend. On the same note, students who were not asked to pray while in the guided meditation and/or study guide groups may have done so, thus blurring differences between intervention groups.

The generalizability of the data is also a limitation. The sample size, due to its small number of students, as well as its creation through convenience sampling, led to limited application of findings. A larger sample size, with at least 100 students, may be ideal for a study of this type.

A final limitation of the study involves the fact that the degree to which students valued prayer may be a confounding variable in the study. It would make sense that students who highly valued prayer would potentially be better able to utilize prayer as an anxiety-reduction strategy than students who exhibited a lower valuing of prayer.

Recommendations for Further Research

Although previous research has explored the effects of guided meditation, relaxation, and eastern prayer on anxiety reduction (Asadi, 2015; Prato & Yucha, 2013), no prior studies appear to have examined the effect of Christian prayer on test anxiety levels in university students. The relationship between prayer (especially Christian prayer) and test anxiety is a relatively new topic of research and because spiritual well-being has been found to be related to lower anxiety levels (Steiner et al., 2016), the findings from this research lead to recommendations for future research with potential to add to the literature on the topic of prayer and test anxiety. It has been suggested that students who suffer from test anxiety desire tools and assistance from others in learning to cope effectively (Atik & Yalçın, 2010; Gallagher et al., 1992; Zeidner & Nevo, 1992), and since test anxiety affects college students at an important

stage of their development, the study of the potential transformational and calming effects of prayer (Hatch et al, 2016; LaBarbera & Hetzel, 2016) on test anxiety are exciting.

As Nater et al. (2005) suggests, further studies are necessary for the investigation of parasympathetic and sympathetic activity on SAA levels in relation to psychosocial and psychological stressors. Allen (2014) suggests that further research on SAA is necessary to establish its usefulness as stress biomarker. The current study suggests that there is reason to research the impact that perceived value of prayer, or any test anxiety reduction technique, has on test anxiety biomarkers. Since descriptive data showed that those who highly valued Christian prayer had lower levels of test anxiety, further research on the relationship between Christian prayer and test anxiety is needed.

Implications for Professional Practice

Gilligan and Furness (2006) suggest that all social work practitioners need to be culturally competent and understand the possible benefits of religious beliefs in their practice and in the lives of their clients: "Social workers need to be able to respond appropriately to the needs of all service users, including those for whom religious and spiritual beliefs are crucial" (p. 3).

Social workers often work with students and adults who suffer from test anxiety. Robotham (2008) stated, a "key role for higher education institutions in relation to stress is the provision of appropriate resources to enable individuals to deal with stress" (p. 7). Although Christian prayer is not part of the culture at every school or workplace, it is part of the culture of some agencies and educational environments. Social workers who interact with clients who have test anxiety inside and outside of Christian settings could encourage students to use prayer, when culturally appropriate and acceptable to the client, to attempt to lower their cognitive and physiological test anxiety symptoms. In such cases, social workers can teach students to use skills that may lower test anxiety to help improve their self-confidence and success (Onyeizugbo, 2010). Although personal Christian prayer is unique to everyone that partakes in the practice (Ladd & Spilka, 2006), it can be used to improve confidence, increase relaxation, and focus on God.

Testing anxiety affects many students and is a problem that has not disappeared, nor does it appear to be moving towards extinction. Although the current study did not find Christian prayer to be a better strategy for reducing test anxiety when compared with strategies such as meditation and studying, the study did find that prayer was equally efficacious when compared to the other strategies. This may indicate that Christian prayer can be a helpful test anxiety reduction strategy for students who are willing to engage in it. ❖

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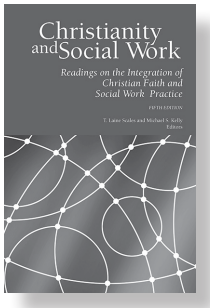
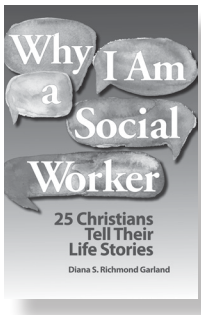
T. Laine Scales and Michael S. Kelly (Editors). (2016). Botsford, CT: NACSW. $55.00 U.S., $42.99 for NACSW members or orders of 10 or more copies. For price in Canadian dollars, use current exchange rate.



At over 400 pages and with 19 chapters, this extensively-revised fifth edition of Christianity and Social Work includes six new chapters and six significantly revised chapters in response to requests by readers of previous editions including chapters on evidence based practice (EBP), congregational Social Work, military social work, working with clients from the LGBT community, human trafficking – and much more! The fifth edition of Christianity and Social Work is written for social workers whose motivations to enter the profession are informed by their Christian faith, and who desire to develop faithfully Christian approaches to helping. It addresses a breadth of curriculum areas such as social welfare history, human behavior and the social environment, social policy, and practice at micro, mezzo, and macro levels. Christianity and Social Work is organized so that it can be used as a textbook or supplemental text in a social work class, or as a training or reference materials for practitioners and has an online companion volume of teaching tools entitled Instructor's Resources.

Why I Am a Social Worker: 25 Christians Tell Their Life Stories
Diana R. Garland. (2015). Botsford, CT: NACSW. $29.95 U.S., $23.95 for NACSW members or orders of 10 or more copies. For price in Canadian dolloars, use current exchange rate.



Why I Am a Social Worker describes the rich diversity and nature of the profession of social work through the 25 stories of daily lives and professional journeys chosen to represent the different people, groups and human situations where social workers serve.

Many social workers of faith express that they feel "called" to help people – sometimes a specific population of people such as abused children or people who live in poverty. Often they describe this calling as a way of living out their faith. *Why I Am a Social Worker* serves as a resource for Christians in

social work as they reflect on their sense of calling, and provides direction to guide them in this process.

Why I Am a Social Worker addresses a range of critical questions such as:

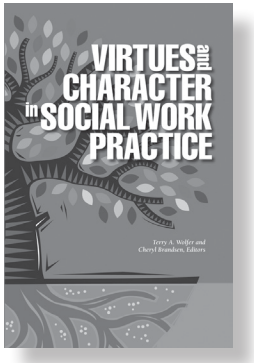
- How do social workers describe the relationship of their faith and their work?
- What is their daily work-life like, with its challenges, frustrations, joys and triumphs?
- What was their path into social work, and more particularly, the kind of social work they chose?
- What roles do their religious beliefs and spiritual practices have in sustaining them for the work, and how has their work, in turn, shaped their religious and spiritual life?

Dr. David Sherwood, recently retired Editor-in-Chief of *Social Work & Christianity,* says about *Why I Am a Social Worker* that:

> I think this book will make a very important contribution. …The diversity of settings, populations, and roles illustrated by the personal stories of the social workers interviewed will bring the possibilities of social work to life in ways that standard introductory books can never do. The stories also have strong themes of integration of faith and practice that will both challenge and encourage students and seasoned practitioners alike.

Virtue and Character in Social Work Practice

Edited by Terry A. Wolfer and Cheryl Brandsen. (2015). Botsford, CT: NACSW. $23.75 U.S., $19.00 for NACSW members or orders of 10 or more copies). For price in Canadian dollars, use current exchange rate.

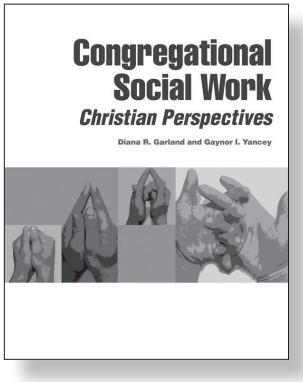


Virtues and Character in Social Work Practice offers a fresh contribution to the Christian social work literature with its emphasis on the key role of character traits and virtues in equipping Christians in social work to engage with and serve their clients and communities well.

This book is for social work practitioners who, as social change agents, spend much of their time examining social structures and advocating for policies and programs to advance justice and increase opportunity.

Congregational Social Work: Christian Perspectives

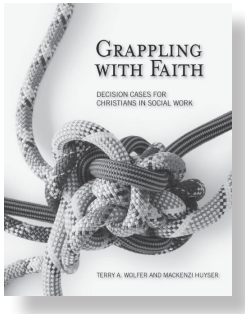
Diana Garland and Gaynor Yancey. (2014). Botsford, CT: NACSW. $39.95 U.S., $31.95 for NACSW members or orders of 10 or more copies). For price in Canadian dollars, use current exchange rate.



Congregational Social Work offers a compelling account of the many ways social workers serve the church as leaders of congregational life, of ministry to neighborhoods locally and globally, and of advocacy for social justice. Based on the most comprehensive study to date on social work with congregations, *Congregational Social Work* shares illuminating stories and experiences from social workers engaged in powerful and effective work within and in support of congregations throughout the US.

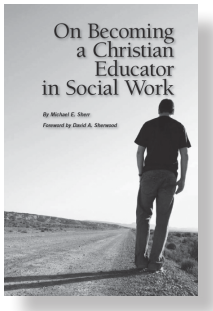
Grappling with Faith: Decision Cases for Christians in Social Work

Terry A. Wolfer and Mackenzi Huyser. (2010). $23.75 ($18.99 for NACSW members or for orders of 10 or more). For price in Canadian dollars, use current exchange rate.



Grappling with Faith: Decision Cases for Christians in Social Work presents fifteen cases specifically designed to challenge and stretch Christian social work students and practitioners. Using the case method of teaching and learning, *Grappling with Faith* highlights the ambiguities and dilemmas found in a wide variety of areas of social work practice, provoking active decision making and helping develop readers' critical thinking skills. Each case provides a clear focal point for initiating stimulating, in-depth discussions for use in social work classroom or training settings. These discussions require that students use their knowledge of social work theory and research, their skills of analysis and problem solving, and their common sense and collective wisdom to identify and analyze problems, evaluate possible solutions, and decide what to do in these complex and difficult situations.

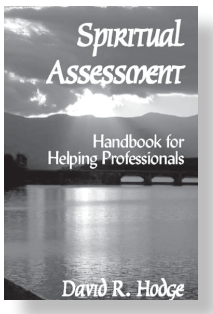
On Becoming a Christian Educator in Social Work
Michael Sherr. (2010). $21.75 ($17.50 for NACSW members or for orders of 10 or more). For price in Canadian dollars, use current exchange rate.



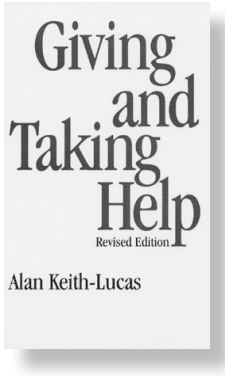
On Becoming a Christian Educator is a compelling invitation for social workers of faith in higher education to explore what it means to be a Christian in social work education. By highlighting seven core commitments of Christian social work educators, it offers strategies for social work educators to connect their personal faith journeys to effective teaching practices with their students. Frank B. Raymond, Dean Emeritus at the College of Social Work at the University of South Carolina suggests that "Professor Sherr's book should be on the bookshelf of every social work educator who wants to integrate the Christian faith with classroom teaching. Christian social work educators can learn much from Professor Sherr's spiritual and vocational journey as they continue their own journeys and seek to integrate faith, learning and practice in their classrooms."

Spiritual Assessment: Helping Handbook for Helping Professionals
David Hodge. (2003). Botsford CT: NACSW. $20.00 U.S. ($16.00 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.

A growing consensus exists among helping professionals, accrediting organizations and clients regarding the importance of spiritual assessment. David Hodge's *Spiritual Assessment: Helping Handbook for Helping Professionals*, describes five complementary spiritual assessment instruments, along with an analysis of their strengths and limitations. The aim of this book is to familiarize readers with a repertoire of spiritual assessment tools to enable practitioners to select the most appropriate assessment instrument in given client/practitioner settings. By developing an assessment "toolbox" containing a variety of spiritual assessment tools, practitioners will become better equipped to provide services that address the individual needs of each of their clients.

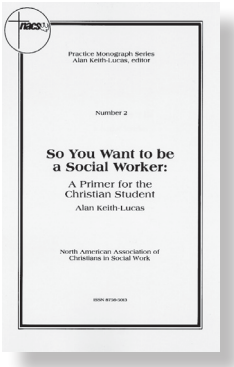


Giving and Taking Help (Revised Edition)
Alan Keith-Lucas. (1994). Botsford CT: North American Association of Christians in Social Work. $20.75 U.S. ($16.50 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.



Alan Keith-Lucas' Giving and Taking Help, first published in 1972, has become a classic in the social work literature on the helping relationship. Giving and taking help is a uniquely clear, straightforward, sensible, and wise examination of what is involved in the helping process—the giving and taking of help. It reflects on perennial issues and themes yet is grounded in highly practice-based and pragmatic realities. It respects both the potential and limitations of social science in understanding the nature of persons and the helping process. It does not shy away from confronting issues of values, ethics, and world views. It is at the same time profoundly personal yet reaching the theoretical and generalizable. It has a point of view.

So You Want to be a Social Worker: A Primer for the Christian Student
Alan Keith-Lucas. (1985). Botsford, CT: NACSW. Social Work Practice Monograph Series. $11.50 U.S. ($9.00 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.



So You Want to Be a Social Worker has proven itself to be an invaluable resource for both students and practitioners who are concerned about the responsible integration of their Christian faith and competent, ethical professional practice. It is a thoughtful, clear, and brief distillation of practice wisdom and responsible guidelines regarding perennial questions that arise, such as the nature of our roles, our ethical and spiritual responsibilities, the fallacy of "imposition of values," the problem of sin, and the need for both courage and humility.

Hearts Strangely Warmed: Reflections on Biblical Passages Relevant to Social Work
Lawrence E. Ressler (Editor). (1994). Botsford, CT: North American Association of Christians in Social Work. $9.25 U.S. ($7.50 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.

Hearts Strangely Warmed: Reflections on Biblical Passages Relevant to Social Work is a collection of devotional readings or reflective essays on 42 scriptures pertinent to social work. The passages demonstrate the ways the Bible can be a source of hope, inspiration, and conviction to social workers.

The Poor You Have With You Always: Concepts of Aid to the Poor in the Western World from Biblical Times to the Present
Alan Keith-Lucas. (1989). Botsford, CT: North American Association of Christians in Social Work. $20.75 U.S. ($16.50 for NACSW members). For price in Canadian dollars, use current exchange rate.

Encounters with children: Stories That Help Us Understand and Help Them
Alan Keith-Lucas. (1991). Botsford, CT: North American Association of Christians in Social Work. $11.50 U.S. ($9.00 for NACSW members). For price in Canadian dollars, use current exchange rate.

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To order a copy of any of the above publications, please send a check for the price plus 10% shipping and handling. (A 20% discount for members or for purchases of at least 10 copies is available.) Checks should be made payable to NACSW; P.O. Box 121, Botsford, CT 06404-0121. Email: info@nacsw.org or call 203.270.8780.

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North American Association of Christians in Social Work

NACSW's mission is to equip its members to integrate Christian faith and professional social work practice.

Its goals include:

- Supporting and encouraging members in the integration of Christian faith and professional practice through fellowship, education, and service opportunities.
- Articulating an informed Christian voice on social welfare practice and policies to the social work profession.
- Providing professional understanding and help for the social ministry of the church.
- Promoting social welfare services and policies in society which bring about greater justice and meet basic human needs.

NACSW
North American Association of Christians in Social Work