SOCIAL WORK & CHRISTIANITY

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ARTICLES

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Social Work & Christianity (SWC) is a refereed journal published quarterly in March, June, September, and December by the North American Association of Christians in Social Work (NACSW) to support and encourage the growth of social workers in the ethical integration of Christian faith and professional practice. *SWC* welcomes articles, shorter contributions, book reviews, and letters which deal with issues related to the integration of faith and professional social work practice and other professional concerns which have relevance to Christianity.

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Submissions should be no more than 500-1,000 words in length and invite conversation as it offers the opportunity for readers to observe an open and civil exchange of ideas and perspectives. Letters which are a response to articles previously published in Social Work & Christianity will be shared with the article author(s), who will have the opportunity to respond to the letter. Such Letters to the Editor are encouraged to ask clarifying questions in a spirit of curiosity (as opposed to a spirit of confrontation), model careful listening, and seek common ground where possible as it shares alternative points of view for readers' consideration. Letters to the Editor which include personal attacks or denigration of individuals or organizations will not be considered.

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ARTICLES

Building and Restoring Relationships Using the Art of Invitation: An Exploratory Phenomenological Study

Debbie Teike & Katti J Sneed

Relationships are fundamental to quality of life and purpose, yet the importance of motivation to build and restore relationships is often overlooked. When one perceives relationships absent of personal benefit, motivation to invest in relationships is challenged. Social exchange theory suggests that when individuals value altruism—putting others' needs above one's own needs— they are more likely to invest energy and time into building and restoring relationships without immediate personal gain. The Art of Invitation (AOI), a psycho-educational approach to relationship building, aims to help participants connect the altruistic value of being "invitational" to the desire to build and restore relationships. This phenomenological qualitative study used purposeful sampling to examine the impact and application of the Art of Invitation on the lives of thirteen former participants. Findings indicated main themes of one's motivation to be invitational, increased openness/non-judgmental approach to others, increased self-awareness, and utilization of second thought as a relationship building skill. It also found support for universal application of the AOI across a wide variety of populations.

Relationships are fundamental to one's quality of life and purpose. The need to belong is a strong motivator to seek and sustain positive interpersonal connections (Baumeister & Leary, 1995). Everyday human connections undergird health and well-being as support is shared and feelings of loneliness are alleviated (Cyranowski

et al., 2013). Social relationships can positively influence one's coping ability, health status, and opportunities for guidance and support (Lincoln, 2008). Cardiovascular health is linked to interpersonal awareness (Uchino, Sanbonmatsu, & Birmingham, 2013). Rook & Charles (2017) confer that positive close social interactions are tied to improved health outcomes.

Courtship, marriage, and parental relationships provide a basis for healthy social exchanges (Paat, 2013). The significance of relationship on purpose and productivity is demonstrated by Bainok, Puddesters, Mac Donald, Archibald, & Kuhl (2012), who find team building among healthcare workers impacts communication, trust, satisfaction, and enhanced quality of care.

People engage with others to fulfill basic human needs. However, when needs are not met, social interactions are avoided or eliminated altogether (Thomas & Iding, 2012). Social exchange theory explains that individuals or "actors" invest in relationships when interactions are of personal benefit and withdraw if interactions prove too costly (Cook, 1987; Stafford, 2015). This theoretical perspective focuses on the outcome or payoff within an exchange or sequence of exchanges (Chadwick-Jones, 1976). Richard Emerson, one of the founders of social exchange theory, suggests that relational exchanges materialize at the subconscious and conscious level and are influenced by one's conditioning. According to Emerson (1987), individuals have choices and subconscious conditioned responses that account for first reactions and ongoing responses (Cook, 1987). For example, receiving a criticism or an insult may trigger an initial impulse to retaliate or withdraw, however, consciously connecting to the benefits of the relationship may motivate the individual to suppress such urges and respond in a more mutually satisfying manner.

Recent developments in social exchange theory include an understanding that individuals have self-interests and interdependent interests. Some interactions are pursued out of self-interest, while others are pursued with the understanding that what benefits everyone also benefits self (Stafford, 2015). Interdependence occurs as exchanges stemming from the efforts of one influence the outcomes of another (Stafford, 2015). However, mutual exchanges do not always achieve equity, profit, or loss, and can develop over time (Segre, 2014). Rook (1984) points to the importance of assessing the quality of social ties, noting that problematic ties with others was found to have potent negative effects of psychological well-being in older women.

Human needs, basic drives, and goals generate energy behind social exchanges. Needs create yearnings, which energize individuals toward growth and action. Satisfying needs and moderating motivations drive individuals toward the pursuit of goals (Thomas & Iding, 2012); motivation drives choices (Vogl-Bauer, 2003). The amount of energy one exerts to satisfy a need or the amount of sacrifice required for another's need is proportionate to the intensity of the need (Thomas & Iding, 2012). Positive and negative

outcomes of the relationship are broadly defined and include any positive reward (i.e. companionship, security) or negative consequence (i.e. financial expense, disappointment) (Leary, 2010; Bradbury & Karney, 2014). Honeycutt (1981) notes that rewards in social exchange may not be immediate or direct. Extrinsic or material rewards often have intrinsic value. For example, one may be employed and receive a salary and also enjoy the company of coworkers. Psychological needs contribute to what rewards are sought in relationships (Blau, 2008).

Developing social neuroscientific discoveries provides evidence of how biological/neurological body systems impact social connection (Gerdes, Lietz, & Segal, 2011; Hari, Henriksson, Malinen, & Parkkonen, 2015; Gottman, 2011). Skill at interacting with others is developed as one's genetic makeup provides a range of potential and is influenced by the environment in which the skill of interaction is learned (Thomas & Iding, 2012). The need to receive support is universal, yet the ability to reciprocate this response in providing support to others is not inheritably genetically connected. Personality influences one's perception of others and the context of the relationship (Lincoln, 2008).

However, within one's genetic and cultural context, social exchange is a voluntary process which relies on trust and goodwill (Stafford, 2015). Expectations vary and are specific to each human exchange. The context of a social exchange influences individual interaction (Blau, 2008). The time frame in these relational exchanges is negotiable, flexible, and undetermined (Stafford, 2015).

Von Lange (2014) identifies six ways in which individuals orient themselves toward others relationally:

> (1) altruism (enhancement of other's outcomes), (2) cooperation (enhancement of joint outcomes), (3) egalitarianism (enhancement of equality in outcomes), (4) individualism (enhancement of one's own outcomes), (5) competition (enhancement of relative advantage over others), and (6) aggression (minimization of other's outcomes).

Although some (Blau, 2008; Honeycutt, 1981) within social exchange theory conclude that altruism does not exist, Von Lange (2014) suggests that altruism exists in the context of empathy and interpersonal connection. Chadwick-Jones (1976) proposes that altruism is an infrequent occurrence and is most likely supported as an internal reward linked to the approval of others. Similarly, cooperation enhancement of outcomes for all involved is more likely fostered when individuals identify with the group, value others, and feel connected.

Stafford (2015) finds reviewers of social exchange theory conclude that relationships based upon "love" do not always equate to a simple

exchange and that the notion of altruism tests the basis of the theory. Pure motives of altruism are difficult to establish because in giving to others, latent and often subconscious, expectations are embedded. Helping others brings social rewards of recognition, psychological self-satisfaction, social approval, and possible reciprocation (Blau, 2008). Acting altruistically can be a reward in itself because of the positive feelings one receives from helping and acting charitably for another person (Stafford, 2015). Blau (2008) suggests that following one's moral imperatives, regardless of cost, is a guide and restraint for human behavior. He contends that complete moral compliance in the face of negative consequences is rarely achieved and only found by "saint and fool" (p.18). Bell (2009) supports the notion that when a person's motivation to act benevolently toward another comes from a moral conviction, an intrinsic reward will be gained by following such conviction. The sociological literature suggests morality as the most plausible explanation to explain why actors, being naturally self-seeking, choose to restrain from self-interests in favor of others (Bell, 2009). Jost and Kay (2010) find the existence of altruism relates to social justice concerns, where people are known to be motivated to make the world a better place.

Judeo-Christian traditions support altruistic behavior without an expectation of personal reward (Friedman, 2002). Additionally, altruism is often identified with The Golden Rule—do unto others as you would have them do unto you (Matthew 7:12, Luke 6:31, The King James Version; Scott & Seglow, 2008). Christianity identifies charity as the highest form of altruism and an important human virtue (Arnold, 2008). The reward in these contexts is suggested to be contained in the personal satisfaction of following the moral and spiritual practices of love (Arnold, 2008). Meaningful connections with religious concepts increase prosocial behavior (Duhaime, 2015). Research links prosocial behaviors to elevation, an emotion linked to spiritual uplift from morally sanctioned behaviors (Erickson & Abelson, 2012).

Gaps in Research

Altruism, caring for others' well-being and needs, is associated with terms like prosocial, compassion, and empathy (Lown, 2016). The origin, motivation for, and benefits of altruistic efforts are debated (Einolf, 2011; Friedman, 2002; Simpson, Harrell, & Willer, 2013; Beardman, 2012). Morality may also be an influencing factor, yet has been largely ignored by the fields of sociology and psychology (Simpson, Harrell & Willer, 2013). Schilbach et al. (2013) suggest the influence of reward as a motivating force in social interactions needs to be investigated as it not only impacts cognition and self-regulation, but also relationships.

Prosocial behaviors can be taught. Kramer, Caldarella, Young, Fischer, and Warren (2014) report increased prosocial behavior from teaching emotional and relational skills to children. Lown (2016) demonstrates that teaching compassion and empathy increases prosocial behaviors in medical students. Bankard (2015) suggests that moral intuition, emotional and cognitive processing as the primary energy for relational and prosocial actions, can be trained to increase prosocial behavior. Many religions see, as part of their teaching, the importance of the Golden Rule (Joseph, 2012) as a moral and behavioral imperative. However, exploration of programs intended to connect altruism with relational skill building are absent in the literature. This article seeks to fill this gap by gleaning the lived experiences of participants who have completed an Art of Invitation workshop.

The Art of Invitation Overview

The Art of Invitation (AOI), a psycho-educational approach to relationships, aims to help participants connect the altruistic value of being "invitational" to the desire to build and restore relationships. AOI equips participants, interested in becoming more inviting to others, with concepts and tools for gaining interpersonal awareness and removing relational barriers. It aims to help participants develop a sense of relational "belonging," whether an "insider" or "outsider" in any particular circumstance. In addition, AOI seeks to strengthen one's ability to gain self-control when relationally triggered and establish congruence between internal experience and external expression (Teike, 2012). Initially created by its founder, Debbie Teike, for seminary students whose future profession requires them to transcend communication barriers in uncomfortable or unfamiliar settings, the program was subsequently presented in churches, a county jail, and nonprofit settings (Art of Invitation, n.d.). By the spring of 2014, approximately 450 people had participated in an AOI workshop.

The eight sections of workshop training include: understanding insider and outsider relational experiences, three interactional approaches (i.e. invitational, presentational, and confrontational), three keys to invitational communication, the second thought process, barriers to invitation (i.e. conflicting values, unmet relational needs, emotional dysregulation, and non-invitational thought), and strategies for overcoming relational barriers through invitation. The Art of Invitation framework is shared through the presentation of ideas, individual and group exercises, videos, discussion, and accompanying written materials. AOI explains how an "invitational mindset" is key to successful interactions and communication.

An invitational approach, as taught in AOI, strives to relate to others as equals, regardless of role or position. It sees value and worth in others and self, despite overt or subtle differences which can be equated to disparities

in power and privilege. Power is a significant factor in relational experience and outcomes, and power differentials between individuals are expressed in style of communication (Albarracin & Vargas, 2010; Fiske, 2010). Gordan, Tanrel, and Duff (2014) discuss an individual's ability to adapt to a communication style, a term called synchrony, as an essential ingredient for social connectedness. Whereas, Echterhoff, Kopietz and Higgins (2017) suggest that human exchanges are often adapted to the audience's attitude. In one study involving referees testing the notion of fairness, a calmer tone of voice and consideration of content were significant to players' acceptance of an on-the-field decision (Simmons, 2010).

Communication style involves characteristics such as directness, length and rate of speech, and manners, all of which can impose power upon another (Fiske, 2010). AOI distinguishes between three types of communication. A presentational approach focuses solely upon conveying information, relating much like a teacher in style. A confrontational approach is directive, highlighting disagreement and using a corrective, oppositional, and pressuring style, whereas, learning to utilize an invitational approach allows for reciprocal relationships. The purpose of distinguishing between these styles is to highlight subtle differences in approach, redirecting individuals from "telling" to mutual sharing (Schein, 2013, p. 58). Participants learn that sharing information (i.e. presenting) and working through differences (i.e. confronting) are natural and normal elements of human communication in a relationship (Epley & Waytz, 2010). AOI helps participants match motive (i.e. altruistic or other) in exchanges with communication style (i.e. invitational, presentational, and confrontational) to provide clarity of intention and approach. Invitational communication takes into consideration the perceived level of trust in the relationship, and information or correction is not forced upon another. Trust is a factor in positive exchanges (Zhao, Ha, & Widdows, 2013; Fisler, 2005; Siegrist & Zingg, 2014; Lieberman, 2010). At the end of each AOI program, participants offer feedback on the relevance of the material as well as suggestions for improvement.

Methodology

Research design

This study examined the lived experiences of AOI participants utilizing an Interpretative Phenomenological Analysis (IPA) qualitative design. Phenomenology assumes that human beings can consciously express lived experiences (Creswell, 2013). Utilizing participants' descriptive narratives, the researchers gained insight into the overarching themes in order to understand the impact from participants' personal and relational experiences (Giorgi, 2012). Qualitative

methodology allowed the researchers to collect and analyze data from thirteen individuals who completed the AOI workshops in order to discover the essence and application of their experiences. According to Smith and Osborn (2014), Interpretative Phenomenological Analysis gives an understanding of the insights into how purposefully selected attendees have integrated their experience of AOI. The data gathered from interviews with the participants was used to interpret the significance of their experience with AOI and to appraise the meanings attached to their experience (Creswell, 2013). The purpose of this study was to develop a description of the integration of AOI experiences. Qualitative research of this nature takes into account variation and context of participant experiences, which can then be applied to Art of Invitation improvement and future research surrounding the effects of altruism and communication style on relationships (Gentles, Charles, Ploeg, & McKibbon, 2015). Purposeful sampling, with maximum variation (Patton, 2002) facilitated the inclusion of as many variables as possible within the research sample of those who had completed the AOI workshop training.

Sampling Design and Participants

Upon the Institutional Review Board's (IRB) approval from Indiana Wesleyan University, the researchers first reviewed the 25 AOI presentations, taking place between the fall of 2009 and spring of 2014 for diversity of group size, presentational format (i.e. one day workshop or weekly/bi-weekly), and setting (i.e. faith-based off campus, church, seminary, jail, small group, not-for-profit). Leaders and organizers from these diverse venues were then contacted to extend an invitation to past participants who might have an interest in volunteering for the study. Those who volunteered were then contacted via email or telephone by the researchers to explain the study, its purpose, their voluntary participation and rights. A purposeful sample consisting of 13 former AOI participants was secured. Participants ranged in age from 28 to 81 years old, with a mean age of 46. Seven of the thirteen participants were female. Participants' employment status included: unemployed while incarcerated, stay-at-home parent, business owner, business employee, volunteer coordinator, seminary student, case manager, director of a community service agency, nurse, church musician, teacher, social worker, and retired. Ten participants were married, and three were single. Two participants were African-American; eleven were Caucasian. An average of one year and ten months transpired from when the participants participated in AOI to when they were interviewed. Table 1 depicts the demographics of participants.

Table 1
Demographic of Participants

PARTICIPANT #	AGE	ETHNICITY	OCCUPATION	MARITAL STATUS
1	81	Caucasian	retired	married
2	29	Caucasian	stay-at-home mom	married
3	59	Caucasian	volunteer coordinator	married
4	50	Caucasian	nurse	married
5	64	African American	business employee	married
6	63	African American	social worker	married
7	28	Caucasian	church music director	married
8	35	Caucasian	social service director	married
9	39	Caucasian	case manager	married
10	39	Caucasian	teacher	single
11	33	Caucasian	unemployed, incarcerated	single
12	50	Caucasian	business owner	single
13	28	Caucasian	pastor	married

Interview procedure

The interviewer was a retired LCSW who offered participants the opportunity to be interviewed in her residence or other private space. Jones, Sherr, and Ashenfelter (2012) suggest that purposeful partnerships between researchers and participants attend to the particulars important to both. At the onset of the interview, each participant was able to ask questions and review the informed consent, prior to subsequent signing of the informed consent form. Three of the participants preferred to be interviewed at their place of work, one was interviewed over the phone, and all others were interviewed in the interviewer's home. All but one, resided within an hour, geographically, from the interviewer in central Indiana.

Semi-structured interviews lasted approximately 60 to 90 minutes. To protect confidentiality, participants' identifying information was separated from collected data. Each participant's data were coded with a corresponding number and the master key was securely stored in a locked office. In addition, all gathered data was held on a password-protected computer. A third party transcribed each interview. Once each transcription was finished, member checking included sending a copy of each transcription to individual participants for review and approval. All participants provided, through review and verification, the accuracy of their interviews; three participants made changes to clarify their thoughts and opinions.

Data Analysis

Interpretive phenomenological analysis (IPA) was utilized in grasping the thematic meanings AOI held for the participants (Smith & Osborn, 2014). Moustakas (1994), a phenomenological inductive reasoning method, was further applied to data analysis. First, researchers practiced epoché, which allowed them to focus upon the data without interfering bias. The beginning of the analysis was simply reading through each transcribed interview and maintaining a perspective of epoché throughout each reading.

The second level of phenomenological reduction included bracketing, horizontaling, clustering the identified themes, and developing a textural description from the themes (Moustakas, 1994). Phenomenological reduction involved a second reading of the interviews with the specific goal of isolating possible themes (Moustakes, 1994). The researcher utilized bracketing in order to suspend preconceived realities in an effort to protect the phenomenological purity while analyzing the data (Farina, 2014). The transcribed semi- structured interviews were dissected into statements of horizontalization (Creswell, 2014). Horizontalization can be defined as a process that involves placing all the data out for examination and then approaching the data as if all are weighted equally (Merriam & Tisdell, 2016). Once this was accomplished, these particular units or statements were translated into thematic groups of subjective meanings (Merriam & Tisdell, 2016).

The goal of the third level, imaginative variation, was to develop a structural description built from the themes and accounting for the possible influences of "time, space, materiality, causality, and relationship to self and others" (Moustakas, 1994, p. 99). Imaginative variation includes the use of inductive reasoning, which Neuman (2006) described as moving from concrete data to interpretation. The analytical process of discovering the interpretive experiences of AOI for participants included examining the various perspectives from their described lived experiences after participating in the program.

Results

Findings indicated main themes of one's motivation to be invitational, increased openness/non-judgmental approach to others, increased self-awareness, and utilization of second thought as a relationship-building skill. It also found support for the universal application of AOI across a wide variety of populations.

Motivation to be invitational

All thirteen participants expressed a heightened awareness of their motivation to enhance relationships as a result of participating in AOI. Participant 4 generalizes her motivation:

> I mean as I think about going into adoctor's office or just places that I go in general… you know, instead of being confrontational to the check-out lady who's miserable in her job and just is watching the clock and the line's long, you know, if I seek to understand that she's a person just like I am and that maybe her child is home sick… I don't know what she's experienced in her day, but by her demeanor I can understand that she's probably not having the best day ever or maybe she's just on top of the world and I'm the one who's having a really bad day.

Participant 6 said:

> You gotta have belief that man is important… there is certain things just as humanness that ties us together and you have to have that basic belief because if you do not believe that, you have no value for life, you have no value for yourself so there has to be that core value of people.

Eleven of the thirteen participants describe motivation to be invitational resulting from a connection made with AOI content to their Christian faith or social service values. Two participants experienced AOI in a secular setting, and yet, chose to share in the interview how AOI aligned with their faith as well as professional values. Participant 3 states, "How will I come across to them? You know, what do I need to say and how do I need to say it…that would please God?" Participant 5 shares, "I think we have to be respectful that God has created us all different." Participant 7 suggests:

> And, so, I would say, you know, the AOI is just understanding how to be more and more like Christ in every single interaction that you have with anybody ever. Everything from the words you choose, to active listening, and not only just listening but actually hearing what that person's saying, what's spilling out of their heart, you know, what are they actually trying to communicate.

Participant 9 explains, "And I think with the Art of Invitation it kind of renewed and gave me a bit of a life and reminded me to stick to the core values." For participant 13, a paradigm shift occurred in his professional demeanor. He reflects:

> I might add that I was quite struck by the frequency with which Jesus engages in invitational speech in the Gospels. It really changed the way I read the Gospels. It has really changed the way I've tried to relate to people as a pastor.

Increased openness/non-judgmental approach to others

Twelve out of thirteen participants identified AOI as enhancing their willingness to expand personal parameters toward others. All twelve made general comments about becoming more open and non-judgmental as Participant 3 states: "I needed to just change my attitude toward others and how I could be more open and understanding of those that are different and knowing that I am responsible for my attitude." Participant 8 responded: "It would be that piece right there, Seeking to Understand, and really trying to figure out, you know, where that person's coming from, what might be affecting their thought process, what might be affecting their physical circumstances." Participant 1 explains, "Try to listen to the other person and don't prejudge and don't respond immediately which I have a tendency to do…."

Increased Self-Awareness

This theme is based on the importance of being self-aware to improve invitational communication and work through barriers. Eleven of the thirteen participants voiced greater self-awareness as the result of AOI. Participant 9 highlighted, "Probably the biggest thing that stood out to me was just being self-aware of how you interact, communicate with your clients, communicate with providers, how you can really create some change for the common good."

Furthermore, those eleven participants pointed to self-correction resulting from enhanced self-awareness. Participant 6 explains: "I learned that there was a couple of things that I did that I needed to put aside." In addition, Participant 10 discloses: "I've always been very reactionary and now since this class and being more invitational, you know, I still may think that I've got the right answer, but I find a different way to get that expressed to people."

Utilization of Second Thought as a relationship-building skill

Eleven of the thirteen participants identified utilizing a second thought process in their relationships. Participants understood the second thought as a concept and tool to help recognize the presence of a non-invitational first thought in order to allow the invitational second thought time to surface. The second thought halts unintended counterproductive responses in relationships and interactions. "I learned I have to adjust what I say and so second thought has come into that a lot because I don't immediately go off the handle on things" as stated by Participant 10. Participant 11 reflected

that "we've talked a lot about second thought process…How your first thought is often not the best thought."

Universal application of AOI

All thirteen participants discussed the significance of AOI being applicable to a wide variety of populations from various socioeconomic, generational, ethnic, and cultural backgrounds. Participants verbalized populations that would prosper from attending AOI. Nine participants specifically stated that "anyone" or "all people" could benefit from AOI. Participant 3 stated: "I can't imagine anyone not benefiting…if they can take the concepts and really apply it to their lives."

Participant 6 identified division in the contemporary world and stated:

> ...we have a broad gap within acceptance of one another for whatever reason that might be. And so, because of that, there isn't anyone or any organization within the realm of this world that should not be using openness in the AOI.

Seven participants specifically spoke from their frame of reference regarding the application of AOI. Participant 2 stated: "I was an inmate at the time I did this… I think other inmates could benefit from it." Participant 11 reported: "I think it's (AOI) definitely good for people, like I said, in recovery. I think it's great for us."

Six participants identified larger groups or organizations, including professions, benefiting from AOI. Participant 8 stated, "Definitely anybody who's working in social work, anybody serving in an area of ministry or counseling… But even not-for-profits… probably anybody that's in any kind of helping profession, you know, healthcare... anyone working at a hospital... occupational of a profession that wouldn't be beneficial for it. I think about attorneys... even people who work in a grocery store…."

Limitations

While the sample size for this study is small in comparison to the number of participants who have completed AOI, thirteen is an adequate number for an exploratory study (Creswell, 2014). Since all but two of the twenty-five presentations of AOI were held in the Midwest, it is unknown if AOI would be received similarly in other geographic regions. Likewise, all but two presentations of AOI were held in churches or faith-based venues calling into question if similar results would have been found in secular circles.

The study's findings may also be influenced by participant bias, as participants may give a favorable review of Art of Invitation due to personal

connection with the founder, who presented the workshops from which the sample was drawn. Debbie Teike, a Licensed Clinical Social Worker, developed AOI in meeting the need of clergy and congregations lacking awareness and skills in developing relationships. To combat this participant bias, a third-party interviewer was utilized to protect against this threat to internal validity. In addition, participants of the study were encouraged to be honest in sharing their thoughts, especially negative experiences or suggested improvements to learn about Art of Invitation. In each case, volunteers provided acknowledgement to the interviewer that they understood that all feedback was valuable.

Generalizability of these findings is limited due to the small sample size, yet internal validity was protected by utilizing an outside interviewer.

Conclusion

This phenomenological exploratory study investigates the impact and application of the Art of Invitation for participants of the program. By utilizing Interpretive Phenomenological Analysis (IPA), the themes of universal application of AOI, motivation to be invitational, increasing openness/being non-judgmental, becoming self-aware, and utilizing second thought emerged.

The Art of Invitation is undergirded by both social work values of dignity and worth of each person and the importance of human relationships (NASW, 2017), as well as the Judeo-Christian value to love one's neighbor as oneself (Matt. 7:12 The English Standard Version). Concepts and tools are derived from the merging of these two entities. AOI provides a psychoeducational approach for those who desire to connect the altruistic value of being "invitational" to the desire to build and restore relationships. Participants identify what they value, gain insights in communication skills, and work through obstacles identified. Findings indicate that participants were motivated to be invitational even in uncomfortable or challenging interactions. To stay connected to others when differences occurred, participants utilized the second thought process.

Study participants expressed living out their value of being invitational internally and toward others. Given the existence of personal and cultural relational challenges of today, (Woodson, 2017; Ruef & Soek-Woo, 2016; Wakefield, 2015; Hendon & Tonoyan, 2011), AOI is a timely option for those seeking to a way to overcome relational barriers and increase positive relational exchanges.

Recommendation for further research

This study's findings suggest several areas for future research. First is the question of the long-term effects of AOI and its ability to produce last-

ing change in participants. While some volunteers were interviewed five years removed from participating in a workshop, the long-term personal and relational effects on participant relationships are unknown. Furthermore, this study did not validate if invitational living creates more trusting, connected relationships. Yet, it explanatorily established that participants were motivated to look inward, be more open and less judgmental, and use a second thought to be invitational with others. Future research might address the long-term effects of AOI on personal and environmental outcomes pertaining to individual, family, marital, friendship, community, church, and/or provider/client relationships, to name a few.

Social exchange theory (Cook, 1987; Stafford, 2015; Thomas & Iding, 2012) suggests that human beings are motivated by benefits and costs. Lieberman (2010) suggests that relationship building relies upon mutual trust, cooperation with one another, and a perception of fairness in the distribution of rewards and responsibilities. In that participants linked the concept of being invitational to already held values and morals, it is unknown if participants who do not hold strong values and morals akin to the Golden Rule would experience the same or similar changes. Additionally, future studies could help explain at what point altruism is too costly to personal or relational gain. Compassion fatigue and burnout may ensue from invitational living without an awareness of personal limitation.

Lastly, the connection between altruism and other Christian virtues could be explored. Wolfer and Brandsen (2015) wrestle with the internal struggles social workers face when virtues, embedded in their faith, contradict values set forth by their profession. Moreover, Wolfer and Brandsen urge social workers to recover some of their deeper meaning virtues and reclaim them, in order to build a solid foundation for social work practice. AOI could help practitioners better identify the context in which faith-based virtues, basic rules of communication, and relational challenges occur. Further, using AOI, practitioners might be able to enhance relational connections with peers and reconcile differences with non-Christians, especially where individual values and approaches may differ. ❖

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Appendix 1: Art of Invitation Interview Questions

1. Describe where, when, and in what venue you experienced the Art of Invitation Workshop?
2. What are some of the key concepts you remember from the training?

   a) of those concepts you mentioned, which were of most value and in what ways?

   b) of those concepts you mentioned, which were of least value and why?
3. Since completing the Art of Invitation workshop, how, if at all, have you altered your interpersonal contacts with others?
4. What do you remember about the concept "Second Thought"?
5. What do you recall about being invitational versus confrontational verses presentational?
6. In what ways, if at all, was the discussion about barriers and values helpful?
7. What populations do you think would benefit from participating in the Art of Invitation? Why and How?
8. What populations do you feel Art of Invitation would not apply to? Why?
9. How would you describe Art of Invitation to someone who knows nothing about the workshop?
10. What other thoughts, comments do you have that might be helpful to someone evaluating? The Art of Invitation?

Debbie Teike, *LCSW, is founder of the Art of Invitation workshop, 1032 Coles Drive, Columbus, IN, 47201. Email: Debbie@artofinvitation.org*

Katti J. Sneed, *Ph.D., LCSW, is Director of the BSW Program at Indiana Wesleyan University, 4201 S. Washington Street, Marion, IN, 46953. Email: Katti.Sneed@indwes.edu*

Keywords: Relationship, Communication, Invitational, Restoration, Art of Invitation (AOI)

Barriers to Health Care: Who Is Affected and How Christians in Social Work Can Address These Barriers

Kristen R. Alford, Ashley Zuverink & Gail Landheer Zandee

This study uses community-based participatory research, acknowledging the importance of engaging communities in identifying problems and finding solutions to health care needs in neighborhoods. The study particularly highlights barriers to accessing health care among people who identify as Hispanic. A random sample of households was drawn of households in three urban neighborhoods in a Great Lakes state. A barrier to health care scale along with sociodemographic questions were used to identify subgroup differences in access to health care. Major findings suggest that those who identify as Hispanic, speak Spanish as their primary language, rent rather than own their home, and do not have access to health insurance report more barriers to obtaining needed medical care. Findings illustrate the need to engage with communities to address these barriers to health care... This study suggests using models of Christian Community Development to promote community leadership in implementing solutions.

As of 2014, there were 55.3 million Hispanics[1] in the United purpose. States, accounting for 17.3 percent of the total population (Stepler & Brown, 2016). Over the past decade, Hispanics constituted more than half of the United States' population growth (Krogstad, 2014). Trends suggest this growth will continue as the number of Hispanics in the United States are projected to reach 119 million by 2060, at which time Hispanics will account for 28.6 percent of the nation's population (United States Census Bureau, 2015b).

For several decades, Hispanic population growth in the United States could be attributed to immigration, but current growth is due primarily to higher birth rates (Krogstad, 2014). The high birth rates are reflected in

current population demographics, as nearly one-third of Hispanics in the U.S. are younger than 18 (Patten, 2016). Nearly 75 percent of Hispanics over the age of five speak Spanish in their home (United States Census Bureau, 2015b). Although Spanish is the primary language in the home, 68 percent speak English proficiently as well (Krogstad, Stepler, & Lopez, 2015).

Since 2000, immigration accounts for 29 percent of the total population growth in the United States (Pew Research Center, September 2015). Of Hispanics immigrating to the United States, approximately 65 percent are Mexican and 13 percent are Puerto Rican or Cuban (Motel & Patten, 2012). As of 2014, there were 11.3 million undocumented immigrants living in the United States (Krogstad & Passel, 2015). Of these, an estimated 49% are Mexican with an additional 26% from other Latin American countries (Krogstad & Passel, 2015).

One of the current challenges faced by American society is the extent of health disparities seen across the nation, and Hispanics are not strangers to this challenge. In comparison to those who identify as non-Hispanic, Hispanics are more likely to forego needed health care and prescriptions due to cost, are more likely to forego early cancer screenings such as mammograms, and are diagnosed at later stages of disease development (Mayberry, Mili, & Ofili, 2000). Additionally, Hispanics have the highest uninsured rates in the United States, with 34 percent of the Hispanic population ages 19 to 64 being uninsured in 2014, compared to ten percent of non-Hispanic whites and 18 percent of blacks (Doty, Collins, Rustgi, & Kriss, 2015).

These demographic changes not only present challenges and opportunities for American society, they also present opportunities for Christians in social work to live out their vocation. This paper explains the inequalities Hispanics face in health care access and promotes social justice efforts in which Christian communities can participate to combat these disparities. Theologian John Calvin argued the government was obligated to fulfill the basic needs, including health care needs, of its citizens (Tuininga, 2012). Furthermore, he stated that the diaconate and civil government must work together to ensure these needs were met (Tuininga, 2012). In today's society, Christian social workers can serve the role as a conduit between the church and the government as they are active and involved in both segments. As it relates to health care needs, social workers are on the front lines of understanding the needs of the most vulnerable among us, and thus are able to articulate what the

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[1]This paper uses the term Hispanic to refer to those who self-identify as having racial or ethnic origins in a predominantly Spanish-speaking country. Hispanics come to the U.S. from dozens of countries and are from a variety of cultures, religions, and socioeconomic statuses, speak an assortment of native languages, and hold varying degrees of citizenship. The authors acknowledge other terms, such as Latino/a or Latinx, are preferred, but this paper uses the term Hispanic to stay consistent with the literature and data sources utilized.

needs are and the best approaches to providing for those needs. As we seek to fulfill both our call in social work to enhance functioning and well-being as well as our biblical call to justice, Christian social workers are uniquely equipped to address health care among underserved populations, including Hispanics, in the United States.

Literature Review

Disparities in health outcomes can be linked to a complex interweaving of political, social, historical, and cultural contexts (Williams & Jackson, 2005). Disparities in health outcomes are related to differences in health care access due to availability and accessibility of health care providers, health insurance status, transportation needs, and primary language spoken (Cristancho, Garces, Peters, & Mueller, 2008; DuBard & Gizlice, 2008; Shi, Lebrun, & Tsai, 2009). Many studies have observed racial health disparities (Adler & Rehkopf, 2008; Williams, 2012; Williams & Mohammed, 2009), but fewer studies observe barriers that might lead to racial health disparities. Previous research acknowledges the complexity of understanding health care needs and suggests that the interaction of different systems contributes to the potential for disparities to arise. These include health and provider organizations, social networks, access to transportation and nutritious food, education, and employment, to name a few (Alegria, Pescosolido, Williams, & Canino, 2011; Warnecke et al., 2008). Major gaps in health inequalities remain despite the tremendous progress that has been made (Bleich, Jarlenski, Bell, & LaVeist, 2012). Hispanics in the United States encounter several barriers to care, including language barriers (Blendon et al., 2015; Cristancho et al., 2008; DuBard & Gizlice, 2008; Fernandez et al., 2011; Sheppard, Williams, Wang, Shavers, & Mandelblatt, 2014; Shi et al., 2009), fear of being turned away by health care providers (Armstrong, Ravenell, McMurphy, & Putt, 2007; Cristancho et al., 2008; Rhodes et al., 2015), cost of health care and prescriptions (Ayon, 2014; Collins, Kriss, Doty, & Rustgi, 2008; Cristancho et al., 2008; Frankenfield et al., 2010; Reed, Brand, Newhouse, Selby, & Hsu, 2008), lack of insurance (Doty et al., 2015; DuBard & Gizlice, 2008; Rutledge & McLaughlin, 2008), and lack of transportation (Cristancho et al., 2008; Silver, Blustein, & Weitzman, 2012; Syed, Gerber, & Sharp, 2013).

Language

Language barriers often prevent non-English speakers in the U.S. from obtaining necessary health care (Fernandez et al., 2011; Flores, 2006; Ngo-Metzger et al., 2007; Solet, Norvell, Rutan, & Frankel, 2005; Wilson, Chen, Grumbach, Wang, & Fernandez, 2005). Limited English

proficiency is directly related with foregoing needed health care (Shi et al., 2009) and better health outcomes for Hispanics are reported when health care providers speak their patient's primary language (Fernandez et al., 2011; Sheppard et al., 2014). According to a study conducted by Blendon et al. (2015), eight percent of Hispanic participants reported their health care professionals' inability to speak Spanish proved to be detrimental to their experience as a patient. In the same study, 11 percent of Hispanics reported they had received poor health care because of their accent or racial or ethnic background. In a systematic review of language barriers in health care settings, Timmins (2002) argued that language barriers can adversely affect quality of care for Spanish speakers. In comparison with English-speaking Hispanics, Spanish-speaking Hispanics reported far worse health status and access to care even when adjusted for demographic and socioeconomic factors (DuBard & Gizlice, 2008; Timmins, 2002). Similarly, Cristancho et al. (2008) demonstrated that having limited or no English proficiency had a negative impact on the Hispanic population in seeking and accessing health care services.

Fear

The quality of a relationship between patient and provider is a strong predictor of an individual's health care experience (Sheppard et al., 2014). Previous research suggests that many Hispanics fear being turned away from the doctor or distrust their health care providers (Armstrong et al., 2007; Ashton et al., 2003; Cristancho et al., 2008; Rhodes et al., 2015). In a study by Armstrong et al. (2007) of 48 metropolitan areas and 12 other communities across the United States, Hispanics had consistently higher mean levels of distrust than did non-Hispanic Whites. Overall, there is a general distrust in the Hispanic community of public services because of their perceptions of past policies and actions, regardless of immigration status, which can lead to underutilization of available health services (Rhodes et al., 2015). This distrust was illustrated in focus groups with Hispanic mothers in North Carolina. Rhodes et al. (2015) found while the women were unclear of details of policies, they sensed an anti-immigrant sentiment paired with fear that their lack of documentation could lead to deportation.

Cost of Health Care and Prescription Costs

Health care and prescription drug costs also serve as a barrier to care in many circumstances. According to the 2015 National Health Interview Survey, 5.4 percent of Hispanics did not obtain needed care in the past 12 months due to cost (Ward, Clarke, N., & Schiller, 2016). According to a study by S. R. Collins et al. (2008), 45 percent of adults ages 65 or younger expressed

having at least one of the following access to health care problems: In the past year they had not gone to a doctor when they should have; did not fill a prescription when it was warranted; skipped a medical test, treatment, or follow-up visit recommended by a doctor; or did not see a specialist when a doctor thought it was needed due to cost. According to a study by Cristancho et al. (2008), Hispanic participants expressed that they were afraid to access health care services because they were unsure if they would be able to afford the bills they received. Similarly Frankenfield et al. (2010) demonstrated that Hispanic ethnicity is significantly associated with foregoing necessary prescriptions due to cost. Of those who identified as Hispanic, 20.3 percent reported foregoing prescriptions due to cost in the past 6 months as compared to 12.9 percent of non-Hispanics (Frankenfield et al., 2010). Another study by Briesacher, Gurwitz, and Soumerai (2007) suggested that non-White respondents were less likely to adhere to prescription recommendations than those who identified as White. However, these associations were no longer present when factoring in income and insurance status, suggesting these factors may better explain the reasons for not adhering to prescription recommendations rather than solely race/ethnicity. Cristancho et al. (2008) observed that, although most Hispanics could afford the cost of a doctor's appointment, it was extremely expensive to purchase prescribed medications. These results are supported by perceptions as Hispanics express the need for affordable health plans that are comprehensive and accessible (Ayon, 2014).

Lack of Insurance

Lack of health insurance is a major barrier to accessing health care, particularly among the Hispanic population. Non-elderly Hispanics have a higher uninsured rate than do non-Hispanics (Rutledge & McLaughlin, 2008). Despite the implementation of the Affordable Care Act, 19.9 percent of Hispanics were still uninsured in 2014, compared to 7.64 percent of those who are non-Hispanic Whites (United States Census Bureau, 2015a). Additionally, in 2014 the Commonwealth Fund found that three-quarters of Hispanics who remained uninsured spoke Spanish as their primary language (Doty, Beutel, Rasmussen, & Collins, 2015). DuBard and Gizlice (2008) report that 55 percent of Spanish-speaking Hispanics were uninsured in comparison to 23 percent of English-speaking Hispanics. Regardless, uninsured rates have major implications on access to health care.

Transportation

Identifying transportation to needed health services often serves as a barrier. Transportation barriers include inadequate public transportation, lack of access to a vehicle, distance, lack of a valid driver's license, and

transportation costs including fuel and repair costs (Cristancho et al., 2008; Syed et al., 2013). A systematic review of the literature by Syed et al. (2013) found that ten to 51 percent of individuals report lack of transportation as a barrier to health care access. Hispanics identify lack of transportation as a factor in restricting their abilities to get to medical appointments, resulting in missed appointments or arriving late and being turned away (Cristancho et al., 2008; Yang, Zarr, Kass-Hout, Kourosh, & Kelly, 2006). In one New York suburb with 73 percent of the population being Hispanic, 23.5 percent of people reported missed or rescheduled appointments due to transportation problems, and 30 percent reported chronic transportation problems (Silver et al., 2012).

Research Questions and Purpose

A cross-sectional research design was used to gather assessment data from each of the three neighborhoods. Surveys were collected between March and May 2009, 2010, and 2011. Surveys were conducted door-to-door and were administered verbally to participants in both Spanish and English. A systematic random sample was drawn from each of the neighborhoods. In two of the neighborhoods, every third street was included in the study; in the third neighborhood every street was included in the study because it was a smaller neighborhood. Across the neighborhoods, sampling began on the north and east ends of the streets. The first house surveyed on each street was determined by a coin flip (heads meant surveying the first house and tails meant surveying the second house). Once the first house was randomly selected, every other house on the first block was chosen to be included in the survey. Of the 1,526 homes in the sampling frame, 480 completed the survey resulting in a response rate of 31%.

Measures and Covariates

Independent variables

Independent variables include primary language spoken in the home, home ownership status, age, racial/ethnic group, gender, health insurance status, and participation in public health insurance programs. Responses for primary language included English, Spanish, and other; home ownership responses were rent or own; race/ethnicity included Caucasian, African-American, Hispanic/Latino, Asian, or other. Age was gathered as a categorical variable (18-29 years, 30-39 years, 40-49 years, 50-59 years, 60-69 years, and 70 and over). Gender was determined by observation. Participants were also asked to describe their health care coverage (yes, they have health care coverage;, no; don't know/not sure; and refused).

Dependent variables

The dependent variable is an eight-item barriers-to-health- care scale (BHC). The BHC items include lack of health insurance, cost of seeing doctors and nurses, lack of awareness of where to seek care, language barriers, fear of being turned away, lack of transportation, inaccessible office hours, and perceived respect by health care professionals. The scale responses range from eight to 24. Those with lower scores on the BHC face more barriers to health care than those who report higher scores.

Statistical Analyses

Statistical analyses were performed using IBM SPSS Statistics 23. ANOVA and MANOVA were used to show differences in means between groups. The Barriers to Health Care scale was tested for internal consistency resulting in a Cronbach's alpha of p=.67.

Results

Relationships between barriers to health care and a number of population characteristics were examined using correlation and regression analyses.

Descriptive Statistics

The characteristics of the sample are provided in Table 1. The majority of the sample participants were female (63%), owned their own homes (57%), and reported having health care coverage (77%). Twenty-eight percent of participants identified as Hispanic and twenty percent identified Spanish as their primary language. The majority of the sample participants were ages 18 to 40 (51%).

Table 1: Personal Characteristics (N=480)

	N	%
AGES		
18-29	138	29
30-39	107	22
40-49	79	17
50-59	84	18
60-69	43	9
70 and older	28	6

	N	%
Missing	1	0.2
Gender		
Female	301	63
Male	177	37
Missing	2	0.4
Ethnicity		
Hispanic	136	28
Non-Hispanic	344	72
Home Ownership Status		
Rent	208	43
Own	272	57
Primary Language		
English	385	80
Spanish	95	20
Health Insurance Status		
Yes, have health care coverage	369	76.9
No, do not have health care coverage	104	21.7
Don’t know/not sure	7	1.5
Barriers to Health Care Scale Range: 10-24; Mean: 21.37; SD: 2.90		

Multiple Regression Analysis

Multiple regression was used to test if demographic and social variables were significantly associated with barrier to health care scores. Ethnicity, home ownership status, primary language, and age all had significant ($p<0.05$) yet weak ($-0.08 \leq r \leq 0.30$) zero-order correlations with the barrier to health care scale. Ethnicity, home ownership status, primary language, and age had significant ($p<0.05$) partial effects in the full model (see Table 2). The model was able to account for 15% of the variance in barriers to health care, ($F(9,470) = 10.267$, $p< .000$), with an R2 of .164 and an adjusted R2 of .148.

Those who self-identified as Hispanic (*M*=19.99, S.D.=3.45) had statistically significant lower scores on the BHC scale than those who self-reported their ethnicity as non-Hispanic (*M*=21.92, S.D.=2.45). Similarly, those who identified their primary language as Spanish (*M*=19.59, S.D.=3.52) had statistically significant lower BHC scores than those who identified their primary language as English (*M*=21.81, S.D.=2.54). The BHC scores for those ages 50 to 59 (*M*=21.06, S.D.=2.92) and 60 to 69

(*M*=21.30, S.D.=3.00) were statistically lower than for those ages 18 to 29 (*M*=21.67; S.D.=2.59). Those who reported no health care coverage (*M*=19.12, S.D.=2.97) had statistically significant lower scores on the BHC scale than those who reported having health care coverage or who did not know their health care coverage status (*M*=21.99, S.D.=2.55). BHC scores for home ownership status were also statistically significant, indicating that those living in rented units (*M*=20.81, S.D.=3.10) had lower BHC scores than those living in homes they owned (*M*=21.80, S.D.=2.66). Gender was not significantly associated with BHC scores and thus, did not contribute to the multiple regression model.

Table 2: Summary Regression Analysis for Variables Predicting Barriers to Health Care (N=480)

BARRIERS TO HEALTH CARE					
VARIABLE	*B*	*SE B*	β	t	p
Ethnicity[a]	-1.17	0.40	-0.18**	-2.92	0.00
Gender[b]	0.13	0.24	0.02	0.54	0.59
Home Ownership Status[c]	-0.84	0.25	-0.14**	-3.38	0.00
Health Care Coverage Status[d]	-2.44	0.29	-0.35**	-8.45	0.00
Age[e]					
30-39	-0.26	0.33	-0.04	-0.79	0.43
40-49	-0.55	0.36	-0.07	-1.53	0.13
50-59	-0.97	0.35	-0.13**	-2.75	0.01
60-69	-1.33	0.45	-0.13**	-2.94	0.00
70 and older	0.20	0.54	0.02	0.38	0.71
Primary Languagef	-0.89	0.45	-0.12*	-1.98	0.05
R^2	0.275				
Adjusted R^2	0.259				
F for change in R^2	3.905**				

a Ethnicity: 0=non-Hispanic, 1=Hispanic.
b Gender: 0=Male, 1=Female.
c Home Ownership Status: 0=Own home, 1=Rent.
d Health Coverage Status: 0=Has health care coverage or doesn't know; 1=Does not have health care coverage
e Age: Age was divided into 6 categories among those ages 18 and above; Those ages 18 to 29 served as the reference group.
f Primary Language: 0=English or other, 1=Spanish.
*p<0.05. **p<0.01.

Discussion

The results of this study are consistent with previous findings in the literature and highlight the vulnerability of specific population groups in accessing timely and appropriate medical care. Specifically, those who identify as Hispanic, speak Spanish as their primary language, rent rather than own their home, and do not have access to health insurance report more barriers to obtaining needed medical care. Those ages 50 to 69 also face more barriers to health care as compared to those in the 18-to-29 year-old age group. Gender was not significant in this model.

Housing issues including home ownership status and affordability have been previously linked to health care decisions and overall health status (Ortiz & Zimmerman, 2013; Pollack, Griffin, & Lynch, 2010). This study found that renting one's home and identifying as Hispanic both led to increased barriers to accessing and obtaining health care. Conversely, Ortiz and Zimmerman (2013) found the relationship between home ownership status and obtaining health care was only significant for non-Hispanic whites and not for racial or ethnic minorities. These differences may be attributed to our inability to fully control for socioeconomic status.

The association between lack of health insurance and increased perceived barriers to accessing and obtaining necessary health care among Hispanics is particularly troubling. Rutledge and McLaughlin (2008) found that between 1983 and 2003, uninsured rates for non-Hispanic adults remained fairly steady while the uninsured rates for Hispanic adults rose among both non-citizens and citizens. Similarly, Abdus, Mistry, and Selden (2015), using pooled data collected between 2005 and 2010 by the Agency for Healthcare Research and Quality (AHRQ), found that Hispanic adults who were United States citizens had lower rates of health insurance coverage, access to health care, and the use of preventive services than non-Hispanic White adults. Since the implementation of the Affordable Care Act (ACA), the uninsured rate among Hispanic working adults has decreased from 43 percent in 2010 to 25 percent in 2015, representing the largest decline among any ethnic/racial group (Doty & Collins, 2017, January 19). However, although the implementation of the ACA has lessened the health insurance coverage gap between Hispanics and non-Hispanic Whites, particularly in states that have opted into Medicaid expansion, major disparities still remain (Buchmueller, Levinson, Levy, & Wolfe, 2016). Further, recent changes in the US political environment leave uncertainty around future modes of health care delivery and insurance. Current efforts to dismantle the ACA will most negatively affect population groups who have made the greatest gains, most notably Hispanics and other minority racial and ethnic groups (Hest, 2017, March 28).

The results also indicated that age can serve as a barrier to health care, particularly when comparing 18-to-29 year-olds to those 50-to-69 years of age. As noted earlier, growth in the Hispanic population in the United States is largely due to high birth rates as compared to previous decades in which these increases were attributed to high rates of immigration (Krogstad, 2014). Hispanics who are foreign-born report more barriers to health care due to lower rates of health insurance coverage, increased language and cultural barriers to care, and more financial barriers to care (Morales, Lara, Kington, Valdez, & Escarce, 2002). Given demographic trends, Hispanic adults who are over the age of fifty may be more likely to be foreign-born and thus may be more likely to report barriers to health care as compared to younger generations.

It is important to identify individuals who are facing barriers to obtaining healthcare as these barriers may lead to the individual foregoing needed health care. For instance, Kalousova and Burgard (2013) showed excessive credit card and medical debts led to foregoing necessary medical care. According to Berkowitz, Seligman, and Choudhry (2014), Hispanics and non-Hispanic Blacks were more likely to report food insecurities while following a prescribed treatment plan. It is imperative to identify ways to eliminate the need for individuals to choose between necessary health care services and other basic needs. Berkowitz et al. (2014) acknowledge that the allocation of scarce resources rarely affects just a single patient but often entire households and extended social networks calling for a multidisciplinary effort. Social work can play a key role in identification of resources and development of interventions to decrease the need for trade-offs.

Strengths and Limitations

This study contains a number of strengths. Researchers collected data using sound methods, including systematic random sampling and an adequate population size. The demographic data of the sample were reflective of the population when compared to correlating census tract data available through the United States Census Bureau. The models used in the analysis demonstrate strong correlation between barriers to health care and sociodemographic variables, thus telling a compelling story of some of the difficulties this population faces in access to health care.

In addition to the stated strengths are a number of limitations. As a study that used secondary data analysis, the researchers had no control over the questions that were included in the surveys or in how they were asked. Consequently, there were a variety of demographic questions that were not asked that may have added more strength to the study such as income and education. Age may have also been asked at an interval level to better understand the relationships. The reliability of the BHC was low

with an alpha level of p=0.67. While this alpha level is acceptable, generally an alpha level of p=0.8 to 0.9 is preferred. Lastly, this study observes Hispanics as one racial and ethnic group and does not take into account the various races, ethnicities, or cultures represented, which can also play a role in survey responses. Identifying the best terms to describe people of Latin American descent is challenging and ever-changing. In the current context, use of Latino/a or Latinx or one's national origin is more generally accepted. However, the paper utilized the term Hispanic in an effort to stay more consistent with the literature and data used.

Implications for Research

Future research will seek to identify changes in barriers to health care following the full implementation of the Affordable Care Act since data for this study were collected prior to the roll-out of this program. However, it may elucidate some of the challenges and barriers if a repeal of the ACA is passed. The neighborhood assessments are conducted every seven years, and it will be important to compare the data across time to understand what may be contributing to and alleviating barriers to health care. Further research should also seek to understand the role of citizenship status on barriers to seeking and obtaining necessary medical care.

Implications for Social Work Practice

This study raises several implications for social work practice, including a call to address barriers to health care, particularly among vulnerable population groups and to empower communities to find and promote solutions to health inequities. The Office of Disease Prevention and Health Promotion (2017) identifies the need to "improve access to comprehensive, quality health care services" as a goal of the Healthy People 2020 initiative. Social workers can play an important role in the fulfillment of this goal as it fits with the mission of our profession. The preamble of the National Association of Social Workers (2017) Code of Ethics states "the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty." Furthermore, the National Association of Social Workers (2016) Standards for Social Work Practice in Health Care Settings states that we are ethically obligated to advocate to ensure that all people have access to adequate health care and to remove barriers to service provision.

As this study suggests, several populations, particularly middle-aged Hispanics who do not have health insurance and rent their home, are particularly vulnerable to disparities in health care access. We are obligated

to address the health care needs and barriers among these populations, seeking to increase not only access but also to ensure the receipt of quality health care.

The data for this study were initially drawn using community-based participatory research (CBPR). This method has been proven to produce change in communities in many areas including health (Heffner, Zandee, & Schwander, 2003; Israel et al., 2005; Minkler, 2010; Minkler & Wallerstein, 2011). Not only is it important to involve communities in developing and applying research through CBPR, but it is also important to engage communities in change efforts. Christian Community Development offers a model that complements CBPR and allows social work professionals and communities to engage in advocacy and community organization efforts around issues such as addressing barriers to health care. The Christian Community Development Association (CCDA) has demonstrated that purposeful, faith-based involvement in communities has the power to transform. Among the CCDA's philosophies are leadership development, listening to community, a holistic-approach, and empowerment (Christian Community Development Association, 2012). Through this model, social workers can engage with church congregations who serve as critical drivers in health promotion and advocating for community health (Campbell et al., 2007; Collins, 2015).. Congregations are key resources in helping overcome social injustices (Hays, 2015) and are perceived as safe havens (Fuchsel, 2012). Christians in social work have the opportunity to engage in Christian community development efforts, recognizing the strengths of communities and solutions that can come from within communities. In the context of health, communities and populations with disproportionate barriers to health care must be engaged throughout, providing expertise, identifying solutions, and communicating results. Further, Christian social workers are in a unique position to bridge the gaps between community needs and congregations. Using social work skills and competencies, Christian social workers can help congregations understand how best to listen to and serve their communities as well as forge meaningful connections between congregations and community agencies.

The role of social workers in community development is particularly important as we consider health inequities among populations. Acevedo-Garcia et al. (2014) suggests the importance of health policy makers collaborating with those involved in community development as a means of improving neighborhood interventions and policies addressing population health. For instance, using existing tools such as The Child Opportunity Index can better inform community health needs assessments and take into consideration populations, including Hispanic children, who disproportionately live in low-opportunity neighborhoods as compared to White children (Acevedo-Garcia et al., 2014). Social service organizations are

already playing key roles in incorporating CBPR into their practice models. For instance, the CDC has funded Prevention Research Centers (PRC) since 1995 to address critical needs in women's health (Centers for Disease Control and Prevention, 2016; Higgins & Metzler, 2001). The PRC model emphasizes working with the community to identify and research health needs as well as implementing community-driven solutions to these needs.

Additionally, Christian social workers are responsible for advocating for vulnerable populations both in their work environments and within their congregations. Several faith-based denominations and organizations have addressed health care reform specifically. For instance, in March of 2017, forty faith-based organizations signed on to a letter to the chairpersons of the United States House Ways and Means and Energy and Commerce Committees requesting any alterations to the ACA consider ten priorities for delivering faithful health care including preservation of coverage gains, ensuring truly affordable insurance and care, and continuing to provide coverage protections for young adults, those with pre-existing conditions, and vulnerable populations (Washington Interreligious Staff Community, 2017). In Just Generosity, Sider (2007) argues that God desires health for all as it is part of abundant life. Further, Sider (2007) questions how Christians can read what the Bible says about the poor and sick and not sense, "a divine call to demand that every person in this nation, starting with the poor, have access to health insurance" (p. 189).

As we consider biblical concepts of justice, both in our professional and personal lives, Christian social workers are called to promote health among vulnerable populations. Active involvement in community development efforts and advocacy efforts, particularly alongside neighborhood congregations, will help ensure that health interventions and policies are developed in ways that consider local populations and needs. ❖

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Kristen R. Alford, *PhD, LLMSW, MPH, Assistant Professor, Department of Sociology and Social Work, Calvin College. Kadmir42@calvin.edu*

Ashley Zuverink, *BSW Graduate, Department of Sociology and Social Work, Calvin College.*

Gail Landheer Zandee, *MSN, RN, Associate Professor and Community Partnership Coordinator, Department of Nursing, Calvin College. gzandee@calvin.edu*

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Korean American Clergy: Knowledge, Attitude, Self-Efficacy, and Behaviors Related to the Prevention of Intimate Partner Violence

Y. Joon Choi, Pamela Orpinas, Irang Kim & Junhoe Kim

This study reports findings from an online survey of Korean American (KA) clergy (n = 55), exploring their knowledge, attitudes, self-efficacy, and intervention and prevention behaviors related to intimate partner violence (IPV). While most respondents reported that they sometimes preached about healthy marital relationships and provided counseling and educational materials, referrals to other resources were least utilized. Self-efficacy and attitudes were significant predictors of KA clergy's preventive behaviors, while knowledge of resources was the strongest predictor of intervention behaviors. To increase appropriate IPV preventive and intervention behaviors, KA clergy need comprehensive and culturally nuanced IPV training informed by social cognitive theory.

In the United States, intimate partner violence (IPV) is a serious problem among Korean American (KA) immigrants. Reliable estimates of IPV among KA women living in the United States are difficult to obtain. The National Intimate Partner and Sexual Violence Survey provides estimates for "Asian and Pacific Islanders" as one large group, but does not examine specific ethnic groups, such as Korean descendants (Black et al., 2011). Smaller studies that have focused on the Korean population, albeit some are older studies, estimate that as many as 60% of women suffer from physical abuse by intimate partners (Ahn, 2002; Lee, 2007; Shin, 1995; Song-Kim, 1992; Yoshioka & Dang, 2000). Research also highlights

that this physical violence is often severe (Lee, 2007; Song-Kim, 1992). In a survey of 150 KA women in Chicago, Song-Kim (1992) found that as a consequence of the violence, 70% of the physically abused women suffered bruises, 19% had broken bones or teeth, 9% experienced miscarriages, and 7% were hospitalized. In a survey of 136 KA women in Texas, Lee (2007) found that the large majority experienced psychological abuse (73%), and many reported physical abuse (29%) and physical injury (25%). In both studies, study participants were allowed to choose multiple answers.

Another indicator of the seriousness of the problem among the KA community is its identification as a cause of divorce. Physical violence by the husband was the leading cause of divorce followed by the husband's extramarital affairs, gambling, heavy drinking, and lack of financial support (Rhee, 1998). Family problems are heightened by the limited English fluency of many KA adults, most of whom are first-generation immigrants. Therefore, access to community services is limited, and many families feel socially isolated (Dasgupta & Warrier, 1996; Harris, Firestone, & Vega, 2005).

The values of Confucianism, such as collectivism, conformity to norms, shame, patriarchal and hierarchal family systems, and rigid gender roles have a strong impact on the structure of and roles within the KA immigrant family (Lee, Wachholtz, & Choi, 2014; Postmus & Hahn, 2007). This philosophical and cultural idea maintains the husband's authority and dominance over his wife and reinforces the wife's submission to her husband's governing role (Kim, Titterington, Kim, & Wells, 2010; Lee et al., 2014; Postmus & Hahn, 2007). Obedience, subservience, quietness, and purity represent the virtues of good Korean women (Moon, 2005; Tran & Des Jardins, 2000), and suffering and perseverance are valued virtues in Korean culture (Song & Moon, 1998; Tran & Des Jardins, 2000). These "virtues" encourage women to accept marital and sexual inequalities, without expressing their needs and desires (Ko, 2006).

Moreover, family appearance and status are extremely important in Korean culture, and the concept of "loss of face" means that an individual family member's bad behaviors will bring shame to the entire family, which will result in loss of respect and status in the community (Moon, 2005). Family honor and reputation are more important than individual problems. Women are valued for enduring hardship and discouraged from discussing family problems when they do occur. In sum, these values contribute to the decision of battered KA immigrant women to stay in abusive relationships (Akutsu, Castillo, & Snowden, 2007; Shin & Lukens, 2002).

Role of KA Clergy

KA immigrant women who suffer violence from their partners severely underutilize formal services such as women's shelters, hotlines, police, and

legal aid, seeking professional help only when they face crisis (Akutsu et al., 2007; Kim, 1997; Moon, 2005; Song-Kim, 1992). A study surveying a number of different Asian groups found that KA respondents were the most reluctant to seek outside help regarding IPV (Yoshioka & Dang, 2000). Instead, they turn to the church for help, even before their own families (Lee, Hanner, Cho, Han, & Kim, 2008). The Pew Research Center found that KAs were much more likely to identify as Christian (71%) than other Asian American groups (42%) (Pew Research Center, 2012). KA immigrant churches play a crucial role in meeting the needs of KA immigrants (Min, 2005). As a result, even those who were not Christians before migrating are attracted to the ethnic churches after their migration, with approximately 40% of non-Christian Korean immigrants converting to Christianity after they arrive in the United States (Min, 1992).

Due to the scarcity of formal social service agencies in the KA immigrant community (Hung, 2007), the role of the KA clergy is vital in preventing or solving problems related to IPV in the KA immigrant community. However, many KA clergy are not equipped with strategies to promote healthy communication, "translate" Korean cultural values into positive family relationships, identify potential victims, conduct safety planning, and refer parishioners to community agencies (Choi, 2015b; Kwon, Ebaugh, & Hagan, 1997; Min, 1992). Frequently, KA clergy are poorly equipped or trained in the area of IPV laws, counseling services, and other resources (Im, 2003). A recent study found that 93% of 152 KA Protestant clergy reported counseling people regarding IPV, but only 16% of them felt well prepared to handle IPV problems (Choi, 2015b). Considering the number of KA IPV survivors who could seek help at their churches, it is crucial that KA clergy receive training to promote cultural norms that support healthy families, change community members' attitudes toward IPV, encourage open discussion of IPV, create supportive and accepting environments for battered women, and implement primary prevention strategies in their church.

Present study

The present study has two objectives. The first objective is to describe the prevalence and characteristics of knowledge, attitudes, self-efficacy, and behaviors related to IPV among KA clergy. The second objective is to describe the association among these constructs and whether knowledge, attitudes and self-efficacy predict preventive and intervention behaviors. The evaluation of these constructs is the first step for developing a program for KA clergy to prevent IPV.

Multiple conceptual models (e.g., Knowledge-Attitude-Behavior model, Information-Motivation-Behavior Model, Social Cognitive Theory)

posit that **knowledge** is a prerequisite to behavior change, although knowledge alone is not sufficient for change (Bandura, 2004). For creating a social and spiritual environment that promotes healthy relationships and does not condone abuse, KA clergy need to know basic information about IPV and about available resources. Knowledge can influence behavior indirectly—through its influence on attitudes, as predicted by the Knowledge-Attitude-Behavior Model—or can also influence behavior directly—as predicted by the Integrated Behavioral Model, an expanded model of the Theory of Planned Behavior (Montaño & Kasprzyk, 2015). An **attitude** is a consistent evaluation of people, objects or ideas. This study evaluated attitudes towards IPV, IPV victims, and clergy's response to victims. According to Social Cognitive Theory, a strong predictor of behavior is **self-efficacy** defined as confidence in one's ability to perform a given behavior. This study measured the confidence of KA clergy in their ability to intervene in situations of IPV. We expect that higher knowledge, more positive attitudes, and stronger self-efficacy will be associated with more preventive and intervention behaviors.

Methods

Participants and Procedures

Participants for the current study (n=55) were recruited from a southeastern state through two methods: 1) in-person recruitment at a monthly meeting of a local Korean Church Association and a monthly meeting of the Korean Baptist Church Association in the state; and 2) phone calls to Korean American churches listed in the online Korean Yellow Pages, which includes mailing addresses, phone numbers, and names of clergy of KA churches in the United States. Participant inclusion criteria were: (a) self-identify as Korean or Korean American and (b) clergy or clergy spouse of a Korean church. We included clergy spouses because they frequently have strong influences within their churches and female IPV victims may feel more comfortable seeking help from the clergy spouses, who are mostly women. The university's Institutional Review Board approved all research protocols. Data were collected through an online survey emailed to all KA clergy who consented to participate. Participants completed the consent form and the survey in the language of their choice (Korean or English).

Measures

Based on the literature on clergy training on IPV, a structured questionnaire was designed for this study, which included scales measuring knowledge, attitudes, self-efficacy, and behaviors.

Knowledge.

The knowledge scale was based on *Myths and Facts,* a document developed by Georgia Coalition Against Domestic violence (2016) for religious leaders. It was composed of two subscales: (1) knowledge of IPV, which illustrates common myths of intimate partner violence and provides facts that challenge those myths (17 items, alpha = .75) and (2) knowledge of resources for handling IPV subscale (3 items, alpha = .83). Response categories ranged from *strongly agree* (1) to *strongly disagree* (4). The items measuring knowledge of IPV were worded as incorrect statements; thus, strongly disagreeing with those statements indicated higher level of knowledge. Examples of statements of knowledge of IPV are: “Intimate partner violence is usually a one-time event, an isolate incident,” “Pregnant women are not victims of intimate partner violence,” “People who are religious do not batter and are not victims of battering,” and “Couples counseling is the solution for domestic violence.” The three items measuring knowledge for handling IPV were: “I know of community resources and services available for IPV victims,” “I know of community resources and services available for IPV perpetrators,” and “I know legal options for victims.” These three items were reverse coded. Scale scores, calculated as the average of all items, range from 1 to 4, with higher scores indicating higher knowledge of IPV and of resources to handle IPV.

Attitude.

The attitude scale used in this study was developed and validated by Jones, Fowler, Farmer, Anderson, and Richmond (2005). The authors had adapted the scale from Centers for Disease Control’s questionnaire on health care professionals’ knowledge, attitude, beliefs, and behaviors. It measures attitudes toward IPV, IPV victims, and appropriate ways to respond to IPV as a clergy (18 items, alpha = .76). Response categories ranged from *strongly agree* (1) to *strongly disagree* (4). Examples of statements are: “It is reasonable to expect clergy to address intimate partner violence within their ministry,” “Addressing the needs of abused women is more the responsibility of counselors or social workers than of clergy,” “Victims of abuse could leave the relationship if they really wanted to end the abuse,” “Abuse occurs because women do not obey their husbands.” Some items were reverse scored. Scale scores, calculated as the average of all items, range from 1 to 4, with higher scores indicating more positive attitudes towards addressing IPV with the congregation.

Self-efficacy.

The self-efficacy scale was developed based on the social cognitive theory (Bandura, 1986) for this study. It assesses participants’ confidence in their ability to intervene in situations of IPV (4 items, alpha = .85). Response

categories ranged from *strongly disagree* (1) to *strongly agree* (4). The items are: "I am confident that I can identify women who experience intimate partner violence," "I am confident that I can counsel women who experience intimate partner violence," "I am confident that I can refer abused women to necessary resources," and "I feel well prepared to deal with intimate partner violence situations." Scale scores, calculated as the average of all items, range from 1 to 4, with higher scores indicating more confidence in personal ability to intervene in cases of IPV.

Preventive behavior.

The preventive behavior scale was adapted from *What every congregation needs to know about domestic violence* by the Faith Trust Institute (Faith Trust Institute, 2009), which includes important clergy behaviors oriented to successfully modify social norms, increase the value of healthy relationships, and highlight the costs of IPV (15 items, alpha = .84). The Faith Trust Institute is one of the most preeminent national, multi-faith, multicultural training and education organizations that provides intervention and prevention training, consulting, and educational materials for faith-based organizations on sexual and domestic violence. Response categories were *never* (1), *rarely* (2), *sometimes* (3), *often* (4), and *always* (5). Example statements are: "Preach about healthy marital relationships," "Use biblical references to speak out against intimate partner violence," "Use Sunday bulletins, posters, stickers, brochures, or the church webpage to educate the congregation about healthy intimate relationships." Scale scores, calculated as the average of all items, range from 1 to 5, with higher scores indicating more frequent preventive behaviors with the congregation.

Intervention behavior.

The intervention behavior scale used in this study was Jones et al.'s validated scale and measures clergy's strategies to work with abused women in their congregation (13 items, alpha = .95) (Jones et al., 2005). Response categories were *never* (1), *rarely* (2), *sometimes* (3), *often* (4), and *always* (5). Example statements are: "Refer to domestic violence programs," "Assess her risk of suicide," "Assess her risk of being killed by her partner," and "Go over safety planning." Scale scores, calculated as the average of all items, range from 1 to 5, with higher scores indicating more frequent intervention behaviors with the congregation. In addition, one open-ended question requested information about how participants intervene with abused women.

Participants reported the following *demographic* information: age, gender, years living in the United States, denomination, role in the church, congregation size, years of ministering, worship location (urban, suburban, rural), and trainings received (pastoral counseling, social welfare, crisis training, clinical pastoral education internship, IPV, and other counseling).

Data Analysis

We examined descriptive statistics of each construct and correlations among knowledge, attitudes, self-efficacy and behaviors. No scale data were missing. Examination of the residual scatterplots proved that the assumptions of linearity, normality, and homoscedasticity were met, and correlation analysis of independent variables proved that multicollinearity was not a problem. We used multiple regression to identify which constructs were significantly associated with prevention and intervention behaviors. First, we examined the association of each construct individually on prevention and on intervention. Second, we examined the combined effect of knowledge, attitudes, and self-efficacy. Finally, we examined the combined effect of the three constructs, plus age, gender, number of years in the United States, number of years as a minister, and number of trainings completed. All predictor variables were entered in the equation simultaneously. All analyses were conducted using SPSS version 24.

Results

Characteristics of Participants

Table 1 displays characteristics of the study participants. The majority of participants were males (n=42), foreign born (n=53), living in an urban area (n=36), self-identified as “pastor” (n=33), and affiliated with the Presbyterian church (n=28) (Table 1). The average age was 47.4 years, ranging from 31 to 75 years old (*SD*=9.81). The average number of years of residence in the United States was 15.5 years, ranging from one to 43 years (*SD*=10.47). The average number of years of working as a minister were 15.4 years, ranging from one to 40 years (*SD*=9.53). Almost half reported working in a small congregation with less than 100 members. All participants reported some pastoral training, but very few indicated training to manage crisis situations (n=2) or domestic violence (n=7). All but one completed the survey in Korean.

Table 1. Characteristics of Participants (N=55)

CHARACTERISTIC	GROUP	N (%)
Gender	Male	42 (76.4)
	Female	13 (23.6)
Age	31–40 years	13 (24.1)
	41–50 years	21 (38.9)
	51–60 years	14 (25.9)
	61 and older	6 (11.1)

CHARACTERISTIC	GROUP	N (%)
Born in the U.S.	No	53 (96.4)
Living years in the U.S.	1-10 years	24 (45.3)
	11–20 years	17 (32.1)
	21 or more years	12 (22.6)
Denomination	Baptist church	18 (32.7)
	Methodist church	5 (9.1)
	Presbyterian church	28 (50.9)
	Others	3 (5.4)
Title	Pastor	33 (60.0)
	Minister	13 (23.6)
	Lay Leader	3 (5.4)
	Seminary student	1 (1.8)
	Wife of pastor	5 (9.0)
Size of congregation	≤ 50 members	16 (29.1)
	51–100 members	11 (20.0)
	101–200 members	4 (7.3)
	201–300 members	6 (10.9)
	301–500 members	5 (9.1)
	≥ 501 members	13 (23.6)
Years in ministering	≤ 10 years	22 (41.5)
	11–20 years	17 (32.5)
	21–30 years	10 (18.9)
	≥ 31 years	4 (7.5)
Location	Urban	36 (65.5)
	Suburban	18 (32.7)
	Rural	1 (1.8)
Training received	Pastoral counseling	45 (81.8)
	Social welfare	19 (34.4)
	Crisis training	2 (3.6)
	Clinical pastoral education internship	14 (25.5)
	Domestic violence	7 (12.7)
	Other counseling	6 (10.9)

Descriptive Analysis by Scale

To address the first objective of the study—to describe the prevalence and characteristics of knowledge, attitudes, self-efficacy, and behaviors related to IPV among KA clergy—we examined descriptive statistics of each

construct. The average of the 17 items measuring knowledge of IPV was 2.9 (*SD*=0.35; range 2.1 to 3.5). The majority of participants understood that IPV affects everyone in the household, not just the adults (*M*=3.89, *SD*=0.32), that IPV will not stop once couples get married (*M*=3.84, *SD*=0.37), that IPV is not an isolated event (*M*=3.35, *SD*=0.84), and that people who are religious can be victims and perpetrators (*M*=3.35, *SD*=0.82). However, the large majority agreed with incorrect items, such as "Drinking and/or drugs cause battering" (*M*=1.42, *SD*=0.60) and "Couples counseling is the solution for intimate partner violence." (*M*=1.87, *SD*=0.64) Although alcohol and drugs are frequently involved in IPV, they do not cause it, and couples counseling is recommended only for IPV that is not motivated by power and control, a situation that may be difficult for the clergy to assess (Armenti & Babcock, 2016).

The average of the three items measuring *knowledge of resources* for handling IPV was 2.3 (*SD*=.79; range 1.0 to 3.7), reflecting a generally low level of knowledge. For all items, the average scores were low, ranging from 2.2 to 2.4.

The average of the 18-item *attitude* scale was 3.1 (*SD*=.32; range 2.2 to 3.7). The majority of respondents believed that emotional abuse is as damaging as physical abuse (*M*=3.78, *SD*=0.57) and that not obeying the husband does not result in abuse (*M*=3.75, *SD*=0.48). The majority agreed that clergy should address IPV within their ministry (*M*=3.49, *SD*=0.66), but at the same time indicated that addressing IPV is more of a responsibility of counselors and social workers than clergy (*M*=2.47, *SD*=0.84). The lowest mean scores, showing least supportive attitudes, were on the beliefs that "Victims of abuse could leave the relationship if they really wanted to end the abuse" (*M*=2.15, *SD*=0.93) and "Very few women in my congregation are abused." (*M*=2.33, *SD*=0.82)

The average of the four-item *self-efficacy* scale was 2.6 (*SD*=.65; range 1.0 to 3.8). The respondents showed the highest self-efficacy on the statement, "I am confident that I can refer abused women to necessary resources," (*M*=2.9, *SD*=.81). However, only one participant strongly agreed with this statement. Further, only three participants strongly agreed with the statement, "I am confident that I can counsel women who experience intimate partner violence." The lowest self-efficacy was on the statement, "I am confident that I can identify women who experience intimate partner violence" (*M*=2.3, *SD*=.77).

The average of the 15-item *preventive behaviors* scale was 2.3 (*SD*=.56, range 1.4 to 3.9). The following prevention behavior had the highest frequency: "Incorporate healthy and equal marital relationships into pre-marital counseling," followed by "Challenge misuse of the Bible that justifies women's subordination to men through sermons" and "Preach about healthy marital relationships." The least practiced prevention behaviors

were: "Participate in domestic violence awareness month events," "Ask women without physical signs of abuse about abuse" and "Support local domestic violence programs by providing material supports and volunteers" (Table 2). The average of the 13-item *intervention* scale was 2.5 (*SD*=.98, range 1.0 to 4.8). The respondents most frequently practiced the following intervention behaviors with women identified as abused: "Talk about the relationship between abuse and mental and spiritual well-being," "Provide some counseling," and "Provide educational materials." On the opposite end, referring men to law enforcement and batterers' program, as well as assessing the battered woman's risk of being killed by her partner were the least practiced intervention behaviors (Table 3). Given that the preventive and intervention behaviors scales could range from one to five, with higher scores indicating more frequent behaviors, the average for both scales is low (in the category of *rarely*).

In an open-ended question regarding how they intervene with abused women, approximately half of the respondents (n=28) commented about what they do and their responses ranged widely. Several stated that they had no experience, as they had never seen an abused woman. Although most highlighted the importance of prayer, a few stated that prayer, "giving advice based on the Bible" and guiding "victims not to hate the abuser" as their main strategy to solve IPV problems. One respondent was hesitant about intervening, as he feared that if he intervened in a domestic violence situation, the family would leave the church. Several participants indicated that they would offer counseling or refer to counseling services. A few respondents showed some experience in intervening in IPV situations and described active solutions to problems: search for a shelter, accompany victims to court, call the police, or introduce victims to community agencies.

Table 2. Mean Scores and Standard Deviation (SD) of Participants' Behaviors to Prevent IPV (n=55)

	MEAN	SD	%1
Incorporate healthy and equal marital relationships into premarital counseling.	3.47	1.20	74.5
Challenge misuse of the Bible that justifies women's subordination to men through sermons.	3.42	1.12	81.8
Preach about healthy marital relationships.	3.18	0.98	78.2
Promote women's leadership within congregations.	2.93	1.15	63.6
Use biblical references to speak out against intimate partner violence.	2.85	1.11	61.8
Ask women with physical signs of abuse about abuse.	2.67	1.38	45.5
Provide educational seminars, workshops, or guest speakers on healthy intimate relationships.	2.20	1.01	40.0
Run newlywed support groups.	2.13	1.07	36.4

Use Sunday bulletins, posters, stickers, brochures, or the church webpage to educate the congregation about healthy intimate relationships.	2.05	0.93	40.0
Provide educational seminars, workshops, or guest speakers on intimate partner violence.	1.82	0.88	21.8
Use Sunday bulletins, posters, stickers, brochures, or the church webpage to educate the congregation about intimate partner violence.	1.75	0.82	16.4
Use Sunday bulletins, posters, stickers, brochures, or the church webpage to educate the congregation about community resources for intimate partner violence.	1.75	0.93	18.2
Support local domestic violence programs by providing material supports and volunteers.	1.64	0.93	18.2
Ask women without physical signs of abuse about abuse.	1.56	0.81	10.9
Participate in domestic violence awareness month events.	1.47	0.72	9.1

Note. Response categories were *Never* (1), *Rarely* (2), *Sometimes* (3), *Often* (4), and *Always* (5).
[1] Percent indicating that *Sometimes, Often*, or *Always* do this behavior.

Correlation and Regression Analyses

To address the second objective of the study—to describe the association among these constructs and whether knowledge, attitudes and self-efficacy predict preventive and intervention behaviors—the following analyses were conducted. The bivariate correlations among the study variables yielded four statistically significant results: (1) self-efficacy and knowledge of IPV resources, $r = .68$, $p < .01$; (2) self-efficacy and preventive behaviors, $r = .43$, $p < .01$; (3) preventive behaviors and intervention behaviors, $r = .42$; $p < .01$; and (4) preventive behaviors and knowledge of IPV resources, $r = .33$; $p < .05$.

A linear regression was calculated to predict preventive behaviors based on knowledge of IPV, knowledge of resources, attitudes, and self-efficacy. First, we entered each construct in an individual model. Knowledge of resources (F (1,53) = 6.45, $p < .05$; $\beta = .33$) and self-efficacy (F (1,53) = 12.20, $p < .01$; $\beta = .43$) were significant predictors of preventive behaviors. Second, when the four constructs were entered in the same model, only self-efficacy (F (4,50) = 4.57, $p < .01$; $\beta = .47$) continued to be a significant predictor of preventive behaviors. The high correlation between self-efficacy and knowledge of IPV resources could explain this change. Finally, we examined whether these effects were maintained after including five demographic variables: age, gender, years living in the United States, years as a minister, and number of trainings attended. This final model was statistically significant (F (9,43) = 2.60, $p < .05$), with a significant effect of self-efficacy ($p < .01$) and attitudes ($p < .05$), and a marginal effect of years living in the United States ($p = .053$). The R2 was .353.

A second linear regression model was calculated to predict intervention behaviors based on knowledge of IPV, knowledge of resources, attitudes, and self-efficacy. Knowledge of resources (F (1,53) = 3.94, p = .052; β = .26) was the only (marginally) significant predictor of intervention behaviors. When the four constructs were entered in the same model, none of them was a significant predictor of intervention behaviors. Similarly, the model was not significant when including demographic variables.

Discussion

Table 3. Mean Scores and Standard Deviation (SD) of Participants' Behaviors to Intervene in Case of IPV (n=55)

	MEAN	SD	%1
Talk about the relationship between abuse and mental and spiritual well-being.	3.25	1.13	72.7
Provide some counseling.	3.16	1.18	70.9
Provide educational materials.	2.73	1.21	54.5
Talk to the abuser about his violent behavior.	2.63	1.26	48.1
Assess her risk of suicide.	2.58	1.29	47.3
Go over safety planning.	2.55	1.33	49.1
Refer to domestic violence programs.	2.40	1.27	43.6
Refer to a physician.	2.38	1.11	41.8
Refer to psychiatric or mental health care.	2.36	1.19	41.8
Encourage her to leave the abuser.	2.20	1.04	34.5
Assess her risk of being killed by her partner.	2.15	1.33	38.2
Refer the abuser to state-approved batterers' program.	2.13	1.26	32.7
Refer to law enforcement.	2.02	1.01	30.9

Note. Response categories were *Never* (1), *Rarely* (2), *Sometimes* (3), *Often* (4), and *Always* (5).
[1] Percent indicating that *Sometimes, Often*, or *Always* do this behavior.

Study Limitations

This study has some limitations. The sample size of the KA clergy was small and the data were collected from only one geographical location. Constructs might vary under different environmental circumstances, such as the number of KA population, access to Korean IPV programs, and access to Korean language media (i.e., newspapers, radio shows, TV programs). This environmental information should be taken into consideration when interpreting our results. Moreover, IPV preventive and intervention behaviors were assessed only by self-reporting. When self-reporting, behaviors deemed good might tend to be overestimated. Gathering data from a larger

sample in multiple locations should be carried out in future studies to increase representativeness of this study's findings.

Implications for Social Work Practice

KA clergy's presence is fundamental for the IPV prevention and intervention efforts in the KA community due to KA immigrants' high church affiliation and the critical roles of the clergy in the community. Our study examined KA clergy's knowledge, attitudes, self-efficacy, and behaviors related to IPV and tested whether knowledge, attitudes and self-efficacy predict preventive and intervention behaviors. Numerous implications for social work practice targeting KA clergy can be drawn from the results of the study.

First, increasing knowledge of resources is fundamental. The results show that KA clergy knowledge on the seriousness of IPV in the United States and the cyclical nature of IPV was relatively high. Participants knew that anyone could be an IPV victim, including pregnant women and church members, and that religious people could be IPV perpetrators. Conversely, participant knowledge of resources and services was low. This pattern is not unique and is very similar to previous research (Martin, 1989; Nason-Clark, 1996). Martin found that a substantial proportion of the clergy in the study lacked knowledge about programs for victims and perpetrators, as well as information about legal aspects of IPV. Victims' advocates and most therapists and clinicians do not support the use of couples counseling in cases of IPV because it may actually endanger the victims due to the power difference between the partners (Rotunda, Williamson, & Penfold, 2004). However, participants' knowledge on the suitability of couples counseling for IPV was the lowest item in the whole scale in this study, which was consistent with studies by Rotunda et al. (2004) and Choi (2015a). These researchers found that clergy's number one response to battered women was suggesting couples counseling, which is not recommended when aggression is about power and control (Armenti & Babcock, 2016).

Several theories/models indicate that knowledge is necessary for behavior change. This study found that one specific type of knowledge was most important: knowledge about resources. When social workers develop IPV training programs for KA clergy, they should incorporate contents on available resources and services for IPV victims and perpetrators, especially local-specific resources and services. In addition, IPV training programs should provide information regarding available legal options, especially for immigrant victims of IPV.

Second, IPV programs for KA clergy should stress not only increased knowledge, but also changing their attitudes and beliefs about victims and clergy roles in addressing IPV in their congregations. Our findings showed

that KA clergy were not aware of many barriers that IPV victims encounter if they decide to leave the abusive relationship. Moreover, although they understood IPV is not rare and that it is a serious problem in the United States, they believed there are very few abused women in their own congregations. KA clergy's belief that addressing the needs of battered women is more the responsibility of counselors and social workers than of clergy is a disappointing finding, considering their influential role in the KA community. Studies on clergy have demonstrated that clergy's attitudes and beliefs have significant influence on their responses to IPV (Choi, 2015a; Nason-Clark, 2000; Nienhuis, 2005). Therefore, it would be important for social workers to develop IPV programs for KA clergy that emphasize the important role KA clergy have in responding to IPV in their church and break the possible misconception that IPV does not happen in their congregation. As long as KA clergy believe IPV is not a problem in their congregation, they would not acknowledge the necessity of congregational efforts to respond to IPV.

Third, different types of self-efficacy—to prevent IPV, identify IPV victims, and handle IPV situations—are needed for KA clergy. Our study showed that, although KA clergy demonstrated the highest self-efficacy in their ability to refer abused women to necessary resources, followed by their ability to counsel abused women, their self-efficacy to identify abused women and be prepared to handle IPV situations was lower than their referral ability. Only one respondent felt *very confident* to identify abused women, and only three felt well prepared to counsel women in IPV situations. Similarly, previous studies showed that only 8% of 332 evangelical pastors (Nason-Clark, 1996) and 16% of 152 KA clergy (Choi, 2015b) reported feeling well-prepared to handle IPV situations. Social cognitive theory posits that self-efficacy is enhanced through previous mastery experiences, observational learning, social persuasion, and emotional arousal (Bandura, 1986). In light of our findings, when developing IPV programs for KA clergy, social workers should provide opportunities for observation, modeling (i.e., vignettes), and hands-on practice activities that focus on developing skills to identify and refer victims and perpetrators to services, while navigating language barriers. Through observing others—especially well-respected KA clergy—and practicing skills, clergy can increase their self-efficacy to address IPV.

Fourth, more is needed to increase IPV prevention by KA clergy. The findings show that the great majority of KA clergy (78.2%) in the study preached at least sometimes about healthy marital relationships, which is much higher than some studies (Hsieh, 2007; Martin, 1989), but equivalent to another study of KA clergy (Choi, 2015b). Also almost two-thirds of KA clergy used biblical references to speak out against IPV. This finding is striking because some of the bible verses—especially Ephesians 5: 22-24, "Wives,

submit yourselves to your own husbands as you do to the Lord…"—are used by clergy who suggest the problem of IPV would be alleviated if the abused woman displayed obedient submission to her husband (Giesbrecht & Sevcik, 2000).. A previous study showed that KA immigrants, especially Korean men, misinterpret the Bible, including Ephesians 5:22-33's intention of reciprocal love and devotion to each other, which is used to justify batterers' violence and compel KA women to stay in abusive relationships (Choi & Cramer, 2016). In the same study, KA immigrants viewed KA clergy as having the most important role in interpreting the Bible and in educating congregation members correctly since their teaching of the Bible is the most crucial factor for congregation members in obtaining correct understanding of the Bible and Christian teachings on healthy marital relationships. Therefore, it is encouraging to see many KA clergy in this study engaged in IPV prevention by speaking out against IPV using biblical references.

By contrast, KA clergy were infrequently involved in supporting local domestic violence programs or participating in domestic violence awareness month events, demonstrating their lack of understanding of and commitment to existing IPV programs. Sixty percent of the respondents had never supported local domestic violence programs, with only two respondents supporting the programs always or often. In addition, 64% of the respondents had never participated in domestic violence awareness month events, with only five respondents participating often or sometimes. This result is similar to the previous finding that only 15% of 143 clergy attended any meeting on IPV (Martin, 1989). Participating in domestic violence awareness month events and supporting local IPV programs are good ways for KA clergy to increase awareness of IPV and signal to the congregation that they are committed to addressing IPV in their congregations and support victims. Korea has a similar program, "Peaceful Month without Domestic Violence," celebrated during the month of May. Thus, linking the traditions of both countries could help increase cultural understanding and support. Therefore, IPV service providers should build trusting and supportive relationships with KA clergy, so that they can become familiar with programs to which they can make referrals for victims and perpetrators.

Fifth, early identification by KA clergy needs to be improved. KA clergy do not ask women about IPV unless there are physical signs of abuse, with 58% indicating they never ask and 31% indicating they rarely ask women about IPV without physical signs of abuse. This illustrates the need for social workers to educate KA clergy regarding signs of abuse other than physical, such as being cautious or fearful and self-censoring in her partner's presence, increasing isolation from friends and family, having symptoms of depression, calling or texting her partner excessively (or receiving numerous calls or texts from the partner), not showing up or canceling meetings frequently, having little money available, or having a drug or alcohol problem.

Finally, referrals for victims to other resources and conducting safety planning with victims are the areas that need to be highlighted in IPV training for KA clergy. KA clergy reported that they provide counseling and educational materials, as well as talking about the relation among abuse, mental health, and spiritual well-being. However, referring abused women to law enforcement and referring the abuser to batterers' programs were the least used interventions. In addition, KA clergy rarely assessed the victim's risk of being killed by her partner. This response might be influenced by their perception that IPV does not exist in their congregation or by their concern that secular resources will not address victims' religious concerns. These results are similar to previous findings that clergy are overwhelmingly opposed to advising victims to seek help from law enforcement or separation or divorce, most suggesting divorce only in the life threatening cases (Alsdurf & Alsdurf, 1988; Levitt & Ware, 2006; Martin, 1989). KA clergy's hesitancy to encourage abused women to leave the abuser may stem from their belief in clergy's role of keeping families together. In addition, one respondent indicated that confronting abuse may lead to the family leaving the church, which the clergy member may believe will further jeopardize the situation of the victim; but it also has economic implications for the clergy. Therefore, social workers need to address KA clergy's ambivalence between keeping the family together and promoting victim safety in clergy training. Tying victim safety to sacredness of life would help KA clergy to put the safety of victims and their children at the forefront of their intervention with victims.

Perceived discrimination and distrust of the American justice system may explain KA clergy's reluctance to refer abused women to law enforcement. Studies show that immigrants are hesitant to report crimes because they do not want to contribute to negative stereotypes of their racial or ethnic group (Abu-Ras, 2007; Cho, 2012). Further, concern for jeopardizing immigrant status is an often-cited reason for battered immigrant women's not seeking help from law enforcement (Kasturirangan, Krishnan, & Riger, 2004; Orloff & Kelly, 1995). This fear of deportation extends to deportation of their children and even of the abuser for reasons such as being dependent on the abuser for finance and legal status, potentially being shunned in their community, or fearing children's separation from their father (Choi, Elkins, & Disney, 2016). This points to the need for social workers to understand the immigrant context that may influence KA clergy's response to victims and to provide information on the VAWA provisions that protect immigrant survivors of IPV in training for KA clergy.

Conclusion

This study highlights that many KA clergy lack knowledge of services and resources in the community. Some clergy members have limited awareness about the cause and nature of IPV and frequently deny the prevalence

and seriousness of IPV in their own congregations. To increase appropriate IPV preventive and intervention behaviors, KA clergy need comprehensive and culturally-nuanced IPV programs with the goal of increasing self-efficacy to engage in IPV prevention and intervention, informed by social cognitive theory. Moreover, further study is needed to assess the effect of the IPV programs informed by social cognitive theory on increasing IPV preventive and intervention behaviors among KA clergy. ❖

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Y. Joon Choi *is Associate Professor, School of Social Work, University of Georgia, 279 Williams St., Athens, GA 30602-7016. (706)542-0844 (phone), (706)542-3845 (Fax), Email: choiyj@uga.edu*

Pamela Orpinas, *Ph.D. is Professor Department of Health Promotion and Behavior Wright Hall – Health Sciences Campus, College of Public Health, University of Georgia, Athens, GA 30602 (706)542-4372 , Email: porpinas@uga.edu*

Irang Kim, *Ph.D., MSW is Assistant Professor, Department of Social Work, Northwestern State University of Louisiana,149 Kyser Hall, Narchitoches, LA 71497*

Junhoe Kim, *Ph.D., MSW, MA, Adjunct Research Professor, Institute for Research on Labor and Employment, Korea University International Studies Hall Room 127, 145Anam-ro, Seongbuk-gu, Seoul 02841, Republic of Korea 82-10-5530-0604, Email: socialpolicy.ins@outlook.com*

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Sanctuary and Social Work: Navigating Moral and Legal Contradictions

Jennifer Scott & Alejandro Caceres

Since 2013, over fifteen undocumented individuals have received sanctuary from deportation in more than a dozen churches in cities across the U.S. Over 400 congregations have been recorded as either supportive of or willing to serve as a host (Evans, Shimron, & An, 2016). Values expressed in the theology of Christianity and professional ethos of Social Work include acceptance and inclusion of immigrants. Yet U.S. immigration law classifies "harboring" undocumented immigrants as a crime (8 USC § 1324). We explore how sanctuary, focusing on the congregational practice of providing refuge to immigrants, navigates this tension. We first discuss the concept of sanctuary, its claim to scriptural authority and the boundaries of its legality in terms of U.S. immigration law. Then we describe a history and practice of the new sanctuary movement. We conclude by discussing the role of social work in sanctuary and its process of continued re-imagination.

> *"And if a stranger sojourn with thee in your land, ye shall not vex him. But the stranger that dwelleth with you shall be unto you as one born among you, and thou shalt love him as thyself; for ye were strangers in the land of Egypt: I am the Lord your God."*
> -Leviticus 19:33-34

> *"Any person who- (iii) knowing or in reckless disregard of the fact that an alien has come to, entered, or remains in the United States in violation of law, conceals, harbors, or shields from detection, or attempts to conceal, harbor, or shield from detection, such alien in any place, including any building or any means of transportation… (B) shall… (ii) be fined under title 18, United States Code, imprisoned not more than 5 years, or both…"*
> -Immigration and Nationality Act (INA), 8 U.S.C. § 1324

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> *"NASW supports immigration and refugee policies that uphold and support equity and human rights, while protecting national security… Respect for due process must be demonstrated for immigrants as well as citizens... immigrant families should not suffer the penalties of deportation for family-related stresses and violence except in the most extreme cases."*
> -National Association of Social Workers Policy Statement on Immigrants and Refugees

The morning sermon at St. Andrew's Presbyterian Church in Austin, Texas, one Sunday in the summer of 2017 focused on the passage from Luke in which a law student asked Jesus to identify the neighbor he must love as himself to inherit everlasting life. In response, Jesus presented the parable of the Samaritan. A Jewish traveler, overtaken by thieves and left wounded and naked in the road, was first ignored by both a priest and a Levite to then be aided by a Samaritan who "had compassion on him" (Luke 19:33). Asked to identify the neighbor of the traveler, the student responded, "He that showed mercy on him" (Luke, 19:25-37). Often shared as a reminder to be like the Samaritan and love thy neighbor, the Reverend asked the congregation to instead consider the parable's importance in terms of the positionality of the traveler. By asking the student to identify the neighbor to the traveler, Jesus asked the student to imagine himself as helpless and needy in relation to the Samaritan. In the Biblical period the Samaritans, people from Samaria in the Northern Kingdom of Israel, were despised by Jewish people for their pagan heritage and lack of allegiance to all the practices of Judaism.

In the current sociopolitical context of the United States, this passage holds particular relevance. January 2017 marked a shift in how the United States receives immigrants with the signing of three Executive Orders (EOs) by the new President. Combined, the EOs limited who could seek asylum as a refugee, increased border militarization and imposed further restrictions on the rights of undocumented immigrants currently living in the U.S. (Trump, 2017a, 2017b, 2017c). This was followed by a revocation of the permission to stay and work in the U.S. legally for millions of undocumented youth who came to the U.S. as children that had been granted by the Deferred Action for Childhood Arrivals (DACA) program (U.S. Department of Homeland Security, 2017). Rather than promoting support for neighbors in need, the new administration's religious and country of origin-based immigration further restricts and promotes open criminalization of many residents who are prohibited from regularizing their status, promoting values in opposition to the Samaritan lesson.

By most recent estimates 11.2 million undocumented immigrants live in the U.S. (Passel & Cohn, 2014). Life with undocumented status is restricted. The persistent risk of detection, detention and deportation, as well as the denial of formal work authorization and, in many states, access to identification and driver's licenses, creates a situation in which undocumented people live in what has been described as "the shadows" (Kossoudji & A. Cobb Clark, 2002; Martinez-Calderon, 2010; Suárez-Orozco, Yoshikawa, Teranishi, & Suárez-Orozco, 2011). Regardless of whether they entered legally and overstayed their visa or clandestinely, people who live undocumented in the U.S. do so for a variety of socioeconomic, political and personal reasons and continue to do so because avenues for legal immigration are narrow and unavailable to them.

Values expressed by both the tradition of Christianity and the profession of social work include acceptance or inclusion of immigrants. Leviticus demands not only that followers welcome strangers, but that such strangers "be unto you as one born among you" (Leviticus, 19:33-34, The King James Version). The National Association of Social Workers (NASW) policy statement on immigrants and refugees also stresses welcoming and accepting immigrants, asserting that "immigrant families should not suffer the penalties of deportation for family-related stresses and violence except in the most extreme cases" (National Association of Social Workers, 2007). Yet U.S. immigration law limits support of the sojourner in the United States; to "harbor" or shield unauthorized immigrants from detection risk is considered a crime punishable by a fine, imprisonment or both (Immigration and Nationality Act Section 274, n.d. (8 U.S.C. § 1324).

In this sociopolitical context that could be said to discourage helping one's immigrant neighbors, how can social workers navigate the tension between obedience to law and social justice? How do social work and Christian values work with (or against) each other and the law to support the inclusion of immigrant communities in the United States? This paper explores how the practice of sanctuary, focusing on the congregational practice of providing refuge to immigrants, functions as a mechanism for navigating this tension. We first discuss the concept of sanctuary and its claim to scriptural authority, then the boundaries of its legality in terms of U.S. immigration law. Then we describe the history and practice of the new sanctuary movement. We conclude by discussing the role and responsibility of social work in the sanctuary movement and in the process of its continued re-imagination.

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[1]Undocumented" is the term used to refer to people who do not have the immigration authorization required to permit residence in the country.consistent with the literature and data sources utilized.

The Concept of Sanctuary

Sanctuary refers to a place of protection and safety, as well as to the area in a church or temple that is consecrated or sacred. While broadly meaning a safe space or refuge, the term's connection to the sacred lends a spiritual connotation to sanctuary even when broadly defined. Initially used to describe sheltering an individual whose "safety or liberty was threatened" inside a house of worship, the concept first gained contemporary significance during the Sanctuary Movement of the 1 Sojourners magazine 980s (K. Barron, 2017, p. 192).

As distinct legal issues are raised in each domain, definitions of sanctuary require consideration of its sphere of influence (Villazor, 2008). In the immigration discourse, as Villazor (2008, p. 138) notes, sanctuary can be analyzed along a "private/public dichotomy." In the private domain, churches provide sanctuary via the provision of food, shelter and other assistance to immigrants seeking relief from deportation. In the public domain, state and local governments provide sanctuary via the establishment of their jurisdictions as "safe havens" for immigrants by actions like limiting local-federal law enforcement interactions and directing service providers not to ask about immigrants' citizenship status (Villazor, 2008, p. 138).

Whether private or public, the contemporary practice of sanctuary is widely understood to have developed from references to the concept of or call for sanctuary found in Judeo-Christian scripture. Specifically, participants and documents describing the sanctuary movement ground the practice in the calls in Leviticus (19:33-34) (cited at the opening) and Matthew (25:35-40) to welcome the stranger, but also in the reminder in the parable of the Samaritan to love thy neighbor, the demand in Isaiah to "hide the outcasts; betray not him that wandereth" (Isaiah, 16:3-4) and the concept in Numbers (6) of designating cities as places of refuge from excessive punishment by relatives avenging deaths of family members accidentally killed (Evans et al., 2016; Van Biema, 2007). How participants use narratives that "operate in the spirit of the ontological narrative of Christianity" (Freeland, 2010, p. 504), i.e. emphasize responsibility to help the poor or provide hospitality to strangers, to frame the practice of sanctuary originates from and further constructs this connection.

This explicit connection of sanctuary to Christian theology, referred to as "Levitical immigration policy" by the founder of *Sojourners* magazine (Wallis as cited in Freeland, 2010, p. 501), rationalizes use of the practice to navigate the tension between compassion for immigrants and U.S. immigration law. As Van Ham (2009) notes, "sanctuary illustrates the juncture at which CBIAs [church-based immigrant advocates] began in theory and practice to relativize the nation-state vis-à- vis a superordinate ethos that combines Christian theology with the language of human rights" (p. 624).

Sanctuary and the Law

Section 274 of the Immigration and Nationality Act (INA) makes it a crime punishable by fine, imprisonment or both to "conceal, harbor, or shield from detection" immigrants (INA, 8 U.S.C. § 1324(a)(1)(A)(iii)). This section of the law threatens legal recourse for harboring immigrants, regardless of whether sanctuary activists claim the practice has scriptural authority. How this is interpreted depends upon the legal definition of harbor as well as consideration of current agency practices and policies.

One interpretation of 'harbor' is that it requires an attempt to shield a person from immigration authorities. When they are public about sanctuary, new sanctuary advocates contend that they are not actively concealing or "purposefully keeping silent" the identity or presence of undocumented families, and thus not in violation of 8 U.S.C. § 1324 (Freeland, 2010; Villazor, 2008). Additionally, immigrants who take physical sanctuary are actively in deportation proceedings, meaning they are already known to immigration officials. The practice of physical sanctuary includes public campaigns with announcements via press conferences, the person's consent to be a public figure for the duration of their campaign, and for Immigration and Customs Enforcement (ICE) to be made aware of the person's name, case number and the consequences to the person if deported.

As explained in a "Sanctuary 101" blog post outlining the fundamentals of sanctuary process, "when we declare Sanctuary for an individual, we are bringing them into the light of the community, not concealing them in the dark of secrecy" (Moreno, 2014). Richard Muñoz (2009) similarly nuances the implications of the harboring clause with regards to unlawful transportation in his article in a 2009 issue of this journal. He demonstrates that churches likely need not change how they transport immigrants as neither their intent nor effect likely leads to "furtherance of such violation" of immigration law, yet recommends clarifying policy with legal counsel as changes in the zealousness of agents or court interpretations could lead to different conclusions (Muñoz, 2009).

Whether this argument--that the public nature of sanctuary disqualifies it as harboring--holds, however, is subject to debate. The first iteration of the sanctuary movement saw the arrest and conviction of a number of activists under the harboring clause. Within a year after its infiltration by federal authorities began, sixteen activists had been arrested (K. Barron, 2017). In 1986, eight of those sixteen were found guilty of 18 felonies, "primarily of harboring and transporting illegal aliens" (Freeland, 2010, p. 494) as the court decided the "church as sanctuary" had no standing in U.S. law (J. Barron, 2007). They eventually had their sentences suspended, or were acquitted or given parole.

The practices of the sanctuary movement of the 1980s, however, did not include public disclosure and often did include attempts to hide persons. The NSM understands its practices as often distinct from those of the earlier sanctuary movement due to the public nature of the sanctuary provided. Some claim that regardless of whether the act is public, providing an undocumented immigrant shelter constitutes harboring because advocates know the immigrant's status (Maun, 2011). However according to the Legal Toolkit developed by the Center for Human Rights and Constitutional Law (2007) there is evidence to support that this is not necessarily the case as past convictions under this clause have not involved defendants who have concealed immigrants unless they are "attempting to conceal such alien from Immigration and Customs Enforcement detection" (p.8). Despite the ambiguity, as Freeland (2010) explains, those in the NSM find the "legal basis for sanctuary is sufficient enough" to "feel a sufficient level of comfort in practicing NSM goals and strategies" (p. 494).

Additional policies that sanctuary movement activists cite as protection for the practice of sanctuary include internal agency policies of Immigration and Customs Enforcement (ICE). The first is the 2011 designation of churches, along with schools and hospitals, as "Sensitive Locations" in an agency memo (Morton, 2011a). While not necessarily legally binding, the memo directs ICE agents to avoid enforcement actions at sensitive locations except in cases of exigent circumstances or prior approval.

The second is the use of prosecutorial discretion, a legal concept that specifies that personnel may evaluate deportation orders based on particular criteria of the individual case (Morton, 2011b). Prosecutorial discretion has historically been used by ICE agents with little transparency or accountability to determine how to prioritize allocation of their resources and time towards immigrant removal. A June 2011 memo by the ICE Director John Morton, clarified that that prosecutorial discretion means ICE officers could use their discretion to halt the deportation of immigrants deemed "low priority" (Morton, 2011b). This has included young people, people living in the U.S. for a long time, people who have served in the military, etc. Both explicitly and by default, this memo also outlines people considered a "high priority" for deportation: people who have a criminal record or pose a threat to national security or community safety (as established by ICE).

While prosecutorial discretion provides a mechanism for leniency in some cases, this mechanism is complicated by the fact that it may serve to further entrench the good/bad immigrant narrative discussed in the following sections. The use of prosecutorial discretion has declined since the beginning of the new administration (TRAC Reports, 2017), though it remains a primary legal mechanism to stop the deportation of people who have exhausted all of their legal options. The law thus shapes the tools and boundaries of sanctuary.

History of the New Sanctuary Movement (NSM)

Movement leaders tie the history of sanctuary in the U.S. to the support of black people escaping slavery and draftees avoiding the Vietnam War (J. Barron, 2007). However, as evident in its name, the New Sanctuary Movement (NSM) is most directly the "resurrection" of the Sanctuary Movement (SM) of the 1980s (Freeland, 2010, p. 488). Born out of a Quaker goat-milking cooperative in the southwest, the initial SM "sought to meet the immediate humanitarian needs" of Central Americans fleeing violence" (K. Barron, 2017, p. 192) yet "overwhelmingly denied refugee status" (Cunningham, 1998, p. 372).

In 1982, Southside Presbyterian Church in Tucson became the first church to declare sanctuary. Along with housing Central Americans, the SM facilitated the movement of people across the border and throughout the United States (Cunningham, 1998). In doing so it challenged the U.S. support and financing of wars in Central America, creating "a zone in which two powerful sources of authority in U.S. culture—church and state—clashed over who and what interests defined U.S. sovereignty" (Cunningham, 1998, p. 371). A primary focus of the SM was the limited acceptance of Central American asylum claims because they were not classified as refugees (Cunningham, 1998; Houston & Morse, 2017; Maun, 2011). In the first six years after passage of the Refugee Act of 1980, only three percent of asylum petitions by Central Americans were approved (Maun, 2011; McConnell, 2011).

Despite debate among church authorities, the SM acquired a membership of as many as 70,000 and formed a tradition of "progressive" or "justice and peace" churches (Cunningham, 1998). It grew to span approximately 34 states and was described by one scholar in the 1990s as the "largest civil disobedience movement in North America since the 1960s" (Houston & Morse, 2017, p. 31).

After changes in immigration policy, like the creation of Temporary Protected Status (TPS) and the Nicaraguan Adjustment and Central American Relief Act (NACARA) (Gzesh, 2006), the SM laid mostly dormant for over a decade while the number of undocumented immigrants living in the U.S. continued to increase. In 2006 the sanctuary network was re-ignited when Elvira Arellano, an undocumented woman from Mexico, sought sanctuary in the Adalberto United Methodist Church in Chicago in hopes that she could postpone, if not avoid, deportation and separation from her 8 year old U.S. citizen son (J. Barron, 2007; Maun, 2011).

The first national gathering of the New Sanctuary Movement (NSM) in January 2007 included leaders across states, regions and religious denominations and was followed within months by sanctuary congregations housing families in several states (Freeland, 2010). Members of the

NSM make commitments to provide or support the practice of sanctuary, whether public or private, for undocumented immigrants. The movement "responds to the contradiction between the basic principles of freedom that have theoretically grounded the American political system and the practices that have allowed for the current measures taken against immigrants" (Freeland, 2010, p. 485).

What is New about the NSM: Differentiating NSM from SM

While both the SM and NSM draw from an ideological foundation grounded in Christian scripture and liberation theology (Houston & Morse, 2017), there are several key distinctions between the early SM and the NSM that go beyond distinctions in legal rationale. Perhaps most notable are the goals of the movement with relation to cases and the nature of the cases themselves. While the 1980s focused explicitly on winning asylum cases, the focus of the NSM is on stopping deportation via prosecutorial discretion (K. Barron, 2017). The distinction is linked to the distinction in the immigrants seeking sanctuary. While immigrants in the 1980s seeking sanctuary were typically newly- arrived Central Americans seeking political asylum, immigrants seeking asylum in the contemporary movement have claims that may not be easily classified under political asylum and are often long-term residents of the U.S. As one Reverend participant in both movements explains, "NSM deals with immigrants who are our neighbors" (Reverend Oines as cited in Freeland, 2010, p. 488).

In both iterations of the movement, "Sanctuary churches are a response. It's not the answer" (Evans et al., 2016). NSM is arguably better understood as a "conduit for mobilization and articulation of the demands of activists whose ultimate objective is comprehensive immigration reform" (Freeland, 2010, p. 486). While the SM aimed to reform refugee and asylum law, the NSM seeks comprehensive reform of the immigration system.

Sanctuary in the Current Context

As of 2016, over 400 congregations have been recorded as either supportive or willing to host undocumented immigrants fearing deportation (Evans et al., 2016), and many say that since the election of President Trump, that number has grown to as many 700 (National Sanctuary Movement, 2017b) or even 800 (K. Barron, 2017). According to the Church World Service's Noel Anderson, since 2013, 15 individuals have received sanctuary from deportation in 13 churches in nine cities (Evans et al., 2016). At the end of 2017, about 20 people have taken or are currently in physical sanctuary with congregations.

From their campaign forward, the Trump administration has promoted a rhetoric that characterizes immigrants, and particularly Mexican immigrants, as "criminals, rapists and drug dealers, etc." (Trump, 2015 statement as cited in Lee, 2015; Neate & Tuckman, 2015; Walker, 2015). Arrests have increased by up to 40% as compared to the same period last year (Alvarez, 2017; Rein, Hauslohner, & Somashekhar, 2017). Additionally, arrests are taking place at and near places ICE designated "sensitive locations" like churches (Carey & Culver, 2017; Morton, 2011a) and schools (Castillo, 2017; Morton, 2011a; Romero, 2017; Winsor, 2017), despite agency websites' assurance that the policies "remain in effect" (U.S. Customs and Border Protection, 2016; U.S. Immigration and Customs Enforcement, 2017).

Additionally, NSM immigrant leaders have recently faced interactions with ICE which some interpret as retaliation. Two prominent members of the New Sanctuary Coalition of New York City (NSC) were detained in January 2018 (Dunne, 2018; Robbins, 2018). NSC Executive Director Ravi Ragbir was eventually released (Hawkins, 2018), however NSC co-founder Jean Montrevil was deported to Haiti after 3 decades in the U.S.(Montrevil, 2018). In Colorado, Eliseo Jurado, whose wife Ingrid has claimed sanctuary, was detained by six ICE agents in front of his two children at a Safeway (Bear & Fields, 2018). Many see these escalations as scare tactics to discourage people from joining the NSM. As Reverend Donna Schaper explained, "if other immigrants see [Jean and Ravi] were deported, they'll obviously think, 'Well then I could be too`" (Schaper as cited in Dunne, 2018; Robbins, 2018).

While troubling, these new facts have also emboldened Sanctuary Networks to develop new ways to support immigrant communities. Sanctuary networks are creating rapid response teams that witness and even disrupt Immigration and Customs Enforcement (ICE) removal operations (Bova, 2017; Bruinius, 2017; Kunichoff, 2017). Formally conceptualized as 'sanctuary in the streets,' these programs operate based on the claim of "home as a place of worship, a holy ground" and assert that thus, "ICE should not be conducting enforcement at that place" (Bruinius, 2017). With this practice the NSM is asserting that shelter from detention and deportation should not be limited to religious spaces.

The Practice of Sanctuary

Practice is both the application of theory and repeated engagement in activity to obtain proficiency (practice, 2017). Sanctuary as a practice attempts to shape the political reality and experience of undocumented immigrants in the U.S. by using scriptural logic to shift normative discourse. Sanctuary as a normative practice refers to the sharing of immigrant narratives in explicit

effort to frame the immigration policy discourse in support of immigrants. Sanctuary in action refers to how people enact the practice of sanctuary – from the provision of physical refuge to accompaniment – to support immigrants in congruence with their personal values and faith.

Sanctuary Practice as Normative: Framing Immigrant Eligibility

A primary activity of both the SM and NSM was the sharing of migrant narratives to establish a personal relationship to migration that allows people of faith to hear "how real-life situations lead to deportation orders and faith based or political involvement" (Houston & Morse, 2017, p. 492). In its early stages, like the SM that preceded it, the NSM prioritized what were considered "winnable" cases – meaning the personal history of the immigrant and facts of their situation were considered more likely to be well-received by immigration officials. Such cases generally focused on an immigrant who had family connections and demonstrated commitment to the U.S. Freeland (2010) identified the following 'eligibility rules' for immigrants interested in sanctuary: parents of children born in the U.S., a good work record, no criminal record, a case currently in deportation proceedings, and stated willingness to participate in trainings on managing public exposure.

Analyses of both the NSM and SM by scholars, immigrants, and activists have challenged this "choice" to highlight particular cases based on socially desirable criteria, because doing so constructs a false good immigrant/bad immigrant dichotomy (K. Barron, 2017; Coutin & Chock, 1997; Houston & Morse, 2017; Yukich, 2013). While motivated by recognition that the public support necessary to resolve cases is typically granted to cases that fit certain types of narratives (Houston & Morse, 2017), focusing on such narratives functions to construct an archetype of immigrant "deservingness."

The cooptation of such narratives to promote regulation can be seen in the process whereby the discourse about the provision of social welfare was shifted (Piven & Cloward, 1993). As Piven and Cloward (1993) delineate, while linking worthiness or eligibility for cash assistance or other aid to behavior may help ensure access for some, such practices function to deny assistance to others, thus "regulating the poor." In reference to sanctuary, by only sharing narratives of immigrants who align with socially desired characteristics, activists are "implicitly portraying certain undocumented immigrants as less deserving of legal residency and citizenship" (Yukich, 2013, p. 302). This practice functions also to limit activist support to only certain immigrants (Houston & Morse, 2017). This "question of deservingness" becomes more obvious given the fact that the U.S. government has explicitly prioritized immigrants with criminal convictions for deportation (K. Barron, 2017).

Houston and Morse (2017) suggest that framing migrant experiences as either extraordinary (in the SM) or ordinary (in the NSM) constructs

deserving/undeserving categories and limits full social inclusion. In the SM, Central Americans were recognized as having experienced extreme adversity both before migrating and on the journey (Houston & Morse, 2017). In the NSM, narratives were emphasized for the opposite effect, the frame aimed to demonstrate the ordinariness of the migrant struggle to work and raise a family in effort to appeal to public sentiments that migrants were just like them. Both frames "reduced the possibilities for other stories to emerge," thereby limiting opportunities for migrants to be included in the movement as full actors (Houston & Morse, 2017, p. 31; Yukich, 2013). Additionally, the fact that migrant safety in both movements often depended upon avoiding visibility, these frames could be "literally muting the voices of migrants themselves," as activists often shared stories on their behalf (Houston & Morse, 2017, p. 33).

However authors like Freeland, Houston and Morse, etc., also further perpetuate this problem by accepting the discourse of immigrants as non-actors in the NSM. At a recent convening of the national movement attended by the authors, it was immigrants themselves who challenged both this narrative and the ability to control the agenda and outcomes. Their challenges build from a dialogue taking place in the NSM about emphasizing different kinds of narratives to expand the space for inclusion in the movement. One example of this is in the recent case of Sulma, a Guatemalan woman who recently sought sanctuary in Austin (Guarecuco, 2015). A lesbian woman and LGBTQ activist, Sulma's personal story and history challenged earlier notions of the "good" immigrant and winnable cases given the history of persecution and stigmatization of LGBTQ identified people in the U.S. until only recently. Her decision to seek sanctuary and that of the Austin movement to support her have expanded the frame of migrant narratives considered worthy to be shared. This recognition of how the framing of migrant stories shapes the politics of exclusion in the immigration policy discourse has helped to broaden how the NSM understands sanctuary, both theoretically and practically.

Sanctuary Practice in Action: Physical Refuge and Beyond

In addition to the practice of sharing migrant stories, sanctuary is practiced by activities ranging from physical stays with congregations to shielding immigrants in business and their homes. Membership in the sanctuary network can take several forms based on the level of comfort and commitment of the congregation or organization. Reflective of differences in sociopolitical context, formal membership is defined at a local level through the formation of city-level coalitions. Generally, this city-level membership is described according to two tiers based on willingness and capacity to provide physical sanctuary. Sanctuary congregations commit to providing physical space if need arises, and supporting or affirming

members commit to offering other types of support, like sanctuary in the streets or accompaniment.

Physical Sanctuary

Perhaps the most well-known sanctuary practice is that of providing physical sanctuary or refuge. In the earlier stages of the NSM there was more structure to the practice of physical sanctuary. Families were initially hosted for three months, at the end of which the congregation could vote to continue providing refuge and support (Freeland, 2010, p. 491). The contemporary practice has become less defined. Congregations base the need of refuge and length of stay on the legal or public campaign of the people they are taking into sanctuary. To do so, congregations work with the immigrant(s) seeking sanctuary to draft a covenant that establishes guidelines for the sanctuary stay.

According to NSM activists, these covenants vary to match the interests of the person seeking sanctuary and campaign goals that differ depending upon the enforcement practices of local immigration offices, proximity to the border, and/or relationship of the sanctuary network to local decision makers. Individual immigrants seek sanctuary with the expectation that outcomes will follow one of two trajectories: one, protection from deportation for an undefined period while they explore their legal options; or two, an explicit timeline for a public campaign aimed at obtaining a stay of removal. The former strategy requires that the person stay in sanctuary until a legal option is found (which could take years) or until the person decides they no longer want to remain in sanctuary. The latter strategy requires a campaign plan that outlines objectives, tasks and goals necessary to secure a stay of removal through prosecutorial discretion. At the end of the covenant period, the progress of the case, public support and odds of winning are evaluated and the agreement is renegotiated. Throughout this entire process the final decision maker is the person in sanctuary; if they decide sanctuary is no longer an option, the network must respect those wishes.

Congregations that have or currently provide physical sanctuary as part of the NSM span the Judeo-Christian theological tradition. According to coversations between the authors and movement leaders, the denominations providing physical sanctuary have primarily been Methodist, Presbyterian, United Church of Christ, and Unitarian Universalist, though at least one congregation from the Catholic, Episcopalian, Mennonite, Jewish and Quaker traditions have also provided physical refuge. While all communities of faith are welcomed, sanctuary as practiced by the NSM has heretofore been largely a protestant activity.

Providing physical sanctuary may require congregations to be visible via media campaigns, thus vulnerable to public harassment and attacks. Through the public nature of sanctuary work, sanctuary congregations

force the public to contend with how they enact their spiritual beliefs and values in their daily lives. As congregations position themselves opposite the federal government, sanctuary congregations are forcing a public choice between two powerful U.S. institutions.

Sanctuary in the Streets

Sanctuary in the NSM extends beyond the concept of physical refuge. Contemporary sanctuary could more appropriately be defined as a mechanism for mobilization held together by religion and a commitment to social justice. Recognizing that not all immigrants are seeking physical refuge and not all supporting congregations can provide it, members of the NSM support undocumented immigrants with sanctuary beyond the provision of physical shelter. The sanctuary in the Streets program was born in Philadelphia out of the realization that congregations could not passively wait for undocumented people to show up to the congregation steps to ask for aid, help or refuge. Thus, congregations moved towards making their individual members carriers of sanctuary who could provide protection from ICE wherever and whenever needed.

Sanctuary networks trained members on direct action and civil disobedience; specifically, on how to become a physical barrier between ICE agents and immigrant communities. Participants learned how to disrupt ICE agents' daily routines, question ICE agents about warrants, and prepare to be arrested if ICE agents wanted to enter a house without a warrant (New Sanctuary Movement of Philadelphia, 2017). Although sanctuary in the Streets varies by regional context, generally the program functions via a network of trained responders who mobilize to witness and stop ICE activity reported on a community hotline. Responders attempt to set up a physical barrier between ICE and the people they are trying to detain by praying, singing, or drawing attention to the raid happening (National Sanctuary Movement, 2017a; New Sanctuary Movement of Philadelphia, 2017). Sanctuary in the Streets is, thus, an extension of physical sanctuary outside of holy walls.

Sanctuary in the Streets provides network members a look into the moments of crisis experienced by the immigrant community beyond active raids. Living in the U.S. as an undocumented immigrant means constant threat of detection and deportation (Robben & Suarez-Orozco, 2000). Networks work to alleviate this constant crisis by showing broad support to the immigrant community via activities ranging from providing legal, financial and spiritual support services to individuals and families, to conducting trainings like Know Your Rights or others focused on defensive strategies to deal with ICE raids to the broader communities (Caminero-Santangelo, 2009; National Sanctuary Movement, 2017a). Other interventions like "pew cards" have also been used to inform im-

migrants of their rights in conjunction with Know Your Rights trainings offered by immigrant leaders (Freeland, 2010).

In many ways, the NSM sees "consciousness-raising" or outreach to people beyond the impacted community as one of its principal tasks (K. Barron, 2017). Strategies employed include "listening groups" in area churches with representatives from the police, faith groups and the larger community to encourage dialogue and connection between the impacted community and officials (Caminero-Santangelo, 2009, p. 122). Perhaps most important in this regard is the use of media attention. Media activities include broad-based campaigns using billboards and other outlets to declare support of immigrants, vigils aiming to improve conditions in detention centers or to expose the dangers of border crossing (Associated Press, 2017), and media campaigns focused on the specific case of an individual (Freeland, 2010). However, as the new U.S. administration clarifies its immigration enforcement strategies, media usage may shift. These media activities may include political advocacy and statements in support of,or against, local, state and national policy changes. Local and national sanctuary networks to a large extent follow the lead of national coalitions like the National Day Labor Organizing Network (NDLON) and United We Dream (UWD) that support immigrant rights to develop their position and strategies.

Accompaniment

A final sanctuary practice seeing a revival with the NSM is that of accompaniment. Originally conceived as an "underground railroad" type strategy during the SM to physically escort people from Central America to sanctuary in the U.S. (Freeland, 2010), conviction of activists for harboring and tightening of the clause inspired NSM to rethink the practice. In its contemporary iteration, accompaniment refers to escorting immigrants facing deportation to their appointments at ICE offices and immigration court hearings, as well as providing support to help them end their deportation process.

Activists provide emotional and legal support, sometimes going to the extent of maintaining physical contact with the immigrant during trips to immigration offices to advocate for their case. One example of this was in the case of Sulma, who was escorted by two clergy who locked their arms with her when she went to the ICE office to receive the final stay of deportation decision that has allowed her to remain in the U.S. (Barragan, 2015).This program aims to build stronger ties between the faith community and the immigrant community, built on more than the shared response to crisis of physical sanctuary. By encouraging congregation members and immigrants to share experiences of confronting the immigration system together, accompaniment builds a model for solidarity that allows

congregations and immigrants to see each other as partners in the struggle for social justice rather than as immigrants in need of saving by Christians. In tandem with other sanctuary practices, this lays the groundwork for continuing to expand the meaning of sanctuary.

Conclusion: Social Work, Christianity and Re-imagining Sanctuary

In 1985 an Anonymous comment was published in Social Work, a principal journal of the social work profession widely read by practitioners, students and researchers alike, that called upon social work to support the sanctuary movement (Anonymous, 1985). According to the author, "social workers should begin to talk to each other about how they can stop arbitrary deportations, secure the well-being of refugees, and put an end to the conflicts and policies that create this tide of suffering humanity," regardless of the risks (Anonymous, 1985, p. 76). Given the few scholarly publications or references to social work in the context of the NSM, thirty years later we ask, is social work heeding this call?

The Social Work profession emerged from and with a "radical" tradition that understands the structural basis of individual problems as grounded in economic inequality, critiques service agencies, and links false dichotomies like public/private (Reisch & Andrews, 2014). Social workers like Jane Addams, Jeanette Rankin, and Francis Perkins were at the forefront of community movements for social change and the enactment of federal policies that form the backbone of the U.S. social welfare system. Yet despite engagement of some modern social workers with communities in political change efforts, contemporary practice can seem disconnected from this history. Many social workers are unaware that the profession's roots include radical political activity, as well as the suppression of these ideas and resistance to such suppression (Reisch & Andrews, 2014).

The profession thus developed navigating the "ongoing and inherent tensions between radicalism and professionalism" (Reisch & Andrews, 2014, p. 8). At its worst, the emphasis on professionalism has led to a role in facilitating morally unjust practices in the interest of serving the state, as seen in the role social workers played in facilitating the internment of Japanese Americans during World War II (Park, 2008) and in the high rates of removal of Indian children from families prior to the passage of the Indian Child Welfare Act (Fletcher, 2009). Over the last several decades, however, "political social work" has (re)emerged in response to the obligation in the profession's Code of Ethics for social workers to engage in "social and political action" (Pritzker & Lane, 2017, p. 80). Encompassing skills like electoral work and policy analysis aimed at "altering the power dynamics in policymaking," political social work focuses on macro-level mechanisms (Pritzker & Lane, 2017, p. 80). Yet the implications of labeling

early social work leaders as "subversives" on additional "self-censorship" of the profession are not fully understood (Reisch & Andrews, 2014, p. 9). One 2010 study found that just under half of social workers surveyed have high political participation and considerable ambivalence regarding their responsibility to politically empower clients (Pritzker & Lane, 2017; Rome & Hoechstetter, 2010).

Both the challenges the profession has faced in navigating the role between social protection and social change and its foundation in radical social change are important to consider in developing its response to contemporary social issues, particularly ones that require navigating racial/ethnic and political boundaries like that of undocumented immigration. Social workers provide crucial support to undocumented immigrants in detention centers and in the community by facilitating access to services, providing mental health support and serving as expert witnesses for asylum cases, indeed "contributing time, skills, energy, money, and other resources," heeding the call to action in Social Work (Anonymous, 1985). However the "social worker's role in the underground railroad" requires contributing these skills in tandem with "advocating for national policy changes" (Anonymous, 1985).

The NASW has begun to take this step, issuing a brief on sanctuary cities, calling attention to the intersection of child welfare and immigration policy in response to the recent change in federal administration (NASW, 2017). The brief did not, however, distinguish the sanctuary movement from sanctuary cities, and fell short of a clear call for participation and political advocacy with and on behalf of immigrant communities (NASW, 2017). Yet social workers have been part of both the early (Melvin, 1987; Snodgrass, 2015) and contemporary (Leibowitz, 2017; STAND Central New Jersey, 2017; Stanton, 2017) sanctuary movements, and Christian social workers have been active participants in encouraging their congregations to become sanctuary congregations. Sanctuary presents an opportunity and a challenge to social workers and Christians as they consider their position in the contemporary immigration debate. Recent ICE targeting of immigrant leaders (Bear & Fields, 2018; Dunne, 2018) point to the need for more congregations who are majority U.S. citizen and white allies to support immigrant communities. Christian social workers could play a key role in connecting congregations to policy advocacy.

As with social work, the sanctuary movement has learned from its past and is undergoing transformation. Aware of how its practices have at times excluded vulnerable immigrant communities and silenced their voices, the movement is now attempting to expand what the term "sanctuary" means in a theological/theoretical sense and a practical sense. How can the movement center and empower immigrant voices and stories without prioritizing some narratives over others? As the social work profession

continues to confront the challenges of the past to center the voices of the most vulnerable, engaging in these discussions on the moral and legal boundaries of sanctuary to develop best practices to support the immigrant community is one way social workers can engage in political practice. ❖

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Jennifer Scott, *PhD, MIA, LMSW is Assistant Professor of Social Work, Louisiana State University, 330 Huey P. Long Fieldhouse Baton Rouge, LA 70803. Phone: (225) 578-0433 Email: jenscott@lsu.edu*

Alejandro Caceres *is Lead Immigration Organizer, Grassroots Leadership and co-founder of Austin Sanctuary Network, 2301 East Cesar Chavez Street, Austin, TX 78701, Email: acaceres@grassrootsleadership.org*

Keywords: immigrants, sanctuary, undocumented immigration, social work

Christian Social Work Students and Gender Variance: An Exploratory Study

Dirk H. de Jong

This article reports on a survey of Christian social work students and recent graduates regarding their views on gender identity and transgender issues, particularly in the context of their professional training. Although about one- third of the sample reported a belief that gender identity is subjective and flexible, the general trend of the findings suggested more conservative beliefs concerning transgender issues, across a variety of measures, than those of social work faculty reported in previous research. Thus, while Christian social work students do not appear to be a homogeneous group, social work educators may need to further explore transgender issues and their importance to practice when teaching students from conservative Christian backgrounds.

More people identify as transgender than was previously thought. Also, currently available prevalence studies tend to under-report due to methodological issues. That said, estimates for adults have ranged from 0.3 percent (Gates, 2011) to 0.39 percent (Meerwijk & Sevilius, 2017) and 0.5 percent (Conron, Scott, Stowell, & Landers, 2012), while one study of urban youth (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009) reported that 1.6 percent of high school students identified as transgender. Even the more conservative percentages translate into a sizable transgender population. For instance, the prevalence rate found by Meerwijk and Sevelius (2017) amounts to a population of almost 1 million transgender adults in the United States. Moreover, as these researchers note: "The available evidence suggests that the size of the gender-nonconforming or gender-variant population may be twice as

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large as our best estimate for the transgender population size" (p. e6). Using more inclusive criteria (i.e., dislike of one's body based on gender identity assigned at birth), a prior Dutch study indeed indicated higher prevalence figures when considering a spectrum of gender dysphoria (Kuyper & Wijsen, 2014). Also, a recent survey among millennials (ages 18-34) in the United States (GLAAD 2017) found that 12% of the respondents identified as other than cisgender (cisgender meaning congruence between assigned and self-perceived gender identity; alternatives to cisgender in the study were agender, gender fluid, transgender, unsure/questioning, bigender, or genderqueer). The numbers cited here have implications for social work practice. Because, in many respects, transgender individuals still face marginalization and discrimination (Grant et al., 2011), they may want to seek out social work help at a disproportionate rate to deal with extraordinary environmental stressors. As has been acknowledged by the Council on Social Work Education (Martin et al., 2009), professional training programs in general have not, at least until recently, adequately addressed the needs of students to learn about this population. More recently, Austin, Craig, and McInnoy (2016) documented transphobia and a lack of transgender content and visibility in social work programs.

Transgender issues have been prominently discussed in many conservative Christian communities, because the notion of gender variance seems hard to reconcile with literal interpretations of the Bible (e.g., Moore, 2013). Thus, a recent survey comparing the attitudes of nonreligious and evangelical respondents found, with some qualifications, more negative attitudes toward transgender individuals among the latter group (Kanomori, Pegors, Hulgus, & Cornelius-White, 2017).

Transgender issues have been particularly contentious in Christian colleges, due to clashing values pertaining to non-discrimination and religious freedom (see O'Brien, 2017, for a first-person account). In terms of social work education, this issue was debated earlier with respect to the "life style requirements" of certain religiously affiliated programs, which appeared to exclude students and faculty in same-sex relationships (Beless, 2001; Vanderwoerd, 2002). In the introduction to a recent special issue of Social Work & Christianity regarding LGBTQ clients, Sherwood (2017) elucidates the complexity of the debate, rooted in "fundamental worldview and faith-based assumptions" (p. 5). Some of these assumptions concern conceptualizations of gender. Thus, in the view of conservative Christians, this conceptualization is essentialist, meaning that gender is a binary and unchangeable proposition (see, for example, Moore, 2013).

With respect to the issue of transgender rights, scores of Christian colleges and universities have now applied for and received Tile IX waivers to avoid required accommodations for transgender students (Human Rights Campaign, 2015). These developments once again create an es-

pecially difficult position for social work programs in these institutions, seemingly pitting the values of gender diversity and religious diversity against each other. Meanwhile, the dialogue about transgender issues in the context of faith is expanding, facilitated by emerging research that elucidates how gender-variant Christians navigate their personal journey (Levy & Lo, 2013), and by the voices of transgender Christians on various media platforms (see, e.g., Austen Hartke's YouTube series "Transgender and Christian," his website austenhartke.com, or the online community of queertheology.com). Moreover, transgender and genderqueer students are beginning to make their presence known even on conservative Christian campuses by way of (often unsanctioned) clubs and/or in alliance with LGBT alumni groups (see onesafetynet.com).

Literature Review

With respect to related literature, there is an existing knowledge base regarding social work education and views on homosexuality (Chonody, Woodford, Brennan, Newman, & Wang, 2014; Cluse-Tolar, Lambert, Ventura, & Pasapuleti, 2004; Scott, Siebert, Siebert, & Chonody, 2012), including some studies that have focused on the role of religion in this respect (Chonody, Woodford, Smith, & Silverschanz, 2013; Dessel, Woodford, & Gutierrez, 2012; Swank & Fahs, 2014; Walls & Seelman, 2014). The tenor of these studies has been that heterosexism is not yet absent from social work education and that religious beliefs tend to correlate with a lag in acceptance of non-normative sexuality among social work students. Much less is known about the views of social work educators and students regarding transgender issues (personal attitudes, policy and practice issues, professional training). Because views on gender identity may be quite distinct from those on sexual orientation, they should be researched separately.

So far, a few studies have specifically examined transgender issues as they pertain to faculty in undergraduate social work education. The first of these surveyed 113 self-selected subscribers to the listserv of the Association of Baccalaureate Social Work Program Directors (de Jong, 2015). It found positive attitudes toward transgender persons and a willingness to include transgender content in the undergraduate social work curriculum. However, it also seemed to indicate a lack of awareness of campus policies and accommodations with respect to transgender individuals. Additionally, the survey found only minor differences between faculty employed by secular schools versus those teaching in religiously affiliated programs. A second study focused specifically on the views of social work faculty in schools belonging to the CCCU, i.e., conservative Christian institutions that integrate "biblical truth" with academics (de Jong, 2017). This survey

found largely positive attitudes among the participants, but reservations in terms of accepting possible transgender colleagues. The results also indicated a desire to integrate religious and professional values, but a degree of uncertainty in terms of how to implement this in the context of "religious freedom."

Because there is not yet any knowledge regarding the views toward transgender issues of Christian social work *students*, the current study was designed around the following research question: What are the views of social work students identifying as Christian with respect to gender identity and transgender persons, and how do these students see transgender issues fitting with their social work education?

Methodology

An invitation to participate in the study was sent to 334 student members of the North American Association of Christians in Social Work (NACSW), using a list of e-mail addresses provided by that organization. NACSW did not have any other involvement with the research. In a follow-up recruitment message, snowball sampling was encouraged as well, precluding the establishment of a response rate (considered acceptable given the study's exploratory nature). Eventually, 85 individuals accessed the online Qualtrics survey and 75 respondents completed it. Most of them identified as Evangelical Protestants, and almost half attended programs affiliated with Evangelical Protestant institutions. In terms of class status, the largest group of respondents consisted of seniors, followed by master's level students. Finally, with respect to gender identity, 80 percent of the participants identified as female, 20 percent as male, and none identified as transgender. Table 1 shows participant characteristics in further detail.

Table 1. Participant characteristics*

Religious affiliation of self (n=75)		
Protestant, Evangelical	41	(55%)
Protestant, Mainline	9	(12%)
Catholic	1	(1%)
Other (e.g., Apostolic, Christian, Nondenominational, Seventh-day, Adventist)	21	(28%)
No religious affiliation	3	(4%)
Religious affiliation of school (n=75)		
Protestant, Evangelical	36	(48%)
Protestant, Mainline	10	(13%)
Catholic	4	(5%)
Other (not further specified)	13	(17%)
No religious affiliation	12	(16%)

Student status (n=74)		
Freshman	0	(0%)
Sophomore	1	(1%)
Junior	9	(12%)
Senior	27	(36%)
Master's	20	(27%)
Doctoral	2	(3%)
Graduated < 2 years	15	(20%)
Gender identity (n=75)		
Female	60	(80%)
Male	15	(20%)
Transgender	0	(0%)
Other	0	(0%)

(* Percentages may not add up to 100 due to rounding.)

The questionnaire consisted of 39 items, including two that allowed for a write-in response. The last 20 items of the questionnaire represented the Attitudes Toward Transgender Individuals Scale, an instrument with demonstrated validity and reliability (Walch, Ngamake, Francisco, Stitt, & Shingler, 2012). The results of the survey were analyzed descriptively and, where possible, inferentially (using the chi-squared test and—in the case of low numbers in certain subcategories—the Fisher exact test, both at $p < .05$, to determine possible associations, and the unpaired t-test to learn about possible group differences). The responses to two open-ended questions were analyzed for possible themes and attitudinal content.

Findings

Views about gender identity

This section of the questionnaire explored the participants' views on gender identity as either binary and fixed, or on a spectrum and flexible. It also asked about beliefs regarding the etiology of gender identity and the participants' views on social work practice with transgender people. The results are shown in Table 2.

Table 2. Views about gender identity*

Do you believe that gender identity is subjective? (n=75)		
Yes	27	(36%)
No	32	(43%)
Not sure	16	(21%)

Do you believe that gender identity is subjective? (n=75)		
Yes	26	(35%)
No	39	(52%)
Not sure	10	(13%)
Do you believe gender identity is a binary (either woman or man) concept? (n=74)		
Yes	43	(58%)
No	20	(27%)
Not sure	11	(15%)
Do you believe that gender identity is… (n=74)		
determined biologically?	8	(11%)
the result of biological and environmental factors interacting	34	(46%)
the result of unknown environmental factors?	2	(3%)
the result of pathological family dynamics during childhood?	5	(7%)
the result of childhood abuse?	3	(4%)
the result of factors not mentioned above?	9	(12%)
of unknown causation?	13	(18%)
Do you believe that, in the future, transgender individuals may want to go back to the gender identity assigned to them at birth? (n=74)		
Very unlikely	5	(7%)
Unlikely	10	(14%)
Can go either way	43	(58%)
Likely	10	(14%)
Very likely	6	(8%)
Do you believe that social workers need to accept transgender persons as they themselves identify? (n=74)		
Yes	56	(76%)
No	6	(8%)
Not sure	12	(16%)
Do you believe that social workers need to fight against the discrimination of transgender persons? (n=74)		
Yes	55	(74%)
No	5	(7%)
Not sure	14	(19%)

(* Percentages may not add up to 100 due to rounding.)

Transgender issues in the explicit social work curriculum

The explicit social work curriculum includes the courses offered by the program (CSWE, 2015) and several survey questions asked about curriculum content regarding transgender issues. Thus, the participants indicated how important they believed this content to be, what they thought the content should consist of, and what they believed should be the moral

perspective (if any) from which to deliver this material. Their responses are summarized in Table 3.

Table 3. Transgender Issues and Social Work Education, the Explicit Curriculum

How important do you believe it is that social work students learn about transgender issues? (n=75)		
Not at all important	1	(1%)
Unimportant	1	(1%)
Neither important nor unimportant	3	(4%)
Important	35	(47%)
Extremely important	35	(47%)
Do you believe gender identity is a binary (either woman or man) concept? (n=74)		
Gender identity as a spectrum phenomenon	44	(59%)
Causation	33	(44%)
Early manifestations (transgender and gender-variant youth)	45	(60%)
The transition process	41	(55%)
Discrimination and marginalization of transgender persons	16	(21%)
None	2	(3%)
Do you think that transgender issues should be presented from a moral perspective? (n=75)		
No, only factual information should be presented.	10	(13%)
Yes, from the perspective that trans-gender persons should be accepted as a manifestation of diversity.	15	(20%)
Yes, from the perspective that trans-gender persons should be accepted as a manifestation of diversity and celebrated for their courage to be true to themselves.	11	(15%)
Yes, from the perspective that, although transgender individuals should be accepted, a transgender identity is in opposition to biblical teaching.	21	(28%)
Yes, from the perspective that, although transgender individuals should be accepted, acting on a transgender is a sin.	8	(11%)
Yes, from a moral perspective not described above (please elaborate)	10	(13%)

(**Respondents could check more than one answer.)

The questions about teaching transgender content elicited the suggestion to also cover intersex and "various forms of biological (chromosomal or otherwise) conditions that can affect gender identity." Also, several participants specifically mentioned the need to discuss the influence of faith-based considerations, such as noted here:

> In Christian academic environments, complementary Biblical principles such as "loving thy neighbor" should be emphasized along with social work values.

The write-in answers to the curriculum question and especially those in response to the item about moral perspectives provided additional insight

into the basic research question about student attitudes. The following are examples of clearly positive statements:

> Yet transgender individuals, although with every other minority group should be treated with dignity and respect, particularly in the aspect of social work as we work for the vulnerable and oppressed.

Transgender issues and the implicit curriculum

The implicit social work curriculum consists of the broader educational context of the program. As noted by the Council on Social Work Education: "The culture of human interchange; the spirit of inquiry; the support for difference and diversity; and the values and priorities in the educational environment, including the field setting, inform the student's learning and development" (CSWE, 2015, p. 14). In terms of the present study, questions about the admission of transgender and gender-variant students, their placement in field, the treatment of transgender faculty, and the availability of gender-neutral bathrooms were considered to relate to the implicit curriculum. The responses are displayed in Table 4.

Table 4. Transgender Issues and Social Work Education

Do you believe that CSWE-accredited social work programs need to accept students who are openly transgender or gender variant (and are academically qualified)? (n=75) Do you believe that gender identity is subjective? (n=75)		
Yes	52	(69%)
No	9	(12%)
Not sure	14	(19%)
Do you believe that all agencies that work with CSWE-accredited programs need to accept qualified students who are openly transgender or gender variant in field placements? (n=75)		
Yes	39	(52%)
No	16	(21%)
Not sure	20	(27%)
Do you believe that CSWE-accredited programs need to continue to provide employment and tenure to qualified faculty who come out as transgender or gender variant? (n=75)		
Yes	47	(63%)
No	8	(11%)
Not sure	20	(27%)
Does the college or university that you attend(ed) have gender-neutral bathrooms? (n=75)		
Yes	10	(13%)
No	51	(68%)
Not sure	14	(19%)

Do you believe that the college or university that you attend(ed) should have gender-neutral bathrooms? (n=75)		
Yes	27	(36%)
No	37	(49%)
Not sure	11	(15%)

(* Percentages may not add up to 100 due to rounding.)

Attitudes toward transgender individuals

The second part of the survey consisted of all twenty items from the Attitudes Toward Transgender Individuals Scale (Walch, Ngamake, Francisco, Stitt, & Shingler, 2012), which had also been used in a previous study of social work faculty (de Jong, 2015). With respect to this study's sample, the average score for each item is shown in Table 5 (higher scores represent more positive attitudes). Analysis of the total score follows below in the discussion section.

Table 5. Mean Scores on Attitudes Toward Transgender Individuals Scale (n=75)

(1=strongly agree; 2=agree; 3= neither agree nor disagree; 4= disagree; 5=strongly disagree)

		Mean
1.*	It would be beneficial to society to recognize transgenderism as normal.	2.60
2.	Transgender individuals should not be allowed to work with children.	3.65
3.	Transgenderism is immoral.	2.75
4.	All transgender bars should be closed down.	3.73
5.*	Transgender individuals are a viable part of society.	3.48
6.	Transgenderism is a sin.	2.61
7.	Transgenderism endangers the institution of the family.	2.87
8.*	Transgender individuals should be accepted completely into our society.	3.47
9.	Transgender individuals should be barred from the teaching profession.	3.81
10*	There should be no restrictions on transgenderism.	2.91
11.	I avoid transgender individuals whenever possible.	3.99
12*	I would feel comfortable working closely with a transgender individual.	3.64
13*	I would enjoy attending social functions at which transgender individuals were present.	3.68
14*	I would feel comfortable if I learned that my neighbor was a transgender individual.	3.81

		Mean
15.	Transgender individuals should not be allowed to cross dress in public.	3.80
16*	I would like to have friends who are transgender individuals.	3.32
17*	I would feel comfortable if I learned that my best friend was a transgender individual.	3.00
18.	I would feel uncomfortable if a close family member became romantically involved with a transgender individual.	2.57
19.	Transgender individuals are really just closeted gays.	3.87
20.	Romantic partners of transgender individuals should seek psychological treatment.	3.28

(*item was reverse-scored)

Discussion

Some questions in the present research were asked previously in a survey of social work *faculty* at schools belonging to the Council of Christian Colleges and Universities (de Jong, 2017). Contrasting the results from that study with those from the current survey show the students to be more conservative than the professors in five of the six areas for which comparable data were collected. With respect to the etiology of gender identity, 11% percent of the students considered it to be the possible result of pathological family dynamics or childhood abuse, while none of the faculty members did ($p=0.049$; FET). While 21% of the students considered it unlikely or very unlikely that transgender individuals may want to go back to the gender identity assigned at birth, a full 69% of faculty members thought so ($p<0.001$; FET). These differences between students and faculty are statistically significant at $p<0.05$. Also, 95% of faculty members were concerned with curriculum content about the discrimination and marginalization of transgender persons versus 73% of the students. In terms of a moral perspective from which to view transgender issues, 64% of the faculty and 35% of the students selected a perspective of accepting and celebrating diversity. Conversely, only eight percent of faculty adhered to the perspective of viewing a transgender identity as in opposition to biblical teaching and a gender transition as sin, while 39% of students held those beliefs (the differences regarding curriculum content and moral perspectives were not analyzed for statistical significance, given the multiple response categories). With regard to student admissions, 85% of faculty members believed that CSWE-accredited programs need to admit academically qualified transgender or gender-variant students, while 70 percent of students thought so. Interestingly, only with respect to the

issue of maintaining and promoting transgender faculty did the students seem to be more accepting, with 63% of students supporting continued employment and tenure for qualified faculty members who come out as transgender and 50% of faculty members expressing that opinion. However, using the chi-square test, the differences about student admission ($p=0.11$) and faculty tenure and promotion ($p=0.41$) are not statistically significant at $p<0.05$.

The mean total score for students on the Attitudes Toward Transgender Individuals Scale was 66.84 out of a possible 100. This scale was also administered in a prior study of BSW faculty at both secular and religiously affiliated institutions (de Jong, 2015); at that time, faculty members in the faith-based schools obtained an average score of 89.75 (although that sample had a higher rate of mainline Protestant schools compared to the student sample). Using the unpaired t-test, the difference between the faculty score and the student score is significant at the 0.05 level: $t(38)=9.1883$, $p<0.0001$. Consistent with some of the other findings of the present survey, the lower score of the students indicates a less accepting attitude toward transgender persons.

Interestingly, more than one-third of the respondents in this study viewed gender identity as subjective and flexible, notions that would seem to contradict the essentialist view of gender typically derived from a literal interpretation of the Bible. Similarly, in response to the question, “Do you believe that gender identity is a binary concept, i.e., that a person is either a woman or a man?”, 27% answered “no” and another 15% indicated “not sure.” This compares to a national survey taken in January 2015 which found that 50% of respondents between 18 and 34 viewed gender as being on a spectrum, while another four% answered “don’t know” (Benenson Strategy Group, 2015). Additionally, 36% of the students in the present study indicated positive views regarding the need for gender-neutral bathrooms on campus. Analyzed statistically, the data showed significant associations (at $p<0.05$) when the following groups were paired with each other: Those who believed gender identity to be flexible or at least considered that a possibility (“not sure”), those who did not believe gender to be binary or were not sure, and those who responded positively (“yes”) with respect to gender-neutral bathrooms (p-values ranging from 0.001 to 0.004; FET). These findings indicate a subgroup of more liberal students within the sample, suggesting – in turn – that social work students who identify as Christian do not make up a homogeneous category (see Harris & Yancey, 2017, for further discussion of this issue). Nevertheless, the overall findings of the present study indicate a lower level of acceptance of transgender people compared to the results from previous research among faculty in religiously affiliated and, specifically, Evangelical Protestant social work programs, This difference is noteworthy,

given the increased exposure to transgender issues via social media and emerging forms of transgender activism in Christian higher education (see, for example, onesafetynet.com)

While the results of this study cannot be generalized, taken together they may reflect a continued influence of the students' home environment during the early years of training and acculturation into the profession. This finding is consistent with existing research indicating that a college education does not necessarily lead undergraduate students to question their religious beliefs as being in conflict with scientific facts (Scheitle, 2011). On the other hand, years of ongoing study, immersion, and acculturation into academia might account for the higher level of acceptance of transgender individuals among the faculty in Christian social work programs.

Limitations and Future Directions

This study was exploratory, and the findings cannot be generalized given the self-selected nature of the sample. Nevertheless, they may alert faculty members to the distinct possibility that students from a conservative Christian background may have difficulty accepting the notion of gender variance and, consequently, may have difficulty working with gender-variant and transgender clients. As it is considered unethical to refer clients out solely because of one's beliefs (Dessel et al., 2017; Harris & Yancey, 2017), all social workers have to accept and advocate for clients who identify as transgender or genderqueer, without any expectations or goals to change that identity. Such acceptance could be facilitated by increasing the scientific knowledge of social work students about gender identity.

As in the previous survey of faculty in Evangelical Protestant programs, the high percentage of "not sure" responses from the students is noteworthy. It was speculated at the time that these responses were in part the result of remaining ambivalence. Certainly, the wording of the survey questions and the limitation of closed-ended response categories could also be a factor. However, several of the qualitative comments offered by the students in the present study seem to reflect such ambivalence as well (although others seem distinctly less accepting than those of the faculty in the prior study). It should be noted that the ambivalence appears to occur in two areas: In one respect, it applies specifically to views on gender identity, in another it concerns the degree to which one accepts the notion of religious freedom vis-a-vis the phenomenon of gender variance. It appears that, particularly with regard to the latter, a certain amount of ambivalence (some might prefer the term "non-dichotomous thinking") is tolerated within the sphere of Christian higher education. However, this study again reflects the tension that exists in certain Christian social work programs around these issues.

While — at times, and for some — ambivalence can be useful, acutely felt ambivalence may lead to cognitive inconsistencies that are perceived as stressful (Newby-Clark, McGregor, & Zanna, 2002), and the literature on cognitive dissonance suggests a change in cognition to moderate conflictual beliefs (Festinger, 1957). Additionally, research regarding instructional strategies has shown that "conceptual change" can occur happen when teachers make cognitive conflict explicit, eventually increasing the learner's understanding of an issue (Guzetti, Snyder, Glass, & Gamas, 1993). The social work classroom is one place where this process might occur with respect to gender identity. Future research could examine how, in the theoretical context of cognitive dissonance, such new understanding does develop, what its substance will be like, and how it will or will not affect views on religious freedom. ❖

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Dirk H. de Jong, *Ph.D., LMSW, Assistant Professor of Social Work, Siena College, 515 Loudon Road, Loudonville, NY 12211. Phone: (518)782-6653. Email: ddejong@siena.edu*

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Forced Migration: Trauma, Faith, and Resilience

Giovanna Ginesini

This pilot study investigates the impact of socioemotional resources, including faith, and protective factors on resilience in a rare sample of 18 female victims of multiple trauma, including trafficking, sexual exploitation and torture, ages 20 to 42 (M= 33, SD=6.22), who were forced to migrate to Italy from Africa (Central and Western) and Eastern Europe. Participants were recruited and interviewed face-to-face at a community shelter for political refugees, asylum seekers and beneficiaries of international protection. Data on trauma, treatment type (educational, clinical, job training), length and outcome were obtained from the shelter staff. The author adopts a combined strength-based and resource-based theoretical approach to explore refugee women's ability to successfully and flexibly cope with multiple traumas. Results reveal resources and protective factors that are fundamental in working with refugee women. Implications for refugee mental health practice are discussed.

Refugee Women: Trauma, Faith and Resilience

The number of refugees coming to Europe has reached staggering proportions (Hebebrand et al., 2016). While some of them choose to migrate voluntarily, millions are forced to leave their countries of origin due to war, famine, poverty, political unrest, fear of persecution, economic instability and natural disasters (Shishehgar et al., 2017).

The dramatic political, economic and legislative changes that have accompanied the rapid globalization of the economies had a disproportionately heavy impact on women's economic opportunities and family responsibilities (Corrin, 2005). Approximately half of the global refugee population are women (Shishehgar et al., 2017) and the share of asylum seekers who are women generally appears to be rising (Spijkerboer, 2017). Globally, women

are disproportionately affected by poverty and other economic limitations due to discriminatory practices in attaining education and employment (Kligman & Limoncelli, 2005). Economic and gender-based inequalities may push women to migrate (Williamson, 2017) and ethnicity and age create racialized sexual stereotypes, further exacerbating their vulnerability and favoring the trafficking of refugee women (Butler, 2015).

The experiences of refugee women, who occupy a ‘neglected position' at the point of intersection of gender, ethnicity, and class (Anthias, 2002) suggests that there is an extra penalty for women refugees due to multiple discriminations: language, race, economic disadvantage, gender and the stigma attached to a refugee's status (Tomlinson, 2010). This compounding of vulnerabilities through discrimination and marginalization in multiple areas places refugee women at a high risk of trafficking.

The Trafficking of Refugee Women

Forced migration - including flow of refugees, asylum seekers, internal protection - is an economic and social process that has increased considerably in volume and political significance during recent years. As an integral part of North-South and West-East relationships, it is closely linked to processes of global social transformation and is raising fears of loss of state control and concerns about security (Dustmann, 2017). The problem of trafficking begins with the conditions that forced the victims to migrate under circumstances rendering them vulnerable to exploitation (Chuang, 2006). In the case of women, the economic factors pushing individuals to seek migration intersect with vulnerabilities stemming from gender, race, and class.

The United Nations Office on Drug and Crime (UNODC, 2012) has calculated Worldwide, between 2007 and 2010, 460 different trafficked routes and 40,000 new victims per year in Europe, with 68% of global trafficking victims sexually exploited. In Europe, trafficking for sexual exploitation is, by far, the most widespread form: an estimated 84% of victims are trafficked for this purpose. Women are trafficked from less developed, poorer regions to more developed and rich regions within Europe. Transnational trafficking represents the greatest part of this phenomenon, favored by a lack of Europe-wide legislation (Mendes Bota, 2014). According to a European Commission report on trafficking in human beings in the European Union (EU), only ten (10) member States have established all forms of exploitation of victims of trafficking as a criminal offence, while fifteen (15) member States adopted a limited and selective criminalization (European Commission, 2016). EU countries continue to differ widely in interpretation and implementation of common European policies against human trafficking and vary in their involvement in the trafficking of women. Some countries are sources of victims, others function merely as transit, while others are final destination

countries depending on where human beings are procured, transported, and enslaved through forced labor or sexual exploitation. For example, Moldova, Slovakia and Ukraine are pure source countries where traffickers exploit the aspirations of those living in poverty and those seeking better lives; Albania, Bulgaria and Romania are both source and transit, as they provide transportation and communication to sell men, women, and children into situations of forced labor and sexual slavery with virtually no risk of prosecution. Czech Republic and Poland are source, transit and destination while Spain, Italy and Greece are major transit and destination countries (Kok, 2017).

Refugee Women Health and Wellbeing

Forced migration inevitably has an impact on the individual's resources, psychological health and wellbeing, and consequently on the refugee's integration ability and success (Ryan, Dooley & Benson, 2008). Women are reportedly at greater risk of post-traumatic stress disorder (PTSD), depression, and anxiety related to lack of social support, poverty, poor health conditions, and discrimination (Shishehgar et al., 2017). Refugee women in particular often face additional traumatic and adverse events associated with migration, like sexual exploitation, sexual abuse and trafficking. The United Nations High Commission for Refugees (UNHCR) declared women a high-risk group for developing serious mental health disorders due to their experiences of rape and sexual violence (Chung, & Bemak, 2002). The psychological reactions that accompany such extreme events present formidable coping challenges for refugee women (Bonanno, Pat-Horenczyk, & Noll, 2011).

The Resource-based Approach

Research on the psychological well-being of refugees has traditionally focused on deficiencies and pathologies, either in terms of psychiatric symptoms or feelings of distress. Among the theoretical models that have driven research on the psychological well-being of refugees are the medical model, the psychosocial stress model (Wagner, Compass & Howell, 1988), and Hobfoll's (2001) conservation of resources (COR) stress theory. The medical model focuses on pathological conditions, the diagnosis of disorders (mostly PTSD), epidemiological studies, and the treatment of symptoms through pharmacological or psychotherapeutic interventions (Ryan, Dooley, & Benson, 2008). Psychosocial stress theories focus on stress and its relationship to the development of psychological and physical symptomatology. Theorists investigate the role of major life events or smaller, more chronic stressors or "daily hassles" as precipitants of symptoms (Wagner, Compas & Howell, 1988). According to the COR (Hobfoll, 1989) theory, individuals seek to acquire and maintain resources, including objects (homes, clothes, food),

personal characteristics (e.g., self-esteem), conditions (e.g. social support, financial security), and energies (e.g. time, money, and knowledge).

To achieve a more holistic view of the life experiences of refugees, and overcome the limitations of these three major theoretical models, Ryan, Dooley, and Benson (2008) proposed a resource-based model (RBM) of migrant adaptation grouping personal, material, social and cultural resources. Resources are typically divided into three different areas or contexts: individual, familial, and community (Blum et al., 2002). Findings from a qualitative investigation of Bosnian refugee women's coping strategies over five years highlighted the importance of family as well as extended family, spirituality, and the availability of community social support services in adjustment to resettlement (Sossou, Craig, Ogren, & Schnak, 2008). Warner (2007) found that refugee women with weak natal kin ties reported greater feelings of distress and symptoms of traumatic stress than did women with strong support networks. A recent study by Shishehgar et al. (2017) identified cultural, social and material, personal, and resilience factors as main themes influencing the health and wellbeing of refugee women. They recommended that resilience factors be incorporated into the resource-based model of migration to help depict a more complete picture of immigrants' challenges and resilience strategies.

The Strength-based Approach

During the normal course of their lives, most adults are confronted with at least one, and sometimes several highly aversive or potentially traumatic events. In the case of forced migration, in addition to the potentially traumatic experiences in the countries of origin, refugee women experience forced labor, sexual abuse, and sexual exploitation (Hebebrand et al., 2016). A cross-national study of trafficked women in Europe found multiple examples of abuse from physical and sexual assault, psychological abuse, coerced use of drugs or alcohol, restrictions on movements, social isolation, economic exploitation and debt bondage, illegal status, and abusive working conditions associated with being a migrant (Zimmerman et al., 2003). Sexual violence, including rape, is the most common form of coercion against female victims (Kok, 2017). Often, women's trafficking results in forced prostitution, and the lack of basic services available in the country of destination represents a barrier to their ability to escape their position as sex slaves (Miller, Decker, Silverman & Raj, 2007).

Resilience in face of trauma is fostered by the ability to flexibly engage in different types of coping responses as needed across potentially traumatic events (Mackenzie, McDowell, & Pittaway, 2007). In contrast to individualized accounts of resilience, Eggerman and Panter-Brick (2010) have stressed the social and process dimensions of resilience and

its ecological characteristics situated in person-environment interactions. Resilience (Gianesini, 2015) is a process that varies across gender lines and changes throughout particular lifespan stages. It is defined by positive and negative emotions, and positive and negative life events. Resilience implies the ability to flexibly regulate emotional expression. Within the heterogeneity of responses to potentially traumatic events, it represents a stable trajectory of healthy adjustment over time. Its relational and contextual dimensions explain both functional and dysfunctional behavior. An ethnographic study among single refugee women (Lenette, Brough & Cox, 2012) provided evidence that despite the upheaval caused by refugee circumstances and juggling multiple responsibilities, refugee women in this study moved through daily life challenges and opportunities with resilient outcomes. Far beyond the simplistic binaries of resilience versus non-resilient, Lenette, Brough, and Cox (2013) argue that more attention should be paid to day-to-day pathways through which resilience outcomes are achieved; this has important implications for refugee mental health practice frameworks.

People respond to stressful events in different ways, depending on the event and on the regulatory strategies they choose. Coping and emotional regulation theorists have proposed dynamic models in which these two factors, the person and the situation, interact over time to inform adaptation (Bonanno & Burton, 2013). Positive emotions produce patterns of thought that are notably unusual, flexible, creative, integrative, open to information, and efficient (Fredrickson, 2001). Thus, positive emotions increase one's preferences for variety and broaden one's arrays of acceptable behavioral options (Tugade, Fredrickson & Barrett, L. 2004). Multiple pathways to resilience have been shown (Bonanno, 2004) with a variety of individual difference variables promoting positive functioning following exposure to trauma. Thompson, Arnkoff, and Glass (2011) suggested that trait mindfulness and acceptance may be an overlooked pathway to resilience.

Hinton et al. (2013) argued that mindfulness is therapeutic for refugees as it increases psychological flexibility and decreases somatic distress, rumination, and the attentional bias to threat. Cultivating the ability to distance from affect and mental content serves as emotion regulation techniques, a core aspect of psychological flexibility (Bishop et al., 2004; Kabat-Zinn, 2003).

Spirituality and Faith as Both Resource and Strength

Faith and spirituality, conceptualized broadly to encompass both religious and non-religious forms, refers to a person's strong belief, based on spiritual conviction (Starnino & Sullivan, 2017) which can contribute to coping with new situations and accompanying shocking experiences (Shishehgar,

et. al 2017). In the life of refugee women, faith plays a double role: it represents a social and community resource to draw upon and an inner strength promoting resilience (Schweitzer, Kagee & Greenslade, 2009). As a resource, faith encompasses the support obtained from both prayer and church attendance, family, community, and friends. As a strength, faith includes having hope and goals, a positive attitude, and perceptions of growth and resilience (Shakespeare-Finch & Wickham, 2009). The potential effects of spiritual and religious beliefs on coping with traumatic events and in fostering resilience in trauma survivors have been widely recognized (Peres, Moreira-Almeida, Nasello, & Koenig, 2007; Ano & Vasconcelles, 2005; Fontana & Rosenheck, 2004). The literature suggests that refugee women employ various strategies to cope with their new way of life. Spiritual fulfilment and social support are commonly used resilience strategies that help asylum seekers and refugee women maintain equilibrium in spite of their uncertain status and ongoing distress (Sossou, Craig, Ogren & Schnak, 2008). Faith is an integral part of the healing and coping process with a significant influence on greater psychological well-being (Walker, Reese, Hughes, & Troskie, 2010).

Faith is strongly based on a personal quest to understand ultimate questions about life, meaning, and relationships with the sacred or transcendent (Moreira-Almeida & Koenig, 2006) and is an important component of almost all cultures. Indeed, religious frameworks and practices have an important influence on how people interpret and cope with traumatic events that may reduce loss of control and helplessness, provide a cognitive framework that can decrease suffering, strengthen one's purpose and meaning in the face of trauma, and help give purpose and meaning to suffering (Pargament, et. al 1998). In addition, faith can provide a sense of hope and motivation (Pargament, et. al, 1998). Traumatized individuals often look for a new sense of meaning and purpose in their life. Faith, by helping to interpret life events and giving them meaning and coherence, may as well contribute to the psychological integration of traumatic experiences (Koenig, 2006). For example, Pardini, Plante, Sherman, and Stump (2000) found that among individuals recovering from substance abuse, higher levels of religious faith and spirituality were associated with a more optimistic life orientation, greater perceived social support, higher resilience to stress, and lower levels of anxiety. Consequently, with such direct and strong links already established between spirituality and resilience, faith is an integral construct to include when studying resilience in refugee women (Smith, Lenz, & Strohmer, 2017).

Drawing upon Ryan, Dooley, and Benson's (2008) resource-based model of migrant adaptation and the strength-based model (Gianesini, 2015), the current paper explores refugee women's pre-migration individual, familial and community resources (intelligence, self-esteem, faith, kin connections and temperament) and protective factors (coping, flexibility, positive and negative affect, and mindfulness) and evaluates their contributions to resilience.

Specifically, it was hypothesized that in the Pre-Migration phase, individual, familial and community resources would enhance the resilience of refugee women (H1); protective factors would strongly influence the impact of Life Events (LES), both positive and negative (H2), and would be predictive of resilience levels in refugee women (H3). In the Migration phase, we expected a reciprocal influence between resilience and life events (both positive and negative) in refugee women (H4). Finally, in the Post-Migration phase, resilience is hypothesized to strongly predict refugee women's well-being and autonomy (H5) and stress level to be correlated with the impact of life events (H6) (See Figure 1).

Figure 1. The Theoretical Model (Hypotheses)

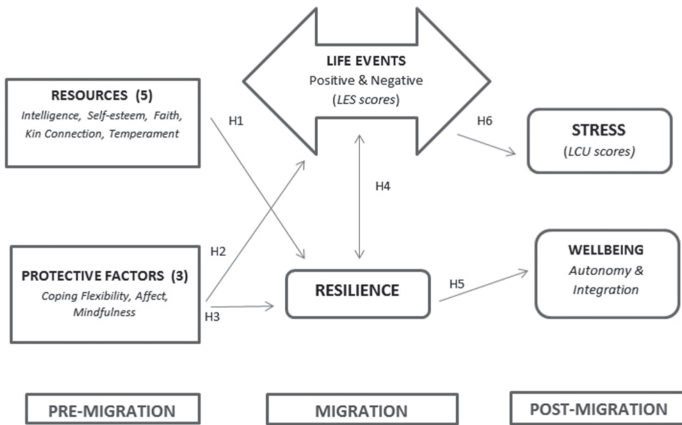
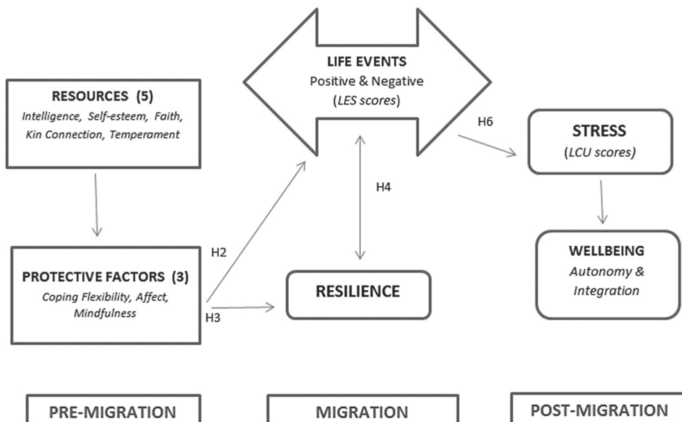


Figure 2. The Empirical Model



Method

This pilot research investigated forced migration, trauma, and resilience in a sample of eighteen (N=18) trafficked immigrant women interviewed using structured questionnaires. The research, involving a vulnerable population, was approved by the Institutional Review Board (IRB).

Participants

Participants were eighteen (N =18) female victims of multiple trauma, including trafficking, sexual exploitation and torture, age 20 to 42 (M=19.17, SD=7.6), who found protection at three different non-profit emergency shelters in Italy, city of Bologna. Those shelters are managed by the same non-profit organization, MondoDonna Onlus (www.mondodonna-onlus.it). This non-profit organization was founded about 20 years ago by a group of women of foreign and Italian origin, with the aim of creating reception services for refugee women. The main objective is to ensure immediate protection to women and their children, providing them with a safe place to live and at the same time, responding to the needs of both children and mothers. The intervention proposed at the shelter aims at helping mothers restore their parental skills, recover personal autonomy while supporting their job placement, and social integration with the host society through education and training.

Material

Participants were asked to complete a "Relational Resources and Resilience" structured paper-and-pencil questionnaire with 174 items divided into the following six6 sections addressing resources and protective factors, during face-to-face interviews with a clinical psychologist. The scales are copyrighted but are free to use. Both the questionnaire and the informed consent were made available in English, as all participants had some understanding of the language.

Procedure

Participants were asked to complete a paper-and-pencil questionnaire during face-to-face interviews with an experienced clinical psychologist over a three-month period. The shelter's personnel were on site to ensure the participants were fully protected and felt safe. To fully respect the participants' language and literacy difficulties, build trust and confidentiality, participants were allowed to self-pace the interview. Moreover, the research was conducted with the aim of reciprocal benefits for refugee participants and researchers,

carefully avoiding their retraumatization and focusing on the participants' current and prior-to-trauma resources. Although the interviews followed a structured questionnaire, they were intended to be informal and permit the interviewee to freely share any aspect of her experiences. The sense of trust and respect the interviewer was able to build with the interviewee over time, helped the easy flow of conversation. Interviewer-administered questionnaires offered the advantages that respondent literacy is not necessary, questions and responses can be clarified, probing for additional information is allowed, complex and open-ended questions are possible and participation potentially increased by personal contact. Both quantitative and qualitative data were collected, however only quantitative data are discussed in this paper. Following completion of the data collection process, participants were provided the opportunity for an informal discussion about their interview experiences and the research. The feedback received was all extremely positive with no need for a treatment referral for secondary trauma related to the research procedure. Participants reported that the interview helped them identify and focus on positive aspects of their pre-migration experiences and resources that helped them to endure the difficulties they faced.

Secondary data were also collected at the shelter on nine specific traumatic life events experienced by these refugee women (i.e. substance abuse, drug addiction, children in foster care, divorce, separation, legal issues/crimes, physical aggression, sexual abuse) together with information on treatment type (i.e. educational, therapeutic, counseling, group support, job placement, self-help group) and treatment length.

Measures

The "Relational Resources and Resilience" is a structured paper-and-pencil questionnaire developed by the author that included the following six sections addressing resources and protective factors and corresponding validated scales.

1. Social Emotional Resources: The Social and Emotional Resources Inventory (SERI, Mohr, 2007) is a comprehensive, 10-factor measure, that combines protective factors from three different areas: individual, familial, and community (Intelligence, Parents Connections and Practices, Self-esteem, Financial Resources, Faith, Talent, Prosocial Adults, Kin connections, Involvement in prosocial organizations, Temperament). The author reported an excellent internal consistency for the scale (.95) and a good-to-excellent internal consistency for its factors ranging from .84 to .97. In the current study, the internal consistency was confirmed for the scale (.95), but was much lower for its factors ranging from .77 to .84, with four factors yielding an unacceptable reliability below .70 (Parents connections & practices, Financial Resources, Prosocial Adults, and Prosocial organizations).

2. *Resilience:* The Resilience scale, short version (RS-14, Wagnild & Young, 1993) identifies the degree of individual resilience. The shortest 14-item version is to be considered unidimensional. The internal consistency of the original English version of RS-14 is high, with a Cronbach α score of 0.93.

3) *Coping Flexibility:* The Perceived Ability to Cope With Trauma scale (PACT, Bonanno, Pat-Horenczyk & Noll, 2011) includes two subscales that measure the perceived ability to focus on processing the trauma (trauma focus) and to focus on moving beyond the trauma (forward focus). The authors reported an excellent internal consistency for the subscale Forward Focus (.91) and a good reliability for the Trauma Focus subscale (.79). In this pilot study both subscales yielded a much lower reliability of .75 and .70 respectively.

4) *Positive and Negative Emotions:* The Positive And Negative Affect Scale (PANAS, Watson, Clark, & Tellegen, 1988) is a brief scale to measure the two primary dimensions of mood— positive and negative affect. The authors reported a good-to-excellent consistency of .85 for the PA subscale and .91 for the NA subscale. In this pilot study, the internal consistency of the overall scale (i.e. NA+PA subscales) was confirmed (.85) while the two subscales PA and Na yielded a much lower reliability of .67 and .45 respectively.

5) *Positive and Negative Life Events:* The Life Events Survey (LES, Sarason, Johnson & Siegel, 1978) measures life changes and allows for separate assessment of positive and negative life experiences as well as individualized rating of the impact of the events. It contains a list of 47 common events that individuals may have experienced in a wide variety of situations. In this pilot study, we only used 42 items of the original scale (24 negative and 18 positive), avoiding re-asking participants about their multiple traumas, as those data were already available. The impact of such events is presumed to be additive; more events are expected to have greater effect. Moreover, to each of the 47 life events was assigned a LCU score, to measure stress according to the Holmes and Rahe Stress Scale (1967). The number of "Life Change Units" that apply to events of an individual's life are added to obtain a final score which can give a rough estimate of how stress affects health. According to the authors, LCU scores above 300 indicate risk of illness; scores between 150 and 299, a moderate risk of illness; and scores below 150 indicate no risk. In this pilot study a subjective (LES scores) and objective (LCU scores) evaluation of life events, both positive and negative, are combined to produce an accurate estimate of the impact of such events.

6) *Mindfulness:* The Mindful Attention Awareness Scale (MAAS, Brown & Ryan, 2003; MacKillop & Anderson, 2007) measures a unique quality of consciousness that is related to a variety of well-being constructs (Kabat-Zinn, et al., 1992) and is associated with enhanced self-awareness. The authors reported a good internal consistency for the scale, with alpha of

.87. The current study confirmed excellent reliability of the scale, with an alpha of .96. All overall scales yielded an acceptable reliability ranging from .70 to .96 (see Table 1). However, some subscales yielded a non-satisfactory reliability below .60 and were excluded from further analysis.

Table 1. Scales and Variables of interest.

Scale/Construct	M	SD	# Items	Alpha di Cronbach
1. Socioemotional resources (SERI)	127.67	54.88	45	.95
Intelligence	14.39	5.44	4	.66
Parents Connections and Practices	13.44	4.74	5	.19
Self-Esteem	16.06	8.69	6	.77
Financial Resources	12.28	7.08	6	.65
Faith	15.83	6.26	5	.77
Prosocial Adults	8.89	4.96	4	.52
Kin Connections	15.06	8.04	5	.84
Prosocial Organizations	11.06	5.47	4	.59
Temperament	17.72	9.39	6	.82
2. Resilience (RS-14)	61.38	5.69	14	.62
3. Coping Flexibility (PACT)				
Trauma Focus	26.44	12.4	8	.70
Forward Focus	58.83	14.7	12	.75
4. Positive & Negative Emotions (PANAS)				.84
Positive Emotions	39.83	9.23	10	.67
Negative Emotions	33.14	7.24	10	.45
5. Mindfulness (MAAS)	47.67	25.58	13	.96
6. Positive & Negative Life Events (LES)			47	

Results

Statistical analyses were performed using SPSS version 24.1. Descriptive statistics were first run, then all six hypotheses were verified using correlations and multiple regressions analysis.

Demographics

Women who participated in the study were a heterogeneous sample representative of 12 different countries, cultures and languages. Of all the languages spoken, a third were (33%, n=6) fluent in English, one spoke Italian, and all others spoke a variety of different languages. They were originally from Eastern Europe (n=7, Yugoslavia, Macedonia, Moldavia, Ukraine), Africa (n=10, Sierra Leone, Nigeria, Morocco, Ivory Coast) and Asia (n=1,

Pakistan). They were forced to migrate to Italy either as teens (33.3%, age 14-19) or young adults (20-27) and a had spent two to 42 years (M=12, SD=10) in Italy; 47.1% (n=8) had remained in Italy for a period between two and eight years. All had from two (44.4%, n=8) to five children (22.2%, n=4), were either single (61.11%, n=11), engaged (22.2%, n=4) or cohabiting (16.7%, n=3). They had completed elementary school (33.3%, n=6), middle school (22.2%, n=2), high school (27.8%, n=6), or no schooling (44.4%, n=4). The majority were unemployed (61.1%, n=11) or working part-time (27.8%, n=5) at the time of the interview. They professed Catholic (50%, n=9), Muslim (22.2%, n=4) or other (27.8%, n=5) religions. They belonged to family with an average of 3.61 members (SD=3.09, range 1-15).

Descriptive statistics of shelter's secondary data.

At shelter admission, participants were assessed on a list of nine traumatic events. Statistical analysis of this secondary data evidenced that none of the women interviewed had substance abuse problems, eight were victims of physical aggression, four were victims of sexual abuse, five had criminal backgrounds, seven were separated and four divorced, and three had their children in foster care (M=1.78, SD=1.3, range 0-4). Their length of stay at the shelter varied from a minimum of three-to-six (22.2%, n=4) to a maximum of two years (72.2%, n=13). At the time of shelter admission, women were unemployed (72.2% n=13) and homeless (50%, n=9). They underwent educational training (38.9%, n=7), therapy (22.2%, n=4), job placement (27.8%, n=5), and only one underwent counseling. Family composition correlated significantly and positively with religion (r=-498, p>0.05) and age (r=.521, p>0.05). Age also positively and significantly correlated with number of children (r=.600, p> 0.01).

Individual, Familial and Community Resources builds resilience in refugee women (H1)

All resources (Intelligence, Self-Esteem, Kin Connection, Faith and Temperament) significantly and positively correlated with each other (from r=.564 to r=.955, p>0.01) (See Table 2). No significant correlation was found with Resilience or Life Events Scores. All resources raw scores were summed to obtain an overall score (M=127.67, SD=54.88, range 40-211), which correlated positively and significantly only with the perceived ability to cope with trauma, Forward Focus (r=.668, p>0.01).

To fully understand the contribution of faith as both resource and protective factor and its role in the life of refugee women, a multiple regression analysis was run to predict faith from other resources. Only Intelligence ($F(9,8)=20.65$, $p=.002$, $R2=.948$, $\eta 2p=.75$) and Kin Connection (F

(9,8)=20.65, p=.019, R2=.948, η2p = .86), added statistically significantly to the prediction, $p < .05$. When a multiple regression analysis was run using Faith as a predictor on protective factors, only Coping Flexibility (F (16, 1) =10.24, p=.006, R2=.390, η2p =.69) added statistically significantly to the prediction, $p < .05$. Finally, a linear regression analysis was run using Faith as a predictor of life events' stress. Only Positive LES Scores (F (16,1)=10.24, p=.007, R2=.390, η2p =.94) added statistically significantly to the prediction, $p < .05$. Results did not confirm the first (H1) hypothesis, as no direct relation was found between resources and resilience, but showed how faith as a resource is predicted by cognitive (intelligence) and social (kin connection) factors and its dual role as protective factor in favoring coping flexibility and influencing the impact of positive life events.

Table 2. Correlation Among Resources

	Intelligence	Parenting	Self-Esteem	Kin Connection	Parent Connection	Prosocial Organization	Faith	Resources	Tempera-ment
Intelligence	1	,817**	,688**	,773**	,716**	,690**	,782**	,564*	,789**
Parenting	,817**	1	,718**	,694**	,658**	,707**	,755**	,593**	,863**
Self-Esteem	,688**	,718**	1	,875**	,800**	,955**	,799**	,752**	,853**
Kin Connection	,773**	,694**	,875**	1	,823**	,891**	,685**	,707**	,783**
Parent Connection	,716**	,658**	,800**	,823**	1	,857**	,700**	,779**	,821**
Prosocial Organization	,789**	,863**	,853**	,783**	,821**	1	,784**	,650**	1
Faith	,782**	,755**	,799**	,685**	,700**	,820**	1	,833**	,784**
Resources	,564*	,593**	,752**	,707**	,779**	,806**	,833**	1	,650**
Temperament	,690**	,707**	,955**	,891**	,857**	1	,820**	,806**	1

** significant at 0,01

Protective factors influence the impact of life events, both positive and negative (H2)

The 43 selected life events were grouped into three main categories based on participants' appraisal evaluation: neutral/positive events with positive scores ranging from 0 to +3 (12), highly negative events with negative scores ranging from -3 to -2 (6), and events which yielded either a positive or negative evaluation, with scores ranging from -3 to +3 (25). Scores for each live event, either positive or negative, were summed for each subject yielding a total score ranging from -13 to +34 (M=12.44, SD=13.24). Few subjects (n=3) yielded overall negative score (-13, -1, -2) and were considered at greater risk for stress, while the remaining subjects evidenced

a positive balance between negative and positive life events (with scores from +2 to +34) (See Table 3). Interestingly, the total life event scores were negatively and significantly correlated with Trauma Focus (r=-.587, p> 0.05) perceived ability to cope with trauma and positively with age (r= .688, p> 0.01). No significant correlation was found between total life events scores and positive or negative affect.

Table 3: Neutral / Positive Life Events

Life Event	Description	Score Range	M (SD)
LES4	Important children's achievement	2/3	2.8 (0.3)
LES6	Going back to school or training	1/3	2.0 (0.6)
LES11	Making new friends	0/3	1.7 (1.0)
LES14	Changes in sexual intimacy with men (infidelity, sexual problems, fights)	0/3	2.0 (1.7)
LES15	Personal Achievement	2/3	2.8 (0.3)
LES17	A new intimate relationship	0/3	1.5 (2.1)
LES19	Pregnancy/Maternity	0/3	2.3 (1.0)
LES22		0/3	2.0 (1.4)
LES23	Received a gift (something you needed: money, clothes, goods)	1/3	2.6 (0.6)
LES24	Comforted by someone's interest in your well-being, caring, love	1/3	2.6 (0.6)
LES28	Obtained a degree or training certificate	2/3	2.5 (0.5)
LES43	Being respected, esteemed for your qualities and who you are	1/3	2.8 (0.5)

When life events negative and positive scores were added separately, positive scores were higher (M=28.11, SD=11.44, range 0 to 55) than negative scores (M=-15.44, SD=10.07, range -3 to 0). However, positive scores were distributed for the majority (44.4%) in the lower range 17 to 27, while negative scores were distributed mostly (55.6%) in the higher range -34 to -13. Surprisingly, positive LES scores were significantly and negatively correlated to four resources over five: Faith (r=-.611, p>0.05), Kin Connections (r=-.588, p>0.05), Self-Esteem (r=-.547, p>0.05), and Intelligence (r=-.505, p>0.05). Positive LES scores also significantly and positively correlated with age (r=.532, p>0.05). Both Positive and Negative LES scores were recoded into low (1), medium (2) and high values (2) based on the frequencies of scores. For Positive scores the range was 0-27 for low (44.4%), 28-34 (33.3%) for medium, and above 34 for high (22.2%). For negative scores, the range was -9 to 0 for low (38.9%), -13 to -23 for medium (33.3%), and -24 and above for high (38.9%) (see Table 4 and 5).

Table 4: Life Events Appraised as Negative

Life Event	Description	Score Range	M (SD)
LES18	Mourning a husband, partner or family member	-3 / -3	-3.0 (0)
LES20	Loss of abilities and competencies	-3 / -2	-3.0 (0)
LES27	Being homeless	-3 / -3	-2.8 (0.3)
LES31	Long illness, accident or disability of a family member	-3 / -3	- 3.0 (0)
LES36	Children in temporary foster care	-3 / -2	-3.0 (0)
LES42	Serious illness or disease	-3 / -3	-3 .0 (0)

LCU scores, on the other hand, were added to obtain an objective measure of stress, indicating low (LCU < 150), moderate (LCU between 140-299) and high (> =300) risk of illness. The majority of interviewed women showed high (83.3%) risk of illness, with only a few (5.6%) at low and moderate (11.1%) risk. LES scores, on the other hand, significantly and negatively correlated with coping flexibility (r=-.557, p> 0.01), faith (r=-.489, p> 0.01), and trauma focus (r=-.607, p> 0.01). LCU scores significantly and negatively correlated with autonomy (ie. having a job) (r=-.478, p>0.05), while LES scores did not. When a multiple regression analysis was run to predict the impact of life events scores (LES, positive + negative) from protective factors, resilience, positive and negat affect and coping flexibility, only the variable Coping Flexibility (F (11,6)=2.38, p=.048, R2=.565, $\eta 2p$ =1) added statistically significantly to the prediction, p < .05. When the multiple regression was ran to predict Positive and Negative Life Events scores separately from protective factors, resilience, positive and negative affect, and coping flexibility, only Negative Affect (F (10,7)=2.30, p=.049, R2=.606, $\eta 2p$ = .89) added statistically significantly to the prediction, p < .05 for Negative LES Scores while only Mindfulness (f(10,7)=4.52, p=.026, R2=760, $\eta 2p$ =. 41) added statistically significantly to the prediction, p < .05 for Positive LES scores.

Coping ability (r=-.539, p>0.05) and Coping Flexibility (r=-.528, p>0.05) significantly and negatively correlated with Life Events total score, while both significantly and positively correlated with Protective Factors total score (respectively r=691 and r=693, p>0.01). More specifically, Coping Flexibility scores significantly and positively correlated with Faith (r=.625, p>0.01). Both Coping flexibility and coping discrepancy significantly and positively correlated with Positive Affect (r=.519, p>0.05 and r=.500, p>0.05, $\eta 2p$ =.87). Moreover, Positive Affect scores were on average higher (M=32, SD=9.39, range 17-47) than scores for Negative Affect (M=26, SD=9.93, range 10-45). No significant correlation was found for Negative Affect with any of the variable of interest. Moreover, there was a significant difference between Positive and Negative Affects group means scores for negative LES scores, as determined by one-way ANOVA (F(15, 2)=49.80,p=.020).

Table 5: Life Events Appraised as Negative/Positive (mixed)

Life Event	Description	Score Range	M (SD)
LES1	Changes in sleeping habits	+3 / -3	-0.6 (2.7)
LES2	Reconciliation with partner/husband/lover	+3 / -3	1.44 (2.0)
LES3	Depending on others for survival	+3 / -3	-1.6 (2.6)
LES5	Divorce/separation		-2.9 (0.3)
LES7	Loss of self-esteem, identity, status quo, personal image	+3 / -3	-2.14 (2.2)
LES8	Changes in social life	+3 / -3	-0.6 (2.3)
LES9	New job or improvement in economic conditions	+3 / -3	0.83 (2.7)
LES10	Problems with family of origin	0 / -3	-1.5 (2.1)
LES12	Mourning of child or abortion	0	0
LES13	Important decision for the future	+3 / -3	1.75 (2.3)
LES21	Change in residency or house	+3 / -3	-0.19 (2.6)
LES25	Sharing with others a similar condition	+3 / -3	1.22 (2.00)
LES26	Learned something new	+3 / -3	2.25 (1.7)
LES29	Change of city or nation/country	+3 / -3	0.75 (2.1)
LES30	Change in eating habits (type, quantity, appetite)	+3 / -3	-0.36 (2.4)
LES32	End of a friendship for fights /arguments	+3/ -2	1.14 (2.3)
LES33	Change in religion or political party	0	0
LES34	Single mother growing children alone	+3 / -3	1.31 (2.2)
LES35	Lost, stolen, destroyed personal belongings or goods	+3/ -2	-0.80 (1.9)
LES37	Court Appearing (for children custody, divorce, maltreatment)	+3 / -3	-1.88 (2.1)
LES38	Lost a friend (for any reason including death, moving)	+3 / -3	-0.86 (2.1)
LES39	Found safe shelter for you and your children	+3 / -3	1.83 (1.8)
LES40	Unwanted pregnancy	-3 / -1	-1.67 (1.1)
LES41	Obtained important info on how to do what you wanted	+3 / -3	1.88 (2,1)

Results confirmed the H2 hypothesis that protective factors influence the impact of life events, although each factors in its own way. Coping flexibility, in fact, predicted the overall impact of life events (as a sum and balance of positive and negative scores), or stress level, while Negative Affect predicted negative life events scores and mindfulness predicted positive life events scores.

Protective factors are predictive of resilience levels in refugee women (H3)

Resilience scores did not correlate significantly with any variable of interest. When a multiple regression analysis was run to predict resilience scores

from protective factors (mindfulness, positive and negative affect and coping flexibility) only the variable Positive Affect (F (11,6)=1.36, p=.048, R2=.427, η2p =.87) added statistically significantly to the prediction, p < .05. Mindfulness scores (M=20.72, SD=29.93, range 16-84) were available only for 39% of the subjects and did not correlate with resilience scores nor Trauma or Forward Focus or any demographic variable (gender, age etc.), or treatment length and type variables. Results confirmed hypothesis H3 only partially. In fact, only one out of three protective factors, positive affect, was found to predict resilience level.

Resilience and the impact of life events influence each other reciprocally (H4)

No significant correlation was found between total life events scores and resilience. When a multiple regression analysis was run to predict resilience from life events stress scores (overall, negative, positive), only stress scores from Negative Events (F (3,9)=10.50, p=.001, R2=.882, η2p =.94) added statistically significantly to the prediction, p < .05. When a multiple regression analysis was run to predict life events stress scores (overall, negative, positive) from resilience, only stress scores from Negative Events (F (1,11)=31.19, p=.000, R2=.860, η2p =.38) added statistically significantly to the prediction, p < .05. Results confirmed a reciprocal influence between the impact of life events and resilience but only for negative life events.

Resilience predicts well-being and autonomy (H5)

As previously stated, no significant correlation was found between resilience and measures of autonomy and well-being, as provided by the shelter staff. When a multiple regression analysis was run to predict well-being and autonomy (treatment outcome, work autonomy, etc.) from resilience scores, none of the variable added statistically significantly to the prediction. Results did not confirm hypothesis H5.

Stress level and the impact of life events are strongly correlated (H6)

Stress level (LCU scores) significantly and positively correlated with overall life events scores (LES) (r=.832, p< .001), mixed live events scores (r=.760, p<.001) and positive life events scores (r=.665, p<.001), but not negative life events scores. When a multiple regression analysis was run to predict overall stress scores (LCU) from life events scores (overall, positive, negative, mixed), none of the variable added statistically significantly to the prediction. Results did confirm hypothesis H6.

Discussion

Drawing upon Ryan, Dooley, and Benson's (2008) resource-based model of migrant adaptation and the strength-based RERR approach (Gianesini, 2015), the current study explores refugee women's pre-migration individual, familial and community resources and protective factors by evaluating their contribution to resilience in the migration phase and their impact on migrants' adaptation and well-being in the post-migration phase. Specifically, this study investigates the impact of five individual, familial and community resources (intelligence, self-esteem, faith, kin connections and temperament), and three protective factors (coping flexibility, positive and negative affect, and mindfulness) on the resilience of refugee women, their wellbeing, autonomy and integration. It was hypothesized that in the Pre-Migration phase, individual, familial and community resources build resilience in refugee women (H1); protective factors strongly influence the impact of Life Events, both positive and negative (H2) and are predictive of resilience levels in refugee women (H3). In the Migration phase, a reciprocal influence between resilience and the impact of life events in refugee women (H4) was expected. Finally, in the Post-migration phase, resilience was hypothesized to strongly predict well-being and autonomy in refugee women (H5), and stress level (i.e. the impact of positive and negative life events) was hypothesized to be influenced by positive and negative affect (H6).

Results of this small sample pilot study confirmed that socioemotional resources at the individual, family and community level have a fundamental role in predicting the ability to flexibly cope with trauma and move forward. Faith, in particular, significantly predicted coping flexibility and a more positive evaluation of life events (positive LES scores) and was predicted by resources both at the individual (intelligence) and family level (kin connection). Moreover, protective factors (i.e. coping flexibility) significantly predicted the impact of life events (LES overall score), while Negative Affect predicted negative scores (LES negative) and Mindfulness predicted positive scores (LES positives). Positive affect also accounted for significant differences in the mean values of positive and negative life events and added statistically significantly to the prediction of resilience scores.

Exploitation, both for sex and for labor, and trafficking are developmental issues strongly affecting the wellbeing of victims (Kok, 2017). Research has shown that trafficked women have experienced high levels of physical, mental and sexual abuse, and that the longer duration of trafficking is linked to higher levels of mental distress and PSTD symptoms (Oram et al., 2012). This study, at multiple levels, demonstrated the benefits of a positive psychology approach to working with sexually exploited and trafficked refugee women. Results have evidenced important pre-migration resources at the individual, family and community level, rather than deficits

and pathologies, which can be used for a screening of vulnerable women in source countries and social and legal policies, together with key protective factors in the migration phase which can be targeted for emergency intervention. Despite being victims of multiple trauma, participants in this pilot study experienced many positive life events, and used their pre-migration resources, especially faith, as protective factors against the abuse. Positive affect was confirmed as an important protective factor and building block of coping flexibility and resilience, while negative affect favored a more negative appraisal of both positive and negative life events. Finally, considering the positive influence of mindfulness on life events, in the direction of a more positive appraisal, it may be worth including it as a treatment option among sexually exploited refugees.

This article focuses on the contributions of the strengths-based model to social work practice and proposes a new framework that can increase its effectiveness and expand its perspectives. In social work, there is a need for a theory that can contribute significantly to the construction of a framework for social work practice. This study has shown that resilience and mindfulness enhancement programs are very promising to apply the strengths perspective in social work with refugee women. This study has also demonstrated that people in vulnerable situations may have their own resources to resist oppression and exploitation which must be acknowledged by social workers to facilitate social justice.

Limitations

The limited number of subjects and the cross-sectional design of the research requires caution in the interpretation and generalization of results. Longitudinal research designs are critical for future research to clarify the association between religion, spirituality, and posttraumatic growth (Peres, Moreira-Almeida, Nasello & Koenig, 2007). Further larger studies are required to confirm these results. Moreover, the fact that no significant findings emerged concerning autonomy and well-being in the post-migration phase may be attributable to the small sample or to missing data and its secondary nature. Further analyses are in progress to differentiate the relevance of life events pertaining to different domains (individual, family or community). However, these findings are relevant to current controversies concerning the impact of policies on combating inequality and discrimination and managing diversity and multiculturalism.

Conclusion

Multiple factors such as war displacement, economic and social inequalities, and demand for sex workers contribute to trafficking of women,

primarily based on gender-based abuse and violence (Miller, Decker, Silverman & Raj, 2007). The trafficking of women stems to a large extent from the degraded status of women within source societies (Corrin, 2005) in the global South and East, where they suffer from exploitation and marginalization. This North-South and East-West divide is deeply connected to race, with the global North and West associated with wealth and whiteness, and the global South and East linked to poverty and non-whiteness. This perpetuates a global system of stratification where gender and ethnicity are correlated with health, income, and educational outcomes and influence human trafficking (Winant, 2004). In the case of refugee women, their dehumanization is intricately linked to sexist stereotypes promoting prostitution and other sexual exploitation (Corrin, 2005). Forced migration of women and trafficking for the purpose of sexual exploitation in Europe poses a large impact on society and leaves both psychological and physical marks on victims (Kok, 2017). Hughes (2000) noted that trafficking for the purpose of sexual exploitation is ultimately the result of family pressures and violence, economic deprivation, and conditions of inequalities for women and has to be considered a form of gender-based persecution (Gallagher, 2009). Country- specific policies and laws play a crucial role in regulating requirements for entry into the country, working conditions and legal status. Trafficking is primarily an offence against the person, and secondarily toward a state. Thus, both individual-oriented policies aimed at protecting the victims and policies aimed at controlling borders are needed (McClure, et al., 2008). As victims are transported across country borders, the waiving of EU visa requirements has led to an increase in women being trafficked to Western Europe. Similarly, legalization and regulation of prostitution in some European countries (Germany, Greece, and the Netherlands), has not proven to have worked or has had an adverse effect (Bosworth, Bowling, and Lee, 2008; Williamson, 2017). The exploitation of women needs to be severely punished with deterring convictions and penalties (Kok, 2017). However, proactive screening for possible victims is also needed (Kok, 2017) in the pre-migration state and in source countries.

To tackle the demand for sex workers, and thus to stop sex trafficking, the underlying causes of migration and victimization need to be addressed. A downfall of globalization seems to have been its success in perpetuating ethnic and gender stratification, greatly influencing trafficking (Williamson, 2017) and the construction of ideal victims and their perpetuation though media has had a negative impact on policy implementation (Wilson & O'Brien, 2016). To implement successful policies against human trafficking and the sexual exploitation of women, as well as any form of violent abuse toward women, policy makers should address the nature of power relations between women and men, and the resulting inequities of wealth, and enhance and respect women's social, economic and political rights.

This research demonstrated the need for positive psychology by integrating factors from resource-based and strength-based theory into a model which describes how refugee women successfully cope with multiple traumatic experiences using both resources and protective factors. By looking at multiple domains and utilizing multiple measures, these findings provided deep insight into the experiences of refugee women and proposed a culturally appropriate and sensitive response to their needs that can be used to develop more specific and successful advocacy programs and interventions for trafficked refugee women ❖

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Giovanna Gianeini, *Ph.D., Dept. Of Human Sciences, University of Verona, Via Cntanare, 24, Room 2.08, 37129 Verona, Italy. 045-802-8744. Giovanna.gianesini@univr.it*

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Multicultural Social Work Practice: A Competency-based Approach to Diversity and Social Justice

Derald Wing Sue, Mikal N. Rasheed and Janice M. Rasheed (2016). Hoboken, NJ: John Wiley & Sons.

Social workers are called to function within the values, ethics and standards of the profession with emphasis upon accommodations towards the needs of diverse clients. Social workers should seek to understand their own personal and cultural beliefs in directions towards understanding the identities of the people they serve. Acquiring cross cultural knowledge and skills is a lifelong process in understanding the history and traditions of client groups that are served along with utilizing appropriate approaches and techniques that will reflect the workers' role in the helping process (NASW, 2017).

Multicultural Social Work Practice is relevant to the social worker's role in acquiring cultural competence. An overarching strength of this book is that it is applicable in teaching cultural competence in a Council on Social Work Education (CSWE)-accredited social work program. It is highly recommended for all faculty as multicultural social work practice should be embedded in each and every course and field experience.

Competency number two from the 2015 Educational Policy and Accreditation Standards (EPAS) prescribed by CSWE requires social workers to be competent and engage diversity and difference in practice. The authors provide an extensive introduction to implications of cultural diversity through voices of individuals who have faced oppression.

The authors continue an overview of multicultural social work with a theoretical foundation based upon the profession's focus of the strengths perspective, ecological systems, social justice, and antiracism as a social work agenda. Chapter three introduces four components of cultural competence for social workers, starting with an initial step of becoming aware of one's own values, biases, and assumptions about human behavior. The additional steps cover the adaption of understanding worldviews of diverse clients, developing appropriate interventions and understanding the organizational and institutional foci that can either enhance or diminish cultural competence. Social workers are called to acquire "awareness, knowledge and skills needed to function effectively in a pluralistic democratic society" (p. 67). A model for multidimensional attention upon cultural competence is introduced with three dimensions that cover race and culture, the components referenced above of awareness, knowledge and skills, and lastly, the focus of cultural competence through society, organizations, professionalism and individualism.

Part II introduces the reader to systemic oppression and social justice through an understanding of sociopolitical implications and microaggressions. Part III looks specifically at racial minorities and white racial identity development. In both chapters, stories are used to apply models and portray the implications with actual examples.

Part IV addresses the practice dimensions of multicultural social work as it applies to barriers, intervention strategies, family interventions, religion and spirituality, antiracist practice, and evidenced-based practice. The chapters contained in this part address the multicultural skills needed in counseling, clinical practice and the relevance of self-disclosure. Case examples continue through this section, targeting simplistic barriers that arise due in part to differences in communication styles. A table (p. 261) exemplifies the differences that are often found in communication patterns with Native Americans, Asian Americans, Whites, and African Americans. A case study in the chapter on organizational perspectives is broken down into seven lessons that reveal failures that often happen when a cultural perspective is not deployed.

The book closes with profiles of diverse populations, specifically addressing skills needed in working with African Americans, Asian Americans, Native Americans, Hispanics, immigrants and refugees, biracial individuals, women, persons who are LGBTQ, older adults, and persons with disabilities.

The book will empower readers to demonstrate critical thinking in order to gain multicultural social work skills. This publication will most likely lead to practice behaviors that develop competencies in multiculturalism.

The authors used creditable sources for providing a wide array of examples in understanding how multiculturalism impacts clients and their lives in numerous settings. They provide applicable sources at the end of each chapter, helpful tools for the student to acquire further knowledge on current multiculturalism practices.

The authors do not make specific reference to the Christian faith, however, there is no indication that the book could not be used in a Christian-based setting. The principles of social justice, empowerment, and strengths are included in the reading aligning with the Christian values of truth.

This publication will be helpful to students in grasping the need for cultural competence and promote a desire to acquire a skill set that can be applied to multiculturalism. ❖

Reviewed by ***Carla J. MacDonald,*** *Ed.D., Social Work Program Director, Associate Professor of Social Work, Huntington University, Huntington, IN. Email: cmacdonald@huntingotn.edu. Fidel Götz Foundation, pdankova@mailbox.org.*

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Spirituality Matters in Social Work: Connecting Spirituality, Religion, and Practice

James R. Dudley (2015).
New York: Routledge

In spring 2018, Rachel Gillespie was an MSW/MDiv student enrolled in a Spirituality in Social Work Practice course at Baylor University, taught by Dr. Holly Oxhandler. Jim Dudley's (2015) *Spirituality Matters in Social Work: Connecting Spirituality, Religion, and Practice* was the primary textbook used alongside two additional texts, as well as a variety of chapters, articles, and other media. The following review offers a side-by-side student/professor perspective that we hope serves those considering this book for their class or in their own professional development.

A Student's Perspective

Dudley's (2015) *Spirituality Matters in Social Work* is a strong addition to social work education, calling the profession not to overlook or undervalue the spirituality of clients when preparing practitioners. He begins by untangling the strands of spirituality and religion, and defines spirituality as a, "search for purpose and meaning in life, a sense of being connected with self, others, and the universe, and an ability to transcend our immediate experience to something larger known by many to be a Higher Power beyond human power" (p. 4). He writes that some of the manifestations of spirituality for our clients and for ourselves include pursuing hope, embracing love, experiencing wonder, and an openness to mystery. A unique element to this text is that Dudley challenges the reader to inspect one's own spirituality as a tool of connecting to clients and to the divine in ourselves. This was the greatest lesson for me as a student in the social work profession.

Throughout the text, Dudley consistently practices cultural competency and humility by including and honoring numerous faith traditions. Although he writes briefly (one chapter) about specific religious and spiritual groups, his summaries are fair and nuanced enough to help the reader have a foundational starting point for working with anyone they might encounter who practices a different faith tradition than themselves. Many social work practitioners might have questions about integrating spirituality into their practice based on ethical concerns. Dudley writes an

excellent chapter highlighting many of the arguments and points around controversies in religious beliefs and social work standards. For me, this was the most rich and challenging chapter, and it is written with grace and truth.

He does a thorough job at providing social work practitioners with spiritual assessment tools, including a discussion on implicit and explicit assessments, across various client populations. His book is interactive, and he challenges the reader with discussion questions and exercises at the end of each chapter. In a couple of chapters, he discusses "spiritual interventions," and I might advocate for a change to "spiritual disciplines" because as a seminary graduate, I don't believe that any of the practices he offers can be correctly labeled intervention. When social work practitioners use the word "intervention", it comes with a connotation that it will fix or change something, and the practices that he describes such as mindfulness, meditation, prayer, and guided imagery really serve as disciplines for reflection and connection with the divine. He also discusses macro spiritual interventions, and at the outset I was very intrigued by this chapter, but I felt that it fell short of my expectations. As an MSW student interested in community practice, I hoped to find some sort of model for intervening on a macro-level for communities. However, the emphasis was on human service agencies and their spiritually-sensitive practice as well as social service practitioners' interface with congregations and faith leaders in the community. I did, however, resonate with his discussion of how faith often leads practitioners into the practice of social work. Dudley also links faith with many social movements, such as the Civil Rights Movement, and social justice advocates who are motivated by their spirituality.

Overall, Dudley's book added to my knowledge and skill base as a social work student. As a seminary graduate, his work encompassed many of the values and strengths of faith leaders and their desire to connect with their congregants and their communities. This work challenged me to see the value in connecting with my own Higher Power as a way of connecting with my clients.

A Professor's Perspective

After reviewing many textbooks and articles across disciplines for a new, cross-listed BSW/MSW course on Spirituality in Social Work Practice, and receiving feedback from a few students, I selected Dudley's (2015) *Spirituality Matters in Social Work* this semester. Our social work program has a tenth competency on the ethical integration of faith and social work practice, and though content is infused throughout the curriculum, this course created a weekly space for students to dive deeply into the complexity of religion/spirituality (RS) in social work practice. Dudley's text complemented the course objectives beautifully, which included understanding:

1) RS within and across cultural boundaries, and across the lifespan; 2) emerging research surrounding the relationship between RS and physical/mental health (including positive and negative religious coping and client preferences); 3) effective and ethically appropriate methods for assessing and integrating clients' RS beliefs and practices (and related challenges); and 4) the connection between RS and professional self-care.

I appreciated Dudley's ability to address complex elements of RS in social work in a way that students could understand, while offering numerous resources to learn more. Some of these elements included RS diversity, ethics of RS in practice, RS assessments, research on RS in social work and its connection to the evidence-based practice process, RS in clinical and community-based interventions, and infusing RS into existing social work approaches. I used all of the chapters and pulled from interdisciplinary research articles, podcasts, guest speakers, or videos to bolster each week's topic and areas for discussion.

Most noteworthy was how well Dudley emphasized that the reader deeply recognize his/her own RS beliefs and practices. This has been a primary research interest of mine and dovetails seamlessly with the quantitative grounded theory, Namaste Theory (Oxhandler, 2017), which proposes that as practitioners deeply recognize their RS beliefs and practices and how they're infused in their daily lives, they tend to recognize the role of RS in clients' lives. Dudley's emphasis on recognizing the reader's own RS beliefs and practices is further corroborated by a recent national survey of LCSWs which indicated that intrinsic religiosity was the top predictor of their attitudes, self-efficacy, perceived feasibility, and frequency of behaviors, with previous training the only other predictor (Oxhandler, Parrish, Torres, & Achenbaum, 2015).

My only critique would be an echo of what Rachel mentioned around the terminology used in chapter 9. Though the spiritual practices described can be easily woven into empirically-supported treatments, I would caution others to not consider them "spiritual interventions." I would also suggest that future editions include more attention to the role of spiritual struggles in chapter 11, given that while spirituality can be a source of support, it can also be a source of struggle and involve negative religious coping for some clients.

Whether you are an instructor teaching a course on spirituality and social work, a current student, or a seasoned practitioner in social work or a related helping profession, I would highly recommend this textbook. It is a fantastic addition to our profession's resources, particularly for this complex area of practice. ❖

*Reviewed by **Rachel Gillespie,** MSW/MDiv student at the Diana R. Garland School of Social Work and George W. Truett Theological Seminary,*

Baylor University; and ***Holly K. Oxhandler*** *Assistant Professor and Associate Dean for Research and Faculty Development, Diana R. Garland School of Social Work, Baylor University.*
Email: holly_oxhandler@baylor.edu.

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Cheap Sex: The Transformation of Men, Marriage, and Monogamy

Mark Regnerus. (2017).
New York: Oxford University Press.

The theoretical content for the book Cheap Sex is based on data from three large nationally representative surveys and in-person interviews. The subjects were heterosexual Americans between the ages of 24 and 32, residing in metropolitan areas. Cheap sex is also referred to as "industrial sex" because of its correlation to two technologies: the pill and high-quality pornography. Regnerus argues that these technologies, more reflective of men's interests than women's, has taken a toll on marriageability. Men are more drawn to powerful physical pleasures while women are more drawn to desirability, affirmation and relationship commitment. Normally, the two are unitary and complimentary. However, with high quality pornography, masturbation, and birth control, the idea of parenting is further removed and therefore loosens the need for relational ties. The former is cheap while the latter is costly.

Bottom line, with cheap sex men don't have to pursue an intimate relationship and women are left hanging. So, women desperately seek affirmation in other ways. For example, women are showing up in record proportions, outnumbering men, in the workforce and in academia. Meanwhile, cheap sex undermines men's motivation. Marriage is costly in terms of fidelity, time, finances, and personal investment. Cheap sex is much more affordable, but not sustainable. Regnerus predicts by 2030 age of consent laws will likely be less enforced, the age of first marriages will rise, numbers of unmarried Americans will rise, and sexuality will become more malleable.

While looking at other sources, my attention was drawn to Professor Sedlacek, a social work educator at Andrews University, who found that only about 10% of the students informally surveyed in his Human Sexuality courses received solid instruction about the topic of sexuality from their parents. The rest learned about it in a class, from their peers, from reading books, or by trial and error (Sedlacek, n.d.). I also reviewed a study conducted by Planned Parenthood revealing that only 43% of parents said they feel comfortable talking with their children about sex (Planned Parenthood, 2014). The underlying message I perceived is that the ethos of sexuality is largely derived from vogue culture rather than parental underpinning.

In my opinion, the current cultural ethos of cheap sex is in direct opposition to Christendom. However, if we embrace a Christian understanding of sex, a new ethos transforms. In Christendom, there is a strong belief that the body is not meant for sexual immorality, but for Christ (1 Corinthians 6:13). Marriage, and by extension, the true intimacy that accompanies it, is more like Christ. "For it is said, 'The two will become one flesh'…whoever is united with the Lord is one with him in spirit" (1 Corinthians 6:17).

For every 100 women who said they wished to be married, only 82 men said the same. However, Regnerus found that once men are married they buy into the institution and want to stick with it. On the other hand, women tend to be very energized into entering marriage, but then after they marry they may want out. Therefore, micro Christian social work practice could focus pre-marital work with men on issues related to marriage disillusionment, and with women, marriage sustainability. In addition, macro Christian social work practice could address the cultural ethos to help guide discussions and strategies aligned with a scriptural understanding of sexuality, abstinence and sexual purity, marriage and family, monogamy, and immorality. Research has shown that teens exposed to abstinence-only interventions can be successful, but research also shows that these individuals, when married, need ongoing intervention in order to maintain stability and monogamy.

This book is highly dedicated to theorizing a cultural concept derived from data, but not largely on giving practical solutions. Regnerus does suggest that, rather than subjugate to men's interests, women become more in charge of how their relationships transpire. With being in charge of the "pricing" negotiations around sex, so to speak, the price of sex will be higher. I find this notion intriguing, and it begs for elaboration, but yet is not given. How can we best add value and worth to fidelity, time, finances, and personal investment needed to sustain relationships and reduce the need for cheap sex? A follow up volume, one that focuses on how to raise the stakes, from both secular and Christian perspectives, would be worthwhile. ❖

Reviewed by James E. Phelan, MSW, Psy.D., program coordinator at the Veterans Health Administration and field practicum instructor for The Ohio State University, 420 N. James Road, Columbus, OH 43219. Webpage: https://va-gov.academia.edu/JamesPhelan. E-mail: james.phelan@va.gov

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May 7, 2018

Dear Editor, *Social Work & Christianity,*

I read with much interest a recent issue of *Social Work & Christianity* regarding LGBTQ topics, with one article in particular:

Dessel, A. B., Jacobsen, J., Levy, D. L., McCarty-Caplan, D., Lewis, T.O., & Kaplan, L. E. (2017). LGBTQ topics and Christianity in social work: Tackling the tough questions. *Social Work & Christianity, 44*(1-2), 11-30.

Dr. David Sherwood, former editor of Social Work & Christianity, once said that it was a professional's responsibility to respect a client's values and goals "…[by] making a professional referral if the nature of the situation creat[ed] unresolvable dilemma…" (Sherwood, 1993, p. 91). This was discussed in the context of Christian social workers who felt they would be ineffective in providing some services because of their inability to reconcile their religious beliefs around certain homosexual expressions (e.g. providing counseling to same-sex couples). But, I'm certain this could apply to other contemporary issues, such as in the case where a client might want assistance with getting an abortion. Sherwood also made the point that "In some quarters, affirmation or acceptance of gay and lesbian persons can only mean one thing – unqualified endorsement of homosexuality and homosexual behavior on all (emphasis added) dimensions. Period" (p. 90).

In the article by Dessel et al (2017), I understand and respect their concern about potential harms to LGBTQ individuals. I also agree that social workers should work to increase competencies for understanding the various needs of LGBTQ individuals. My concern is similar to Sherwood's, and in this case where the authors assert that, "If a referral occurs because a social worker's value system does not affirm (emphasis added) LGBTQ clients, this could be considered a discriminatory (emphasis added) act" (p. 18). My view differs because I do not consider a referral necessarily a negative action, but as Sherwood asserted, a respect to clients' values and goals. In other words, when a social worker and client are unable to reconcile value incongruence, then, in some cases, a referral is appropriate. I don't feel that social work service delivery is limitless. In other words, I feel social workers are obligated to respect those situations where they are unable to reconcile their religious beliefs around certain expressions, coming to terms with the fact that they can do more disservice than good.

I respect the authors' advocacy to protect clients' rights to self-determination. However, where they assert, "If a client requests… reparative or

conversion therapy…the social worker should not provide this therapy or refer to others who offer [it]" (p. 21), and that the reasons to refuse treatment accompany only information about its lack of effectiveness and risk of harm, is contrary to my understanding of self-determination. I believe that client self-determination applies to all clients, including clients who welcome reparative therapy. In addition, to allow clients the full ability to make their own decisions, I believe they should have all the information. For example, where the authors listed selected support networks such as DignityUSA and the Metropolitan Community Church, I would respectfully ask them to consider adding other ecclesiastical resources to the list, such as support networks endorsed by Restored Hope Network, for example.

In terms of "reparative" therapy also referred to as "conversion" therapy, I appreciate the authors' efforts to find a compass to inform their conversation. They assert that what informed them about the harms and lack of efficacy of reparative-based interventions were derived from a report by the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts (SOCE) (2009). To enhance this conversation, I would add the fact that the Task Force concluded that they were not able to say if SOCE was effective or harmful or not based on the research they reviewed. In addition, Lee Beckstead, a principal member, later admitted that the entire authorship was biased and ideologically opposed to SOCE, and, as such, did a great disservice to readers by blocking inclusion of reparative therapy proponents (Beckstead et al., 2017).

I respect the authors' concern that SOCE have been repudiated by the major membership-based mental health guilds (e.g. APA, NASW, etc.). In addressing this concern, I would add that, while those organizations are well-meaning and provide many good community services (I am a member of some of them), they do not regulate social work licensees nor dictate how therapeutic methods should be applied. For the states and cities that have prohibited licensed mental health professionals from practicing conversion therapy, they do not prohibit people from seeking help in other non-clinical ecclesiastical formats.

While I understand and respect the fact that the authors' ideas are diametrically opposed to those of SOCE, I would respectfully ask them to consider others' views, ideas, and faith convictions. For example, they should understand that some Christian social workers and clients may not agree with all the ideologies of non-regulatory guilds. It is my opinion that Christian social workers are better servants to faith-based clients when they provide them with all the facts and let them think for themselves, allowing them the opportunity to make choices that best fits their values and belief systems.

In closing, I would like to thank the authors for their efforts to "tackle the tough questions" related to "LGBTQ topics and Christianity in social

work," and in allowing me the opportunity and grace to be a part of this important conversation relevant to Christian social workers.

Respectfully,
James E. Phelan

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James E. Phelan, *LCSW, BCD, Psy.D, clinical social worker, field instructor Ohio State University, member NACSW. e mail jpmphelan@sbcglobal.net*

August 19, 2018

Dear Editor,

We appreciate the opportunity to respond to Phelan's letter to the editor of *Social Work & Christianity.* To preface our response, we would like to acknowledge the merits of engaging in dialogue about tough questions and difficult topics. Indeed, this is why we and our colleagues originally wrote an article about LGBTQ topics and Christianity for publication in *Social Work & Christianity* (Dessel et al., 2017). Still, we want to be clear that by engaging in conversation about these topics, we hold fast to the profession's stance on Sexual Orientation Changes Efforts (SOCE). As mentioned by Phelan, the APA Task Force on Appropriate Therapeutic Response to SOCE (2009), did not state there were no potential benefits to SOCE. It stated that research on this topic (from 1960 to 2007, with most studies conducted prior to 1981) had significant methodological issues and showed sufficient evidence of harm. Beckstead has attempted to work across faith

differences in his more recent work within the Reconciliation and Growth Project. In moving beyond the polarizing terms of SOCE, conversion therapy, or reparative therapy, this collaboration of mental health workers agrees: “We believe it is unethical to focus treatment upon the assumption that a change in sexual attractions or gender identity will or should occur” (Reconciliation and Growth Project, 2017, p. 10). As we continue to engage in dialogue around LGBTQ topics and Christianity, we reiterate that SOCE are not appropriate treatment modalities and refer back to our original article for further information about providing or referring clients to organizations who focus on SOCE (Dessel et al., 2017).

We do appreciate the opportunity to discuss other points made in response to our article. In the spirit of the guidelines provided by *Social Work & Christianity,* we want to approach this response with humility and with intent to understand. We appreciate and respect multiple views and faith convictions and recognize that some Christians in social work may struggle, or experience distress, due to incongruence between their religious beliefs and values and those of their clients.

We want to clarify that when we discuss affirming clients’ sexual orientation, we refer to affirming the dignity and worth of individuals without conditions, treating clients holistically, and considering all aspects of clients’ identities. Social workers practice unconditional positive regard, which we believe aligns with the Christian values to love and to not judge. These are values that can support the therapeutic process. We acknowledge the difficulties faced by the social worker who holds sincere and deep beliefs. Providing affirming therapy means affirming the sexual orientation and the religious convictions of the client, not the social worker. One of our greatest concerns when thinking about social workers who are struggling with LGBTQ topics and their own religious beliefs is that the social worker’s issues are playing out with, and/or taking precedence over, the client. Social work, especially clinical social work, should focus on the client, not the social worker.

We acknowledge that making a referral when not able to best serve a client may be the most appropriate action in an immediate situation; however, choosing to use referral as the default response for a particular population without efforts to become competent does not consider the well-being of the client and does not align with the National Associate of Social Workers (NASW) Code of Ethics. Referral may, in fact, cause great harm.

Stepping into vulnerability I (Jeanna) will share my personal experience. In my 20s, I struggled deeply with my religious beliefs and sexuality. I sought services from an LCSW who practiced in a religiously-based social service agency. After meeting with her for several sessions and pouring out my heart about the conflict I felt, with all the love and compassion in her heart, she stated, “I do not think I can help you with where I think you want to

go. You might be better served by seeing another therapist." I knew that this social worker had the best intentions. I felt the kindness in the referral she recommended. And still the implicit message that I heard was: "Here is one more piece of evidence that I will never be accepted and there is no place for me in this religion." I left counseling and did not return until after a near suicide attempt.

This is one anecdotal story and cannot be generalized, but it does demonstrate the harm that can be done. At this time, we have been unable to find scholarly research examining the effects of referral on a client. While the profession has been discussing the ethics of referral in the abstract (including the 1993 article cited by Phelan and numerous, more recent scholarly works), no researcher has yet studied the client experience in depth. We invite our colleagues to fill this gap.

The Code of Ethics states that social workers should refer clients when "other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe they are not being effective or making reasonable progress with clients" (NASW, 2017, p. 17), not when the social worker's values differ from the client's values. If social workers were to refer clients due to their own value conflicts, what would this mean for the profession of social work? For social workers who work alone in rural communities? For emergency social workers? Would social workers only have the duty to serve clients who hold values that align with their own? In sum, referral should be about the client, not about the social worker. A social worker holds a responsibility to provide the space in which a client can do the difficult therapeutic work required.

In his letter, Phelan shared his thoughts about the roles of membership-based guilds, including NASW. While NASW may not regulate licensure, they do represent the profession and publish the profession's Code of Ethics. The Council on Social Work Education (CSWE, 2015), which accredits social work programs, clearly establishes required competencies expected of all social workers, including recognizing "personal values and the distinction between personal and professional values" (p. 7) and engaging in diversity and difference. Social workers are committed to working at the margins of oppression and at the struggles of the intersections. If a social worker finds one-self trying to distance from the values and stated purpose of the profession, then we believe it is appropriate to ask whether this it the right profession for them. This does not mean that this individual does not have worthy skills and knowledge to provide in another helping profession or that this individual is unable to continue to develop professionally into a competent social worker. In fact, we believe that engaging in this type of critical reflection can lead to professional development and ensure competent social work practice. Moving forward as a profession, we must

ask ourselves: What does it mean to be a social worker? This is much like asking: What does it mean to be a Christian? Christianity encompasses different denominations and variations of belief, holding space for diversity while being grounded in common foundational principles. Likewise, our hope is that social work as a profession welcomes those with diverse religious beliefs, and also remains committed to core values of the profession which include: service, social justice, the dignity and worth of the person, the importance of human relationships, integrity, and competence, in addition to human rights, and scientific inquiry (CSWE, 2015).

We thank *Social Work & Christianity* for providing us with the opportunity to respond to this letter to the Editor. We hope to continue this dialogue with the broader social work community and encourage others to thoughtfully reflect on these topics and join our discussions.

Respectfully,
Jeanna M. Jacobsen & Denise L. Levy

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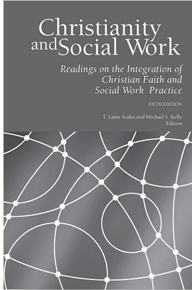
Jeanna M. Jacobsen, *Ph.D. LCSW. Social Work Assessment Coordinator, Barbara Solomon School of Social Work and Human Services, Walden University, 100 Washington Ave., Suite 900, Minneapolis, MN 55401 e mail. jeanna.jacobsen@mail.waldenu.edu*

Denise L. Levy, *Ph.D., Associate Professor of Social Work and Associate Dean for Academic Support in the Beaver College of Health Sciences at Appalachian State University, Box 32170, Boone, NC 28608 e mail. levydl@appstate.edu.*

PUBLICATIONS AVAILABLE FROM NACSW

Christianity and Social Work: Readings on the Integration of Christian Faith & Social Work Practice (Fifth Edition)

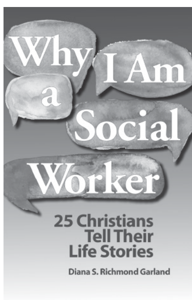
T. Laine Scales and Michael S. Kelly(Editors). (2016). Botsford, CT: NACSW. $55.00 U.S., $42.99 for NACSW members or orders of 10 or more copies. For price in Canadian dollars, use current exchange rate.



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:

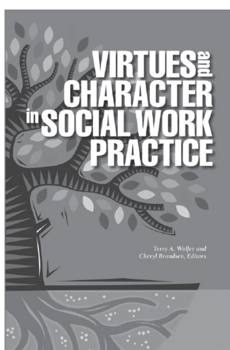
- How do social workers describe the relationship of their faith and their work?
- What is their daily work-life like, with its challenges, frustrations, joys and triumphs?
- What was their path into social work, and more particularly, the kind of social work they chose?
- What roles do their religious 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.

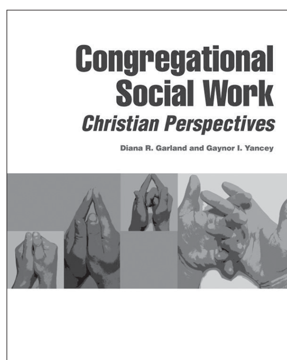


Virtues and Character in Social Work Practice offers a fresh contribution to the Christian social work literature with its emphasis on the key role of character traits and virtues in equipping Christians in social work to engage with and serve their clients and communities well.

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

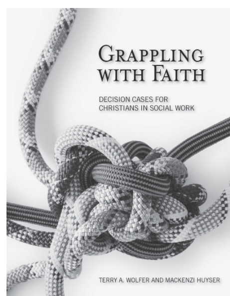
Diana Garland and Gaynor Yancey. (2014). Botsford, CT: NACSW. $39.95 U.S., $31.95 for NACSW members or orders of 10 or more copies). For price in Canadian dollars, use current exchange rate.



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

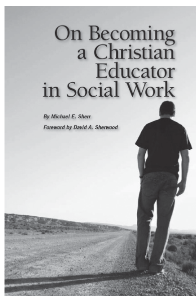
Terry A. Wolfer and Mackenzi Huyser. (2010). $23.75 ($18.99 for NACSW members or for orders of 10 or more). For price in Canadian dollars, use current exchange rate.



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.

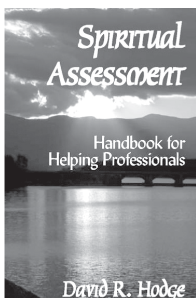


On Becoming a Christian Educator is a compelling invitation for social workers of faith in higher education to explore what it means to be a Christian in social work education. By highlighting seven core commitments of Christian social work educators, it offers strategies for social work educators to 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

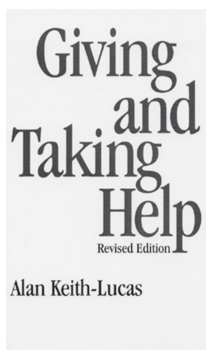
David Hodge. (2003). Botsford CT: NACSW. $20.00 U.S. ($16.00 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.

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)

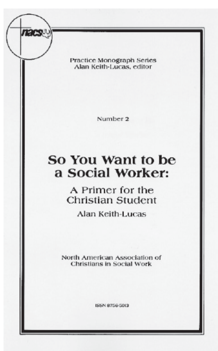
Alan Keith-Lucas. (1994). Botsford CT: North American Association of Christians in Social Work. $20.75 U.S. ($16.50 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.



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.

To Order Publications:

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.