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STATEMENT OF PURPOSE

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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Social Work, Christianity, and Addictions: Relationships with God, Others, and Ourselves

The person struggling with addiction experiences a culmination of intense feelings of alienation, apartness, emptiness, powerlessness and lack of purpose in life. Moral values are often compromised in the erratic acting out of addictive behaviors, urges, cognitions, and motivations (Rotgers, Morgenstern, & Walters, 2005). Knowledge about self and conviction about personal goals appear to fade and become confused as the addiction progresses. Despair leads to more use. Alcohol, drugs, sex, food, or other destructive behaviors serve as a quick "fix." However, this temporary fix only leads to greater emotional and spiritual distress, and the cycle continues until the hand of hope is offered and accepted.

Inherently, Christians in social work should be offering this hope, however, historically that has not always been the case. Religious institutions, specifically Protestant-affiliated, have viewed gambling, alcohol, and drug use as sinful and immoral (Van Wormer & Davis, 2008). Addiction has been conceptualized as a sign of weak character, a personality disorder, or a habitual series of bad personal choices (Bisaga, 2018). This is easy to understand. Many persons with an addiction disorder may fail to carry out normal role functions. Persons challenged by addiction may lie, cheat, steal, hurt those they love and hurt themselves in a seemingly senseless behavioral cycle. Observing these behaviors, one can understand why addiction disorders have been stigmatized and considered a sin.

The sin model emphasizes moral culpability and personal responsibility, while recognizing God's holiness, man's fallen nature, and the need for justice, grace, and redemption. From this viewpoint, addiction involves the willful decision to disobey God, escalating behavioral issues, a growing preoccupation with the focus of the addiction and, ultimately, spiritual bankruptcy and bondage to an idol.

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In contrast to the sin model, the disease model suggests that addiction involves a biological illness characterized by physical and psychological dependence, preoccupation with a behavior, and loss of control. Proponents of the disease model assert that addiction is less about choice and more about a biologically-mediated propensity for the disease of addiction. The environmental model purports that a lack of healthy coping strategies in the face of serious life stressors leads persons to unhealthy coping through behaviors that dull the emotional pain. The diathesis-stress model recognizes the intersection of a genetic or biological predisposition that is activated by a self-medicating approach to life stressors resulting in addiction that impacts body, mind and spirit. The Big Book of Alcoholics Anonymous (1998), describes alcoholism as a biologically mediated allergic reaction to alcohol, with some individuals demonstrating this allergic reaction and others experiencing relative immunity. It also speaks of persons addicted to alcohol having a disease of the body, mind, and spirit. Generally, the disease model is embraced by the medical profession (American Medical Association), while the recovery (12-step) communities follow the social work lead of a person-in-environment, diathesis-stress model. All models emphasize the need for treatment and support, while recognizing the biological basis for destructive behaviors and affirming loss of control as the hallmark of addiction. From our viewpoint, the notion of a biological and spiritual disease is not necessarily incompatible with the sin model – although there are conceptual differences between the two camps. The two camps differ on their points of emphasis and their view of wise intervention and healing.

Interestingly, research suggests that the utilization of spirituality in the treatment setting is often ignored, while simultaneously suggesting that numerous positive outcomes stem from the integration of spirituality in treatment processes (Oxhandler & Ellor, 2017; Oxhandler & Giardina, 2017). The discussion of spiritual matters in the United States is frequently complicated by the fact that the words religion and spirituality are commonly but incorrectly used interchangeably (Doweiko, 2006). To understand better the difference, one may view religion as the form or structure, whereas spirituality is the content of one's personal belief (Miller, 2003). This distinction makes it possible to understand how a social worker can assist a client in exploring their spiritual world without advocating for any specific religious group or doctrine.

The spiritual emphasis in addiction treatment has its roots intertwined with the development of recovery and Alcoholics Anonymous (Ringwald, 2003). Bill Wilson and Dr. Bob, founders of AA, adopted the principles for their movement from membership of the Oxford Group, an evangelical Protestant organization. The notions of powerlessness, seeking divine guidance, making confession and restitution, and carrying the message to

others were among the concepts borrowed. Whether thought of as God or as the vitality resulting from communing with others, spirituality can inspire and sustain people to move through the life-changing process of recovery. Many people in substance use treatment are dispirited. Beliefs and experiences that connect them to others and challenge discouragement can be thought of as spiritual (Rotgers, Morgenstern, & Walters, 2005).

Yet much traditional social work education includes only the basics of addiction and treatment, leaving many professional helpers ill-equipped to treat persons with addictive disorders. It is in this vein that *Social Work & Christianity*, the NACSW journal, provides this special issue focusing on addiction. This issue supports a combination of more narrative personal insight approaches while integrating traditional scientific method research. The topic of addiction is broad-based; therefore, authors were invited to submit a wide array of articles, including personal and professional insights on the nature of addiction and treatment interventions, providing readers with practical techniques that could be incorporated into social work practice. This issue further sought exploration of one's Christian faith in navigating the ethical implications of expanding the client's spiritual formation and incorporating personal faith into addiction treatment. In compiling the articles for this special issue, we reviewed a broad spectrum of possible topics. While difficult to narrow the submissions, we selected articles that touched on a variety of areas, including personal reflection as a professional in recovery and student supervision in managing faith in addiction practice. In addition, special attention is given to issues surrounding women in treatment. Specifically, a faith-based intervention program geared toward incarcerated women is introduced along with an exploration of faith in African American women. Ethical and spiritual implications in treating mothers and babies in medically assisted opioid recovery is further explored.

Our hope is that the voices represented in these pages will challenge us to explore our call as Christians in social work when working with persons struggling with addiction, while providing tangible techniques surrounding spirituality and faith. Our prayer is that this special issue provides both information, faith integration, and innovation in the treatment of addiction. ❖

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An Examination of the Relationship Between Religious Beliefs, Behaviors, Commitment, and Connection and Addiction Among African American Women

Sha-Lai L. Williams Woodson, Joseph G. Pickard, & Sharon D. Johnson

This study examines the religious/spiritual practices of 106 African American women when addiction is present. Stratified sampling was based on addiction status: no addiction (n=58); addiction to one of either alcohol, marijuana, or cocaine (n=22); and addiction to two or more of the substances (n=26). Using items from the Religiosity Scale to assess belief in God, religious behaviors, commitment and connection, analyses revealed that most of the women (84%) believe that God exists and is active in their lives. However, not all demonstrated formal religious behaviors or have a commitment or connection to religious activities. Women addicted to two or more substances were more likely to report religious behaviors, commitment, and connection such as regular personal religious-based reading/studying and having a feeling of religious commitment compared to women with no or only one addiction. Women with co-occurring addictions may utilize religious-based practices in an attempt to alleviate their emotional pain. Further exploration of religious/spiritual practices and co-morbid substance addiction is needed, as this research may be vital to implementing effective interventions with this population.

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Substance use disorders (SUD) continue to be a growing problem among people aged 12 or older in the United States. Approximately 20.1 million individuals experienced SUD in 2016 (Substance Abuse and Mental Health Services Administration, 2017) and nearly 10% of adults develop non-alcohol drug use in their lifetime (McCabe, West, Jutkiewicz, & Boyd, 2017). Although African Americans have significantly lower rates of SUD compared to Whites (Krentzman, Farkas, & Townsend, 2010), they have been cited as using more dangerous drugs (Curtis-Boles & Jenkins-Monroe, 2000) and are more likely to be polysubstance users (use of multiple illicit substances at the same time) (Krentzman et al., 2010; McCabe et al., 2017). In addition, African Americans tend to have the highest rate of emergencies related to drug use (Curtis-Boles & Jenkins-Monroe, 2000), a higher likelihood of alcohol-related problems such as liver cirrhosis and mortality, and higher rates of legal problems related to drinking (Zapolski, Pedersen, McCarthy, & Smith, 2014) compared to Whites.

Of particular concern is the fact that, over a 10 year period, the rates for illicit substance use among African American women increased and were higher than that of the national average (6.2% versus 5.7%, respectively) (Stevens-Watkins, Perry, Harp, & Oser, 2012). Once they start drinking, African American women are at higher risk for alcohol dependence at all levels of heavy drinking compared to White women (Witbrodt, Mulia, Zemore, & Kerr, 2014) and they have also been found to engage in heavy drinking for longer periods within their lifetime, relative to Whites (Schmidt, Greenfield, & Mulia, 2006). Moreover, African American women have alcohol-related deaths at rates that are two to four times higher than those of White women (Curtis-Boles & Jenkins-Monroe, 2000), indicating that along with an increase in problematic use, the consequences tend to be more severe for women of color. Despite strong indications that alcohol use among African American women is increasing, and persists across their lifetime, there is limited research that specifically explores substance use among this population (Stevens-Watkins et al., 2012).

This paucity of literature warrants additional investigation of possible determinants, as well as potential interventions, which may be related to substance use among African American women. Current research indicates that several factors may contribute to increased rates of substance use among African American women, including experiences of racism, sexism, discrimination, trauma, and life stresses such as economic oppression, residential segregation, and community violence (Cross, Crow, Powers, & Bradley, 2015; Curtis-Boles & Jenkins-Monroe, 2000; Ehrmin, 2002; Stevens-Watkins et al., 2012). Focusing specifically on traumatic experiences and substance use, available literature indicates there is a relationship between the two for African American women. For example, in a mixed-methods study of 60 African American women (30 substance

abusing and 30 non-abusing), researchers found that significantly more women with substance abuse histories reported being battered compared to non-abusing women (93% versus 63%, respectively) as well as having experienced at least one other traumatic event in their lifetime (5.6 versus 4.6, respectively) (Curtis-Boles & Jenkins-Monroe, 2000). Similarly, in a retrospective study of a sample of predominantly African American women (94% of the sample), the researcher found that 61% of the women had experienced at least one experience of sexual abuse and 44% indicated that it happened more than once (Boyd, 1993). Dealing with these types of difficult life experiences has also been found to prompt some African American women to "numb" their emotional pain through the use of substances. In a qualitative study of 30 African American women in various stages of recovery, Ehrmin (2002) observed several prominent precipitating life events that frequently led to substance use among the study sample. Participants cited the pain of prejudice, the death of a loved one, the pain of physical and sexual abuse (including rape and incest), and the pain of childhood rejection by others as often leading them to use drugs and alcohol to escape the pain and memory of stressful life events (Ehrmin, 2002). While the use of substances to "numb" the pain of early trauma may not be exclusive to African American women, it nevertheless is a way to "turn off" and avoid unfortunate moments of their difficult lives (Daniulaityte & Carlson, 2011).

Additionally, African American women's use of substances can be further confounded by the mediating effect of mental illness on the association between trauma and substance use. Literature indicates that, in general, African Americans have the highest lifetime prevalence of post-traumatic stress disorder (PTSD) compared to other race/ethnicities (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011). Moreover, among a sample of African American women (n=107), nearly 40% met the diagnostic requirement for PTSD, while approximately 64-100% reported past 30-day trauma and 62-90% reporting substance use in the past 30 days (Sullivan, Weiss, Price, Pugh, & Hansen, 2018). Another study found that approximately 94% of the all African American woman sample (n=104) had experienced at least one trauma in their lifetime and almost 72% received a clinically elevated score for depression based on the Center for Epidemiological Studies-Depression Scale (CES-D) (Meshberg-Cohen, Presseau, Thacker, Hefner, & Svikis, 2016). There is also an increase of antisocial behavior (e.g., a lack of concern for the basic rights of others and/or rules) among young African American women, with this population having higher instances of violent behavior, use of weapons, and nonviolent antisocial behavior compared to non-Hispanic Whites and Hispanic young women (Salas-Wright, Tirmazi, Lombe, & Nebbitt, 2015). The relationship between trauma, mental illness, and

substance use is complex and often leads to subsequent adverse consequences for African American women.

Consequences of substance use disorders. In addition to the unfavorable factors that may lead to substance use among African American women, the consequences of ongoing substance use can be increasingly devastating with an additive effect. Repercussions of substance use can include unemployment, homelessness, serious illness, death, incarceration, and, for African American mothers in particular, the additional fear of involvement with child welfare and the removal of one's children (Brady & Ashley, 2005; Canfield, Radcliffe, Marlow, Boreham, & Gilchrist, 2017; McCabe et al., 2017; Olthuis et al., 2013; Perl et al., 2014). In fact, compared to White mothers with similar rates of substance use, African American mothers are 10 times more likely to receive child protective service reports (Cross et al., 2015). This is also true for poor mothers, and lends one to hypothesize that poor, African American mothers may be less likely to report substance use or seek out treatment (Cross et al., 2015). Likewise, some African American mothers may even delay or avoid treatment for fear of losing their children due to not only experiencing a SUD but also because treatment facilities are typically unable to provide comprehensive and simultaneous services to their children (Brady & Ashley, 2005; Jackson, 1995). Given that African American mothers are traditionally seen as the pillars of their family and community, the possibility of their detachment from this role, whether due to emotional, psychological, or physical separation, has the potential to create a severe crisis among the African American community (Curtis-Boles & Jenkins-Monroe, 2000). For example, compared to African American men, African American women are more likely to be single parent caregivers (Cross et al., 2015), thus, if they are removed from the home due to incarceration for substance use or participation in in-patient substance use treatment, this may have a substantial destabilization effect on African American families and communities. Furthermore, drawing from a more Afrocentric perspective, Jackson (1995) notes that the drifting away from more communal interactions among African Americans has caused increased fragmentation and unsuccessful outcomes for African American communities, and for women and children especially. Thus, it is essential to explore not only the impact of substance use on African American women but also factors that may facilitate, or hinder, recovery.

Religion and spirituality. One factor of interest in the literature is that of religion and spirituality and its relationship to substance use among African American women. In the same way that African American women are viewed as pillars in their community, religion and spirituality are generally identified as integral aspects of the African American persona and frequently acknowledged as a vital part of recovery in issues related to

both physical and mental health (Brome, Owens, Allen, & Vevaina, 2000; Johnson, Elbert-Avila, & Tulsky, 2005). Although religiosity and spirituality are often used interchangeably, it is important to note the difference between the two concepts. Religiosity is typically operationalized as one's attendance in, or adherence to, a particular set of doctrines, beliefs, and practice rituals such as church attendance (Mattis, 2000). Spirituality usually refers to the belief in, and relationship with, a higher power or sacred force that exists in all things, that is a source of one's strength, energy, or purpose (Berkel, Armstong, & Cokley, 2004; Brome et al., 2000; Mattis, 2000).

Spiritual practices such as personal prayer and meditation, as well as religious activities such as church membership and involvement, are viewed as enhancing one's relationship with God and are seen as critical coping mechanisms for African Americans (Berkel et al., 2004; Curtis-Boles & Jenkins-Monroe, 2000). Mattis (2000) notes that religious and spiritual beliefs impact multiple aspects of African Americans' lives including determining the meaning of life, navigating interpersonal relationships, improving physical and psychological well-being, and increasing one's ability to deal with adversity. These facets of religion and spirituality are so vital to African Americans that they have been found to read religious materials (i.e., the Bible) more, attend religious services more, and more often seek and find comfort in religious and spiritual activities compared to Whites (Blakey, 2016; Pew Research Center, 2014). In fact, in a study of African American women, researchers found that both substance abusing women and non-abusing women had similar rates of Bible reading, church membership, prayer frequency, and spiritual meditation (Curtis-Boles & Jenkins-Monroe, 2000). These findings lead one to believe that having a sense of religiosity or spirituality may transcend substance use among this population.

Religion, spirituality, and substance use. The results from the study are interesting given that substance use is often considered the antithesis of religion and spirituality (Bliss, 2007; Miller, 1998). However, there is a growing realization that substance use and religiosity/spirituality may have a more complex intersectionality than previously considered (Bliss, 2007). One way to enhance one's understanding of substance use among individuals who practice some type of religious behavior or have a strong sense of spirituality is to consider Miller's (1998) framework of spiritual dimensions, which examined four salient aspects of the relationship between substance use and spiritual dimensions. Specifically, his framework explored the association between religious/spiritual variables and addictive disorders, highlighting the following four areas of consideration: (1) the risk/protective factors of alcohol and other drug use/abuse, (2) religious/spiritual practices as elements of the course of substance use, (3) spiritual health/development as dependent variables affected by alcohol and other

drug abuse, and (4) religion/spirituality as components of the recovery process (Miller, 1998).

The first component of Miller's (1998) framework posits that participation in spiritual/religious activities decreases the likelihood of substance use. Research investigating this point has found that spirituality/religiosity is, in fact, a protective factor against substance use. However, he notes, that if a person has a more negative impression of God or religion, they may be more likely to develop substance use issues, yet this relationship is unclear and understudied. Secondly, Miller (1998) discusses religious/spiritual practices as a possible unknown variable within the context of substance abuse. He indicates that while spirituality/religiosity may lower the risk of substance use before a problem starts, less is known about the impact of spirituality/religiosity if a person is already diagnosed with a SUD. He highlights the importance of studying broad aspects of religiosity/spirituality to gain a better understanding of the relationship between them and substance use. The third area of the framework explores the possibility of substance use facilitating (rather than hindering) one's spiritual well-being. For example, he mentions that some drugs have sacred properties (e.g., some Native American practices) that may actually heighten one's spiritual consciousness. According to Miller (1998), there is the need for further research disentangling this issue. Miller's (1998) last component, and one that appears to be the most studied, focuses on religiosity/spirituality as an important part of recovery from a SUD. He noted the success of programs such as Alcoholic Anonymous, and the key role of spirituality/religiosity, as maintenance for some people's sobriety.

There is evidence that involvement in religious/spiritual activities decreases one's likelihood to use/abuse substances; thus, serving as a protective factor (Bliss, 2007; Miller, 1998). Data from one study found that a unit increase in belief in God (as determined by the Spiritual Well-Being Scale) was correlated with a 30% decrease in substance use in the past 30 days (Staton-Tindall, Duvall, Stevens-Watkins, & Oser, 2013). In addition, there are numerous anecdotal reports or case studies of African American women in recovery that highlight their belief that spirituality/religiosity helps them maintain abstinence from drugs and alcohol (Arnold, Avants, Margolin, & Marcotte, 2002; Blakey, 2016).

While Miller (1998) theorizes that individuals who use/abuse substances are less likely to consider themselves religious or spiritual; subsequent research does not necessarily support this point. For example, in a mixed methods study of abusing and non-abusing African American women, Curtis-Boles & Jenkins-Monroe (2000) found similar rates of church membership, Bible reading, frequency of prayer, and spiritual meditation between the two groups. These findings imply that even while using substances, African American women continue to participate in behaviors that they consider religious or spiritual. Little research had been conducted to examine spirituality as

a dependent variable influenced by alcohol or substance use at the time of Miller's (1998) research, and, even now, there continues to be a scarcity of literature exploring each of the four aspects of his framework among African Americans, and specifically, among African American women (Bliss, 2007). According to a systematic review of 44 articles that focused on spirituality and alcoholism (Bliss, 2007), studies tended to focus more on middle-class, White male participants of Alcoholics Anonymous, with four of 44 studies utilizing samples that included women and only two of those examining substance use among a sample of African American women. This disparity may be expected given that studies of alcoholism focusing on ethnic minorities, including African Americans, has only recently become more common in the last 30-35 years (Krentzman et al., 2010). Thus, it is important to further the literature by exploring, in part, Miller's (1998) framework among African American women who are experiencing a SUD.

The paucity of research examining substance use among African American women is surprising given that they are disproportionately represented among the substance using population and often suffer from some of the more severe consequences of substance use, both individually and within their family structure (Curtis-Boles & Jenkins-Monroe, 2000; Jackson, 1995; Witbrodt et al., 2014). Additionally, few studies have explored the intersectionality of religion/spirituality and substance use among African American women, despite the general knowledge that religion/spirituality is likely to (1) serve as a coping mechanism and provide a sense of comfort and (2) decrease the likelihood of substance use among this population (Bliss, 2007; Brome et al., 2000; Johnson et al., 2005; Staton-Tindall et al., 2013). Given the gap in the literature, this current study aims to utilize the second component of Miller's (1998) framework, religious/spiritual practices as elements of the course of substance use, to examine religious/spiritual practices among African American women who are non-substance users, substance users, or polysubstance users.

Research Question.

Specifically, the study asks, in what ways do belief in God, religious behaviors, commitment, and connection among African American women vary depending on whether they have no substance addiction, one substance addiction or two or more substance addictions. This exploratory study is warranted and timely for several reasons. First, it is important to conduct research on an understudied and often marginalized population. Second, this study may increase our understanding of the association between religiosity/spirituality and SUD among African American women, which has both research and practical application. Third, the information generated from this study will not only extend the literature on this topic, but its findings can then be disseminated to formal helping professionals, such

as physicians, social workers, and counselors, as well as informal sources of support, including clergy, family members, and friends to better assist in providing quality care to African American women experiencing SUD and/or in recovery.

Methods

Design. Primary data for these analyses were collected in a research study entitled Developmental Psychopathology and Maternal Substance Use which examined the role of maternal substance use on adolescent outcomes among urban African American women. In this quantitative effort, standardized assessments were administered during a cross-sectional effort with approval from the authors' university Institutional Review Board. Women were recruited through street outreach and fliers at local social service agencies. Initial screenings determined eligibility for study inclusion which included a history of substance abuse or dependence for the targeted women and demographically matched non-substance using women. After the researchers obtained informed consent, interviews were conducted in a private office on the university's campus, a location within the home, or in a private room at a public library for subject convenience. Small incentives were provided to all of the participants. The current effort is secondary analysis of the collected data for the project as it does not address the aims of the primary data collection effort.

Sample. The 106 women included for the current analyses represent 67% of the women initially screened for eligibility and who provided data for addiction and religious practices assessment. The women ranged in age from 25 to 64 with a mean age of 39.78 (SD=6.02). All the women had a least one child and the sample had an average of 4.07 (SD=1.98) children. The majority of the women (69.8%) had obtained at least a high school diploma. Over half (54.7%) had never married, and over half (57.5%) reported being in good or excellent health.

Measures. Demographic variables, substance use, depression, antisocial personality disorder, and PTSD were assessed with items from the Computerized Diagnostic Interview Schedule Version IV (C-DIS-IV; Robins et al., 2000). The C-DIS-IV allows subjects to self-report responses to items assessing diagnostic criteria for use, abuse, and dependence on substances and the presence of disorder for mental health categories such as depression. In this study, an interviewer read items to the subjects and entered their responses into the computerized program. Substances assessed included alcohol, cocaine, and marijuana use, abuse, and dependence. Normative data for the C-DIS IV diagnostic features were obtained in a study of substance abusers revealing fair to excellent reliability for the assessed disorders (Dascalu, Compton, Horton, & Cottler, 2001).

Belief about God (1 item) and religious behaviors, commitment, and connection (7 items) were measured with the Religiosity Scale (Rohrbaugh & Jessor, 1975). The one item assessing belief in God asked respondents to specify which of five statements captured their belief about God. The response options were then dichotomized to capture belief (I am sure that God really exists and that He is active in my life and Although I sometimes question His existence, I do believe in God and believe he knows of me as a person) and nonbelief (I don't know if there is a personal God, but I do believe in a higher power of some kind; I don't know if there is a personal God or higher power of some kind, and I don't know if I will ever know; and I don't believe in a personal God or in a higher power). The seven items assessed religious behaviors, commitment, and connection and each varied in its scaled response. We therefore considered all as independent measures that were dichotomized for independent analyses and then scaled for a collective measure of religious practices for these analyses. The items included past year frequency of attending church, worship services, or other religious activities for something other than a funeral or memorial service (regular attendance = 1; non-regular=0); practice of prayer or religious mediation (daily prayer=1; non-daily =0); reading/studying a holy book such as the Bible (usually or almost always = 1; sometimes, rarely or never = 0); frequency of taking religious advice or teaching when having a serious personal problem (usually and almost always = 1; sometimes to never = 0); influence of religion on the way you choose to act and spend your time each day (large influence = 1; fair to no influence = 0); past year feelings of religious commitment and devotion (frequently to daily = 1; sometimes to rarely = 0); and agreement with religion providing a great amount of comfort and security in life (agree to strongly agree = 1; uncertain to strongly disagree = 0). The seven dichotomous religious items were independently assessed and combined into one measure to assess the sum of religious practices (Cronbach's alpha=.66).

Analyses. All analyses were conducted with SPSS (V 24). Descriptive frequencies were computed to stratify the sample into three groups based on addiction status. Chi-square analyses were performed to examine differences in demographics, dichotomous religious practices, commitment and connection and the absence or presence of psychopathology. One-way analysis of variance (ANOVA) with post-hoc tests provided a comparison of summed religious practices across the three groups.

Results

An assessment of addiction status reveals that 54.7% of the women reported no alcohol, marijuana, or cocaine addiction while 20.7% had one addiction and 24.5% had two or three addictions (polysubstance users). As

indicated in Table 1, once the sample was stratified based on their addiction status, they did not vary in any of the demographic factors examined. Thus,each group was relatively equally represented among those who had completed high school or more, had never married, reported being in good or excellent health, and were on average similar in age and in number of children.

Table 1

Demographic Factor Comparison for African American Women based on Addiction Status (N=106)

Addiction Status	*None*	*One*	*Poly*	
	N=58	N=22	N=26	
	%	%	%	X^2
Education completion	69	63.6	76.9	1.04
Never married	58.6	50.0	50.0	.79
Good/excellent health	62.1	59.1	46.2	1.89
				F (df) p
Mean Age (SD)	39.17 (6.50)	40.68 (6.06)	40.38 (4.81)	F(2, 103) .67
Mean Number Children (SD)	4.14 (1.83)	3.59 (1.33)	4.31 (2.67)	F(2, 103)= .86

As shown in Table 2, the women overwhelmingly believe in the existence of God and this belief did not vary based on addiction status (84%). When each religious factor was considered independently, the groups vary on the reported frequency of reading or studying a holy book such as a Bible with women who are polysubstance users overwhelmingly reporting this practice (65%) compared to non-addicted women (31%) and women with one addiction (13.6%). Women who were polysubstance users also more highly report feelings of religious devotion (80.8%) versus non-addicted (58.6%) and women with one addiction (50%). When the dichotomous religious items measuring behaviors, commitment, and connection were totaled (sum of religiosity), an analysis of variance showed that women who were poly-addicted have a significantly higher mean of religiosity (M=4.88; SD=1.75) than did women who were non-addicted (M=3.76; SD=2.05) and those with one addiction (M=3.55; SD= 1.18) F (2, 103) =4.14, p=.02. Interestingly, with the exception of belief in God, daily prayer, and religious influence, non-addicted women have higher percentages (though not significantly so) of each of the religious factors than did women with one addiction.

Table 2

Religious Practices Comparison for African American Women based on Addiction Status (N=106)

Addiction Status	*None*	*One*	*Poly*	
	N=58	N=22	N=26	
	%	%	%	X^2
Belief in God	94.8	95.5	96.2	.07
Attend weekly	36.2	31.8	38.5	.24
Pray daily	72.4	86.4	84.6	2.64
Reading/studying a holy book regularly	31.0	13.6	65.4	15.17 ***
Take religious advice	63.8	59.1	76.9	1.98
Religion influences	43.1	50.0	57.7	1.57
Feel religious devotion	58.6	50.0	80.8	5.53
Comfort & Security	72.4	63.6	84.6	2.79
	Mean (SD)	Mean (SD)	Mean (SD)	F (df)
Sum of religious practices	3.78 (2.05)	3.55 (1.18)	4.88 (1.75)	F (2, 103)= 4.14*

*p<.05, **p<.01, ***p<.001

Addiction status distinguished psychopathology among the groups of women as those with more than one addiction were more likely to have diagnosable post-traumatic stress disorder (PTSD, 42.3%), depression (58.3%), and antisocial personality disorder (ASPD, 92.3%). Psychopathology is progressive across the groups with prevalence of the disorders among women with multiple addictions being highest, one addiction prevalence being lower than polysubstance but higher than the prevalence among non-addicted women.

Table 3

Demographic Factor Comparison for African American Women based on Addiction Status (N=106)

Addiction Status	*None*	*One*	*Poly*	
	N=58	N=22	N=26	
Psychopathology	%	%	%	X^2
PTSD	15.5	27.3	42.3	7.07 (.029)*
Depression	20.4	36.4	58.3	10.98 (.004)**
ASPD	43.1	72.7	92.3	19.85 (.000)***

*p<.05, **p<.01, ***p<.001

Discussion

This study sought to determine in what ways religious/spiritual practices differ among African American women depending on if they are non-substance users, substance users, or polysubstance users. Findings reveal that those who were polysubstance users were, by a wide margin, more likely to display religious behaviors (sum of religious practice score) than those with one or no addiction. At the same time, no group of women was more likely to attend religious services more frequently, to pray or meditate more often, to take religious advice, to agree that religion influenced the way they chose to act and spend time, or to agree that religion provided comfort and security in their lives. African American women with polysubstance addictions reported a greater likelihood of psychopathology (PTSD, depression, and ASPD), while those with no reported addictions reported the least amount of psychopathology.

While some previous research has found similar rates of religiosity (as measured by Bible reading, church membership, prayer, and meditation, etc.) among African American women who abuse substances as well as those who do not (Curtis-Boles & Jenkins-Monroe, 2000), this study found that African American women with polysubstance addictions read some form of religious literature and to feel a sense of religious devotion more than the other women sampled, and women with no addiction had slightly higher religiosity scores than those with one addiction. When people are under stress, they actively try to alleviate negative feelings using both conscious and unconscious coping strategies. Dealing with the negative effects of an addiction (or more than one) coupled with past histories of trauma is a stressful endeavor, and these women are likely seeking to address their distress in ways that are familiar to them.

The greater religiosity among the women with more psychopathology and multiple use of substances could be related to the nature of religious coping that is different for African American women. African Americans tend to display greater levels of religiosity than their White counterparts in that they read religious materials more frequently, attend religious services more frequently, and are inclined to strive for the comfort that comes from being in relationship with a higher power (Brome et al., 2000; Taylor, Chatters, & Levin, 2004). Being confronted with extremely difficult life circumstances, they are turning to the comfort of what they know and what has worked for generations of African American women before them.

Historically, African Americans have been denied the same level of political participation, health care, mental health treatment, and other social services as White Americans. To combat the lack of organizations serving the needs of African Americans, African American churches have risen as places that provide care when other formalized institutions denied access to

assistance. Further, they have organized efforts to help alleviate suffering of individuals and families and of the African American community in general (Cnaan, et al., 2002; Chatters, Mattis, Woodward, Taylor, Neighbors, & Grayman, 2010; Taylor et al., 2004). Issues addressed by African American churches include poverty, food insufficiency, job training, assistance to those who are sick, and helping to cope with varying losses (Dilworth-Anderson, Williams, & Cooper, 1999; Taylor et al., 2004). In a fundamental way, they have also served to protect members of their communities from the damaging psychological effects of institutional and overt racism (Taylor et al., 2004). Studies have found that about two-thirds of adult as well as older African Americans reported receiving some type of assistance from fellow congregants, with this likelihood increasing with greater levels of church attendance (Taylor et al., 2004). This relationship of assistance receipt and church attendance may, in part, help to explain the high levels of religious attendance found among the women in this study. African American churches and religious activities and beliefs may have provided instrumental support, and they also may help to buffer the effects of living in a challenging world.

Diagnosable PTSD was found in 42.3% of study participants who were polysubstance users, which is not surprising due to the high correlation between the development of SUDs and experiencing racism, sexism, discrimination, economic oppression, and traumatic events (Curtis-Boles & Jenkins-Monroe, 2000; Ehrmin, 2002; Stevens-Watkins et al., 2012). It is likely that the women in this study who have tried to self-medicate their emotional pain are actually thinking of substance use issue as a spiritual ailment requiring a spiritual solution that can be addressed through the use of spiritual tools such as prayer and reliance on a higher power.

We do not know how many women in this study have been to treatment for substance use/abuse or are actively engaged in some form of recovery group as it was outside the purview of the original study. However, many such recovery groups are based in the form of spirituality that emphasizes increasing the person's relationship with their conception of a higher power, prayer and meditation, reading of recovery literature – often of a spiritual nature – and other spiritual beliefs and activities. One such recovery group that is well-known in the US is Alcoholics Anonymous (AA). For certain populations, AA and its variants (Narcotics Anonymous, Cocaine Anonymous, etc.) are some of the most important recovery services available. In fact, over 60% of people with a lifetime diagnosis of a SUD have attended some type of 12-step program (Cohen et al., 2007; Perron et al., 2009). Thus, it is possible that some of the study participants with a SUD may have, at some point, attended a 12-step group which could possibly increase the reporting of spirituality in this study.

Twelve-step programs are paraprofessional, voluntary, and have spirituality as a basis. The 12-steps that are used in AA are shared in many of the other derivative groups. The steps mention God or a higher power throughout and encourage living a spiritual life (Alcoholics Anonymous World Services, 2001), which could help explain why the women with the most severe addictions (polysubstance users) might be treating their malady with a spiritual therapy. Twelve-step programs encourage participants to seek knowledge of their higher power's will and to try to live according to what that might be – presumably, a life free of drug and alcohol abuse. However, as indicated earlier, less is known about the benefits of AA among African American women in particular, so further research is needed to evaluate the value of the specific program among this population.

Our data do not indicate in which stage of recovery these women are. Therefore, it is difficult to ascertain if they are praying and attending church to stop using substances or if, perhaps, they are on the road to better health and are trying to maintain the gains they have already acquired. It is possible that the women in this study considered themselves highly religious or spiritual before using substances - as African American women tend to be more spiritual in general than the overall population (Taylor et al., 2004) - and continued in those activities after using. No matter where they might be on the continuum, the women in this study with more psychopathology and correlated greater levels of SUDs might be trying to fill a need in some way. Drugs and alcohol are a way to fill the emptiness for some people and to still an overactive mind. For these women, it is possible that they are trying to recover the feeling of belonging that they had from a previous spirituality or to produce one that they never had. Many people – possibly the women in this study – also find that the emptiness is a "God-shaped hole" (Hagedorn & Moorhead, 2010) that can also be filled through religious/spiritual practices.

The women in this study did not differ statistically in their rates of attendance at religious services, though those who were polysubstance users did report the highest attendance of the three groups. It is possible that the stage they are in with their recovery could affect their attendance. Those who are still actively using might actually attend even more if they were healthier and were able to release some of the attendant shame that is so common in people who have histories of trauma and substance use (Cordington, 2017). Attendance at religious services is a natural place for African American women who are trying to fill the emptiness to seek some fulfillment, particularly considering that those with the highest rates of trauma and substance use in this study are also the ones displaying the highest levels of religiosity. Most churches eschew the use of drugs and try to emphasize activities that help to develop a closeness to God, and when people are trying to recover from a SUD, they generally find it easier if they

are in regular contact with like-minded people who are more accepting than judgmental.

Though it remains unclear whether faith-based recovery efforts are less helpful, equal to, or superior to formal mental health and substance use disorder services, this is the natural place to which people turn in times of distress (Pickard & Tang, 2009; Wang, Berglund, & Kessler, 2003; Weaver et al., 2003). For that reason, and knowing that many women with substance use issues still seek to support their religiosity, it is important that helping professionals (clinical social workers, psychologists, marriage and family therapists, etc.) understand and support this phenomenon as a part of the healing process (Pickard, 2012; Pickard, Inoue, Chadiha, & Johnson, 2011). Helping professionals should be willing to encourage religiosity when appropriate and to work with faith communities on trainings, prevention programs, and program development (Wallace, Meyers, & Osai, N.D.). At the same time, clergy and other religious leaders have assets at their disposal that they could tap to help congregants and communities, such as delivering sermons concerning substance use and the support that could be gained via their religious organization and calling on the strengths of professionally trained members as part of a ministry to help other members in crisis (Wallace et al., N.D.).

Limitations

Some limitations of this study lead us to believe that further research is needed. For example, this study asks respondents about belief in God or some higher power, though the specific religious faith with which they identify is not available, nor is this study able to establish whether these women are actually part of twelve-step recovery groups. Given the likelihood of spirituality among African American women, a possibility exists that some of the women are very strong in their faith but do not adhere to any specific faith tradition, which could affect the amount of support they receive, though we are unable to determine that from this study. Additionally, research examining religious beliefs prior to substance use is needed, as we are unable to ascertain if the women in the polysubstance use group are continuing with what they know or if they have developed a newfound faith to help them in their attempt at recovery or if it is a continuation of previous levels of religiosity. This study is cross-sectional only and is unable to ascertain that information.

Conclusion

This exploratory study sheds light on the religiosity among a sample of African American women experiencing substance use and psychopathology

such as PTSD, depression, and antisocial behavior. We found that women who were poly-addicted were more likely to report regular personal religious-based reading/studying and having a feeling of religious commitment compared to women with no or only one addiction. It is also possible that women with co-occurring addictions may also utilize religious-based practices in an additional attempt to alleviate their emotional pain. More research is needed to more fully identify the reasons for higher levels of religiosity among participants who were polysubstance users. In addition, further exploration of religious/spiritual practices and co-morbid substance addiction is needed, as this research may be vital to implementing effective interventions with African American women experiencing SUDs. ❖

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Restoring Damaged Relationships Through the Art of Invitation: Application with Addicted Incarcerated Women

Katti J. Sneed & Debbie E. Teike

This article presents a description of Art of Invitation as a complementary approach to traditional addiction treatment through the alignment of Art of Invitation (AOI) with Substance Abuse and Mental Health Services Administration's (SAMHSA) Ten Guiding Principles for Recovery. AOI is a faith-based relationship building approach that combines key Judeo/Christian teachings with relationship building tools, skills, and concepts for those seeking to build and restore relationships. SAMHSA spearheads public health efforts to advance behavioral health within the United States. Each Guiding Principle is presented along with a description of how AOI is shared with incarcerated women, an often neglected population, participating in an inpatient treatment program housed in a community corrections facility.

BUILDING AND RESTORING RELATIONSHIPS IS A SIGNIFICANT FOCUS and motivation for those recovering from addiction (SAMSHA, 2012a). Additionally, many desire that spiritual and/or religious perspectives be offered alongside traditional recovery treatment modalities (Arnold, Avants, Margolin, & Marcotte, 2002). Yet, there is a lack of integrated addiction treatment options. The Art of Invitation (AOI), a faith-based psychoeducational relationship building approach, is one potential option for those recovering and desiring access to faith-based perspectives, along with traditional treatment modalities. Alignment with Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) Ten Guiding Principles of Recovery provides validity for AOI to be recognized as a viable resource in working with persons in recovery. Further support for AOI as a recovery

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resource for persons with substance use disorders is found in the literature where connections between SAMHSA's Guiding Principles and AOI's approach are established. The application of AOI with Women Recovering with a Purpose (WRAP) provides tangible examples for service providers and those supporting individuals in recovery of how integration between a faith-based offering and a traditional treatment provider is achieved.

Art of Invitation

AOI, a relationship building approach, is one option for those recovering from addiction who desire spiritual and religious integration with traditional treatment modalities. In 2009, AOI was created to equip seminary students with skills to overcome communication barriers with parishioners in their future vocation by Debbie Teike, LCSW. The program was subsequently presented in churches, a county jail, and nonprofit settings with modifications ranging from a one- time workshop style to a multi-week sessional style option fitting the needs of the audience (Teike & Sneed, 2018). Teike and Sneed (2018) conducted a phenomenological qualitative study and found support for universal application of AOI across a wide variety of populations (Teike & Sneed, 2018).

AOI is an integration of social science and Judeo/Christian teachings, specifically social exchange theory and the Golden Rule in practice (Teike & Sneed, 2018). Social exchange theory holds that people do what benefits them in relationship and withdraw from interactions with negative impact (Cook, 1987; Thomas & Iding, 2012; Stafford, 2015). Blau (2008) and Bell (2009) note that if a moral conviction is in place, altruistic motives may account for exceptions to social exchange theory in its purest form. Such moral convictions can be found in Judeo-Christian traditions which support altruistic behavior without an expectation of personal reward (Friedman, 2002). In addition, Duhaime (2015) finds that meaningful connections with religious concepts increase prosocial behavior. Therefore, AOI has the potential to help those in recovery build and restore relationships as it combines Judeo-Christian teaching, respects social work tradition and ethics, and aligns with best practices for recovery as outlined in SAMHSA's CSAT TEN Guiding Principles for recovery-oriented systems of care. It is possible that participants benefit through integration of these separate ideals, as Chamiec-Case (2015) purports, for a thoughtful and sensitive integration of faith and social work as having the potential to create much more together than could be accomplished separately.

AOI connects the altruistic value of being "invitational" to the desire to build and restore relationships, and helps participants develop a sense of relational "belonging" whether an "insider" or "outsider" in any particular circumstance (Teike & Sneed, 2018). An invitational approach strives to

relate to others as equals, regardless of role or position. Equal status is found in John 3:16 (New International Version), which declares that God loves the whole world. Equal status is also established for Americans in the Declaration of Independence which states, "All men are created equal, that they are endowed by their Creator with certain unalienable rights that among these are life, liberty and the pursuit of happiness" (US 1776). These two references, among others shared in AOI, help individuals identify and connect internally with motivation to treat others and themselves as equals and to match communication style with their intent. Invitational, presentational, and confrontational options are explored and practiced, along with challenges commonly faced from conflicting values, unmet relational needs, emotional dysregulation, and difference of opinion.

Early in AOI teachings, participants identify their current and desired relationships along with why they are important. This exercise allows for awareness of the potential to increase the number of satisfying relationships as well as to reduce negative energy generated from any unhealthy relationships of significance. While embracing their personal power to make changes within these significant relationships, AOI participants often express hope as well as other emotions, including grief. Recovery itself can be conceptualized as a grieving process, a letting go of the past and moving toward the future (Denning, 2004). Grief work can be essential in moving past self-blame into a realm of higher consciousness and is an integral part of the human process and a spiritual journey (Carroll, McGinley, & Mack, 2000). Likewise, the heavy load of guilt that recovering people typically feel explains the desire many individuals have for reconciliation and renewal, even forgiveness (VanWormer & Davis, 2008).

After the personalization of one's relational world, other structural elements of AOI are taught, which include: insider and outsider 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 uninvitational thought) and strategies for overcoming relational barriers invitationally (Teike, 2012). AOI 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 (Teike & Sneed, 2018).

AOI seeks to strengthen one's ability to gain self-control when relationally triggered so as to establish congruence between internal experience and external expression (Teike, 2012; Teike & Sneed, 2018). Cerasoli and Ford (2014) conclude that intrinsic motivation is significant to goal attainment. Using an invitational approach, congruence is achieved as participants match motive (e.g. valuing others as equals; treating others

as self) to communication style (e.g. invitational as defined by the Golden Rule and 1 Corinthians 13). Participants have opportunity to discover personal motivation and choices in their interactional styles with others as they progress through units which focus upon value clarification, relational needs, emotional regulation and dysregulation, and perspective. According to AOI, being invitational comes from the heart, which is hidden from view by others (1 Sam 16:7).

Significance of Relationship Building for Those Recovering from Addiction

The disease of addiction is impacted by relationships and has devastating effects on relationships. In fact, recently, Luke, Redekop, and Jones (2018) conceptualized addiction as a "relational disorder," linking the neurophysiology of substance use disorders to interpersonal relationships (p. 184). The singular focus on the substance (e.g. alcohol, meth, heroin) or process (e.g. gambling, pornography) takes priority over the needs of others, as well as one's own health and well-being (Horvath, Misra, Epner, & Cooper, 2018). The by-product of this reality typically leaves all involved feeling deceived, abandoned, and hurt. The nature of addiction circumvents relationships, causing an inward focus and pre-occupation, and, in many cases obsession, with the item of addiction (VanWormer & Davis, 2008). Hari (2015) states, "The opposite of addiction isn't sobriety—it's connection" (p.32). Internal personal judgment, decision-making, and perceptions are corrupted, leaving the individual who is living with addiction isolated from substantial relationships (Bryan, Quist, Young, Steers, & Lu, 2016).

While relationships suffer from addictions, relationships can be restored (U. S. Surgeon General, 2016). People are built for relationships; belonging, connecting, and mattering one to another are essential ingredients of life (Baumeister & Leary, 1995; Cyranowski et al., 2013; Seppala, Rossomando, & Doty, 2013; Genesis 1:26; Genesis 2:18; Matthew 22: 36-40; Romans 12:5). God created us to live in community and encourages us to love, pray for, encourage, and bear with one another (Colossians 3:13, James 5:16, John 13, I Thessalonians 5:11). A common denominator in the recovery process is supportive persons who foster recovery characteristics like hope and gratitude, while suggesting strategies and resources for change (Sheedy & Whitter, 2013). Cavaiola, Fulmer, and Stout (2015) concluded that social support was a powerful influence in maintenance of long-term recovery and has a positive impact on self-reported improvements in quality of life areas (i.e. ability to cope, social functioning, and health). Moreover, reciprocity and trust across multiple formal and informal relationships has emerged as an essential theme in men who were incarcerated (Laferty, Treloar, Butler, Guthrie, & Chambers, 2018). Ranjbaran and colleagues (2018) identified

peer influence to be a major factor in addiction tendencies in college-age adults. Those with whom people interact affect who they are and who they become. This finding has also been confirmed in several other studies: Haller, Handley, Chassin & Bountress, 2010; Tarter, Fishbein Tompset, Domoff, & Toro, 2013.

AOI and WRAP

Women Recovering with A Purpose (WRAP) is an inpatient treatment program, which is housed in a community corrections facility as a partnership between a county community corrections and mental health provider. The inpatient portion of WRAP spans four to six months and includes the following program components: Seeking Safety, which focuses upon safety from Post-Traumatic Stress Disorder (PTSD) and substance abuse; Residential Drug Abuse Program (RDAP), an interactive journaling program which includes individual work, group work, and counseling; Texas Christian University Mapping Enhanced Counseling, a cognitive strategy shown to be effective in increasing client motivation, engagement, participation, and retention in treatment; and Moving On, a program toward reintegration into the community (McClure, 2018). Once the inpatient component is completed, those in WRAP participate in aftercare through day reporting to Court Services-Community Corrections with an electronic monitor (McClure, 2018).

AOI is one of several community-based voluntary offerings for participants in WRAP (Gaskill, 2017). AOI in WRAP began in 2012 through the cooperation and support of a local church involved in jail ministry. Weekly AOI offerings as part of WRAP, lasting an hour and a half in duration, have been primarily presented by Debbie Teike, LCSW. Ms. Teike has had assistance from lay ministers and an IOP Coordinator who holds ICADC, CADAC II certification. The version of AOI presented in WRAP is consistent in content to material shared in other venues, but it is tailored to be meet the needs of those recovering from substance use disorders.

Alignment of AOI with SAMHSA CSAT Ten Guiding Principles for Recovery-Oriented Systems of Care

Individuals, organizations, agencies, and communities all over the country are organizing toward a better system of care for those affected by substance use disorders (NIDA, 2015). For the Art of Invitation or any other faith-based initiative to be recognized as a viable resource in working with persons in recovery, it needs to align with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) Ten Guiding Principles of Recovery. These

historical, landmark guiding principles were derived through a multi-stage process, following the National Summit on Recovery forum in 2005. Key stakeholders were tasked to develop a definition of recovery and a common understanding of best practices (Sheedy & Whitter, 2013). Revised in 2010, the guiding principles include the following: Hope, Person-driven, Many Pathways, Holistic, Peer Support, Relational, Culturally Based, Addresses Trauma, Strengths / Responsibility, and Respect (SAMHSA, 2012b). Below is a description of how AOI is aligned with each guiding principle and demonstrated through selected examples of AOI in WRAP.

Recovery Emerges from Hope

Hope is a quality emphasized throughout the literature on substance use counseling (Miller, 2003; Doweiko, 2006; Walker, Godlaski, & Staton-Tindall, 2013). Without hope, there can be no effort, no working toward a meaningful goal (VanWormer & Davis, 2003). Belief in a greater power can foster hope, as hope, according to Asher (2001), is the palpable feeling that goodness is going to emerge in the world, the uplifting, even joyful experience of anticipating things to come. The belief that a loving Higher Power is in control and has one's best interest at heart creates feelings of hope that life will get better.

We would be remiss to discuss hope without also mentioning the connection between hope, forgiveness, and God. Forgiving oneself is a crucial element in recovery (Lund, 2017). Guilt and shame often lead to self-hatred. Self-hatred does not provide favorable grounds for a new sober life (Webb, Girsch, Conway-Williams, & Brewer, 2013). Religiosity and spirituality are known to have a positive connection with increasing forgiveness (Hernandez, et al., 2012). Interestingly, McGuire (2008) and Day & Lynch (2013) comment that it is not the Christian doctrine which assists in recovery, but the lived religion and belief that provides a foundation to explore such treatment issues as forgiveness, shame, and guilt. Self-hatred and self-forgiveness can be seen as linked to receiving forgiveness from God, consequently leading to hope (Lyons, Deane, Caputi, & Kelly, 2011).

Through connecting with one's value as redeemed and loved by God, participants come from a strengths-based perspective to navigate through potentially difficult conversations. This faith-based perspective, combined with communication tools, equips AOI participants to address stigma and judgment, which Miller and Carroll (2006) identify as very real deterrents to hope and change. One technique taught in AOI is the Three Keys to Invitation: 1. seeking to understand without judging, fixing, or having an agenda; 2. sharing openly and honestly; and 3. caring and receiving care. The Three Keys are concrete tools to help with communication and improving future, particularly conflictual, interpersonal interactions. In one session, a WRAP

participant was able to reframe interviewing dialogue while addressing a felony in her background by introducing herself as a person embracing recovery rather than as someone who made bad choices. After practicing with the group, this woman now had hope that she could communicate positively about herself and be in a better position to obtain employment.

Recovery is Person-Centered

The AOI content is shared in a descriptive as opposed to prescriptive manner; this allows for a person-driven application of the material. Addiction professionals and AOI facilitators alike need to abandon expectations about who is in control. According to Denning (2004), "When clinicians view an addict as being the problem or not motivated or in denial, they are often speaking of this conflict in expectations surrounding control" (p. 108). AOI embraces the fact that motivation for change (including abstinence from substances) resides in the person, not the facilitator (SAMSHA, 2012a). Consistent with the social work value of self-determination, Denning (2004) goes on to encourage clinicians to clearly affirm clients' right to live their own lives, find their own goals and make their own decisions while helping them actuate their intent. Puffer, Skalski, and Meade (2012) further hone in on the importance of the person-centered approach; clients then may guide the discussion of spiritual issues. While the format of AOI provides content for participants to build relationships and seek spirituality, discussion is adjusted to focus upon questions and issues of interest to participants. For example, in the AOI section focusing upon values and relational barriers, participants identify spiritual, moral, and personal values and relational needs once hidden by active use of substances. They then ask questions within the group as they feel comfortable. This experience of reconnecting to spiritual values in a sober state creates awareness of values congruent with one's true self, and the group experience allows participants to invitationally listen and share with others: new insights, intentions, and meanings for personal and relational growth. In AOI, no one is "called on" or pressured to share, providing respect for each person's privacy and comfort level of self-disclosure.

Recovery occurs via Many Pathways

Addiction treatment has historically undergone many transformations in modalities and interventions. Long-term and short-term inpatient and outpatient group treatment, day treatment, various medication assisted programs, 12-step self-help models, and interventions like Stages of Change, Cognitive Behavioral, and Rational Emotive have been just a few options. Studies conducted over the past 25 years consistently show that participation in some sort of substance use treatment program is effective

as measured by reductions in substance misuse, improvement in personal health and social functioning, and reductions in public health and safety risks (U. S. Surgeon General, 2016; Zabatsky, Mendenhall, Fowler, & Harris, 2017). Yet, the National Institute of Drug Abuse (NIDA, 2018) reports that in 2011, only 2.3 million of the 21.6 million Americans needing treatment for a drug or alcohol use problem received treatment. The U. S. Surgeon General cites one in 10 receive some form of specialty treatment. Flynn and associates (2003) summarized that, collectively, only a third of clients successfully completing traditional long-term treatment were still sober during follow-up studies. Therefore, traditional treatment centers should not be the sole option for persons desiring to remain sober. AOI recognizes and reinforces core components of traditional treatment, yet offers additional pro-social teachings leading toward restoration of healthy relationships, increased self-awareness in communication style, awareness of the barriers to establishing solid relationships, and connection to Biblical teachings.

Recovery is Holistic

Moral values are often compromised in the erratic acting out of addictive behaviors, urges, cognitions, and motivations (Rotgers, Morgenstern, & Walters, 2005). Therefore, it makes sense that recovery needs to include a holistic view of balancing a spiritual and faith component with mind and body as they intersect with all other areas of a person's life (Sheedy & Whitter, 2013). Spirituality has been found to reduce stress in the present and worries about the future (Jarusiewicz, 2000). Spirituality and religiosity sought out in recovery provides internal strength, facilitates the ability to cope, and promotes altruism toward others (Arnold, Avants, Margolin, &Marcotte, 2002; Puffer; Skalski, & Meade, 2012).

Literature on health, spirituality, and religiosity continues to support its positive contributions across a wide range of health, mental health, and addictions interventions (Koenig, King, & Carson, 2012; Oxhandler & Pargament, 2014). Clients are asking for inclusion of their spiritual and religious beliefs (Arnold, Avants, Margolin, & Marcotte, 2002) and expressing a preference for healthcare providers to initiate this discussion as integration supports their healing process (Stanley et al., 2011; Barrera, Zeno, Bush, Barber, & Stanley, 2012). Many addiction treatment counselors believe that when individuals are reconnected to a positive spiritual momentum, they are more likely to take control of their lives (DiLorenzo, Johnson, & Bussey, 2001). Nearly all (95%) of Americans report a belief in a God or a higher power, with 75% of them indicating that religion/spirituality influences the decisions they make (Billioux, Sherman, & Latkin, 2014). Miller & Thoresen (2003) summarize the benefits of spirituality as clarifying what is trivial and what is truly vital in life, reducing self-critical

and hostile cognitions while fostering love, compassion, and forgiveness.

Pardini and colleagues (2000) conclude that counselors need to incorporate spirituality into their interventions with substance abusing individuals. Believing in a master creator allows individuals to make sense of their trials and tribulations. It gives a sense of understanding and desire to help others (Koenig, McCullough, & Larson, 2001). Studies on addiction recovery indicate that approaches to heightened spiritual awareness markedly increase a sense of purpose in life (O'Connell, 1999; Wigmore & Stanford, 2017), which is a critical ingredient in recovery (VanWormer & Davis, 2003). Internalized spirituality provides recovering individuals with an optimistic life orientation, buffers against emotional negativity, and provides a means for managing stress (Miller, 2003; Lyons, Deane, Caputi, & Kelly, 2011).

Connecting to a higher power invites and entices human beings in recovery to choose good over evil (Richards & Bergin, 2005). This influence further encourages the individual to bring his or her life into harmony with universal moral truths or laws of living such as personal and social responsibility, family commitment, self-sacrifice, integrity, humility, and respect for life (Miller, 2005). Turner (1993) interviewed recovering individuals who were sober for two or more years. Sommer (1992) did the same with those having between four and seven years of recovery. Each noted the significant elements spirituality played in creating the changes in self-perception, worldview, and behaviors leading to long-term abstinence. A more recent study by Acheampong and colleagues (2016) concurred that high levels of religion/spirituality were directly associated with decreased odds of relapse, even with those in a very risky subpopulation of drug users, and with women in recovery from polysubstance use.

The efficacy and pervasiveness of mutual-help groups such as AA and NA are well established as the primary means through which most engage in the spiritual component of recovery (Kelly & Yeterian, 2011). A spiritual program not affiliated with any particular religion allows individuals the freedom to overcome potential stumbling blocks, as was the case for Bill Wilson in the early years of AA's founding (Gross, 2010). The importance of mutual-help groups is honored and respected by AOI as people find support, coping strategies, value, respect, and continual motivation toward recovery (Kelly & Yeterian, 2011). The addition of a religiously affiliated experience can also be of significance to those with substance use disorders (Crisp, 2010). As Hodge (2011) affirms, many individuals desire to integrate spiritual and religious perspectives into treatment.

Spiritual and religious practices stemming from the Judeo/Christian tradition are integrated into the AOI experience through celebrations of the church year, such as Christmas and Easter. Movies, advent wreath making, and observance of Holy Week are a few examples of activities included as

opportunities for experiencing meaningfully significant activities together. Rituals such as these can lead to feelings of "peace, joy, meaningfulness, reassurance, and even ecstasy for participants." These optional spiritual and religious practices help connect to the sacred, heighten social interconnection, and promote feelings of stability, balance, and unity (Canda & Furman, 2010, p. 345). Additionally, a form of centering prayer is sometimes offered at the end of AOI sessions as a mindfulness experience and an opportunity to rest in God's presence. AOI prayer time purposes to provide what Ferguson, Willemsen, & Castaneto (2010) suggest is a goal of centering prayer —being in relationship with God.

Music, mindfulness breathing, and progressive relaxation exercises are incorporated into the centering prayer experience, allowing participants a time to rest and/or contemplate. Meditation can be experienced as a way to cultivate a sense of inner calm, harmony, and transcendence often associated with spiritual growth (Leigh, Bowen, & Marlatt, 2005). This is most likely accomplished once the individual learns a technique of turning off or bypassing cognitive processing of usual daily preoccupations and concerns, allowing access to these other aspects of being (Marlatt, 2002; Fox, Gutierrez, Haas, Braganza & Berger, 2015). A growing body of research indicates that practices such as prayer, transcendental meditation, Zen, and yoga have measurable effects on the physiological processes in the brain (Miller & Thoresen, 2003; Leigh, Bowen & Marlett, 2005; Koenig, King, & Carson 2012; Morelli, Torre, & Eisenberger, 2014). Pargament, Murray-Swank & Tarakeshwar (2005) further found that prayer is an important coping response in helping individuals deal with the noxious effects of stress. Evidence suggests that praying for others may exert a positive effect on the health of the person praying (Krause, 2003). Tangenberg (2001) emphasized the importance of chemically dependent mothers with HIV utilizing their spiritual beliefs and practices as a coping mechanism. In a similar study, Arnold and associates (2002) summarized that in managing the challenges of living with HIV infection, drug abusers turned to spirituality to cope and support their recovery program. The fact that spiritual contemplation can be registered in terms of brain activity leads to a neuro-scientific reality (Begley, 2001).

Recovery is Supported by Peers and Allies

The format of AOI in WRAP is similar to offerings of AOI in other settings, with the addition of observances for special events and celebrations of holidays. These enrichment activities are intentionally added to help create community and mutuality among the incarcerated women and facilitators. Incorporating a snack, conversation, and prayer with unfamiliar people from outside the correctional facility may equate to what Goldberg and Hoyt

(2015) call a microcosm of reality. Participants in the small group become familiar with that which might also be experienced in the larger community in the form of support from peers and allies. Relational exchanges are shared pertaining to faith or not significant to faith at all. AOI aims to provide what Denton (1990) notes as a faith nurturing perspective, emphasizing love and support as opposed to a distancing frame of reference, with an "us vs them" mentality. Successfully engaging in meaningful relationship equates to acceptance. Acceptance helps reinforce hope for betterment.

Recovery is Supported Through Relationship and Social Networks

Social support is a significant factor in considering treatment, engagement in treatment, and recovery (Cavaiola, Fulmer, & Stout, 2015). Making new friends, connecting with the outside world, modeling social behaviors and norms outside of substances are described as being as significant to the AOI experience as the tools and concepts themselves. Participants get to know contacts from the church and community, receive and show care, and live out concepts of AOI in real time. Inclusion into the larger faith community is an essential part of recovery and can successfully foster a sense of hope (Robinson-Dawkins, 2011).

In addition to assisting with recovery in general, AOI's focus on relationship building can directly assist persons who are incarcerated as they reintegrate into society. Berg and Huebner (2011) emphasize the importance of relationships in rebuilding after incarceration and find recidivism is reduced with strong social ties. Strong social bonds are essential for reintegration and yet relationship dynamic variables change over time (Hepburn & Griffin, 2004). Lafferty, Treloar, Butler, Guthrie, & Chambers (2016) reinforce the importance of developing social capital for reentry success and note the significance of trust and safety among other elements in the development of formal and informal interpersonal connections. Being away from community and family can be isolating (Weill, 2016), and reintegration into the community from incarceration is enhanced through strong social relationships, a stable residence, and employment among other prosocial behaviors (Western, Braga, David, & Sirois, 2015).

Congregations hold vast resources of social capital which hold potential for relational connection, stability in residence, and employment networking. Doors of connection are explored and experienced through AOI for those who desire to reconnect or make a new connection with the local church as noted by Trulear (2011).

Recovery is Culturally Based and Influenced

Hodge (2011) argues that religion and spirituality represent a fundamental aspect of culture which is significant to the cognitive and emotional lives of many substance abuse clients. Westermeyer (2014), in his study on Alcoholics Anonymous, concurs that culture and spirituality are closely interconnected. An individual's spiritual and religious beliefs, like any other set of cultural values, are legitimate considerations in the clinical process. To the extent that these beliefs are pertinent to a client's recovery, they deserve the same respectful, ethical, and skillful attention as any other relevant value. Hodge (2011) suggests that spirituality emphasizes the personal, whereas religion emphasizes the corporate. Individuals who are normally uninterested in seeking traditional chemical dependency treatment may be more open to treatment that incorporates spirituality as a central dimension of therapy as it connects to their cultural values.

While spirituality and religiosity have been found to be culturally relevant, Canda and Furman (2010) caution social workers from executing a spiritually and religiously based program for fear of exerting undue influence from a position of power, neglecting participants' rights to self-determination. Additionally, they caution against inappropriate pressure and proselytizing. Not addressing ethical concerns and the possible limitations of AOI would be an oversight (Hodge, & Lietz, 2014). Knowing oneself, one's motivation, and one's hidden agendas (Locke, Myers, & Herr, 2001) is fundamental to respecting the first standard listed in the NASW *Code of Ethics* (2017), 1.01 Commitment to Clients: "The primary responsibility is to promote the well-being of clients. In general, clients' interests are primary." Therefore, any interactions with participants must be purposefully intended to assist attendees in making desired changes. According to multicultural practice competencies, social workers' awareness of their own biases, knowledge, and skills with regard to their respective cultural backgrounds is fundamental (Straussner, 2004).

To address multicultural practice competencies on a programmatic level, WRAP staff makes a non-pressuring invitation to participants of the opportunity to attend AOI each week; some subsequently attend, and others choose not to participate. For those who choose to attend, participants learn that AOI is a faith-based relationship building approach with a connection to God's invitation to us and our invitation to one another. John 3:16, Matthew 7:12, and Luke 6:31 of the New Testament Scriptures are pivotal verses, shared initially to provide a brief introduction. Participants are told that no one is called on or singled out; all input and beliefs are honored.

The weekly experience of AOI is about sharing tools and concepts while listening without judgement or assessment. In this way, AOI is not clinical or diagnostic. While formed out of social work tradition, AOI is

shared in WRAP as a non-denominational, faith-based approach, identified with the church. This is culturally relevant because most participants of AOI self-identify as Christian, and many have a familiarity with the Scriptures. The predominant religious affiliation of WRAP participants, expressed as Judeo-Christian, is not surprising in that 71 out of 100 people in the U. S. identify as Christian, with the South and Midwest showing the most pervasive presence (Alper, & Sandstrom, 2016). Some participants in AOI describe having had negative experiences with the church, while for others the church has been a place of sanctuary. AOI provides a non-judgmental space for group members to explore and/or reconnect with their spiritual and/or religious cultural beliefs and values. When participants attend from other faith perspectives, sensitivity is shown to respect and honor participant self-determination of religious preference. This type of sharing is consistent with AOI keys to invitation: seeking to understand without judging, sharing openly and honestly, and caring and receiving care. The voluntary nature of the program, feedback from participants and staff, along with the positive findings from the exploratory study suggesting universal application of AOI across populations (Teike & Sneed, 2018) suggest that the potential benefits of offering a religiously- and spiritually-based program outweigh the potential risks of exerting undue influence upon those in recovery programs such as WRAP.

Recovery is Supported by Addressing Trauma

The National Center on Substance Abuse and Child Welfare (2015) cites exposure to trauma as a significant factor in substance use disorders. A study of 60 female participants in a prison-based substance use treatment program found that over half were diagnosed with PTSD and had significantly higher rates of drug relapse upon release than did women with a background of substance misuse only (Kubiak, 2004). Typically, sources of the trauma were early childhood sexual abuse and/or later domestic violence and rape experiences.

One of the most important system changes for a person needing help with coexisting disorders is the development of integrated treatment programs, now the preferred model of SAMHSA (2005). A parallel development of the principle of "no wrong door" means the healthcare delivery system (mental health, physical health, and substance use treatment) has a "responsibility to address the range of client needs wherever and whenever a client presents for care" (SAMHSA 2005, p. 12).

As part of the system of care, AOI is not intended to replace the intense therapeutic work leading to healing from traumatic occurrences. Yet, AOI could be considered a trauma informed environment in that it promotes safety, provides for transparency of purpose and context, recognizes the

importance of peers, is collaborative, fosters an environment of mutual respect, encourages individualized strength building, and seeks cultural competence (SAMHSA, 2014).

One of the leading experts in trauma, Van Der Kolk (2015) connects trauma with a sense of shame and self-hatred that becomes trapped in the mind and body. Often these feelings become overwhelming and, in an attempt to suppress unwanted emotions, persons turn to chemicals to cope, consequently leading to addiction (Puffer et. al. 2012). Therefore, the incorporation of religiosity and spirituality in addiction treatment, as found in AOI, is encouraged (Jacobsen, Southwick, & Kosten, 2001). Positive religious coping is characterized by a belief in a loving God or Higher Power that offers support and help (Piderman, Schneekloth, Pankratz, Maloney, & Altchuler, 2007), as well as the use of a theological framework that helps one make meaning out of suffering (Pargament, Koenig, & Perez, 2000).

Religious coping may be mobilized during times of acute stress, specifically when an individual's typical coping strategies may be insufficient to meet the demands of the stressor (Koenig, King & Carson, 2012). This also motivates the individual, without high religiosity, to use religious coping (Pargament et al, 2000). Acute stress is common to all persons in recovery; when coupled with trauma, developing healthy coping strategies, including religious coping, becomes instrumental in maintaining long-term sobriety (Glaser, 2013).

Van Der Kolk (2015) purports mindfulness as a way to calm the survival regions of the brain triggered by trauma yet stresses this only becomes truly helpful when combined with self-compassion. AOI is specifically designed to increase each group member's sense of self-value; this leads to self-care and self-compassion. AOI participants often end each weekly session with a mindfulness meditation and/or prayer and, subsequently, group members report experiencing a sense of peace.

Recovery Involves Individual, Family, and Community Strengths and Responsibility

"Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery" (SAMHSA, 2012b, p. 7). The role of the church within communities needs to be addressed. Griffith, Myers, and Compton (2016) suggest that the church can help eliminate stigma and provide sanctuary when it is intentional about caring for those recovering or needing specialized care. Their research is with significant mental illness, but the implications are there for those recovering from substance use as well. Perez (2009) suggests the number of persons struggling with addiction are staggering, resources are limited, and people of faith can make a difference.

AOI provides the opportunity for church communities to responsibly address discrimination and foster social inclusion on two levels. First, content and group interaction aim to validate participant worth and value on an interpersonal level. Self-perception issues which stem from stigma and judgment, even stigma and judgment from within the church, are refuted. The director of WRAP (R. Gaskill, personal communication, March 16, 2018) suggests the power of AOI, from the women's perspective, is when people who are not in recovery want to associate with them. Social ties can transform identity (Weill, 2016), and in AOI, facilitators and participants are sojourners of faith, equally loved by God. Facilitators of AOI create what Saleebey (2006) describes as a helping environment through which skills, attributes, and abilities are consciously modeled.

Second, AOI helps fight stigma and judgement within the church, which is part of the larger community. As women from WRAP re-enter life in the community, they have the potential opportunity to connect with those within the church with a common language and experience. Where invitational and compassionate community is found within the church, those who may have at one time felt overlooked, forgotten, stigmatized, insignificant, and/or like an outsider can find places of connection (Teike, 2012) as insiders, which is particularly significant for those who desire to be a part of the larger church community. Having returned to the community, belonging is communicated through signs like greetings and other welcoming nonverbals (Crisp, 2010). As WRAP participants interact with AOI facilitators and others in the community, interpersonal validation and inclusion in non-drug related community activities becomes an ordinary, yet significant, means of fighting stigma and judgment.

Recovery is Based on Respect

Respect is at the heart of AOI. An invitational approach strives to relate to others as equals, regardless of role or position. Ferguson & Walker (2002) identify respect as being one of the top ten relational needs of human beings. This spiritually based conclusion aligns with the significant work of John Bowlby, author of Attachment Theory, and Mary Ainsworth, who established the importance of a secure base and essential human needs for security, belonging, and acceptance (Riggs, 2010). People thrive when these relational needs are met and struggle when they go unmet (Leary, 2010; Seppala, Rossomando, & Doty, 2013). Significant to recovery is the work of Lieberman (2010) who asserts that pain experienced from rejection and relational distress runs through the same biological centers as physical pain. Maslow suggested that basic needs of food, shelter, clothing and safety are the most critical; however, brain science has revealed that relief from extreme social pain is critical to survival as well (Lieberman, 2010).

A respectful environment is essential in promoting recovery. To support this ideal, participants of AOI share together experiences of respect and disrespect as they connect to choices of communication style. For example, as participants role play a scenario in which a landlord shares a lease with a tenant in a confrontational, presentational, or invitational style, respect or lack of respect is viscerally experienced and discussed from both sides of the exchange. Additionally, the relational needs of Jesus, Paul, Mary, and Moses provide tangible Biblical examples of instances when relational needs of significant spiritual leaders were met, as well as neglected. As discussions ensue, individual experiences, insights, and perspectives are respected as authentic and valuable.

Through consistent investment of time and attention, respectful conversation, patience, and care, AOI strives to communicate a high relational value which equates to what Leary (2010) suggests is needed to experience acceptance.

Conclusion

This article demonstrated the alignment of AOI with the Ten Guiding Principles set forth by SAMHSA as demonstrated through the application of AOI with incarcerated women in a treatment setting. The guiding principles include: 1) recovery emerges from hope, 2) recovery is person-centered, 3) recovery occurs via many pathways, 4) recovery is holistic, 5) recovery is supported by peers and allies, 6) recovery is supported through relationships and social networks, 7) recovery is culturally based and influenced, 8) recovery is supported by addressing trauma, 9) recovery involves individuals, family, and community strengths and responsibilities, and 10) recovery is based on respect.

While AOI did not originate with the purpose of intervening with persons struggling with addiction issues, past participants of AOI suggest that there are universal applications in both secular and faith-based settings (Teike & Sneed, 2108). AOI is an additional option that complements other traditional addiction treatments. Since 2012, AOI has been facilitated in a Midwestern USA county inpatient treatment program with incarcerated women called Women Recovering with A Purpose (WRAP). As a psychoeducational approach to relationship building, AOI is a synthesis of science, social work practice, and Judeo-Christian beliefs, creating what Califano Jr. (2002) calls a sum total experience that is greater than its parts. The women in AOI and WRAP have anecdotally, consistently, and voluntarily expressed appreciation for the content, as well as the approach of AOI, as it relates to a spiritually based, psychoeducational offering. Insights and connections vary from person to person; however, when given the opportunity to reflect upon their experience, WRAP participants express overwhelming agreement that AOI supports their needs and recovery.

As past participants support the use of AOI in diverse settings (Teike & Sneed, 2018), the church has an opportunity to utilize AOI not only to show God's love and kindness, but also to provide tangible and relational support to those seeking a restored life. Goode, Lewis, and Trulear (2011) suggest that churches should have specific ministries that provide for culturally sensitive approaches to special needs. Whereas churches are oftentimes known for culturally sensitive ministries for those who are homebound, those who are hospitalized, and those in hospice, AOI could be used by ministries and/or chaplaincies as a means to integrate faith and care for those with substance use disorders. Substance use has often led to persons being hungry, thirsty, sick, a stranger, and in prison - those identified by Jesus as in need of our care (Matthew 25: 35-36; Luke 25-37).

While widespread application has yet to be tested, utilization of AOI with the women of WRAP seems to show great promise for the purposeful application of AOI in recovery and incarceration settings. Further development of AOI should include training materials for those who desire to share AOI with those recovering and/or incarcerated. A formal study could allow for greater understanding of recovery benefits and best practices. Restoration of relationships during recovery is essential, and as many people desire spiritual and/or religious perspectives to be incorporated and/or offered with traditional treatment modalities, AOI is one approach for those seeking a Judeo-Christian connection. ❖

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The Christian Social Worker in Recovery: A Personal Reflection on Professional Stigma, Bias and Discrimination

Denise L. Jaillet Keane

As a professional social worker in long-term substance use recovery, I have come face-to-face with stigma, bias and discrimination regarding those who struggle with the disease of addiction. I have made choices regarding when and where and if to disclose that I am a person in recovery. I have listened to colleagues engaging in "us" and "them" conversations, forgetting that I am both them and us, not realizing how offensive and judgmental their language was. Funders overlooked my identity as a person in recovery, as they requested agencies to hire more "peer mentors," but did not count recovering clinicians or senior management. The result of a qualitative self-interview on the experiences of being a Christian social worker who just happens to be that 1-in-7 (Hafner, 2016) who has faced a substance use disorder, this paper presents a person-centered perspective regarding working as, or with, a social worker in recovery.

David Miller, LISW, ACSW, DCSW and past national chair of Social Workers Helping Social Workers, believes that the field of social work is in denial about substance use among its 165,000 NASW members (Miller & Fewell, 2002). Although the organization has been in existence since 1980, Miller reported in 2002 that this organization that directly assists professional social workers with substance use issues had only counted 800 members in total over those 22 years. Christine Fewell, CSW, BCD, CASAC and chair and founding member of the Peer Consultation Committee of the NASW, New York City Chapter's Addictions Committee, concurs (Miller & Fewell, 2002). Fewell believes

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it is a "complicated phenomenon" that involves shame, secrets and… all the feelings that our professional aspirations and training have added about ethical responsibility, control of our feelings and behavior, (and the) defensive need to be the caretaker and helper rather than the one who receives help" (p.102-103). Media stories often feature high-profile personalities who have substance use disorders looking their worst, being arrested, going into treatment. The words used to describe them are often unkind and stigmatizing. The advances in genetics and neurology that have brought us scientific evidence that makes it clear that substance use has biological components that cannot just be willed into submission have not eliminated moral, class, and ethnic stigmas associated with the disease. If Miller and Fewell are accurate in their conclusion that social work is in denial about social workers with substance use disorders, it is not a denial based upon readily available scientific data. The denial is a demonstration of a socially acceptable, ingrained bias that "good" persons do not get addicted to substances, fed by negative media portrayals and perhaps an unconscious desire of social workers to feel they are a step up from their clients.

Kubek (2007) chronicled the story of a social work student in recovery who "feels a bit annoyed whenever she hears fellow classmates . . . make judgmental comments about people who abuse alcohol and other drugs." The student in recovery felt they should be learning how to convey acceptance, and knew from personal experience that judgmental language is not safe. Without direct confrontation, the negativity towards those with a substance use disorder will continue into the field. It will impact the future social workers' relationships with clients and co-workers. Social work as a field must not be in denial of this problem – a problem experienced not just by the story noted above, but one I have also experienced.

Lived Experience

Like all persons, my life is a kaleidoscope of relationships and roles. Some know me as the person they see in the gym, as someone they have seen shop in the local food co-op, or as the professor from a course last semester. Others may recognize my name from a political yard sign, from a list of board members of a non-profit organization, or as the clinical director of a behavioral health agency sometimes featured on the local radio show. To others, I am mom, grandma, aunt, sister, partner, and friend. Those closest to me recognize that I am a Christian in recovery.

If asked the common interview question of "How would your co-workers/supervisor describe you?", I would without hesitation reply, "As an intelligent, creative, dedicated, hard-working and reliable employee." I identify as a Christian, a social worker, a philosopher, and a person in recovery.

I have written this paper from an experiential perspective as a multi-faceted, multi-talented, and probably over-extended person, who has embraced life on life's terms.[1] I cannot write from an objective, observer perspective. My lived experience[2] has merit in and of itself. I therefore write of my experiences through a lens developed by relationships, roles and experiences too numerous to mention.

The Lens

The overriding paradigm in which I function is that of Christian ideals. Faith, hope and love guide my life and my clinical and macro practice. These ideals are the foundation from which I respect the dignity of each individual person and fight against oppression at large. My Christianity informs my interactions, both micro and macro, as a social worker. I attempt to model Christian ideals. I discuss religion with my clients and co-workers. I attempt to be a light in the darkness for others, and when feeling unsure or overwhelmed, I stop and pray for guidance and the knowledge of God's will. I am thankful to have faith, hope and love as my guideposts for social work, as I do not understand how social workers can maintain effective, quality clinical care without them.

The second paradigm for my life is the Alcoholics Anonymous (AA) 12-step philosophy. Although clearly not designed to be a religion, 12-step philosophy perfectly complements my religious practices and the way I live as a Christian. While some persons in AA have embraced G.O.D. as an acronym for "Group of Drunks" or "Good Orderly Direction," most of my AA friends are also Christians who recognize God as the father of Jesus and the essence of the Holy Spirit. The basic principles of AA – a spiritual awakening, humility, patience, faith, confession, forgiveness, demonstrated love for others, making amends for wrongs done, seeking God's will through prayer and meditation, and sharing the good news – align perfectly with basic Christian principles. While both paradigms are therefore complementarily directing my lens, the 12-step philosophy is more directly guiding the practice-driven experiences expounded in this paper.

Theoretical Perspective

There are aspects to the participatory and constructivist perspectives that resonate with me and are relevant to this paper. For example, a participatory view is that "validity is found in the ability of the knowledge to become transformative according to the findings of the experiences of the subjects" (Lincoln, et al., 2011, p. 114). Knowledge which has the ability to transform must have such a high level of authenticity that it creates an inherent power; that level of authenticity equates to validity. What can

be more authentic than a person's lived experience, documented in their own words? The collaborative nature of the constructivist paradigm in which people are participants in documenting and telling the truth of their experiences, rather than subjects, (Guillemin and Gillam, 2004), minimizes superficial power differentials. It resonates for me as someone who does not want to choose a label – am I the researcher or the researched? Am I the professor or the student? Am I the social worker or the client? The constructivist paradigm amalgamates the interpretations of my multifaceted perspectives regarding my lived experiences so that they have the power to inform; that perspective is "ontologically relative, epistemologically transactional/subjectivist, methodologically hermeneutical and dialectical" (Lincoln, Lyndham, and Guba, 2011, p. 99). "Denise the Christian" joined with "Denise the Social Worker" and "Denise the Person in Recovery" in an integration of the ethics, values, knowledge and experiences of these roles to form the whole of who I am and how I interact with and experience life.

First Professional Interview

One of the first experiences I recall as a social worker in recovery was actually quite positive. After obtaining an undergraduate degree in philosophy and religion, and a Master of Arts degree in education, I felt the distinct call to social work. I started a Master of Social Work program and after the first year, I applied to be the program director of a female gender-specific Department of Correction work release/treatment program in a larger umbrella behavioral health agency that I will call "XYZ." During my interview for this position, I was asked how I felt about incarcerated women. Knowing that most of the program participants were incarcerated due to substance-related offenses, I honestly answered that if not for some good luck and God's will, I could just as easily be sitting in their seats instead of where I was. This was the first time I publicly acknowledged that I was a person in recovery from a substance addiction. Due to the nature of the work for which I was applying, and knowing that the agency was committed to hiring people in recovery, I felt confident that my disclosure would not be used against me. Not only did I get the job, but I discovered that the two social workers on my clinical team were also Christians and in recovery. What a wonderful experience for us as co-workers and for the vast majority of women who benefitted from that program who were also Christians in recovery.

Classroom Experience

However, at the same time as I was experiencing this freedom of truthfulness, I was not feeling free to have the same level of openness in other areas of my life: my church family, my volunteerism with local

non-profit organizations, or my MSW program. During my last semester as a MSW student, one of my professors was upset that I used the term "alcoholic" in self-reference during a class discussion. She felt that the terms "alcoholic" and "addict" were too negative; she directed us to use the terminology "a person with an addiction concern." Instead, I wanted to debate this with her, let her know that it took me a year of attending 12-step meetings and actually receiving my one year coin[3] before I had acquired the reality and humility necessary to say, "I'm Denise and I'm an alcoholic." I wanted to explain to her and the other almost-social workers that those of us with the disease of alcoholism want everyone to be as comfortable with naming the disease for what it is as they are with saying "he has diabetes" or someone announcing "I'm a vegetarian." By being oh-so-careful with the words, social workers can actually endorse the stigma associated with the name of the disease instead of working to eliminate it. Additionally, social workers can give the message to those who want the freedom to tell their truth that they should not, that saying the name of their disease is like saying the name of "He-who-shall-not-be-named." The repetitive declaration in AA rooms that I am an alcoholic has been vital in keeping me from the fantasy that I am cured. I wanted to say all of this, but did not. I was not yet confident enough in 2003, after nine years of sobriety, to enter into this needed discussion on the difference between labelling others and self-labelling.

This view of the use of the word "alcoholic" is in stark contrast to my usual testiness at the limitations placed upon persons through labels, categories, and generalizations. I cringe when others attempt to put me into a box that fits within their own narrow window of experience, and I fight for the rights of others to whom this happens. However, I also know the freedom of finding out the name of the disease or disorder with which one is living and facing the realities of that disorder head-on. "Alcoholic," used as a term for someone with a brain disorder, is liberating to me. It allows me to understand why my body will crave something that is so harmful to me, something that I do not intellectually want, and something that affects my ability to live according to my Christian ideals. It permits me to give and accept forgiveness for things I have done while under the influence, and to have empathy and understanding for those who are just learning they have a chronic addiction. However, if someone does not understand that alcoholism is an incurable disease and is using the term "alcoholic" to belittle, deride or dismiss, then it becomes a pejorative label that should not be tolerated.

Continuing Education Experience

A few years later, after becoming a licensed clinical social worker, I attended a continuing education course on Cognitive Behavioral Therapy offered by our state's Department of Mental Health and Addiction Services.

This was an intensive four-day course taught by a professor whom I knew, as I was a field instructor for some of his interns. Over the course of the four days, he referred to the differences between how "we" (social workers) think and how "they" (substance users) think so many times that I lost count. The message I received was that substance users all have cognitively distorted thinking patterns and social workers do not. At first, I wrote this off as a necessary convenience of speech, but after a while it became more and more irritating. Was he implying that there was no social worker in the class who ever had to reframe their thinking? Was he ever going to mention that persons in recovery work on being aware of, and reframing their thinking daily, so that they actually become quite expert at it? Did he mean to give the message that no one in this class could possibly be both a social worker and in recovery themselves, despite the one in seven statistic (Hafner, 2016) of persons in the U.S. facing a substance use disorder?

Alcoholism, as any disease, knows no boundaries based upon class, ethnicity, gender, religion, or other demographics. The Substance Abuse and Mental Health Services Administration (SAMHSA) website notes that 6.4% of the population of the United States, or approximately 17 million persons, met the criteria for an alcohol disorder in 2013 (SAMHSA, 2018). Bush and Lipari (2015) analyzed statistics from SAMHSA's 2008-2012 studies and found 8.7% of persons in full-time employment between the ages of 18 and 64 used alcohol "heavily" during the last month. Heavy alcohol use is defined as "drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on five or more days in the past 30 days." Given these statistics, the probability that I was not the only person in recovery in that classroom was high. However, again, neither I nor anyone else spoke up. I addressed the issue by going to a 12-step meeting after the last course session where I felt I could safely talk about how offended I felt.

Reflecting upon this experience, I realize I had two primary reasons for not confronting the offensive language head on. First, the instructor was a colleague of mine at my part-time adjunct faculty position in a state university. I had been a field advisor for that university's BSW program and been invited by this very instructor to join the adjunct team. I was concerned how my being a person in recovery would impact my status in the department that someday I hoped to join full-time. Secondly, I was hoping for someone else to speak up on behalf of social workers in recovery. I still had enough shame and embarrassment associated with being in recovery at that time to be looking for a rescue from being the spokesperson on this issue. I understand now that it is unrealistic to expect those who are not in the same situation to always recognize when apparently common language is offensive to someone else. Each of us is the one and only expert on our own experiences. It is incumbent upon

those of us who have experienced discrimination or bias to inform others as to the impact of their words or actions.

Professional Behavioral Healthcare Experiences

Over the course of my professional social work career in the behavioral health field, I have become more open about my recovery status–not in all my roles, but with the staff and clients of XYZ, and with people and organizations in which I have a trusted status. Many times my self-disclosure receives a response along the lines of "No way" or "Well, no one would know it." They are often surprised to hear that I continue to attend as many AA meetings a week as I can (usually 3-4). This is despite the fact that they tell clients with substance use disorders that they will have their disease forever and might want to try to attend AA or Narcotics Anonymous (NA) as an aftercare measure when they are no longer in formal treatment. For some reason, when it comes to a colleague in a senior management position, these same expert clinicians do not stop and think about the fact that I will also always have a need to manage my disorder so that it does not resurface. I know that these colleagues have the academic knowledge that alcoholism is a chronic, progressive disease, sometimes manageable into remission, and cannot be "cured." I wonder if they understand the "us" and "them" perspective they are portraying by their incredulity that I vigilantly work my recovery every day. These social workers appear to have a need for staff to be different (maybe better?) than the individuals they are assisting. I am thankful that I continue to know that, but for the grace of God, any one of us could be sitting on the other side of the desk.

Perceptions of Relapse

A message I have often heard from colleagues is that "relapse is a part of recovery". This has been said directly to me; I have overheard from those around me, and it has been reported by clinicians, mentioned by state experts, and believed by clients themselves who heard it from XYZ staff. It has become a common phrase used not just after a relapse, but used by those in the field prior to a person's recurrence of substance use. However, persons in recovery who remain compliant with the management of their disease through a personalized regimen that can include 12 step meetings, working the program of AA or NA with a sponsor, therapy, medication, or other treatments, may never experience a recurrence or relapse. Relapse has not been part of my recovery, nor has it been part of many of my friends' recovery stories. I am hopeful that it never will be. Clearly meant to empathetically support those who slip while walking their recovery paths, the "relapse is part of recovery" message is not a positive message for those who do not

experience such a recurrence of use. I feel the hackles of defensiveness rise in me every time I hear it. An accurate and caring alternative is the message that "relapse is sometimes a part of recovery." This message can prepare a client if a relapse occurs, but also promotes the hope that relapse need not happen. The reality is that relapse may be a part of recovery, or it may not. The path of recovery is not a straight path, nor is it without its potholes and obstacles. Sometimes a person in recovery will traverse it without slipping despite the trials; sometimes a person may fall down and reach for an old coping strategy. The innate judgmental quality of "relapse is a part of recovery" when presented to or about every person challenging a substance use disorder diagnosis is a message of inevitable failure that should not be sent to a client or a co-worker. It is not an unconditional message of faith, hope or love.

Staff Relapse

During the years that I have worked for the company XYZ, it has experienced the relapse of some of its staff in recovery. These relapses have ranged from a short-term, easily managed with an outpatient treatment program bender, to the death of a staff member from an irrecoverable alcohol overdose. Each time a relapse has occurred, I have witnessed a perceptible change in management's willingness to hire another person in recovery. Rather than look at the feelings generated by the relapse and what we, as an agency, could do to better support staff with this disease, management diverted the issue in other directions. The ideas that someone who attends 12-step meetings is unable to maintain professional boundaries and that persons in recovery just "don't get it when it comes to professional ethics" began to be freely floated around in meetings in which I was in attendance. All participants in those discussions knew I was in recovery. My request to stop anecdotally generalizing, to recognize that our staff in recovery were especially effective with our clients, that "you do remember that I am in recovery too," were all either ignored or dismissed. When I first joined XYZ, 40-50% of staff were in recovery from a substance use disorder, with staff in recovery openly recruited as beneficial to the agency.

At the end of 2017, when after over 10 years of advocacy I finally obtained permission to start an in-house 12-step meeting to support staff in recovery, I could only find five other staff in recovery out of a workforce of 110. During those years, the percentage of applicants in recovery remained the same, but the perspective of the hiring managers progressively favored persons not in recovery. Agency oversight of staff in recovery became more intense, with a prevailing attitude that persons in recovery were suitable only as peer mentors for clients, volunteers for leading in-house client support groups, or to manage the recovery houses. The concept of recruiting

clinical or administrative and management staff in recovery to enhance the diversity of our teams no longer existed. Unfortunately, reinforcement of this attitude is an unintended consequence of state-sponsored initiatives to have agencies hire Recovery Support Specialists and Recovery Coaches — persons in recovery who operate as paraprofessionals.

Staff in Treatment

One staff member who had not yet made his disease public experienced direct discrimination. While one of his co-workers went out on medical leave for several months to deal with a "medical" illness, harsh questioning ensued as to why he needed more than 30 days to attend an inpatient program to treat alcoholism. Senior management questioned the seriousness of his need for treatment because "we've never seen any signs that he had a drinking problem at work." Having overcome the hesitation early in my career to speak too much about my disease, I reminded my co-workers that no one ever knew I was an alcoholic at my previous places of employment, prior to my being in recovery. I let them know that given my past pattern of drinking and still functioning at my job, they would never be able to tell if I relapsed unless I chose to tell them. I reminded them that, as an agency, we know that once someone has reached the point of needing residential treatment, 30 days will only clear the head enough to start in-depth work – that is why XYZ's residential treatment program has a four-to-eight month stay, dependent on individual needs. Why would we hassle a staff member for wanting to take 60 days to learn to manage his chronic disease? Both the HR manager and the CEO of XYZ were social workers and they continued to be unsupportive of more than 30 days for his treatment, despite a letter from his treatment provider stating the need for a longer stay.

Employment Challenges

Social workers in recovery who choose to work in behavioral healthcare have many employment-based challenges. For example, some agencies have restrictions that include not attending or not sharing at 12-step meetings where agency clients are present, not having enough time during the day to catch a noon-time 12 step meeting and/or missing dinner to participate in a distant evening meeting, not sponsoring clients, and not self-disclosing your recovery status. Staff in recovery couple these stressors associated with maintaining treatment compliance for their chronic disease of addiction with the everyday stressors of interacting with clients who often exhibit the physical signs, smells and behaviors of active addiction and the vicarious traumatization often experienced by behavioral healthcare staff.

As another example, it is common to find that persons in recovery are only considered for entry level "peer" positions in an agency, rather than professional positions. When state funders requested the presence of persons on XYZ's boards and committees with lived experience, they did not accept "professional" staff in recovery as fulfilling that request. I cannot speak for others, but this staff-in-recovery is unable to dissociate myself from a person- in-recovery perspective. I live and breathe my recovery, as I do my Christianity. It informs and defines who I am. I recall a state auditor asking how many peer support staff worked within one of XYZ's programs. When I included myself in the count, the auditor responded, "Well, you don't count – we are only counting peer support." This was a perfect example of what Kaplan (2005) called the concept of associating staff in recovery only with para-professionals. I responded that I was a peer support and role model, as the residents of the program knew I was in recovery. The auditor dismissed me with, "but you're, well, you're different." Her perspective appeared to be that only persons in recovery who are not also behavioral health professionals count as "peers;" alternatively, it could have been that once you have achieved a professional status, you no longer count as a person in recovery. Either perspective is offensive and discriminatory to those of us who are living a life that merges those roles.

An employment-based role challenge for me is the opposite ways in which some co-workers regard my "Christian" tag as compared to my "person-in-recovery" tag. When religious clients came to our agency, intake screeners often assigned them to receive services from the few openly "religious" staff (myself included). Other social workers support this move by saying that they are not familiar enough with religion to give quality care – they have not read the religious texts, they do not attend religious services, and they feel inadequate to the task. However, when clients come to our agency to receive help with their substance use disorders, the same social workers do not feel inadequate even if they have not read Alcoholics Anonymous, have not attended 12-step meetings, and do not have a substance use issue themselves. I believe that any social worker can effectively work with any client if they are open to a transactional relationship in which each is learning from the other. What is curious to me is why I am regarded as a go-to social worker for religious clients, but I am no different than any other social worker for clients with substance use issues. I would love to be a resource for co-workers as a person in long-term recovery who can dispel the myths that surround AA, who can teach the AA lingo[5] of the rooms,[6] who may be able to shed some light on why a client does not appear to be progressing even after "last chance" behavior contracts and ultimatums. Agency staff whom I have supervised continue to utilize the knowledge regarding alcoholism and alcoholics I have acquired through my personal experiences and choose to share with them. However, XYZ

is uncomfortable in acknowledging that I, or other staff in recovery, may have useful knowledge not found in textbooks.

Despite the prevailing attitude, there have been those staff who have actively sought my help with challenging recovery situations. A former MSW intern of mine hired by XYZ often requested my person-in-recovery perspective, as well as my clinical social worker perspective, in consultation for challenging clinical situations. In addition, one Program Director within XYZ often called upon my insight as a person in recovery to assist with both individual and group situations. I recall a time when a particular 12-step meeting in the wider community requested that the residents of the treatment program she directed not return to the 12-step meeting. She realized that neither she, nor any of her staff, understood the etiquette involved in 12-step rooms and therefore was unsure how to resolve this dilemma. One of the privileges I afforded myself as a senior management team member was the opportunity to take off the "big boss" hat and replace it with the "AA Old-timer"[7] hat, as appropriate to the situations. This I did when speaking with the residents as to the unwritten expectations of attendees at the 12-step rooms in our community. For instance, they needed to "take the cotton out of their ears and put it in their mouths"[8] (just the opposite of treatment). I also reminded them that there were very few 12-step group members whom I did not personally know and who did not hesitate to contact me when there were issues within the meeting rooms caused by agency clients. This was a dual relationship. However, there are times when dual relationships are not only permissible, but helpful. I was able to contact a few of that particular 12-step meeting group's members and facilitate the invitation to our program residents to return the following week. This was not a dual relationship that was exploitative, or resulted in harm to the clients, or personal gain for the social worker. Dual relationships between social workers in recovery and their clients are often inevitable, particularly in small communities. The measure of appropriate ethical behavior in those circumstances lies in ensuring that the needs of the client are paramount (in this case, learning to appropriately participate in AA and be accepted at any and all AA meetings, so that this life-long treatment tool can be successfully utilized) and that the social worker is receiving no personal benefit or gain. I am always thankful when a co-worker recognizes the unique contribution a social worker in recovery can bring to those to whom we offer substance use treatment services.

Recommendations for Practice

Working within a behavioral health agency afforded me the opportunity to be a role model for thousands of clients trying to obtain and maintain their sobriety and/or clean time. However, careful to maintain my professional

boundaries, I did not sponsor women in the 12-step meetings I attended. Living in a small community, there was a chance that if someone was not already a client of my agency, she would be at some point in the future. I also did not share my personal story in 12-step meetings where agency clients are present.[4] I do share treatment and other recovery resource information with anyone in a 12-step meeting who asks for it. Thankfully for my own recovery, I have a strong recovery network of persons who are also in long-term recovery that I can call and share with outside of a meeting room.

The field of social work should embrace the experiences of social workers in recovery as easily and positively as those many clients from XYZ did. I continue to use discretion about when, where and why to discuss my disease with others. Due to a lack of education and understanding about addiction, there are personal contacts and parts of my life in which disclosure of my disease is not possible. However, I did expect that social workers would understand and not show any signs of stigmatizing, bias or discrimination towards fellow social workers who happened to be in recovery. The basis for that expectation was partly due to social workers' educational knowledge and partly due to the application of our field's ethical principles and statements found in the *NASW Code of Ethics* (2017):

- Social workers respect the inherent dignity and worth of the person.
- Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity
- Social workers strive to ensure… equality of opportunity and meaningful participation in decision-making for all people.

My personal experiences and reflections can provide a foundation for positive change by the elimination of professional social work stigma, bias and discrimination towards peers in recovery. They can also remind social workers that embracing diversity includes those with addiction. Therefore, I recommend these steps for social workers to integrate into their practice:

1. Avoid "us" and 'them" dichotomies between social workers and persons in recovery.
2. Acknowledge, respect and leverage the lived experience of colleagues in substance use recovery.
3. Reframe "relapse is a part of recovery" to "relapse may be a part of recovery."
4. Recognize that self-labelling as an alcoholic or an addict can be liberating and empowering for the person living with that chronic disease – let the person in recovery be your guide in this matter.
5. Maintain unconditional positive regard for anyone in recovery; examine your reactions toward hearing that someone has an addition and be sure it is not tinged with moral overtones.

6. Educate yourself on the biological components of the disease.
7. Speak of addiction as the "brain disorder" that it is.
8. Speak up when you hear language, remarks or assumptions that a person in recovery may find offensive.

I recommend the following action items to behavioral healthcare agencies and programs in order to better embrace and benefit by the wealth of knowledge and lived experience brought into an agency through staff in recovery:

1. Acknowledge the usefulness of appropriate staff self-disclosure of their recovery status.
2. Allow staff in recovery to appropriately share on the tenets of the program with clients in agency-based 12-step groups.
3. Provide parity in support and care for staff with substance use health needs to staff with physical health needs.
4. Allow flexibility in work schedules to permit staff in recovery to attend recovery meetings outside of the agency.
5. Provide opportunities for social workers or other staff in recovery to hold support meetings within the agency.
6. Allow staff to continue to sponsor someone with whom they had a recovery relationship prior to becoming employed by the agency.
7. Avoid pigeonholing persons in recovery to para-professional status – hire persons in recovery for every level of clinical, supervisory and management positions.
8. Utilize staff in recovery as a resource for staff training and case consultations.

In Summary

Looking between the lines of my experiences, I find the themes of shame and embarrassment, stigma and secrets that have slowly transformed after a quarter of a century of recovery into rebuttal, pride, and willingness to point out the hidden repression of social workers in recovery. Social work prides itself on being non-judgmental and empowering. Yet, I believe that any social worker in recovery would be able to recount experiences similar to those I have chosen to share. The lived experience of social workers in recovery is a valuable resource to acknowledge and embrace. Awareness that one in seven people have a substance use disorder (Hafner, 2016) should have an impact upon the language social workers utilize in their interactions with colleagues. Agencies should use that same data to review the sometimes restrictive parameters within which their social workers in recovery serve their clients and care for themselves. Substance use is a common, treatable disorder. Social workers should be taking a leading role in demonstrating, through words and actions, that we know that the acquisition of a substance

use disorder is not a choice or moral failing. While each person makes the initial decision to drink a beverage with alcohol in it, to smoke a cigarette, to take an opiate pain medication, or to try an illegal substance, they do not choose to incur an addiction to that substance. Social workers, Christian or not, are as apt to have a substance use disorder as anyone else. It is time that as a profession we step out of denial and inclusively embrace the lived experiences of social workers in recovery. ❖

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Endnotes

[1] "Life on life's terms" is a demonstration of acceptance related to step one in Alcoholics Anonymous. "Nothing, absolutely nothing, happens in God's world by mistake. Until I could accept my alcoholism, I could not stay sober; unless I accept life completely on life's terms, I cannot be happy" (Alcoholics Anonymous, 2001, p. 417).

[2] "Lived experience" is a sociological research notion that "aims to provide concrete insights into the qualitative meanings of phenomena in people's lives" (Manen, 2004, p. 580).

[3] Coins, or chips, are used in many AA groups to recognize monthly or yearly periods of recovery.

[4] Sharing of one's personal story at AA meetings is considered part of working the program of AA, but would violate professional ethics if the person sharing was behavioral healthcare staff and clients were in attendance.

[5] "AA lingo" refers to the phrases, idioms and verbiage that is common to those who participate in AA meetings, but not normally used by those who do not attend AA.

[6] "The rooms" is a phrase used by AA members to denote AA meetings.

[7] "Old-timer" is a term of respect given to AA members with decades of continuous sobriety.

[8] "Take the cotton out of your ears and put it in your mouth" is a phrase often used by AA sponsors to encourage the person new to AA to listen and learn in the meetings.

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The Spiritual and Ethical Implications of Medication-Assisted Recovery in Pregnancy: Preserving the Dignity and Worth of Mother and Baby

Cayce Watson , April Mallory, & Amy Crossland

Reducing harm, supporting autonomy, and affirming dignity are foundational values in social work practice. Attempts to balance personal beliefs, faith, and ethical responsibilities with client-centered therapies can elicit internal conflicts for practitioners. These challenges are even more evident when working with opioid dependent pregnant women in medication-assisted recovery. Medication-assisted treatment (MAT) is evidence-based and a recommended first-line approach for treating opioid use disorder in pregnancy; however, neonates exposed to opiates, either street drugs or MAT, may develop neonatal abstinence syndrome (NAS). Disagreement among treatment providers, insufficient resources for pregnant clients, and incomplete service delivery compound the stigma surrounding pregnant women living with opioid misuse. This article explores current evidence and best practices for pregnant women with opioid use disorder, the spiritual and ethical dilemmas of social workers supporting a harm reduction approach, and recommendations for individual and community-based interventions that support the dignity and worth of both mother and baby.

THE NATION'S OPIOID EPIDEMIC HAS BEEN RELENTLESS, AND the scope of opioid misuse and opioid-related deaths is a catastrophic public health crisis. Approximately 702,568 drug-related overdose deaths occurred from 1999 to 2017, and 56.8 percent of those deaths were related to an opioid (Scholl, Seth, Kariisa, Wilson, & Baldwin, 2018). The Center for Disease Control and Prevention estimates that opioid overdose

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claims the lives of 115 individuals in the United States daily (Center for Disease Control and Prevention [CDC], 2017). According to the 2017 National Survey on Drug Use and Health, 11.4 million people over the age of 12 reported misusing opioids, with most use attributed to prescription opioids (Center for Behavioral Health Statistics and Quality, 2018). Prescription opioids are a broad category and encompass several drugs typically prescribed for pain; among these are morphine, hydrocodone, oxycodone, and fentanyl. More than 47,000 opioid-related deaths were reported in 2017 alone; synthetic opioids such as illicitly manufactured fentanyl have been the primary factor driving the surge in opioid-related overdose deaths (Scholl et al., 2018).

Misleading information regarding the addictive potential of opioids, irresponsible prescribing practices, and access to prescription drugs have fueled the epidemic (Frenk, Porter, & Paulozzi, 2015; Hedegaard, Warner, & Minino, 2017). When individuals are unable to acquire an opioid prescription, they often turn toward heroin or other illicit substances to prevent uncomfortable withdrawal symptoms (CDC, 2017). Additional complexities associated with the epidemic include widespread social and familial devastation, increases in health-related expenditures, and strains on behavioral health systems and child-welfare agencies (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). Harnessing public health resources to track current trends in opioid misuse, providing education on overdose awareness, and expanding access to evidence-based options such as medication-assisted treatment are vital to prevention efforts (CDC, 2017; Scholl et al., 2018).

Impact on Women

The opioid crisis has had a significant impact on vulnerable groups, specifically women. Women are increasingly likely to die of prescription drug overdose with rates rising by an estimated 471 percent since 1999 (CDC, 2013; Office on Women's Health, 2016). Several factors place women at an increased risk for opioid misuse. Women may progress along the continuum of substance misuse at a faster rate than their male counterparts; they are more likely to experience issues related to chronic pain and often continue prescription pain medications for extended periods of time post-surgery and vaginal delivery (American Society of Addiction Medicine, 2016; CDC, 2013; Jarlenski et al., 2017; Salter & Ridley, 2015). Social work practitioners commonly encounter women with opioid prescriptions for endometriosis, chronic fatigue, migraines, and even dental pain. A woman's physiological response to substances may also be altered by hormonal and neurobiological factors, which can impact both the progression of substance misuse and the incidence of

relapse (National Institute on Drug Abuse, 2017). Furthermore, social issues including domestic violence, trauma, and poverty compound vulnerability for developing a substance use disorder. Although trauma and violence are often factors leading women toward substance use as a coping mechanism, the misuse of substances "inevitably leads to more victimization" (Van Wormer & Davis, 2018, p. 280).

In 2015, the CDC's Morbidity and Mortality Weekly Report noted the importance of screening for opioid use, specifically among women of reproductive age (Ailes et al., 2015). Opioids were prescribed broadly to this category of women from 2008-2012, and individuals enrolled in Medicaid were prescribed more opioids than those privately insured (Ailes et al., 2015). In 2014, a study of commercially insured pregnant women found 14.4 percent, or 76,742 women, had been prescribed an opioid at some point during pregnancy (Bateman et al., 2014). Additionally, a multistate analysis of hospital discharge data from 1999-2014 revealed a four-fold increase in the prevalence of opioid use disorder (OUD) among pregnant women at delivery (Haight, Ko, Tong, Boham, & Callaghan, 2018). Universal screening is critical to determine if women are misusing opioids or at risk for opioid use disorder (OUD); a comprehensive assessment can lead to early intervention before and during pregnancy (Ailes et al., 2015; American College of Obstetrics and Gynecologists [ACOG], 2017; SAMHSA, 2018; World Health Organization [WHO], 2014).. .

Pregnancy Risks

Several concerns arise for women of reproductive age related to the adverse impact of opioid misuse on prenatal safety and neonatal outcomes. One specific risk related to opioid exposure in utero is neonatal abstinence syndrome (ACOG, 2017; Association of State and Territorial Health Officials [ASTHO], 2014; Hudak & Tan, 2012; Jones et al., 2008; Ko et al., 2017; SAMHSA, 2018). Neonatal abstinence syndrome (NAS) is the term utilized to describe the clinical symptoms associated with physical withdrawal in newborns and may include excitability, excessive irritability, poor feeding, gastrointestinal distress, and difficulty with sleep (ACOG, 2017; ASTHO, 2014; Hudak & Tan, 2012; Ko et al., 2017; SAMHSA, 2016). The incidence of NAS in the US has risen from 3.4 per 1000 births in 2009 to 5.8 per 1000 births in 2012 (Patrick, Davis, Lehman, & Cooper, 2015; Patrick et al., 2012). Prenatal substance exposure and NAS rates have paralleled the rise in opioid misuse and prompted discourse among practitioners regarding best practices for the prevention and treatment of OUD in pregnant women (ASTHO, 2014; Haight et al., 2018).

While several complex maternal and neonatal characteristics contribute to the development of NAS, these characteristics cannot explicitly predict

the presence of NAS or its severity (ASTHO, 2014; Hudak & Tan, 2012; Patrick, Dudley, Martin, et al., 2015). Contextual factors during pregnancy, including duration of opioid exposure, tobacco use, and the category of opioid prescribed, have been shown to elevate the risk of NAS (Patrick, Dudley et al., 2015). NAS can manifest with both illicit drug use and medication assisted treatment; however, the former may expose women to trauma, abrupt withdrawal, tainted street drugs, and preterm labor (ACOG, 2017; Watson & Mallory, 2017). Despite the potential outcome of NAS, the current recommended approach for pregnant women with OUD is medication-assisted treatment.

Medication-assisted treatment (MAT) during pregnancy includes the medically-monitored administration of daily methadone or buprenorphine along with prenatal care and behavioral interventions (ACOG, 2017; ASTHO, 2014; SAMHSA, 2018). Presently, MAT is preferred over medically supervised detox due to the high rates of recurrent substance misuse which can worsen outcomes for both mother and baby (ACOG, 2017; SAMHSA, 2018). Post-treatment relapse has serious adverse implications, including non-compliance with prenatal care and accidental overdose (ACOG, 2017). Though NAS can occur with MAT, the symptoms are treatable, and MAT offers the greatest possibility for a safe and healthy recovery (National Association of State Alcohol and Drug Abuse Directors [NASADAD], 2015).

A 2018 clinical guide released by the Substance Abuse and Mental Health Services Administration strongly recommends the use of MAT to treat OUD in pregnant women and asserts "treatment without any pharmacotherapy is complicated by poor fetal health, high rates of return to substance use, and the consequences such as risk of overdose" (p. 25). The benefits currently outweigh the risks for MAT in pregnancy, and those benefits significantly outweigh the harm of untreated opioid misuse (ACOG, 2017). However, the inability to eliminate the risk of NAS can prompt deep concerns and create challenging dilemmas. Practitioners may find themselves directing pregnant clients toward the current recommended evidence-based approach, while feeling profoundly conflicted about infant outcomes. Clinicians who practice in settings that do not readily embrace a harm reduction approach may also encounter dissonance between personal values, faith principles, and professional practice experience.

A Harm Reduction Perspective

Harm reduction supports autonomy and is strengths focused; when applied to substance use disorders, its core principles are implemented to engage individuals along a continuum of substance misuse rather than categorical definitions of addiction versus recovery (Bigler, 2005; Harm Reduction Coalition [HRC], 2018; MacMaster, 2004; Van Wormer

& Davis, 2018; White, 2012). While non-abstinence therapies may appear antithetical to traditional recovery goals or agency programming, the magnitude of the opioid crisis requires practitioners to think critically about best practices and redefine recovery from the framework of the clients they serve. The prevention and treatment of NAS must be an integrated approach that includes elements of public health, harm reduction, psychosocial support, and policy advocacy (ASTHO, 2014).

Harm reduction has much in common with social work practice, including a focus on vulnerable populations, social justice, empowerment perspectives, and environmental press (Bigler, 2005; HRC, 2018; MacMaster, 2004; Torchalla, Linden, Strehlau, Neilson, & Krausz, 2014; Van Wormer & Davis, 2018). A least harm perspective can enhance client motivation and foster an understanding of the potential consequences of high risk behaviors (National Association of Social Workers [NASW], 2016). Social workers implement harm reduction perspectives in a variety of client-centered practice models, including safety plans with domestic violence survivors, self-mutilating behavior management, binge drinking campaigns, teen pregnancy prevention, and HIV education (Van Wormer & Davis, 2018). A core principle of harm reduction includes seeking a broader conceptualization of social problems by acknowledging the inequitable environmental structures that increase one's risk for harm and the ability to cope with harm (HRC, 2018; Torchalla et al., 2014).

Historically, harm reduction has been criticized as a pathway for legalizing drugs (Des Jarlais, 1995). Some have perceived it as granting permission for individuals to continue using substances without consequences. Instead of viewing the positive aspects of reducing disease transmission, preventing overdose, and ameliorating risky behaviors, many conceptualize harm reduction in moral terms. Focusing on the benefits of harm reduction can provide an opportunity for advancing ethical social work practice and a more comprehensive approach to substance disorder treatment. This paradigm is consistent with a public health perspective by protecting the collective through a marked reduction in drug-related harm and social risks, while incorporating both medical and social perspectives in community-based interventions (Des Jarlais, 1995; HRC, 2018; MacMaster, 2004; Torchalla et al., 2014; Van Wormer & Davis, 2018; White, 2012). Thus, harm reduction is a multilevel practice approach leveraging both individual attributes and community resources to sustain positive change.

Opioid maintenance therapy has been used for decades and is a hallmark harm reduction approach to opioid misuse (Drucker, 1995). In pregnancy, MAT mitigates dangerous fluctuations in opioid levels, creates a stable environment for the baby, prevents withdrawal, decreases cravings, and enables the mother to focus on parenting and prenatal care

(Jones et al., 2008; SAMHSA, 2016). MAT also reduces the risk of relapse which is associated with overdose and improves overall compliance with prenatal care (ACOG, 2017).

The most contentious feature of harm reduction is engaging at-risk individuals for treatment, without insisting they commit to total abstinence (Van Wormer & Davis, 2018). For years, opioid misuse was characterized as a "moral failing" and medication assistance was falsely labeled as "substitution therapy" given to clients who were too weak to adhere to traditional abstinence-based programming (Center for Substance Abuse Treatment [CSAT], 2005, p. 8). In contrast, serving clients on their terms, without imposing judgment, is foundational to ethical social work practice. For clients who have been previously engaged in confrontational intervention methods, harm reduction offers an equal partnership by honoring self-determination and valuing individual treatment goals (NASW, 2013).

While negative beliefs toward opioid maintenance in pregnancy are often rooted in sincere concern for the safety of newborns, these beliefs are counterproductive when engaging pregnant women in treatment and ultimately have an adverse impact on maternal and neonatal health. The most incendiary image perpetuating stereotypes among practitioners and the public is the addicted baby. Addiction is commonly described as continuing negative behaviors regardless of consequences; however, the presence of withdrawal in newborns is due to physiological dependence only (Abrahams et al., 2013; SAMHSA, 2016). Applying the term addiction to babies is misleading and can provoke feelings of hostility toward birth mothers who have been faithful to their recommended evidence-based treatment plan.

In pregnancy, untreated substance misuse may result in exposure to prostitution, homelessness, trauma, and gender-based violence (Torchalla et al., 2014, p. 1). These issues pose grave risks to both mother and baby, and the outcomes can be tragic. If social workers intend to serve pregnant women ethically and professionally, they will have to confront negative beliefs about harm reduction and resolve any reticence in supporting MAT clients.

Ethical and Spiritual Implications

Values-based ethical dilemmas are normative experiences for social workers in a variety of settings. Several issues arise when providing services to pregnant clients with OUD; these include conflicting ideological practices, discriminatory policies, societal stigma, and uncertainty with

neonatal outcomes. Internal struggles are often triggered by the paradox between practitioner values, professional ethical mandates, and client autonomy. Thinking critically through these dilemmas, as professionals with self-awareness and empathy, is key to untangling assumptions, fears, or cultural expectations regarding client behaviors. Faith-based practitioners working with pregnant clients on opioid maintenance may find value conflicts even more arduous as they attempt to balance potential competing beliefs related to faith and practice. Although Christian faith principles will be explored within the framework of several social work values for the purposes of this article, the authors intend for practitioners of diverse faiths to apply the information to their individualized perspectives.

Professional objectivity is guided by the *Code of Ethics*, agency programming, and social policy; nevertheless, opposing treatment philosophies for opioid misuse in pregnancy, deep-seated stigma, and the risk of NAS can alter perceptions, creating division and subsequent discrimination. Rhodes (1998) suggests that practitioners should approach ethical conflicts with a willingness toward new perspectives, personal humility, and a core focus on the client's narrative (p. 232). Initial conceptualizations of values-based dilemmas are strongly influenced by individualized worldviews and societal norms (Hartman & Laird, 1998; Sherwood, 1998). Salient to competent practice is the recognition of how personal values shape fundamental beliefs about clients, chosen intervention strategies, and the overall measurement of client success (Reamer, 2006).

According to Sherwood (1998), discernment of one's worldview and its faith components is paramount to understanding how worldviews can potentially influence judgment and create bias (p. 108). He concludes that diverse worldviews ultimately lead to diverse interpretations of reality. This may explain why some social work practitioners view faith and spirituality as reconcilable with professional ethical mandates, while others experience significant internal struggles. For example, if one's interpretation of faith is rooted in redemptive grace, she may be less likely to experience internal conflicts related to client autonomy and a harm reduction approach. If another's interpretation is largely representative of unequivocal paths of right versus wrong, ambiguity or relativity may feel quite burdensome. Furthermore, if one concludes that substance misuse is simply a matter of choice or sinful behavior, she may view punitive measures as not only necessary, but as just.

A Personal Experience with a Harm Reduction Approach

I was working with a pregnant client in medication-assisted treatment who had a history of intravenous drug use and high rates of tobacco use.

In our first week together, she was smoking nearly two packs of cigarettes each day. Although it is not illegal to smoke cigarettes during pregnancy, we discussed the significant risk of continued tobacco use on both maternal and fetal well-being. My client did not feel ready to completely abstain from smoking; however, she agreed to reduce the number of cigarettes she smoked each day as part of her recovery plan. She hoped to cease all tobacco use prior to delivering her baby. As a long-time smoker, she felt overwhelmed, but she also had a strong desire to reach her goals and protect her child. We negotiated (on her terms) which cigarettes she wanted to give up. By the end of her first week, she reduced by double what we set as her goal. We continued to focus on small achievable treatment goals and celebrated each time she reduced her tobacco use. By the beginning of her second trimester, she had reduced her smoking to between 4 and 6 cigarettes per day. I was excited to share her progress with the treatment team. During the meeting, I expressed praise for my client who had worked diligently to reduce her smoking. My excitement was met with a stern comment from a colleague whose response was, "But, she's still smoking!" In that moment, I realized how challenging recovery would be for my client. She would not be given much grace, and many expected her to fail. She would not be seen by some as deserving to parent — no matter her efforts. I viewed and defined her incremental progress as a great success, but some perceived it as a total failure. The difference was a matter of perspective… altered by beliefs and values.

Dignity and Relationships

Social workers champion the value of human dignity, and upholding worth is primary to engaging pregnant women in treatment, developing safe therapeutic relationships, and supporting healthy outcomes. Projecting authenticity and empathy with a client who has historically felt excluded or unworthy is crucial. Relationships can be damaged or halted when practitioners deem client behaviors as immoral or reckless (Goldstein, 1987; Hartman & Laird, 1998). Nonetheless, some may find it challenging to view a pregnant woman who has exposed her baby to opioids within the context of her strengths.

Pharmacotherapy, combined with psychosocial services and prenatal care, generates positive outcomes, but the risk of NAS cannot be fully eliminated. Apprehension and even good intentions often become catalysts for paternalistic practice such as mandating detoxification or treating clients with less than therapeutic doses of medication (Jones et al., 2008, p. 245). Abrupt and non-medically supervised detox can have catastrophic results, and pregnant women who cease opioid use and relapse have a higher risk of overdose (SAMHSA, 2016). Assessing the risks

and benefits of a least harm approach can become overwhelming, and initial frustrations with options may lead to blaming, negative emotional reactions, or prejudice.

Comartin and González-Prendes (2011) recommend that practitioners abstain from viewing a client's behavior as inherently right or wrong and universalizing said behavior to encompass the client's total worthiness (p. 7). Part of the solution relies on the social worker's commitment toward a personal journey of self-awareness, reexamination, supervision, and self-correction (Comartin & González-Prendes, 2011). Social workers practice in challenging settings with vulnerable populations, and decision-making is commonly fraught with flawed solutions. Navigating emotionally charged ethical dilemmas and tolerating ambiguity are expected (Kirst-Ashman & Hull, 2016). Ethical practitioners purposefully seek compassionate and equitable solutions that alleviate suffering and elevate dignity, recognizing that "personhood stands above moral judgements regarding risky or socially negative behaviors" (Bigler, 2005, p. 76).

Pregnant clients who misuse opioids frequently experience bias from family members, treatment providers, and society. Prejudicial experiences can lead to social isolation and internalized negative perceptions of the self (Ahmedani, 2011; Watson & Eack, 2011). Engaging a client with compassion to encourage her self-perception of dignity is consistent with social work values and is a fundamental component of a Christian perspective (Lund, 2017; Sherwood, 1998). Although guilt and shame are recurrent emotions for individuals who misuse substances, the promise of redemption offered within a spiritual framework of choice can enable a client to cope with a negative self-concept and yield a sense of purpose (Lund, 2017).

Individuals are formed in Imago Dei (image of God) and are not meant to exist alone, but within a fellowship of humanity and love (Sherwood, 1998, p. 121). The essence of Imago Dei is the birthplace of human dignity and creates a spiritual connection with God and one another (Cherry, 2017). Dignity and relational connectedness are core to social work practice and faith traditions; a spiritual relationship established in God's unconditional love can foster compassion and tenderness toward others (Prior & Quinn, 2012). Focusing on dignity moves a clinician's perspective away from negative stereotypes and provides an opening for an authentic relationship with clients to unfold (ACOG, 2015; Roche, 1999).

The physical, spiritual, and emotional bond between a mother and her baby is inextricably intertwined. When helpers advance the dignity of a mother, dignity extends to her baby — and sustains a meaningful and healing connection. Saleebey (2000) explains that affirming relationships cement the possibility for "confronting the difficult and considering the imaginable" (p. 131). MAT affords an expectant mother with the stabil-

ity she needs to focus on the value of human relationships and envision herself as a capable and nurturing parent. Profound transformation can occur within the context of compassionate therapeutic alliances in which the client's dignity remains central and relationships are encouraged (ACOG, 2015; Roche, 1999; Saleebey, 2008).

Self-Determination and Empowerment

When practitioners preserve dignity, they promote strengths, empowerment, and client self-determination (NASW, 2017). Ressler (1998) offers three suggestions for social workers striving for harmony between the value of self-determination and personal faith perspectives (pp. 181-182). First, he recommends embracing a balanced conceptualization of spirituality and the temporal world, with an emphasis on environmental variables. Consistent with an ecological perspective and social justice orientation, this view enables a clinician to seek a holistic context for understanding client choice. Second, according to Ressler, it is essential for one's theological framework to be inclusive of self-determination as a "right" bestowed upon all of humanity, by God Himself. While God covers individuals with grace, He also allows free will and consequence. Finally, faith practitioners can exercise meekness by resisting the "temptation" to force faith-based values on their clients. Ressler (1998) posits that this human inclination is minimized by understanding one's spiritual role in the secular world "as one of salt and light rather than conquerors" (p. 182). When practitioners intentionally form an equal partnership with clients, the alliance strengthens self-efficacy and allows the emphasis on self-determination to rest with the client (Bigler, 2005; Saleebey, 2000).

Believing in a client's capacity to choose creates an impetus for empowerment. Clients who feel empowered have a greater sense of belonging and a hopeful orientation toward the future (Saleebey, 2000). MAT is consistent with strengths-based perspectives and empowers clients to direct their own pathways to recovery. The use of strengths-based strategies with marginalized groups counters disempowerment and purposefully allows for the recognition of diverse lived experiences (Roche, 1999). This empowering approach shifts the instinctive orientation toward pathology and labeling to one that begins with defining recovery in the client's terms by honoring her narrative. When a pregnant client is in medication-assisted recovery, she is engaged in treatment, prenatal care, and positive change.

Recovery is a process, and the process cannot be measured or defined solely as abstinence (White, 2012). The assertion that recovery from opioid misuse begins when medication management ends is discriminatory, and "recovery from no other chronic health condition rests on such a

proposition" (White, 2012, p. 204). Strengths-based practitioners validate incremental changes and focus on the reduction of risks and social harms. Clinicians can remain strengths-centered by abstaining from the use of shame-based labels toward clients. Words carry meaning, imagery, and an emotional response; therefore, the authors of this article intentionally resist utilizing terms such as substance abuser or addict, which tend to elicit negative emotions and reinforce stereotypes (Global Commission on Drug Policy [GCDP], 2017). Supporting the application of positive language such as medication-assisted recovery with pregnant clients in treatment affirms the recovery process and more accurately reflects strengths (White, 2012).

Social Justice and Advocacy

Ethical practitioners see beyond an individual framework and are cognizant of the systemic and environmental barriers impacting disenfranchised groups. Individual beliefs and values significantly influence the collective policy response to social issues and shape societal attitudes toward at-risk groups (Segal, 2016). Social workers have an ethical responsibility to seek justice and advance a more compassionate and tolerant response at all levels of practice (Collins & Garlington, 2017). Collins and Garlington (2017) suggest that comprehensive and compassionate social policy tends to favor those who are viewed as worthy in a society, while the unworthy receive "more regressive, punitive, and underfunded" social welfare (p. 398).

Negative beliefs and stereotypes play a detrimental role in the way pregnant clients with opioid misuse are perceived and treated by the community, healthcare providers, and policy makers. The overarching stigma toward pregnant clients undermines dignity, self-efficacy, treatment accessibility, and the helper relationship (ACOG, 2015; Bartlett, Brown, Shattell, Wright, & Lewallen, 2013; GCDP, 2017; NASADAD, 2015; SAMHSA, 2016; Watson & Eack, 2011; White, 2012). Clients in medication-assisted recovery are frequently labeled as criminals, unworthy mothers, and addicts who have simply replaced one drug for another. This language is dehumanizing and prevents women from seeking proper treatment due to fear of reproach from healthcare providers. Pregnant clients with substance misuse also fear implications with the child welfare system, social rejection, and loss of employment. The harmful effects of stigmas are an ethical issue, because they sharply limit treatment accessibility for the most vulnerable (ACOG, 2015; Ahmedani, 2011; GCDP, 2017; NASADAD, 2015).

The stigma is ubiquitous and has prompted many states to focus policy efforts toward measures that criminalize pregnant women with

OUD. Pregnant women of color are exceedingly susceptible to the aforementioned bias. Van Wormer and Davis (2018) affirm that pregnant women who are "the primary targets of government control are the ones who are the least likely to be able to defend themselves and the least able to conform to the white middle-class standard of motherhood" (p. 518). Depending on legal statutes, incarceration, and the vilification of individuals to reduce substance misuse in at-risk communities has a detrimental impact on population health and social well-being (ACOG, 2015; Des Jarlais, 1995; GCDP, 2017).

When clients are either openly or surreptitiously treated with contempt, they disengage from the treatment process and have worse outcomes; a non-judgmental and compassionate approach is best to promote the highest level of health (Bartlett et al., 2013). From a Christian perspective, Jesus came for the vulnerable, the outcasts, and the stigmatized. If one member suffers, all suffer together; if one member is honored, all rejoice together (1 Corinthians 12:26). Compassion is foundational in many faith traditions; therefore, faith structures, including congregations, have a primary responsibility to advocate for a merciful response toward social problems (Collins & Garlington, 2017).

Marshall (2012) maintains that God's justice is restorative, focusing not just on the inescapable consequences for wrongdoing, but on "the restoration of right relationship" which is a gift afforded by grace (p.15). A compassionate and relational justice enables healing and transformation, seeks to include the excluded, and invites the alienated into a spiritual connection (Grimsrud, 2008). Restoration is a common theme throughout scripture, and individuals are encouraged to "dispense true justice and practice kindness and compassion" to one another (Zechariah 7:9). Shifting away from ideologies that comprise only retributive measures and embracing comprehensive treatment approaches which elevate restoration and social justice are paramount. Moreover, ethical social workers must advocate for compassionate social welfare policies that advance dignity and strengthen the relationship between a mother and her baby.

Most pregnant women living with OUD are genuinely motivated to seek treatment and have a strong desire to create a safe environment for their babies (SAMHSA, 2018). This desire translates into a remarkable moment for practitioners to walk alongside pregnant women, alleviate their fears about treatment options, and support individualized recovery goals. Social workers serve marginalized groups with evidence-based knowledge, diversified practice skills, and professional values. Thus, social workers are uniquely prepared to provide expert leadership in treatment centers, child welfare agencies, faith communities, and policy arenas to combat the opioid crisis.

Recommendations for Evidence-based Social Work Practice

While the specific steps toward comprehensive evidence-based interventions are too great to fully capture in this article, there are several recommendations that provide guidance for practitioners working with pregnant clients. Social workers in all areas of practice should be trained in and apply universal screening, using the SBIRT (Screening, Brief Intervention & Referral to Treatment) model. SAMHSA supports the training of allied health professionals in this public health approach to early intervention, and it is the recommended approach for non-judgmental interviewing and universal screening for substance use and misuse across professions (ACOG, 2017; SAMHSA, 2018). Assessing and identifying substance misuse with a validated screening tool prior to pregnancy is critical for prevention and early intervention efforts (ACOG, 2012; ASTHO, 2014; Health Resources Services Administration, 2014; WHO, 2014).

A comprehensive practice approach including prenatal care, pharmacotherapy, psychosocial support, relapse prevention, and postnatal planning increases successful outcomes and mitigates the symptoms of NAS (ACOG, 2017; ASTHO, 2014; Salter & Ridley, 2015; SAMHSA, 2018). Clinical social workers can implement therapeutic interventions to support a client's emotions, assess her readiness for change, prevent relapse, and enhance family functioning. Providing a client with coaching, intervention, and support for smoking cessation is essential (SAMHSA, 2018). Smoking cigarettes is associated with higher rates of NAS, but the added risk diminishes with a reduction in cigarettes-per-day (Patrick, Dudley et al., 2015). Interventions must incorporate a heightened awareness of the complex health and social issues impacting pregnant women who misuse substances, including trauma history, intersectionality, structural discrimination, and poverty (Torchalla et al., 2014). Engaging a client in prenatal care, parenting classes, and nutritional support maximizes healthy outcomes (SAMHSA, 2018). Additionally, brokering tangible resources such as Women, Infants, and Children (WIC), prenatal and postpartum home visiting programs, peer-recovery support, and case management services will promote a client's overall health and social well-being.

Social workers have a significant role on multidisciplinary treatment teams in medical centers and public health clinics. Because some infants require pharmacological management for withdrawal and longer hospital stays than their mothers, social workers can arrange transportation, housing accommodations, and sibling childcare to reduce familial stress during the postnatal period. Practitioners can also advocate for non-pharmacological interventions that diminish NAS and strengthen

the maternal-infant bond. Rooming-in is the current standard of care and housing a mother and her infant together during the postnatal phase fosters attachment, supports bonding, enhances wellness, and decreases NAS (SAMHSA, 2018, p. 87). Babies who room-in with their mothers require less medical intervention and have shorter hospital stays (Saiki, Lee, Hannam, & Greenough, 2010). Women who are stable and adherent to their medication-assisted recovery plan are also encouraged to breastfeed (ACOG, 2017; Jones et al., 2008; SAMHSA, 2018). Rooming-in, breastfeeding, skin-to-skin contact, and family visits support the mother-infant dyad, and they are suggested best practices (ACOG, 2017; SAMHSA, 2016; SAMHSA, 2018).

Furthermore, expanding wraparound services and increasing support for clients during pregnancy and post-delivery can meliorate long-term recovery efforts. Medication-assisted recovery and abstinence-based perspectives, such as traditional 12-step groups, are not mutually exclusive; however, clients on opioid maintenance often feel rejected by these groups (CSAT, 2005). The exclusion of clients in medication-assisted recovery from transitional living facilities, intensive outpatient programs, and other forms of substance use disorder treatment creates pernicious barriers to long-term recovery (SAMHSA, 2016; White, 2012). The lack of treatment facilities specifically for pregnant clients also generates gaps in service delivery. Social workers can collaborate with community agencies to include medication-assisted recovery clients in mutual-help groups such as Celebrate Recovery or practitioners may develop and facilitate adapted groups to destigmatize treatment and encourage positive social connections.

Mobilizing spiritual leaders and faith-based programs to offer an integration of faith and medication-assisted programming for pregnant clients will also contribute to a more comprehensive treatment system. Faith-based programs have a rich history of meeting the needs of culturally diverse communities (SAMHSA, 2013). The SAMHSA Faith-based and Community Initiatives, or FBCI, is a collaboration between government agencies and faith-based organizations to support the role of faith-based providers in the prevention and treatment of substance use disorders and mental health services (SAMHSA, 2017). Faith programs have trusted ties with their communities and are key in the provision of outreach services, direct care, and client referrals (SAMHSA, 2013; Placido & Cecil, 2014). The current scope of opioid misuse requires diverse partnerships such as FBCI, and members of varying beliefs can unite together to "harness the power of both faith and secular community organizations" in an effort to bring collective healing and recovery from the opioid epidemic (SAMHSA, 2013, p. 2-3).

To reduce the stigmasurrounding harm-reduction interventions and advance policies which increase access to comprehensive services, practitioners must engage and educate their elected officials and policy makers. Social work advocates can serve on an agency or governmental task force, testify on behalf of pregnant clients, and provide evidence-based training within their communities. Moreover, social workers can advocate for appropriate family preservation policies, consistent mandated reporting, and objective data collection on NAS. A report prepared by the National Center on Substance Abuse and Child Welfare found "considerable variations" in state policies and practices regarding substance-exposed infants, as well as varied CPS reporting mandates in response to the Child Abuse Prevention and Treatment Act (Young et al., 2009, p. 1). Infants born with a wide-range of substance-exposure from alcohol to prescription opioids are frequently included in NAS data reports (ASTHO, 2014). Neonatal opioid withdrawal syndrome or NOWS is an emerging term that may identify opioid-exposed infants more appropriately and promote standardized treatments (SAMHSA, 2018). Standardized hospital and nursery protocols for pregnant women with OUD, availability of affordable and quality healthcare, appropriate funding for treatment and long-term recovery, and access to family planning services are also significant policy issues to consider. Finally, to promote social justice, policies that criminalize pregnancy and undermine the relationship between mothers and babies should be vigorously opposed.

Conclusion

While the evidence base provides clear guidance for ethical practice with pregnant women, it does not ensure the absence of internal conflict. Dissonance between personal values and the actions of clients is most effectively examined through a strengths-based lens and a least harm perspective. Viewing deeply-held faith principles and professional values within a strengths narrative is equally beneficial and enables one's faith and social work values to emerge in harmony rather than conflict. Practitioners of faith can also seek resolve in biblical examples where harm reduction is elevated over social expectations and law (Manning, 2006, p. 2). Jesus' action of healing on the Sabbath exemplified a commitment to a deeper understanding of the social environment and valuing a vulnerable life over law (Manning, 2006). Similarly, Jesus exalted God's mercy in choosing to forgive the woman brought to him by the Pharisees and challenging her accusers to see her as worthy.

Values-based dilemmas will undoubtedly occur when working with this vulnerable population. Internal conflicts may begin in solitude, but the resolution often occurs in community. We are reminded that where

there is no guidance, people fall, but in an abundance of counselors, there is safety (Proverbs 11:14). Seeking the counsel of competent supervisors, professional mentors, spiritual leaders, and experienced colleagues also provides a means to untangle what may feel insurmountable.

Social workers have a pivotal role in the treatment of pregnant women in medication-assisted recovery. Transforming the discriminatory narrative toward pregnant clients to one that emphasizes worthiness and competence is possible through deliberate action. Advocates can create a socially just environment in which pregnant women are treated with dignity and their babies thrive. At times, practitioners may find themselves questioning personal beliefs, available options, or best practices. While seeking balance in the chasm between professional mandates, faith principles, and individual beliefs can be daunting, ethical practitioners uncover a space where compassion takes precedence. Social workers cultivate positive change and nurture resilience within this space. The shared space between practitioners and clients is a sacred one—and allows for an abundance of God's restoration to flow freely. When we are mindfully present in this space, we are stewards of grace who faithfully preserve the dignity and worth of both a mother and her baby. ❖

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Supervision Strategies for Social Work Students: Managing Faith and Spirituality in Addictions Practice

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Field placement in addictions treatment offers social work students several diverse and rich opportunities for learning. Addictions practice exposes students to spirituality as a domain of health and well-being foundational to many recovery programs. For practicum students, learning to manage personal religious beliefs and spirituality can be a significant need in field supervision. Based on the supervisory experiences of a field instructor and field coordinator who have collaborated in field education for 10 years (as well as were colleagues on a family drug court team prior), this article presents strategies for helping students manage their personal beliefs about faith and spirituality in addictions practice. Supervision strategies presented include: (a) separating spirituality from religion, (b) reframing addiction viewed as sin, (c) offering reflective feedback, (d) self-reflecting through journaling, process recording, and other assignments, and (e) promoting experiential activities to connect personally with people of different backgrounds.

FAITH-BASED SERVICES AND INITIATIVES WERE AT THE VERY ORIGINS OF the social work profession, from almshouses to shelters, hospitals, and orphanages (Popple & Leighninger, 1999). "Jewish and Christian values of love of neighbor, charitable service, and justice directly shaped the formation of the profession's values" (Canda & Furman, 2010, p. 32). Social workers of faith have regularly cited a religious or spiritual calling to the vocation of social work (Canda & Furman, 2010). For a profession that frequently encounters difficult issues and human tragedies such as family violence, sexual abuse, human rights violations, and social injustices,

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social workers have also noted their religious faith as a source of strength, solace, and resiliency (Chamiec-Case, 2016; Wagenfeld-Heintz, 2009). Faith can be a source of personal strength for social workers that, at times, can become a challenge in practice. Personal issues of faith and spirituality may become troublesome for social work students and practitioners if they struggle to understand clients with differing beliefs and maintain personal and professional boundaries.

Issues of spirituality are common to social work practice, particularly in addictions treatment and recovery. Students' exposure to spirituality as a domain of holistic health and well-being can begin during field practicum. Social work practicum offers real-life, practice experiences for the basis of student learning (Merriam & Bierema, 2014) in which the learning opportunities focus on students' personal growth and transformation (Taylor, 2009). Practicum is the learning laboratory where students integrate classroom and theoretical concepts with actual social work practice. Students are fully immersed into complex, highly personal issues in practicum, and they are expected to demonstrate basic cultural and spiritual competence for social work practice (Darrell & Rich, 2017). Practicum can be a highly stressful and emotionally charged experience for students (Dill, 2017); one source of stress can be found in issues surrounding faith and spirituality.

During practicum, social work students need to develop critical thinking skills as they learn to apply theory to practice, conduct assessments, help clients with problem-solving, and make case decisions (Nesoff, 2004). Self-awareness is needed to understand interpersonal relationships, emotional responses, and communication patterns both verbal and nonverbal. Self-reflection is the "examination, contemplation, and analysis of one's thoughts, feelings, and actions" (VandenBos, 2015, p. 958). We engage in self-reflection to gain greater self-awareness, an understanding of self with knowledge of one's behaviors, motives, attitudes, defenses, personal strengths and weaknesses (VandenBos, 2015). "Students need educational support and direction to deepen their capacity to develop a professional self...to recognize, understand, and utilize their feelings and insights" (Urdang, 2010, p. 532). Practicum and the field supervision process are highly important for student social workers, as greater self-awareness builds professional competence (Urdang, 2010)..

Transformative Learning in Field Education

"At the heart of adult learning is engaging in, reflecting upon, and making meaning of our experiences, whether these experiences are primarily physical, emotional, cognitive, social or spiritual" (Merriam & Bierema, 2014, p. 104). Social work practicum delivers experiences in all of these

domains: physical, emotional, cognitive, social, and spiritual. Activities that focus on in-depth experiential learning and personal values, such as social work practicum, can foster transformational learning for students (Taylor, 2009). Experience is "the primary medium of transformative learning" (Taylor, 2009, p. 5), including the learners' prior experiences and what they experience in the field setting. Transformative learning "involves a fundamental questioning and reordering of how one thinks or acts" (Brookfield, 2000, p. 139). Students reflect on their practicum experiences as they discover new things about themselves and the world around them (Taylor, 2009). As educators, "the main part of our work...involves engaging people in incrementally deepening their understandings of ideas and actions" (Brookfield, 2000, p. 140). Furthermore, "critical reflection must be a collaborative project...[a] social process...only accomplished with the help of critical friends" (Brookfield, 2000, p. 146). Critical friends are those "critical mirrors who highlight our assumptions for us and reflect them back to us in unfamiliar, surprising, and disturbing ways...[and who] provide emotional sustenance" (Brookfield, 2000, p. 146). For practicum students, their community of critical friends may include field instructors, fellow students in practicum seminar or group supervision, and their faculty liaison. In this article, our focus is on the primacy of the field instructor relationship and supervision techniques field instructors may employ to facilitate reflection and learning as students reconcile issues of faith and spirituality in addictions practice.

Transformative learning theory is highly applicable for field educators as we conceptualize our role as guides during practicum. Applying transformative learning theory necessitates helping students think critically about their assumptions, prompting students to "reflective judgment... regarding one's beliefs, values, feelings, and self-concepts" (Mezirow, 2009, p. 29), and supporting them during what can be a "disorienting" process (Ettling, 2012, p. 541). Social work students value receiving feedback and experiencing a supportive relationship with their field instructors (Ketner, Cooper-Bolinskey, & VanCleave, 2017). Further, students have noted the importance of field supervision in their learning to ethically integrate faith and social work practice (Harris, Yancey, Myers, Deimler, & Walden, 2017). To facilitate transformative learning during practicum, field educators must care genuinely about students' development, be intentional in their work with students, use a wide variety of supervisory techniques, and be self-aware of their own values and beliefs (Taylor, 2006).

Field practicum is the signature pedagogy of the social work profession. As such, a great deal of responsibility falls to field instructors to facilitate and consolidate student learning from classroom to the field. Moreover, students require guidance to become more aware of how their behaviors, attitudes, feelings, and relationships with clients impact the helping process

(Urdang, 2010). Using transformative and experiential learning theories as our overarching theoretical frameworks, we present five supervision strategies to help social work students process issues of faith and spirituality in addictions practice.

Many students confuse concepts of spirituality with religion, so we begin by discussing ways to help students separate spirituality from religion. Addiction is highly stigmatized in our society, often viewed through a lens of morality (Lay & McGuire, 2008); therefore, we also discuss helping students reframe addiction viewed as sin. We continue with offering students reflective feedback and engaging them in self-reflection. Field instructors can help facilitate students' self-reflection using a variety of methods. We will review process recordings, journaling, and other self-reflective assignments and their specific application for faith in addictions practice. To conclude, we present experiential learning activities that can help students connect personally with people of different backgrounds.

As we offer supervision strategies, we will apply them to scenarios with example students who are facing various struggles in an addictions field placement. The scenarios and supervision strategies apply to both undergraduate and graduate students. Profiles represent actual student issues we have encountered, but in amalgam to respect and protect confidentiality. See Table 1 for an overview of each student scenario and the suggested supervision strategies. In our examples, we will use the term field instructor to describe the onsite, agency staff person who oversees a student's daily practicum activities and evaluates student performance. The faculty liaison is a full-time university faculty member who conducts agency site visits with the social work student and field instructor and teaches a co-requisite practicum seminar course. In situations where faculty roles are held by multiple people, all would be involved in supervision and consultation activities we suggest.

Supervision Strategies in Addictions Practice

Separating Spirituality from Religion

It is important to distinguish and understand the differences between religion and spirituality. These two terms are often used interchangeably, but in fact have very distinct differences and meanings. While religion includes spirituality, spiritualty does not always include religion. Religion is "an institutionalized pattern of values, beliefs, symbols, behaviors, and experiences" (Canda & Furman, 2010, p. 76). Religion encompasses our practices. Spirituality encompasses our feelings. Spirituality is "the process of human life and development focusing on the search for a sense of meaning, purpose, morality, and well-being" (Canda & Furman, 2010, p. 76).

Spirituality includes our connection to the world around us and may or may not include a higher power.

Table 1

Student Scenarios and Suggested Supervision Strategies

	Separating Spirituality from Religion	Reframing Addiction Viewed as Sin	Offering Reflective Feedback	Self-Reflecting	Promoting Experiential Activities
Student	***Ann***	***Rob***	***Adam***	***Tasha***	***Cassie***
Practice Challenges	Personal bias Proselytizing Lack of knowledge Narrow interpretation of spirituality	Judgmental attitude Viewing clients as sinners Separating people from their behaviors Lack of addictions knowledge	Poor boundaries Inappropriate use of self-disclosure Dual relationships Personal judgment and bias	Personal bias Stereotypes Difficulty establishing rapport	Intimidation/fear Insecurity Personal bias Stereotypes Lack of addictions knowledge
Supervision Strategies	Assign readings on spirituality and religion Participate in addictions education Participate in client intakes and services Conduct client interviews Engage in self-reflection and -awareness exercises Reinforce diversity coursework Consult with faculty liaison	Challenge addiction myths Teach disease model Participate in addictions education Teach and model professional terminology Expose student to addictions clients Help student connect with clients on a human level Encourage peer consultation Facilitate professional mentoring for student	Offer constructive feedback and correction Provide actionable guidance Engage in self-awareness exercises Model professional behavior and boundaries Assign readings on ethics and use of self Require additional education and ethics trainings Institute moratorium on self-disclosure Consult with faculty liaison	Assign process recordings Engage in dialogue journaling Assign written exercises Process with minute papers Utilize practicum workbooks Offer reflective feedback and correction	Expose student to people of different backgrounds Participate in addictions education Expand learning activities beyond the practicum setting Attend open recovery support groups Tour partner agencies Participate in client intakes and services Participate in diverse community activities Engage self-reflection via journaling and group supervision

Social work has its roots in Christianity. Early social work in the 19th century was connected to Christian social movements. "Friendly visitors," as they were called, were often very moralistic and focused on teaching "appropriate behavior" (Krieglstein, 2006, p. 22). As social work evolved and professionalized in the 20th century, religion and proselytizing were viewed as incompatible with the new professional role (Krieglstein, 2006); however, the concept of spirituality and its importance in the field remained.

According to Hunt (2014), spirituality is a necessary component of social work practice, but one that is often considered too sensitive and difficult to discuss. The personal nature of spirituality means that social workers must approach this topic with their clients with open-mindedness

and respect (Hunt, 2014). Canda and Furman (2010) discussed the diverse nature of spirituality and suggested that tolerance of other religions and spiritual practices is not enough. Social workers must learn to appreciate and understand their clients' unique views on this subject in order to work within a client-centered view (Canda & Furman, 2010). As with clients, the same can be said of our work with students. Supervisors, too, must recognize that students will come to the field with a variety of religious and spiritual experiences and practices that will foster bias. In order to guard against personal bias, we must be aware and acknowledge the bias exists (Hunt, 2014). Social workers, and social work students, have an ethical and professional responsibility to address bias, which will protect against judging or proselytizing (Shulman, 2012).

We have found some Christians have difficulty accepting a concept of spirituality that does not include God, but rather another form of higher power or no higher power at all. Consider the case of Ann, a practicum student in addictions treatment:

> *Personal belief is strong in Ann who is a devout, born-again Christian. She believes it is her duty to witness to clients because addiction is a matter of sin and bad moral character. If clients would only submit and become Christians, they will be freed from their addiction. Ann is challenged by the 12-step approach of a Higher Power versus Jesus Christ. She is uncomfortable with clients who are agnostic or atheist or worship in a non-Christian faith. Ann states, "I look at clients and think: They just need Jesus."*

Ann is struggling to understand the difference between spirituality and religion. In many ways, she is biased toward her own definition of spirituality, which she sees as synonymous with her faith. The National Association of Social Workers (NASW) *Code of Ethics* (2017) clearly outlines our responsibilities as they relate to diversity and non-discrimination. Differences in religion and spirituality among clients and social workers must be not only accepted, but also celebrated. Working with Ann, it is important to help her understand how personal biases can unwittingly lead to discriminatory behaviors. We would encourage Ann to become aware of her own biases, so that she can evaluate her responses, both internal and external, to clients.

The Book of Acts teaches us that God moves by grace and sincerity, rather than by rule or law (see Acts 3-4, New International Version). In our experience, however, we have seen students who are legalistic and focused on religious rules, which can lead to feelings of superiority or denigration of others who do not subscribe to their ideas. Critical thinking is a skill many students struggle with, especially as they first begin the transition from student to professional. Students have spent years in formal institutions

that outlined their behaviors, their tasks, and yes, their rules. At practicum, students are expected to be more autonomous, to focus on a bigger picture, and to understand that their actions are not just affecting their own outcomes, but those of their clients. Narrow, legalistic thinking prevents students from assessing, treating, and interacting with clients holistically. This fits with some of Ann's struggles; she has become "boxed in" to her own way of thinking and seemingly lacks understanding of different viewpoints on spirituality.

To help Ann become more acquainted and accepting of other cultures, both religious and nonreligious, we would use teaching and exposure techniques. Ann would be asked to read about diversity and other religions, perhaps attend religious services outside of her usual denomination, and to share these experiences with her field instructor during supervision. At the same time, it is important for the field instructor to support Ann and affirm her rights to her own beliefs while expanding her awareness and empathy for others. Because we have found great value in understanding the differences between religion and spirituality, we might ask Ann to read Canda and Furman's (2010) *Spiritual Diversity in Social Work Practice*. We would employ other supervision strategies outlined in this article to help Ann discern spirituality from religion. For example, we would assign written self-reflection exercises to raise self-awareness and help Ann better grasp how her beliefs and values are in conflict with her actions. Ann would be asked to interview clients of different religious backgrounds and would be specifically assigned clients who have different viewpoints. These supervision strategies would help challenge Ann's beliefs and assumptions and could foster greater understanding. Education in Ann's situation might include attendance at a group on the disease model, but also a group or groups on spirituality so that she can begin to understand the constructs and how spirituality relates to addiction. In addition, the field instructor may consult with the faculty liaison to reinforce Ann's coursework on diversity.

Reframing Addiction Viewed as Sin

Throughout history, addiction has been viewed through many different lenses. One of the earliest views describes addiction as an issue of moral character, or sin, and as such, indicates that individuals should be addressed through punishment rather than treatment (Kinney, 2008). In the early 1900s, individuals struggling with forms of addiction might find themselves incarcerated or committed to psychiatric institutions, never to be released (Van Wormer & Davis, 2008). Because this behavior was viewed as an issue of moral failing, the church was involved in early efforts to fight alcohol addiction (Kinney, 2008).

A second paradigm, the concept of addiction as a disease, has its roots in the late 1700s when a physician, Dr. Benjamin Rush, published

a pamphlet in which he described alcoholism as a disease (Van Wormer & Davis, 2008). Over the next three centuries, a multitude of influential persons have embraced addiction as a medical ailment. In the early 1900s, after spending extensive time with residents of settlement houses, Jane Addams, one of the the founders of social work, recognized that there was more to addiction than poor choices. Addams was noted for likening addiction to a disease and recognizing contributing factors beyond personal choice and control (Van Wormer & Davis, 2008). The disease model was further supported by the founders and original members of Alcoholics Anonymous (AA) in the 1930s. The growth of AA was instrumental in reducing stigma related to addiction (Van Wormer & Davis, 2008); however, it was several years later when the disease concept gained additional merit.

In the 1940s and 1950s, the World Health Organization (WHO) commissioned physician E.M. Jellinek to study addiction. His task was to establish standardized definitions of addiction, and his research led to new ideas about the origins of such. Dr. Jellinek's work ultimately influenced both the WHO and the American Medical Association (AMA) to declare addiction a medical condition in 1951 and 1956 respectively (Van Wormer & Davis, 2008). In the 1980s, Dr. David Ohlms presented information that continued to challenge our understanding of addiction. While the concept of addiction as a disease was more widely accepted, many people believed that addiction was a "secondary illness," meaning it was the result of another disease. In his groundbreaking book *The Disease of Alcoholism* (1988), Dr. Ohlms presented evidence that addiction was a primary disease with its own symptoms, characteristics, and treatment. Today, addiction is most commonly treated and approached from a disease model (Wiens & Walker, 2014), supported by the AMA, WHO, AA, National Institute on Drug Abuse, and National Institute on Alcohol Abuse and Alcoholism (AA, 2001; Van Wormer & Davis; 2008; Wiens & Walker, 2014). Even so, the disease concept has its critics, most notably those who claim that accepting addiction as a disease takes away personal responsibility and discounts the idea of personal choice (Kinney, 2008).

Now, let us visit the case of practicum student Rob:

> *Rob displays judgmental attitudes toward clients. His primary lens for viewing clients is through a "sin" orientation in which addiction is a moral failing or character defect. He struggles dealing with clients' histories such as hurting others in interpersonal and family violence and motor vehicle accidents, stealing from friends and family, and engaging in behaviors like prostitution, gambling, and having children outside of marriage.*

Supervising Rob, we recognize that he does not understand or accept the disease concept of addiction. Many students who choose to work in addictions enter the field with life experiences that do not support an understanding of recovery (Lay & McGuire, 2008); therefore, it becomes the field instructor's responsibility to help challenge myths likely held by the student. In religious terms, people struggling with any form of sin are often referred to as "fallen," a term that can encompass a multitude of issues (Seinfeld, 2012, p. 244). For much of addictions treatment history, it was believed that people must "hit rock bottom" before they were able to achieve recovery (Seinfeld, 2012, p. 244). The parallel of those two terms, "fallen" and "rock bottom," could certainly lead to confusion for students entering the field of addictions. People struggling with addiction are often labeled with negative descriptors that project the idea of lowered status: junkie, manipulator, and liar (Lay & McGuire, 2008). We would work with Rob to help foster understanding that placing stigmatic labels on a client creates a hierarchy that unwittingly designates the student to encompass a higher status (Lay & McGuire, 2008). In our experiences working with students, teaching appropriate use of addictions language and terminology can help to close this gap and foster rapport with clients. For example, help students use person-first language such as person in recovery as opposed to junkie or addict and refer to drug screen results versus "The client is dirty." When students use language that acknowledges addiction as an illness and recognizes clients' struggles, we find that clients respond more openly and are willing to become more vulnerable in sessions and groups.

One technique we have used very successfully is to help students identify that clients are experiencing pain, and that addiction is a coping skill they use to address that pain. In a study of nurses working in the field of addiction, Thorkildsen, Eriksson, and Raholm (2014) found that nurses who sought to understand the human being, rather than the addiction, provided care that allowed clients to feel more comfortable in expressing themselves and seeking help. We have found the same to be true with social work students. Our approach with Rob would include helping him to connect with clients on a human level—understanding that we all experience pain, and many of us have dealt with pain in unhealthy ways in our past. Rob's faith background would also lend to discussions that focus on grace and mercy, and their offering for all of us, regardless of our past behaviors.

Supervision sessions with Rob would focus on challenging some of his misguided beliefs about addiction through teaching and discussion. Providing an overview of the disease model of addiction could be accomplished through reading assignments or discussion, but it might also be accomplished by asking Rob to attend an education group offered to clients on the same topic. We could refer Rob to seek consultation from other members of the treatment team (such as chaplains or pastoral care) or

from peers who are also working in the field; however, the technique with which we have seen the most success in breaking down misconceptions about addiction is exposure. As students spend time with clients, listen to their stories in group sessions, participate in the assessment process, and observe clients journey through treatment, we see understanding and compassion naturally emerge. Students like Rob begin to connect with clients in a different way, begin to advocate for their recovery, and develop respect and admiration for the courageous work they are engaging in to seek recovery.

Offering Reflective Feedback

"What we believe about our practice may not be the same as what we actually do in practice" (Merriam & Bierema, 2014, p. 116); therefore, honest, constructive feedback is invaluable to student social workers as they practice and develop their helping skills. During practicum, the goal of feedback is to improve students' knowledge, skills, attitudes, and behaviors (Cantillon & Sargeant, 2008). Increasing students' self-awareness is accomplished through various techniques that might include inviting self-assessment, providing actionable guidance, and describing the students' behaviors to offer constructive compliments and correction (Cantillon & Sargeant, 2008). Accepting feedback can, at times, be difficult for students. Bogo, Regehr, Power, and Regehr (2007) identified three circumstances in which students struggle to accept feedback from their field instructors: (a) when students did not understand the professional role of social work, (b) when students had previous work or personal experience prior to practicum and already felt competent, and (c) when students' personality styles were problematic and interfered with forming interpersonal relationships.

We will describe a supervision scenario in which feedback will be vitally important to help increase the student's self-awareness and competence. Consider Adam's situation at practicum:

> *Adam is in recovery and openly shares his personal story with colleagues and clients. In fact, Adam regularly uses self-disclosure to establish rapport, offer guidance, and align with clients. He knows what works in faith-based recovery and has difficulty being open to other avenues of achieving sobriety. Further, Adam's use of therapeutic self-disclosure is becoming excessive. The field instructor discovers he is friending clients on social media and suspects he may be spending personal time with clients.*

As Myers (2003) noted, "The recovering...[student] is often only a few steps ahead of the client [and]...may over-identify with clients,

unconsciously wish to rescue the client, [or] feel unsure of their separate, professional identity" (p. 101). Furthermore, if these issues are "not explored and monitored, countertransference can...result in an unfortunate or even catastrophic blurring of boundaries and roles" (Myers, 2003, p. 101); therefore, reflective, honest, and constructive feedback from field instructor to student is necessary.

Helpers in recovery. It has been a longstanding tradition for addictions treatment programs to employ staff who are in recovery. Many addictions professionals gained their "education" through their own experiences of successfully working 12-step programs (Monroe Whitley, 2010, p. 347). The 12th Step of Alcoholics Anonymous specifically states that recovering alcoholics are to "carry" the message to other alcoholics (AA, 2001, p. 60). Curtis and Eby (2010) found that among professionals working in the addictions field, those in recovery showed greater commitment to their profession and to their clients. Their commitment seemed likely due to the nature of the recovery identity, which is so ingrained for those in recovery (Curtis & Eby, 2010). On the surface, this seems like a very positive trait; however, it also poses unique challenges, as it becomes impossible for the student in recovery to avoid a dual relationship—that of both peer and professional. Dual relationships pose ethical challenges in many situations, but particularly so in the field of recovery (Doyle, 1997). Doyle (1997) highlighted five specific areas in which dual relationships, as they relate to the field of recovery, can be problematic: (a) confidentiality and anonymity, (b) attendance at self-help group meetings with current and former clients, (c) social relationships among self-help group members, (d) sponsorship in a self-help program, and (e) employment.

Self-disclosure. Adam needs feedback and guidance from his field instructor—his critical friend—to correct his behaviors. The field instructor can acknowledge that Adam's identity as a person in recovery and his commitment to helping others is strong, but his personal history is impeding his professional judgment when it comes to self-disclosing personal information and setting boundaries. Adam's vulnerability, and the risk he assumes by providing so much personal information to clients, is concerning. Self-disclosure can cause confusion for clients, who often struggle with maintaining personal and professional boundaries themselves. When the professional struggles as well, it becomes nearly impossible to separate the personal relationship from the professional relationship. Self-disclosure can be a useful tool in working with clients (Shulman, 2012), and our goal would be to help Adam find the balance that will protect his privacy and benefit his clients. Dewane (2006) provided guidelines for the use of self-disclosure that Adam may find helpful: Self-disclosure must lead to client growth, promote the therapeutic relationship during rapport building, or validate client experiences. We would assist Adam in

determining the risks and benefits associated with the use of self-disclosure.

Self-disclosure of personal recovery should be used carefully (Doyle, 1997). We would model this behavior by using our own self-disclosure judiciously and with careful thought. During supervision, we would discuss with Adam the situations in which he might find self-disclosure useful for building rapport or assisting clients in moving further in their own recovery. For students of faith in recovery, they must be mindful and sensitive that their self-disclosures and personal stories of sobriety and grace, or even conversion, are not presented as proselytizing or coercing to clients. Kaplan (2005) iterated the importance of a supportive supervisory relationship in which the student can feel safe discussing these challenges.

When there is overreliance on self-disclosure, supervisor and student must explore its roots. For example, the student may lack self-confidence or self-awareness to use other helping techniques. During supervision, we would provide feedback to Adam regarding his interactions with clients to assist him in learning how to respond differently to his clients. In extreme cases, we have established a moratorium on the student's personal self-disclosures to both clients and staff. We begin with a one-week timeframe in which the student may not self-disclose personal information to any clients or staff members. During supervision, we discuss their experiences, including the challenges to maintain boundaries, identification of thoughts and feelings that predicated the student's impulses to self-disclose, and progress in using alternative helping interventions. Another supervision strategy requires the student to prepare a list of helping skills, interventions, and techniques that may not include self-disclosure. From the list, the student practices intervention techniques independently and with field instructor monitoring. In supervision, there is ongoing discussion and evaluation of the student's progress in successfully using a wider repertoire of helping skills with clients.

Dual relationships. Doyle (1997) and Kaplan (2005) offered suggestions for how addiction professionals who are in recovery can maintain professional conduct related to their dual roles. First, Doyle (1997) suggested that professionals need to educate themselves on regulations regarding dual relationships. In this instance, we would ask Adam to read the newly revised *Code of Ethics*, and in particular, the section about conflicts of interest and dual relationships (Section 1.06). Recent revisions to the *Code of Ethics* address the use of technology in practice. Various social media outlets have changed our ability to maintain our own privacy, putting social workers in the vulnerable position of being easily discovered outside of our professional roles. Adam would be asked to focus on sections pertaining to the use of social media and technology (Section 1.06 e-h). During supervision, we would discuss ethical guidelines and expectations for both agency and university policies and share feedback on our observations of

Adam's behaviors in the practicum setting. We might also ask Adam to participate in additional, formal training on professional ethics (Kaplan, 2005). Adam would be expected to comply with the *Code of Ethics* and not engage in social media activities with clients. For behaviors reaching this level of seriousness, the field instructor should be communicating with the faculty liaison for consultation and coordination of supervision strategies and evaluation for continuing the practicum.

Adam's behaviors suggest that feedback is necessary on how to avoid outside interaction with clients (Doyle, 1997). We would discuss that helping professionals often attend a wide variety of recovery support groups in order to avoid ongoing personal interactions with clients whenever possible. Furthermore, we would recommend that Adam take advantage of online resources or possibly attend closed groups for other professionals to avoid interactions with practicum clients outside the field agency. With students of faith, we sometimes have to address that professional boundaries indicate they should not, for example, invite clients to services and events at their personal religious organization or their home group for faith-based recovery.

In addition to the struggle understanding his professional role, Adam has indicated bias for faith-based treatment approaches. The role of educator is critical to students' professional development in field (Knight, 2001). We would begin educating Adam on the various approaches to treatment, asking him to read about the history of addictions treatment, attend a group on such, and research success rates of various treatment approaches. Again, the *Code of Ethics* mandates respect for diversity, and we would encourage Adam to consider this in relation to his bias. As we will discuss in the case of Tasha later on, an experiential learning activity we have found very beneficial with students is visiting other addiction treatment programs. We might arrange for Adam to visit other area programs to meet with treatment staff, learn about other treatment approaches, and visit with clients who have had success in various programs.

Self-Reflecting through Process Recording, Journaling, and Other Assignments

Self-reflection is foundational to student learning and is a necessary element for transformative learning in the practicum setting, particularly as students learn to manage their personal beliefs and integrate faith with practice. Field instructors may prompt students' self-reflection using a variety of methods. Here, we suggest using process recording, journaling, and other written exercises.

Process recordings. Process recording is a traditional social work training tool in which a student describes and writes intensively about a client interaction (Myers, 2003; Urdang, 2010). Myers (2003) endorsed

the use of process recordings for training addictions professionals, specifically. Most recording formats are configured in a columned structure to document: (a) Interview Content, (b) Student's Thoughts, (c) Student's Feelings with room for (d) Instructor's Comments, where the supervisor comments on the session, offers interpretations, or suggests future approaches and interventions (Mullin & Canning, 2007; Myers, 2003). The student describes interactions with the client including dialogue, nonverbal communication, use of skills, feelings experienced, along with the student's thoughts, personal reactions, observations, and impressions of the client meeting (Myers, 2003; Urdang, 2010). Process recordings offer optimal learning when students' narratives are highly detailed with rich descriptions of the client meeting as well as their thoughts and feelings about the interaction (Mullin & Canning, 2007).

Process recordings serve multiple learning functions. Students begin reflecting on emotional aspects of client meetings and how they managed client interactions. Deeper still, students may gain insight into their reactions (or failure to act). Process recordings provide a format for evaluating students' skills and how well they are applying theory to practice. In addition, students and supervisors work collaboratively as they dialogue via the recording and evaluate the learning process (Myers, 2003). Through process recording, supervisors can help students recognize key client issues and guide students on specific helping techniques to use and when to use them (Urdang, 2010). Consider the following student scenario:

> *Tasha is a Christian social work student who has a high socioeconomic background. She states that she does not want to work with clients who are poor and uneducated and struggle with activities of daily living. Tasha is unable, and sometimes unwilling, to connect with clients interpersonally. The field instructor observes that Tasha's body language is closed off, she is withdrawn during client activities and interactions, and she fails to advocate for clients.*

An underlying issue for a student such as Tasha is her personal bias. All social workers bring personal biases into the helping relationship. In our field education experience, students often have difficulty admitting biases—for a variety of reasons, such as fear of failing academically, embarrassment or shame, as well as basic lack of awareness. In Tasha's situation, we could utilize process recording to prompt self-reflection on the emotional tenor of her interactions with clients, with the aim of helping her recognize the impact of her biases toward certain types of clients and the negative impact on her helping relationships. Further, the process recording gives the field instructor a format for commenting on Tasha's affect, body language, and use of helping skills—particularly acts of omission, when Tasha fails to

take action or fails to respond to topics that do not interest her. As Tasha reveals personal thoughts and feelings in the recording exercise, we can eventually explore how Tasha's faith can be a source of compassion and grace for clients, no matter their backgrounds. By first dialoging in a written format using the process recording columns, the field instructor can allow Tasha time to read and digest comments before discussing them in person in their next field supervision session. The conversations will continue in subsequent sessions.

Christian social workers often cite Jesus Christ as their model for reaching the "untouchables" of society such as the leper (Matthew 8), the woman at the well (John 4), and the paralyzed man (Luke 5). As field personnel who are Christians, we have grappled at times with situations in which a student professes faith, but that student seems to be missing the love and grace of Jesus in both their attitudes and actions toward clients. In these situations, we have worked to keep ourselves in check within our supervisory roles, being careful not to impose our own beliefs onto students while steadfastly enforcing behavioral expectations of social work's professional values and ethics. We have found that using self-reflective techniques, such as process recording, can facilitate conversations about students' personal values and faith as they impact practice.

We acknowledge that process recording is a time-intensive activity for students and supervisors alike, but believe the learning justifies the effort. Mullin and Canning (2007) noted that using process recordings predicted positive supervisory relationships and student learning. Further, process recording applies Schön's (1983) adult learning principles of *reflection-on-action and reflection-in-action*. Reflection-on-action occurs retrospectively. After an experience, we examine and evaluate what transpired (Merriam & Bierema, 2014). In the self-evaluation of a process recording, students are practicing reflection-on-action. Eventually, it is hoped that students, as they mature into experienced practitioners, will begin processing and reflecting simultaneously during their work with clients. When personal reflection is happening concurrently with the helping process, the social worker is embodying Schön's (1983) process of reflection-in-action. Ultimately, as field instructors and faculty, we are trying to develop reflective practitioners, social workers whose "thinking serves to reshape what...[they] are doing while...[they] are doing it" (Schön, 1987, p. 26).

Journaling. Reflective journaling is another commonplace assignment for social work students during field training. Journals are valuable teaching tools that allow supervisors to peer into students' internal thoughts and feelings about client interactions (Hubbs & Brand, 2005). Journals also offer a way to assess students' learning, particularly about client interactions and application of theory to practice. In a study of student journaling in field and classroom courses, Nesoff (2004) found that reflective journals

encouraged critical thinking. Further, social work students recognized value in journaling assignments, and they were impacted by the journaling experiences in positive, helpful ways.

For journaling to be a fully effective learning experience, students must demonstrate both openness and vulnerability to share honestly their inner thoughts and feelings. Hence, there are necessary conditions for using student journals well. First, students need clear instructions on the purpose of field journals as well as the writing expectations (Nesoff, 2004). Example guidelines include explanation that journals are for describing field experiences and making observations, exploring thoughts and feelings about those experiences, and providing a safe place for sharing personal responses. If students are expected to link their experiences to theory or classroom learning, that must be expressly communicated or students may write personal journals prepared in a "dear diary" format. Importantly, students must feel safe to disclose authentic thoughts and feelings in journals. Supervisors and educators should outline clearly who will read and have access to students' narratives (Hubbs & Brand, 2005; Nesoff, 2004). In addition, supervisors must read and provide timely feedback on students' journals (Nesoff, 2004) to be fully present in the supervisory relationship, to provide response immediacy, and to reinforce the importance of the exercise. Trust in the supervisory relationship and journaling process can be developed as the field instructor provides the student with feedback, encouragement, and validation (Jensen-Hart, Shuttleworth, & Davis, 2014).

Returning to our example student Tasha, we would suggest using a dialogue journal between the student and field instructor. In dialogue journals, the student/field instructor (and possibly the faculty liaison) engage in ongoing communication with each other in an iterative process (Jensen-Hart et al., 2014). Jensen-Hart et al. (2014) found dialogue journals a powerful agent for ongoing discussions related to faith and spirituality in social work practice, particularly when students were "giv[en] permission for spiritual exploration" (p. 359). Students can be prompted to complete holistic self-reflections in their journals by exploring thoughts, emotions, and spiritual aspects of themselves and their field experiences. Field instructors can also expand their availability to students via dialogue journals, which is also indicated in the case of Tasha. Because dialogue journaling is completed asynchronously, via an on-line electronic discussion platform, supervisors and students can maintain regular communication even when they are not physically together. With Tasha, we could use journaling feedback to probe her statements about client populations. We could discuss body language and nonverbal communication with clients and the impact on the helping process. Spiritually, we could explore how personal faith beliefs and practices can both help and hinder social work practice.

Other self-reflective assignments. In addition to process recording and reflective journals, we endorse the use of (a) minute papers, and (b)

practicum workbook activities. The Minute Paper is a well-known and widely used classroom assessment technique developed by Angelo and Cross (1993) that seeks a quickly written response about students' learning in the span of two to three minutes. Near the conclusion of class, the instructor asks students to reflect on the period's most important points and to pose unanswered questions. We suggest that the utility of minute papers is not limited to the classroom, but also beneficial in field supervision. Field supervisors can assign minute papers for immediate reflection on practicum experiences. For example, if the field instructor is not available to immediately debrief verbally with the student after a practicum experience, students can stop and write freely about the experience or respond to a prompt such as: *What were the most important things you learned from this client meeting? What was most surprising during the interview? What questions do you have now? What don't you understand after this meeting? Questions related to issues of faith and spirituality could include: What issues of personal faith were raised in this client interaction? How might your personal faith and beliefs help or hinder your future interactions with this client?* Minute-paper reflections can be particularly helpful for students who prefer to process experiences internally before immediately engaging in conversation or situations in which a pause in the action for thoughtful reflection would be helpful for student and supervisor.

Additionally, there are numerous practicum companion texts to guide students through their social work field experience. These texts are often organized into subject units with discussion prompts and workbook activities. Written assignments that ask the student to identify who they are as a professional social worker are effective in the development of critical self-awareness (Marlowe, Appleton, Chinnery, & Van Stratum, 2015). We have used activities from Garthwait (2008) with success. For students struggling with issues of faith in addictions practice, we suggest workbook units dealing with use of supervision and diversity. A workbook activity from Garthwait's unit on supervision asks:

> (9) Are you afraid of anything related to your practicum? What is a positive way of dealing with these fears? (10) It has been said that people often avoid the experiences they need most in order to learn and grow personally. Are you avoiding any practicum-related experiences? Why? (p. 51).

Garthwait's diversity unit probes:

> (6) How might your identity, characteristics, and membership in particular groups affect your work with clients who are different from you [who are seeking treatment or are in recovery]?...(8) What are your most common thoughts and feelings when you encounter people who are different

> from you [or are seeking addictions treatment]? (9) What biases and stereotypes, if any, have you identified within yourself as you have encountered clients..[who are seeking addictions treatment or are in recovery]? (p. 148).

Field instructors can assign workbook activities to be completed and brought to the next supervisory session. In addition, workbook exercises can be used by the field instructor and faculty liaison collaboratively to send consistent messages to the student, offering feedback and evaluating the student's skills. Workbook activities can easily be used in tandem with process recording, journaling, and minute-paper tools to facilitate students' self-reflection and personal/professional growth.

Promoting Experiential Learning Activities

The role of experience is central to learning (Merriam & Bierema, 2014), and experiential learning is the heart of social work practicum. New experiences often require new learning. Learning opportunities for practicum students are not limited to experiences within the immediate practicum agency setting. Field instructors can purposely plan and facilitate additional experiences to help students connect personally with people of different backgrounds. When students participate in experiential activities with other people, they gain greater empathy (Merriam & Bierema, 2014). Personal bias can be decreased through exposure and engagement with other people groups, while knowledge, awareness, and compassionate responses can be increased (Kabli, Liu, Seifert, & Arnot, 2013; Shor & Levit, 2012; Wahler, 2012).

We will promote experiential learning activities as we supervise another practicum student in the following scenario:

> *Cassie is a traditional-aged undergraduate student who describes having lived a "sheltered" childhood in a religiously conservative family. The field instructor observes that Cassie is reluctant to speak in client groups and staff meetings. She seems intimidated and afraid. In one-to-one interactions with her field instructor, Cassie demonstrates sound knowledge, basic helping skills, and good understanding of addiction principles. During a field supervision session, Cassie voices feeling ill-equipped and inadequate to help clients because of her lack of life experience.*

When the learning needs are related to low self-confidence, fear, personal bias or stereotypes toward clients, we have found experiential activities to be beneficial teaching and learning tools. We will outline several experiential activities that may be used in both practicum and classroom settings.

Like Cassie, some students have little prior exposure to alcohol and drugs, addictions, or treatment. In these instances, we find experiential activities valuable for increasing students' knowledge, awareness, and familiarity with common substances and treatment options. For example, it is important for students to have basic recognition of drugs and paraphernalia, especially if they conduct home visits. Students can participate in drug-recognition activities via photos, presentations, and workshops. We also encourage students to view magazines such as *High Times* to observe substances and learn more about drug culture. Some students do not know about alcoholic beverages and may not fully understand common client references such as "a fifth." Here, we suggest that students peruse a grocery display of alcoholic beverages to observe products, brand names, and packaging. For students such as Cassie, learning street language and common vernacular for drugs and alcohol can help her gain confidence, enabling her to relax and be more assertive in her work with clients. Additionally, it is important for students to experience, as appropriate, aspects of addictions treatment. All students, regardless of practicum setting, should observe intakes from a client's perspective to gain empathy and to learn agency procedures. In addictions settings, we recommend that practicum students attend an open meeting of Narcotics or Alcoholics Anonymous to learn more about 12-step recovery programs.

Exposure and experiential activities can also help mitigate stereotypes and students' personal bias (Shor & Levit, 2012). We suggest several activities to help increase students' understanding of, comfort with, and empathy for commonly oppressed and marginalized client populations. We regularly require students to spend practicum time visiting partner agencies where clients participate in services. Students visit other sites, as clients would, such as an income maintenance office; Women, Infants, and Children (WIC) Program; local office of the National Alliance on Mental Illness (NAMI); Housing Authority; Social Security Administration; community physical and mental health clinics; and a psychiatric unit for acute dual-diagnosis treatment. To help students better understand structural barriers to treatment, we have them use public transportation to travel to and from common service providers. We encourage students to attend speaker panels in the community to hear client narratives directly on topics of recovery, family violence, refugees, immigration, and LGBTQ, for example. We highly value immersive experiences, too, and facilitate students' participation in activities such as poverty simulations, hunger banquets, and Tunnels of Oppression. Students can also learn much by attending cultural and religious celebrations meaningful to their clients (Garthwait, 2008), including open religious services, festivals, dances, or fairs. To further their understanding of addiction treatment models, we encourage students to visit other addiction treatment programs in the area as well.

Experiential activities alone are often not enough to help students develop empathy and insight or overcome fear and intimidation. Experiences can become transformative when students begin "to question...assumptions about how the world works or how life is" (Merriam & Bierema, 2014, p. 107). Thus, field instructors can help prompt deeper self-reflection and understanding by applying Kolb's (1984) four stages of experiential learning. In *Concrete Experience,* the learner encounters a new experience or situation or reinterprets a prior experience. We have presented several examples of *Concrete Experiences* for social work students in addition to regular practicum duties. Field instructors can prompt further learning by engaging students in review and reflection on their experiences through individual discussions, group supervision, or journaling to promote *Reflective Observation.* Students form new ideas or review their prior assumptions in *Abstract Conceptualization.* Under the field instructor's supervision, students move to *Active Experimentation* when they apply new learning in their work with clients at the practicum setting and begin responding to others in new ways (Merriam & Bierema, 2014).

Conclusion

Practicum can be a disorienting time for students as they face people and problems that may challenge and contradict their beliefs and assumptions about the world. Of course, students bring their prior experiences, worldviews, and biases to the field setting. In addictions practice, students are particularly exposed to spirituality's role in treatment and 12-step traditions. During practicum, students will likely encounter clients whose spiritual beliefs and religious practices differ from their own. Students' personal bias becomes problematic when it interferes with helping and learning processes. Field educators play a vital role in confronting issues of bias and helping students manage issues of personal faith during practicum. In this article, we offered five supervision strategies to help students gain greater self-awareness and learn to competently and ethically integrate their faith into addictions practice: (a) separating spirituality from religion, (b) reframing addiction viewed as sin, (c) offering reflective feedback, (d) self-reflecting through journaling, process recording, and other written assignments, and (e) promoting experiential activities. Through candid, caring, and supportive supervision, field educators can guide and mentor students as they develop into competent and ethical social workers. While the supervision process may be demanding for students and field personnel, practicum can be the experience in which transformative, career-defining learning takes place. ❖

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Wiens, T. K., & Walker, L. J. (2014). The chronic disease concept of addiction: Helpful or harmful? Addiction Research & Theory, 23(4), 309-321. doi:10.3109/16066359.2014.987760Lisa A. Street, MSW, EdD, LCSW is Assistant Professor of Social Work and Coordinator of Field Education, Evangel University, Department of Behavioral and Social Sciences, 1111 N. Glenstone, Springfield, MO 65802. Telephone: 417-865-2815, ext. 8614.E-mail: StreetL@evangel.edu

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Key Words: addictions, field education, spirituality, social work supervision, social work practicum

Brave, strong, true: The modern warrior's battle for balance.

Thomas, K. H. (2015). Collierville, TN: Innovo Publishing.

In this book, Dr. Thomas presents a resiliency framework for those individuals who serve in the armed forces. Her honesty in detailing the responsibilities of service personnel serves as a strong catalyst for social workers to better understand the challenges facing this population. Born from her own military experience, the author combines research data with personal experience to present a well-articulated, practical model that can be implemented within the armed forces' training

The author begins by establishing the need for such a framework, describing the current mental health crisis facing the military and defining the unique mental health challenges of veterans. A key point in understanding the crisis is the recognition that military training and service reinforce a culture where need is synonymous with weakness; therefore, veterans rarely access available services post-deployment. Thomas argues the key to addressing the mental health needs of military personnel is to shift from a focus on treatment to the proactive development of resiliency during military training.

Thomas identifies three key elements for the resiliency framework: social support, self-care, and faith. Military personnel face a level of isolation in society, due in part because contemporary wars are no longer central in American society; concurrently, studies highlight the positive influence of social support for military personnel upon returning home from deployment. Therefore, part of developing resiliency is intentionally building a meaningful social network for veterans, post-deployment. In discussing self-care, Thomas encourages balanced self-care. She advocates for self-care that incorporates nutrition, physical movement and meditation.

The third component of Thomas' resiliency framework is faith. She defines faith as "organized religiosity," which is inclusive of both a person's belief system and his or her practices such as church attendance, community and volunteer activities (p. 103). Sharing her own journey of faith and current research on the impact of faith, Thomas examines the practical, psychological, and spiritual benefits of a faith system with application to the needs of veterans. Her emphasis is not only on the healing power of a belief system, but also on the impact of living out one's faith.

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The book concludes with a summary of the framework and its application to current military practices, making recommendations for its inclusion in military training. The author also briefly discusses the framework's application outside the military culture.

Dr. Thomas does a good job detailing the needs of this population and advocating for services that are positioned to work with veterans. The strength of the book is primarily in the practical nature of the resiliency framework. Well-defined, the author presents a framework that can be employed by social workers in a variety of fields, especially those in military social work. Additionally, the blend of the author's experience with empirical research allows the reader to come away with both a qualitative and quantitative understanding of the issue. A strong advantage of the book is the Endnotes, with references to applicable studies and brief annotations, allowing for further reading and exploration. For Christian social workers, the inclusion of faith into the framework reinforces the centrality of faith for this population, and the discussion of faith provides further knowledge on the role of faith in healing and wellness.

One challenge in reading this book is the writing style. The book is written informally. The author's blend of her voice and research can be confusing, making it difficult to follow her logic. The level of informality weakens her presentation which, in turn, can lead one to view the resiliency framework as deceptively simple.

A clear use for this book is with military social workers and chaplains. Social workers and chaplains within the military can advocate for the inclusion of the framework into training pre-deployment. This can be a helpful text for both the classroom and for continuing education, introducing the needs of veterans. For those working with military personnel post-deployment, the book provides a framework that can be incorporated into treatment. Another possible use is with church staff. An understanding of the role of social support, faith, and self-care for this population can equip church staff to come alongside veterans in their congregations and advocate proactively for these framework elements. ❖

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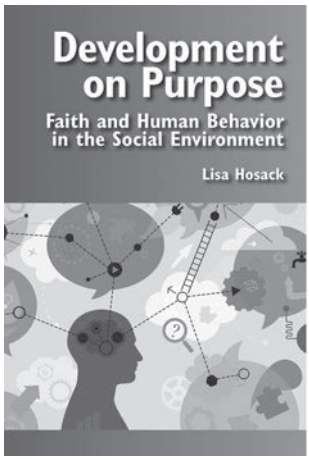


Development on Purpose: Faith and Human Behavior in the Social Environment
(2019) by Lisa Hosack , MSW, PhD.

Development on Purpose provides both students and seasoned professionals with a coherent framework for considering human behavior in the social environment from a Christian perspective. It was developed to be a companion text for HBSE and related courses at both undergraduate and graduate levels.

Courses in human behavior and the social environment raise important questions about the nature of persons and our multi-layered social world. The Christian faith offers compelling answers to these deep questions about human nature and our relationships with one another and the world by providing a defining purpose for human development.

Steeped within the Reformed tradition, *Development on Purpose* describes how this grand purpose informs our understanding of the trajectory of our lived experience and sustains our work on behalf of those at risk in the world. Check out the introductory chapter and video introducing you to this important new book for Christians in social work!

The first half of *Development on Purpose* outlines a purpose for human development, examining biological, psychological, and social theories through the lens of faith. This includes chapters on:

- Biblical Themes to Ground Us
- A Theological Model for Understanding Human Behavior in the Social Environment (HBSE)
- The Perspectives of Social Work from the Lens of Faith
- The Biological Dimension
- The Psychological Dimension
- The Social Dimension

The second half of *Development on Purpose* then uses detailed case examples to illuminate the way that faith can relate to work with persons across the lifespan. This includes chapters on:

- Infancy: Early Growth toward God and Others
- Childhood: Playing and Learning (ages 3-12)

- Adolescence: Leaning into Identity (ages 13-18)
- Emerging Adulthood: Feeling In-Between
- Middle Adulthood: At the Intersection of Growth and Decline
- Older Adulthood: Finishing Well

In showing how a Christian understanding of people can inform the study of human behavior throughout the life course, *Development on Purpose* is an excellent companion text for Human Behavior in the Social Environment and related courses in faith-based social work programs. To support the use of this book in the classroom, NACSW is developing a collection of online teaching resources for your use. These free resources will include summaries of key concepts and terms found in *Development on Purpose*, discussion questions, suggested class activities and assignments, and an annotated bibliography.

Hear What Others Are Saying About *Development on Purpose*

Gaynor Yancey, Professor & Baylor Master Teacher at the Diana R. Garland School of Social Work & George W. Truett Theological Seminary, says that: "In *Development on Purpose*, Lisa Hosack does a great job of not only encouraging readers to be knowledgeable in the theories and practices of human development, but she also includes the added dimension of faith as a vital and necessary element for social workers to consider in our work with people in various stages of the life course. The author's purpose is not to replace one focus of practice (social work theories and skills) with theology. Rather, she is encouraging all Christians in the social work profession not to neglect the theological context of how we are made, in God's image, when we address various behaviors across the life course. This book will serve as wonderful addition to the preparation of social work professionals. This work truly celebrates the link of social work with our Christian faith tradition! What a gift it is to all of us!"

Marleen Milner, Ph.D., MSSW, BSW, Professor of Social Work and BSW Program Director at Southeastern University, writes that: "In *Development on Purpose*, Lisa Hosack provides a long overdue faith-based perspective on critical social work theories on human development and the environment, highlighting the significance of spirituality in human flourishing. The author offers a systematic biblical critique of micro, mezzo, and macro social work theories, drawing on both social work and theological literature. Part 1 provides an excellent and coherent overview of commonly used social work theories with commentary on the agreement and tensions with a biblical worldview. Part 2 covers developmental theories across the life span. A significant strength of the text is the detailed case studies which will facilitate the application of the theoretical and biblical perspectives to assessments in the various life stages. This book will be a beneficial addition

to an HBSE course at the undergraduate or graduate level, or a course on the integration of spirituality and social work practice."

Regina Chow Trammel, Ph.D., LCSW, Assistant Professor of Social Work at Azusa Pacific University, says that "Lisa Hosack's *Development on Purpose*: Faith and Human Behavior in the Social Environment is an important contribution to the field of social work. She provides a comprehensive, clear, and sound integration of Christian theology with social work theory and practice concepts. This book is a needed resource for any social worker and easily used as a primary or supplemental text in any HBSE classroom. Lisa engages readers and primes them for deeper learning through the use of case studies, and discussion questions to apply the learning material in each chapter. This is a deep and rich text that I am looking forward to using in my classroom."

Kristen Alford, Ph.D., MSW, MPH, Associate Professor of Social Work at Calvin University offers that "Dr. Lisa Hosack's *Development on Purpose*: Faith and Human Behavior in the Social Environment provides a comprehensive understanding of the role of faith in human development and social work practice. The book allows students to fully investigate the interplay of faith and spirituality with biological, social, and psychological functioning. It also provides students with tools to critically evaluate social work and related theories and practices using a lens of Christian faith. *Development on Purpose* is a useful companion to other HBSE resources as it provides a foundation for understanding the role of faith, an oft-overlooked yet essential area of human flourishing."

Helen Wilson Harris, Ed.D, LCSW, Associate Professor of Social Work at the Diana R. Garland School of Social Work at Baylor University, writes that: "Dr. Lisa Hosack has written a highly integrative companion textbook for Christians interested in a theological/faith perspective of human behavior and the social environment. *Development on Purpose* addresses in two parts both major theories and Old and New Testament scripture and themes specific to human behavior and social work practice. The author provides both a broad overview of human development theory from the various disciplines and application of theological and scriptural content to that theory and to case studies across developmental levels. The social worker seeking to apply relational theology to social work practice will find resonance the author's stated goal of social work to assist clients in human development and relationships including those with God, with themselves, and with all aspects of creation including other persons and the world."

David Sherwood, Ph.D., LICSW, ACSW, Past Editor in Chief of Social Work & Christianity for 34 years, says: "Lisa Hosack's *Development on*

Purpose: Faith and Human Behavior in the Social Environment provides Christian social work students, faculty, and practitioners with a helpful resource for thinking about the complexities of understanding and evaluating theoretical frameworks and their application in social work practice. Dr. Hosack acknowledges both the limitations and the importance of our models as we try to understand and help others. Using her Reformed Christian perspective, Dr. Hosack applies Biblical themes of relationality, fallenness and the need for redemption, embodiment, and agency to gain insight into human behavior in the social environment. This is an important complement to the literature in the field."

Scott Sanders, MSW, PhD, Professor of Social Work and Program Director at Cornerstone University, writes that "*Development on Purpose* is divided in two sections. The first introduces the reader to a biblical and theological understanding of human behavior in the social environment and then uses that lens to provide an overview of theoretical frameworks commonly used in HBSE study. The second walks the reader though the developmental lifespan, using case examples to highlight an integration of the theoretical foundations discussed in the previous section. A useful companion text, and I think, the first of its kind, for aspiring social workers studying human behavior in the social environment who also care deeply about the integration of that knowledge with a Christian worldview."

About the Author

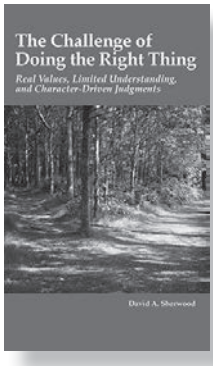
Lisa Hosack (MSW, University of Illinois-Chicago; PhD, Michigan State University) is an associate professor at Grove City College where she founded and directs the social work program. Prior to her teaching career, Dr. Hosack was a practitioner for over twenty years, working in child welfare and clinical social work in Chicago and Grand Rapids, MI. Additionally, she ran a college counseling center at small Christian college for six years. The sum of these experiences is a passion for reclaiming social work's roots in Christianity. Her research and writing focuses on the intersection of theology, human development, and social work. She is married and the proud mother of three grown daughters.

Exam Copies and Ordering Information

Development on Purpose: Faith and Human Behavior in the Social Environment (IBSN # 978-0-9897581-5-4) is over 225 pages long, and has 12 chapters. *Development on Purpose* costs only $24.95 or only $19.99 for NACSW members (plus shipping).

The Challenge of Doing the Right Thing: Real Values, Limited Understanding, and Character-Driven Judgments

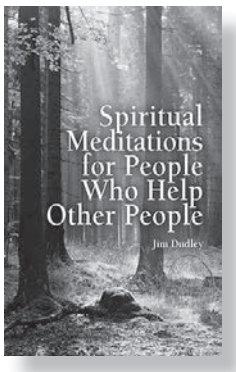
David A. Sherwood. (2018). Botsford CT: NACSW. $21.95 U.S., $17.55 for NACSW members or orders of 10 or more copies. Available as an eBook only. For price in Canadian dollars, use current exchange rate.



The Challenge of Doing the Right Thing: Real Values, Limited Understanding, and Character-Driven Judgments is a 450-page collection of 44 editorials and articles written by David Sherwood for *Social Work & Christianity* and for the North American Association of Christians in Social Work between 1981 and 2017 focused on integrating Christian faith, values, and ethics with competent professional social work practice. In this book. Dr. Sherwood argues that in ethical decision-making, decisions frequently involve making judgments that functionally prioritize legitimate values that are in tension with each other. He contends that the mission of NACSW and *Social Work & Christianity* has been to walk the difficult middle road—clearly committed to both Christian faith and competent social work practice, not presuming to have the final answers in either, and helping members and readers to come as close to faithfulness and competence as possible.

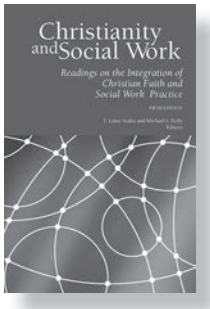
Spiritual Meditations for People Who Help Other People

James R. Dudley (2019). Botsford, CT: NACSW. $20.75 U.S., $16.60 for NACSW members or orders of 10 or more copies. Available as an eBook only. For price in Canadian dollars, use current exchange rate.



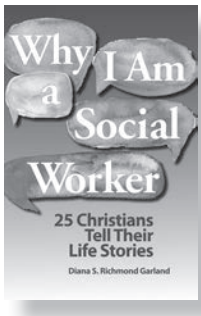
Spiritual Meditations for People Who Help Other People is written for social workers and others who devote their lives to helping other people. The 25 spiritual meditations in this book are designed to nurture and strengthen caregivers, focusing on ways that we can enhance our relationship with God. Finding God in times of stillness, experimenting with different forms of prayer, and growing our patience and gratitude are examples. The meditations also focus on our relationships with the people we help. These meditations help us view our clients and our services as sacred territory, urge us to celebrate our clients, help us love our adversaries, and encourage more openness to miracles. Spiritual Meditations contains more than 25 individual meditations.

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:

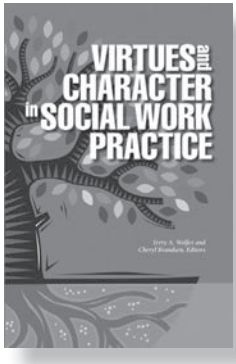
- How do social workers describe the relationship of their faith and their work?
- What is their daily work-life like, with its challenges, frustrations, joys and triumphs?
- What was their path into social work, and more particularly, the kind of social work they chose?
- What roles do their religious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

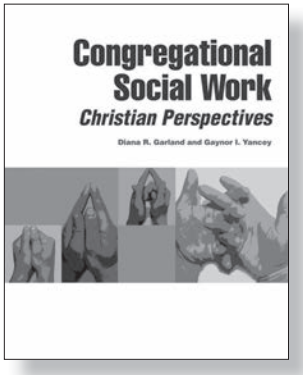


Virtues and Character in Social Work Practice offers a fresh contribution to the Christian social work literature with its emphasis on the key role of character traits and virtues in equipping Christians in social work to engage with and serve their clients and communities well.

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

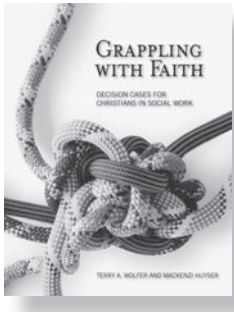
Diana Garland and Gaynor Yancey. (2014). Botsford, CT: NACSW. $39.95 U.S., $31.95 for NACSW members or orders of 10 or more copies). For price in Canadian dollars, use current exchange rate.



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.

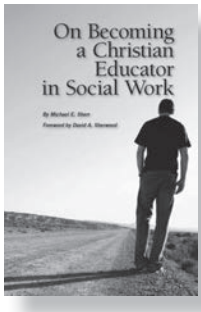
Grappling with Faith: Decision Cases for Christians in Social Work

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.

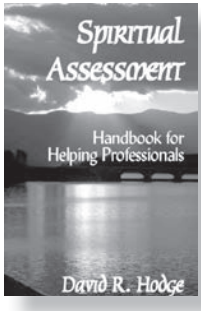
On Becoming a Christian Educator in Social Work
Michael Sherr. (2010). $21.75 ($17.50 for NACSW members or for orders of 10 or more). For price in Canadian dollars, use current exchange rate.



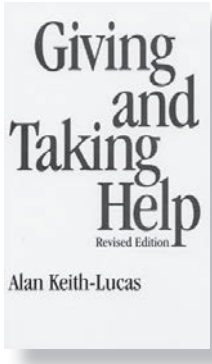
On Becoming a Christian Educator is a compelling invitation for social workers of faith in higher education to explore what it means to be a Christian in social work education. By highlighting seven core commitments of Christian social work educators, it offers strategies for social work educators to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

Hearts Strangely Warmed: Reflections on Biblical Passages Relevant to Social Work

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

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

The Poor You Have With You Always: Concepts of Aid to the Poor in the Western World from Biblical Times to the Present

Alan Keith-Lucas. (1989). Botsford, CT: North American Association of Christians in Social Work. $20.75 U.S. ($16.50 for NACSW members). For price in Canadian dollars, use current exchange rate.

Encounters with children: Stories That Help Us Understand and Help Them

Alan Keith-Lucas. (1991). Botsford, CT: North American Association of Christians in Social Work. $11.50 U.S. ($9.00 for NACSW members). For price in Canadian dollars, use current exchange rate.

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