SOCIAL WORK & CHRISTIANITY

JOURNAL OF THE NORTH AMERICAN ASSOCIATION OF CHRISTIANS IN SOCIAL WORK

VOLUME 50, NUMBER 3 • FALL 2023

ISSN 0737-5778

NACSW
North American Association of Christians in Social Work

SOCIAL WORK & CHRISTIANITY

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). The purpose of SWC is 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.

Views expressed by authors are their own and do not necessarily reflect those of *SWC* or NACSW. Membership in NACSW or publication in *SWC* in no way implies endorsement or certification of the member's or author's qualifications, ability, or proficiency to practice social work. NACSW and *SWC* do not assume responsibility in any way for readers' efforts to apply or utilize information, suggestions, or recommendations made by NACSW, its publications, conferences, or other resources.

INSTRUCTIONS FOR AUTHORS

Social Work & Christianity publishes four types of articles: a) conceptual articles; b) research articles; c) practice articles; and d) point of view articles. Go to swc.nacsw.org to check out the criteria used by reviewers to evaluate submissions for each type of article, and to submit a manuscript to *SWC*.

Submit your manuscript electronically to *SWC* as a Microsoft Word file which includes the following information: a) the full title of the article; b) an abstract of not more than 150 words; c) the full text of the article (without author identification); d) references and any tables or appendices (please use the current edition of the American Psychological Association Style Manual for in-text references and reference lists); e) keywords or phrases (4–8) to facilitate online searches.

To ensure the integrity of the blind peer-review process, before you submit your manuscript, please delete the name(s) of the author(s) anywhere they appear in the text, and remove the author identification from the "properties" section of your document.

At least three members of the editorial board will anonymously review manuscripts based on: a) relevance of content to major issues concerning the ethical integration of competent social work practice and Christianity; b) potential contribution to social work scholarship and practice; c) literary merit; d) clarity; and e) freedom from language that

conveys devaluation or stereotypes of persons or groups. The editor in chief will make final acceptance decisions.

Authors may correspond with the Editor in Chief by email at editor@nacsw.org

BOOK REVIEWS FOR *SWC*

Social Work & Christianity welcomes book review manuscripts for the Reviews section of the journal. Book reviews should be relevant to *SWC*'s readership and therefore should include content pertinent to Christians in social work. Book review authors should follow these guidelines:

- To submit a book review to *SWC*, go to: swc.nacsw.org.
- Ordinarily books should be fairly recent (published within two years); if later, reviewers should provide some justification for why an older book has current relevance.
- Reviews should be about 600–800 words in length.
- Reviews should include an overview of the book's main points, especially those pertaining to Christians in social work.
- In addition to a descriptive summary of the book's content, reviews should provide some assessment, critique, and analysis of the book's strengths and weaknesses, and its contribution to the field of social work practice, especially to specific audiences such as subfields of social work practice, students, academics, administrators, and church leaders.
- Reviews should adhere to general guidelines for formatting and writing escribed in the general Instructions for Authors.

All submitted book review manuscripts, whether invited or not, are subject to editorial review and acceptance by the book review editor, in conjunction with the editor-in-chief, who will make final decisions regarding acceptance for publication.

Reviews submitted for a special topic issue should be clearly marked as such.

Please contact James Vanderwoerd, Book Review Editor, Social Work & Christianity, with any questions or additional information. Email: jwoerd@redeemer.ca

LETTERS TO THE EDITOR

Social Work & Christianity welcomes Letters to the Editor. To submit a Letter to the Editor to *SWC*, go to: swc.nacsw.org.

The purpose of the Letters to the Editor section in *Social Work & Christianity* is to provide creative space for dialogue about complicated topics for Christians in social work. Our hope is that submissions in this form allow for the healthy exchange of ideas and perspectives. The Letters to the Editor section is grounded in our Christian values of humility, mutual respect, and generosity of spirit, as well as our professional values of critical thinking and integrity.

Letters to the Editor should be no more than 500–1,000 words in length and invite conversation as it offers the opportunity for readers to observe an open and civil exchange of ideas and perspectives. Letters which are a response to articles previously published in *Social Work & Christianity* will be shared with the article author(s), who will have the opportunity to respond to the letter. Such Letters to the Editor are encouraged to ask

clarifying questions in a spirit of curiosity (as opposed to a spirit of confrontation), model careful listening, and seek common ground where possible as it shares alternative points of view for readers' consideration. Letters to the Editor which include personal attacks or denigration of individuals or organizations will not be considered.

SUBSCRIPTIONS & INDEXING

Four issues per year of *SWC* are a benefit of membership in NACSW. Membership information may be obtained by contacting NACSW at info@nacsw.org or 888.426.4712.

Subscriptions are available for $135/year for institutions located in the US, $155/year (US$) for institutions located in Canada, and $150/year (US$) for institutions in all countries outside of North America. This low subscription rate includes both hard print copies as well as on-line access to *Social Work & Christianity.* Please note that on-line access allows access to issues of SWC going back to 1974.

Back orders of most issues of *SWC* (formerly *The Paraclete*) are available for $5 per copy. For more information, including a list of contents by issue or questions about advertising in *SWC,* contact NACSW directly. *SWC* is indexed in *Social Work Abstracts, Sociological Abstracts, Social Services Abstracts, Guide to Social Science and Religion in Periodical Literature, PsycINFO, and Christian Periodical Index*. Full text articles from *Social Work & Christianity* appear in both ProQuest as well as EBSCO's *SocINDEX with Full Text*, *Academic Search Complete*, *and Social Sciences Full Text* bibliographic research databases.

Individuals and organizations that wish to advertise professional events, resources, and programs that are compatible with the mission of NACSW should contact the NACSW office (info@nacsw.org or 888.426.4712) for rates, publishing procedures, and deadlines.

SOCIAL WORK & CHRISTIANITY

JOURNAL OF THE NORTH AMERICAN ASSOCIATION OF CHRISTIANS IN SOCIAL WORK

FALL 2023
VOLUME 50, NUMBER 3
ISSN 0737-5778
DOI:10.34043/SWC.V50I3

CONTENTS

Book Reviews

Social Work & Christianity is published quarterly by the North American Association of Christians in Social Work, 6601 W College Dr. Palos Heights, IL 60463.

ISSN 0737-5778

POSTMASTER: Send address changes to NACSW, 6601 W College Dr. Palos Heights, IL 60463

Words, Images, and the Mind of Christ

Peter Szto

WORDS ARE ESSENTIAL FOR HUMAN COMMUNICATION. They help convey meaning, form ideas, and express feelings. Without words, it would be difficult for social workers to actively listen, assess needs, or articulate empathy. Words also facilitate mental images that form in our minds. As you read my words now, what images form in your mind? Some say thinking is like viewing word-pictures in our heads, like a miniature slide show or movie. How our mind's eye operates is important for social workers. Social work is an observational science and what our minds see shapes how we help. The relationship between words and images is important for Christians in social work, especially in light of the Scriptural injunction to put on the mind of Christ.

Wonderful words of life. These lyrics are from the classic hymn on Scripture that invites people to consider their eternal welfare. Beautiful words, wonderful words, wonderful words of life, wrote Philip P. Bliss in the 19th-century, on words endowed with transcendent authority. Scripture makes plain that Jesus Christ is the eternal incarnate Word, the Word made flesh. Thank God for divine words, but what about human words? God created words for us to communicate directly with Him, and with one another. Yet human words, more often than not, obscure, rather than convey coherent meaning. The reason for the muddling is how sin taints and distorts our words. The Apostle Paul described our cognitive imperfection as seeing through a glass darkly. Bummer.

The good news is that Jesus Christ came to restore our souls, renew our fallen minds, and to see anew. His atonement restores us into a right relationship with God the Father. Redemption means the Holy Spirit renews our minds – to put off negative recurring thoughts and core beliefs. What does it mean then for social workers to have the mind of Christ? To think

Social Work & Christianity, Vol. 50, No. 3 (2023), 216-217
DOI:10.34043/swc.v50i3.383
Journal of the North American Association of Christians in Social Work

as Christ did? To think all thoughts after Him? To process information with moral clarity and to discern the social world? The Bible says a resounding YES on developing a Christian mind.

Putting on the mind of Christ signifies seeing the world as God intends His creation to be. Thinking redemptively is to see social injustices for what they are, and to take appropriate action. Redemptive thinking involves seeing social structures as fallen and in need of restoration, transformation, and reform. Christians active in the public square are to be salt and light amidst chaos and confusion. The Old and New Testament narratives are replete with God's servants acting boldly and justly for the Kingdom of God. Moses in Pharoah's court, Joseph serving in Egypt, Solomon's wisdom for the common good, Habakkuk calling out injustices, and Paul at the Areopagus. They did so in faith, acting in human frailty, yet without compromise. Christians in social work are likewise called to respond in faith and to put on the mind of Christ. To live out the Sermon on the Mount. What images are in your mind today?

Peace,
Peter ❖

Peter Szto, MA, MAR, MSW, Ph.D., Fulbright Senior Scholar; Peter Kiewit Distinguished Professorship, Grace Abbott School of Social Work, University of Nebraska at Omaha, is the Editor-in-Chief, *Social Work & Christianity*, email: editor@nacsw.org

CONCEPTUAL ARTICLE

Coping Behavior Changes in Christian Congregations in the United States: A National Survey

Aynsley H. M. Scheffert, Amanda Wilson Harper, and Gaynor Yancey

During the COVID-19 pandemic quarantines, stay-at-home orders, and other precautionary measures impacted the ability of individuals to engage in group religious practices associated with positive religious coping, a protective factor for community resilience following disaster. The aim of this cross-sectional survey of Christian congregations in the U.S. was to 1) assess the impact of the COVID-19 pandemic on congregation members' coping strategies, and 2) evaluate any changes to Christian coping behaviors. Paired samples t-test identified changes in coping behaviors associated with avoidance, as well as resilience. Implications for Christian congregations and social workers in responding to these changes are discussed in the context of the ethical integration of faith and practice.

***Keywords*:** Coping, religion, pandemic, disaster, Christian congregations

THE COVID-19 PANDEMIC REPRESENTS A LENGTHY and widespread public health crisis experienced by individuals across the globe, which has significantly disrupted major societal institutions including economic, health, educational, governmental, and religious institutions, as the prolonged disaster has required constant adaptation by institutions and organizations (Author[1], 2023). Preventative measures instituted to slow the spread of the COVID-19 virus have required changes in communities with adaptations to meet mandates and expectations for precautions, such as stay-at-home orders, social distancing, and mask mandates (Coleman, 2020; Jiang, 2020). Organizations and

Social Work & Christianity, Vol. 50, No. 3 (2023), 218-238
DOI: 10.34043/swc.v50i3.340
Journal of the North American Association of Christians in Social Work

institutions have changed their operating procedures to include telework, virtual appointments (Secon, 2020). Many churches, congregational communities, and places of worship adapted and moved their worship services online (Higgins, 2020). Adaptations have also been necessary at the individual level with the need to adapt and modify previous ways of living and daily life (Okafor et al., 2022).

Individuals adapted as well, through the strategy of religious coping. This involves finding comfort and meaning in the individual's spiritual beliefs or through engagement with their spiritual or religious community (Mesidor & Sly, 2019; Stratta et al., 2015). Individuals affected by disasters may experience increased psychological distress and mental health concerns, such as depression, anxiety, or post-traumatic stress disorder (PTSD; Chen et al., 2021; Ekanayake et al., 2013; Haynes et al., 2017). For individuals, patterns of behavior which are meant to reduce psychological distress in response to the disaster and its impact are known as coping behaviors (Mesidor & Sly, 2019; Stratta et al., 2015). Coping behaviors may be behavioral or mental, conscious or unconscious, and seek to help the individual respond to stressful situations (Stratta et al., 2015). A variety of coping behaviors have been identified over the past several decades and provide a framework for conceptualizing those behaviors employed by individuals to manage psychological distress (Budimer et al., 2021; Lim et al., 2019). Examples of specific coping strategies may include active stress coping—the attempts of the individual to actively respond to the stressor prompting psychological distress (Stratta et al., 2015). In the case of positive reframing, individuals attempt to consider the stressor from a positive viewpoint.

The relationship of mental health coping strategies to psychological well-being in response to disasters has been established in the literature (Budimir et al., 2021; Esterwood & Saeed, 2020; Lim et al., 2019). Previous research notes clusters of coping behaviors, grouped in coping strategies, which have both positive and negative relationships to the reduction of psychological distress (Budimer et al., 2021; Lim et al., 2019; Mesidor & Sly, 2019). For example, in a study of survivors of the L'Aquila earthquake in Italy, Stratta and colleagues (2015) note the use of problem-focused coping strategies, which included coping behaviors of planning, active stress coping, reframing, and acceptance. The problem-focused coping strategies have also been termed "positive" coping strategies due to the relationship of these coping behaviors with reduced psychological distress and increased resilience (Mesidor & Sly, 2019; Stratta et al., 2015). Conversely, the use of emotionally-focused coping strategies, including coping behaviors of venting, self-blame, and emotional support, were associated with increased distress and mental health correlates of depression, anxiety, and PTSD (Lim et al., 2019, Stratta et al., 2015). The use of substances,

behavioral disengagement, and denial were also noted to be predictive of psychological distress and PTSD (Esterwood & Saeed, 2020; Stratta et al., 2015). Although these coping behaviors and strategies are not noted as "negative" coping strategies, the relationship of these coping styles to increases in psychological distress and incidence of mental health disorders indicate that significant use of these strategies warrant monitoring (Budimer et al., 2021; Esterwood & Saeed, 2020; Stratta et al., 2015). Those that use Christian religious coping strategies might practice such things as the following: prayer, singing, journaling, bible reading, gathering together, and service to one another.

Post-traumatic growth is the process of positive personal transformation because of coping in response to a stressful or traumatic life event (Aslam & Kamal, 2015). Post-traumatic growth is most commonly associated with the problem-focused coping strategies and coping behaviors of acceptance, positive reframing, and positive religious coping. In a study of flood-affected survivors, Aslam and Kamal (2015) note the predictive relationship of the use of active stress coping, instrumental support, positive reframing, religious coping, and acceptance coping behavior strategies to post-traumatic growth.

In addition to the relationship of positive religious coping in development of post-traumatic growth, religious coping has been identified as having protective functions against mental health risks and psychological distress following disasters (Mesidor & Sly, 2019; Sipon et al., 2014). Positive religious coping includes activities which help the individual maintain a sense of the world as benevolent and are built upon the belief in a higher power as nurturing and providing for the individual (Aten et al., 2019; Chen et al., 2021 Davis et al., 2019; Haynes et al., 2017). Positive religious coping is associated with enhanced resilience following disasters or trauma and can mitigate development of PTSD or depressive symptoms (Chen et al., 2021; Ekanayake et al., 2013; Haynes et al., 2017; Shannonhouse et al., 2019). Faith and religious coping at the individual level aids in the development of meaning making, which is an important coping function (Ai et al., 2003; Aten et al., 2014, 2019; Shannonhouse et al., 2019). Multiple activities within religious fellowship, such spiritual teachings in the context of community messages (sermons, homilies, etc.) or one-on-one counsel with religious leaders, aid in development of spiritual coping (Rivera & Nickels, 2014; Roberts & Ashley, 2008). Access to a faith community, then, becomes a protective factor in increasing resilience following disaster and can be an important focus for disaster response (Rivera & Nickels, 2014; Tausch et al., 2011).

In addition to the protective role of religious coping on individual psychological well-being, religious coping is also associated with increased community resilience (Rivera & Nickels, 2014; Tausch et al., 2011;

Wlodarczyk et al., 2016). Religious coping has been shown to enhance communal grieving, as well as community cohesion in disaster-affected areas (Rivera & Nickels, 2014; Tausch et al., 2011; Wlodarczak et al., 2016). Wlodarczak and colleagues (2016) studied coping strategies employed by natural disaster survivors in Colombia, Spain, and Chile and noted the protective function of religious coping at both the individual and community levels. Additionally, collective gatherings associated with community religious practices aided in the development of community resilience and post-traumatic growth.

The COVID-19 pandemic is unique among disaster literature due to the drawn-out nature and long-lasting uncertainty this public health crisis has represented (Author1, 2023). Several studies have investigated the impact of various coping strategies on mental health and well-being in various contexts (Budimir et al., 2021; Okafor et al., 2022). Positive thinking, social support, and active stress coping were noted as being negatively associated with psychological distress, depression, and anxiety during the COVID-19 pandemic (Budimir et al., 2021). Alcohol and substance use were predictors of stress, depression, anxiety, and insomnia (Budimir et al., 2021; Okafor et al., 2022). Okafor and colleagues (2022) also note behavioral disengagement and emotional support coping were associated with increased depression and anxiety about the future.

Additionally, religious coping in the context of the COVID-19 pandemic has been assessed in the literature. In an analysis of the religious coping behaviors and mental health of individuals under stay-at-home order in Morocco, Zarrouq and colleagues (2021) identified positive religious coping as providing a protective function against anxiety and depression. Similar findings were noted by Mahamid and Bdier (2021) among a sample of adults in Palestine. In contrast, Budimir and colleagues (2021), in a study of adults in Austria during the COVID-19 pandemic, found use of positive religious coping to be a positive predictor for perceived stress, insomnia, depression and anxiety. However, these studies have not yet explored the specific impact of the closures of places of worship and religious organizations during the COVID-19 pandemic on their members' coping strategies and coping strategy change during the pandemic in the United States.

Given the demonstrated importance of religious coping in the contexts of disasters, and specifically in the context of the COVID-19 pandemic, this study sought to examine Christian religious coping in members of Christian congregations across the United States. The impacts of public health precautions—such as stay-at-home orders, quarantines, and social distancing—on the coping strategies of members of places of worship and religious organizations requires further examination. The aim of the current cross-sectional survey of congregation members in the United States was to 1) assess the impact of the COVID-19 pandemic on congregation members'

coping strategies, 2) evaluate any changes to Christian coping behaviors, and 3) assess demographic and other factors' impact on coping behavior changes in response to the COVID-19 pandemic.

Methods

Study Design

This quantitative study used a cross-sectional design to assess the coping behaviors of members of Christian congregations in the United States related to the COVID-19 pandemic between November 23, 2020 and January 20, 2021. This study was reviewed and approved by the authors' Institutional Review Board.

Data Collection and Instrumentation

The survey was conducted online using Qualtrics and consisted of 53 items, including demographic variables (age, marital status, race/ethnicity, denomination), as well as political affiliation, congregation response to COVID-19 precautionary recommendations, and geographic information. Respondents' faith background was assessed and response options based on the Religious Landscape study (Smith et al., 2015) were used. The survey concluded with three open-ended questions related to changes and coping in response to the COVID-19 pandemic. The Brief COPE was used to assess coping in this survey. Two composite variables were also included in the survey to assess two constructs – individual Christian coping (individual prayer, reading of religious texts, and find comfort in spiritual or religious beliefs) and community Christian coping (attend worship services/group religious practices, pray with a group or in community, and seek counsel from religious leaders). The survey was vetted by five members of Christian congregations including pastors and lay persons, as well as experts in the field of religion and spirituality and congregational social work until items were deemed to have no problems with clarity prior to survey publication.

Brief COPE

The Brief COPE measures coping behaviors (Carver, 1997). The Brief COPE is a shortened version of the COPE and consists of two-item factors representing the majority of coping strategies cited in the full COPE with the exception of the 'focusing on' subscale. The scale consists of 30 items, each with a four-point Likert scale, with higher scores on each factor indicating a higher level of use of the identified coping strategy. The scores per factor ranged from 2 to 8. The Brief COPE has good internal consistency reliability of α=.80 across studies, as well as test-retest reliability and content, factorial, and criterion validity (Carver, 1997).

Individual Religious Coping

A composite individual religious coping variable was calculated based on responses to three survey items assessing use of private or individual religious coping behaviors. The items of this composite variable were embedded in the Brief COPE using a four-point Likert scale mirroring the Brief COPE items (1= I usually don't do this, 4= I usually do this a lot). The first item was "I try to find comfort in my spiritual or religious beliefs;" the second item was "I read the Bible, Torah, Qur'an or other religious texts;" and the third was, "I pray or meditate." These items were summed for a score ranging from 3 to 12.

Community Religious Coping

A composite community religious coping variable was calculated based on responses to three survey items assessing use of community religious coping behaviors. The items of this composite variable were embedded in the Brief COPE using a four-point Likert scale mirroring the Brief COPE items (1= I usually don't do this, 4= I usually do this a lot). The first item was "I pray with someone else or a group of people;" the second item was "I attend worship services or engage in other group religious practices;" and the third was, "I seek counsel from religious leaders (such as my pastor, priest, rabbi, etc.)." These items were summed for a score ranging from 3 to 12.

This survey was distributed to a nationally representative sample of Christian congregations created through the Baylor Religion study via email with a Qualtrics link to the survey. The email detailed the inclusion criteria and invited congregation members to share their experiences of the impact of the COVID-19 pandemic on their coping. The survey began with an online informed consent statement detailing the purpose of the research study, the anonymous and voluntary nature of the study, and the primary investigator's contact information. This consent required respondents to agree or decline to participate prior to proceeding to take the online survey. Those who opted out of participating were invited to complete a link that indicated reasons for non-response.

Sample and Response Rate

The study population included full-time and part-time religious leaders (pastors, priests, rabbis, etc.), lay leaders, house of worship staff members, and lay congregation members in Christian congregations across the United States in Fall 2020. The survey was distributed beginning November 23, 2020 and remained open through January 28, 2021. The survey was sent through email on three separate occasions on November 23, 2020, December 7, 2020, and January 6, 2021. The survey was distributed to 695 Christian congregations and was completed by 96 participants, giving the survey a 14% response rate. A total of 71 surveys were fully completed,

yielding a survey completion rate of 74%. Survey responses were collected from 27 states and the District of Columbia. A non-response link was provided if respondents declined the informed consent to assess reasons for non-response. Three respondents chose to withdraw from participation in the study following review of the informed consent and did not respond to the nonresponse item to provide reasons for their nonresponse.

Data Analysis

As missing data were less than 1% for any variable used in the proposed analyses, data were eliminated listwise, as suggested by Tabachnick (2019). Descriptive statistics were utilized to report demographics and scale response items for the sample. A paired-t test was then used to assess change in congregants' coping behaviors before and after the onset of the COVID-19 pandemic. For purposes of the proposed variables in this and in the latter analysis, Cronbach's alpha was calculated to assess internal consistency reliability of each subscale and the proposed composite variables (individual religious coping and community religious coping). A multiple linear regression analysis was conducted to assess the prediction of model variables (age, gender, and member role) on the coping behavior change score. The coping behavior change score was computed by taking the difference between the congregants' coping behaviors total scores prior to the onset of the COVID-19 pandemic and their coping behaviors total scores after its onset.

Results

Characteristics of Respondents

Respondents' roles within their congregations/places of worship were varied, as shown in Table 1. Twenty-nine respondents (41%) identified as paid clergy, 17 (24%) as full-time paid church staff, five (7%) as part-time paid church staff, 10 (14%) identified as lay leaders, and 10 (14%) reported they were congregants/parishioners. Religious/faith background and denominations were also varied (see Table 1). The largest percentage of respondents (n=18, 25%) identified their faith background as Roman Catholic, followed by Baptist (n=11, 15%), and Nondenominational (n=11, 15%). Nine respondents (13%) identified as Methodist, five as Lutheran (7%), four as Episcopalian/Anglican Pentecostal (6%), four as Unitarian Universalist (6%), three (3%) as "other Christian," and two (3%) as "other not specified." Additionally, one (1%) respondent identified as Churches of Christ, another one (1%) respondent as Russian Orthodox, and one (1%) as Religious Society of Friends.

The mean age of respondents was 53 years (range 27-71, SD= 11.4). The racial/ethnic demographics of respondents (see Table 1) was majority White (n=58, 82%), with eight respondents (11%) identifying as Hispanic/

Latinx, two respondents (3%) identified as Black/African American, and three respondents (4%) identified their ethnicity as "other." No respondents identified racial identities of Asian or Native American/Pacific Islander. Nearly half of respondents (n=35, 49%) identified their gender as female, another 35 (49%) identified their gender as male, with one respondent (1%) identifying their gender as other than those specified. Respondents' political ideologies were also assessed. Twenty-five respondents (35%) identified their political ideology as conservative, 13 respondents (18%) identified as moderate, five (7%) identified as centrist, 18 (25%) identified as liberal, and 10 (10%) identified as progressive.

Table 1.
Sociodemographic Characteristics of Participants

Characteristic	N	%
Congregants Membership Role		
Paid Clergy	29	41%
Full-time Paid Church Staff	17	24%
Part-time Paid Church Staff	5	7%
Lay Leader	10	14%
Parishioner/Congregant	10	14%
Faith Background/Denomination		
Baptist	11	15%
Methodist	9	13%
Nondenominational	11	15%
Episcopalian/Anglican	4	6%
Pentecostal		
Churches of Christ	1	1%
Roman Catholic	18	25%
Russian Orthodox	1	1%
Lutheran	5	7%
Unitarian Universalist	4	6%
Religious Society of Friends	1	1%
Other Christian	3	4%
Other	2	3%
Race/Ethnicity		
White	58	82%
Black/African American	2	3%
Hispanic/Latino	8	11%
Other	3	4%

Characteristic	N	%
Gender		
Female	35	49%
Male	35	49%
Other than those specified	1	1%
Political Ideology		
Conservative	25	35%
Moderate	13	18%
Centrist	5	7%
Liberal	18	25%
Progressive	10	14%

Congregants' Coping Strategies Identified by Brief COPE

The Brief COPE asked participants to rate their use of specific coping strategies both in general and following the onset of the COVID-19 pandemic in the United States. The Brief COPE consists of 30 items rated on a four-point Likert scale. This four-point Likert scale is used for rating the use of identified coping strategies in general and following the onset of the COVID-19 pandemic. The scale is broken up into specific coping strategies with two items per coping strategy. All items showed good internal reliability with Cronbach's α between .8 and .91 for all subscales in general and following the onset of the COVID-19 pandemic.

Mean scores for each subscale for both the general coping in response to stressful life events data points and those following on the onset of the COVID-19 pandemic were calculated for each respondent. The top coping behavior for each respondent was identified (see Table 2). Respondents with multiple coping behaviors with a tied highest score were noted to have multiple most common behaviors and can be seen in the percentages summed to over 100%. The five most common top coping strategies for coping in response to general stressful life events were active coping, individual religious coping, planning, positive reframing, and acceptance. The five most common top coping strategies following the onset of the COVID-19 pandemic were active coping, individual religious coping, planning, positive reframing, and self-distraction.

Means of each subscale for general coping and coping following the onset of the COVID-19 pandemic were calculated. Means for the coping behaviors in general included self-distraction with a mean of 2.71 (*SD*=.70); active coping with a mean of 3.37 (*SD*=.59); denial with a mean of 1.21 (*SD*=.46); substance use with a mean of 1.29 (*SD*=.56); emotional support with a mean of 2.76 (*SD*=.63); instrumental support with a mean of 2.69

(*SD*=.71); behavioral disengagement with a mean of 1.25 (*SD*=.41); venting with a mean of 2.40 (*SD*=.68); positive reframing with a mean of 3.20 (*SD*=.57); planning with a mean of 3.26 (*SD*=.68); humor with a mean of 2.20 (*SD*=.85); acceptance with a mean of 2.88 (*SD*=.59); religious individual coping with a mean of 3.31 (SD=.68); and religious community coping with a mean of 2.87 (*SD*=.64). Means for coping behaviors following the onset of the COVID-19 pandemic included self-distraction with a mean of 2.97 (*SD*=.77); active coping with a mean of 3.44 (*SD*=.60); denial with a mean of 1.30 (SD=.60); substance use with a mean of 1.32 (*SD*=.61); emotional support with a mean of 2.82 (*SD*=.76); instrumental support with a mean of 2.77 (*SD*=.80); behavioral disengagement with a mean of 1.32 (*SD*=.54); venting with a mean of 2.70 (*SD*=.72); positive reframing with a mean of 3.20 (*SD*=.57); planning with a mean of 3.26 (*SD*=.68); humor with a mean of 3.02 (*SD*=.76); acceptance with a mean of 3.06 (*SD*=.63); religious individual coping with a mean of 3.38 (*SD*=.66); and religious community coping with a mean of 2.79 (*SD*=.67).

After the mean of each subscale for general coping and following the onset of the COVID-19 pandemic was calculated and the rank of coping strategies utilized by respondents based on group means is depicted in Table 2. The top five coping strategies in general prior to the COVID-19 pandemic were active stress coping (*M*=3.37, *SD*=.67), individual religious coping (*M*=3.31, *SD*=.68), planning (*M*=3.26, *SD*= .68), positive reframing (*M*=3.2, *SD*= .57), and acceptance (*M*=2.88, *SD*= .59). The top five coping strategies respondents identified using during the COVID-19 pandemic were active stress coping (*M*=3.45, *SD*= .6), individual religious coping (*M*=3.38, *SD*=.66), planning (*M*=3.31, *SD*=.63), acceptance (*M*= 3.06, *SD*= .63), and positive reframing (*M*=3.02, *SD*= .78).

Table 2.
Respondents' Endorsed Coping Behaviors

Coping Behavior	General Stress Event			COVID-19 Onset		
	N (%)	*M*	*SD*	*N (%)*	*M*	*SD*
Self-distraction	9 (13%)	2.71	.70	16 (23%)	2.97	.77
Active Stress Coping	31 (44%)	3.37	.59	35 49%)	3.44	.60
Denial	0 (0%)	1.21	.46	0 (0%)	1.30	.60
Substance Use	1 (1%)	1.29	.56	2 (3%)	1.32	.61
Emotional Support	8 (11%)	2.76	.63	11 (15%)	2.82	.76
Instrumental Support	10 (14%)	2.69	.71	10 (14%)	2.77	.80
Behavioral Disengagement	0 (0%)	1.25	.41	0 (0%)	1.32	.54
Venting	4 (6%)	2.40	.68	9 (13%)	2.70	.72

Coping Behavior		General Stress Event			COVID-19 Onset	
	N (%)	*M*	*SD*	*N (%)*	*M*	*SD*
Positive Reframing	22 (31%)	3.20	.57	18 (25%)	3.20	.57
Planning	26 (37%)	3.26	.68	25 (35%)	3.26	.68
Humor	6 (8%)	2.20	.85	4 (6%)	3.02	.76
Acceptance	12 (17%)	2.88	.5	13 (18%)	3.0	.63
Individual Religious Coping	26 (37%)	3.31	.68	28 (39%)	3.38	.66
Community Religious Coping	7 (10%)	2.87	.64	4 (6%)	2.79	.67

Changes in Coping Strategies Used During COVID-19 by Respondents

Participants' use of coping strategies were assessed for changes from those they endorsed using, in general, in response to stressful life events compared to those they used following the onset of the COVID-19 pandemic. In order to assess these changes, paired samples t-tests were used to compare general use of specific coping behaviors to those used following onset of the COVID-19 pandemic. Significant results of this analysis are reported below.

The paired samples t-test identified significant increases in use of venting (t(70)= -3.948, p<.001). Venting increased following the onset of the COVID-19 pandemic (*M*=2.7, *SD*=.72) as compared with the use of venting as a coping strategy prior to the COVID-19 pandemic (*M*=2.4, *SD*=.68). The increase in the use of the venting coping strategy had a large effect size (d=.65).

The use of positive reframing decreased significantly following the onset of the COVID-19 pandemic (t(70)=2.067, p=.021). Participants identified their use of positive reframing in general in response to stressful life events (*M*=3.20, *SD*=.57) and then following the onset of the COVID-19 pandemic (*M*=3.02, *SD*=.76). The decrease in use of positive reframing also had a large effect size (*d*=.73).

The coping strategy of self-distraction was also identified to have a significant increase (t(70)= -5.210, p<.001) following the onset of the COVID-19 pandemic (*M*=2.97, *SD*=.77) compared with use of self-distraction prior to the COVID-19 pandemic (*M*=2.71, *SD*=.70). There was a moderate effect size (d=.42) for this increase in the use of self-distraction.

The paired samples t-test identified significant increases in the use of the coping strategy of denial (t(70)= --1.686, p=.048) following the onset of the COVID-19 pandemic (*M*=1.30, *SD*= .60) compared with the use of self-distraction prior to the COVID-19 pandemic (*M*=1.21, *SD*=.46). There was a moderate effect size (*d*=.46) for this increase in the use of

self-distraction.

Finally, acceptance as a coping strategy also increased (t(70)= -3.372, p<.001) following the onset of the COVID-19 pandemic with respondents reporting higher use of acceptance during the pandemic (*M*=3.05, SD=.071) than prior to the pandemic (*M*= 2.88, *SD*=.59). The increase in acceptance as a coping behavior had a moderate effect size (*d*=.43).

Individual and Community Religious Coping

The composite variables individual religious coping and community religious coping were assessed for internal consistency reliability using Cronbach's alpha for both assessments of coping strategies prior to the COVID-19 pandemic and during the COVID-19 pandemic. Individual religious coping had good internal consistency reliability in the retrospective prior to the COVID-19 pandemic (Cronbach's α= .77) and during the COVID-19 pandemic (Cronbach's α=.73). The community religious coping had acceptable internal consistency reliability prior to the onset of the COVID-19 pandemic (Cronbach's α=.6) and during the COVID-19 pandemic (Cronbach's α=.6). All religious coping items had good internal consistency reliability when assessed together prior to the onset of the COVID-19 pandemic (Cronbach's α=.83) and during the COVID-19 pandemic (Cronbach's α= .81) indicating these items likely related to a single factor.

It is notable that respondents reported no significant changes in use of individual religious coping (t(70)= -1.602, p=.114) during the COVID-19 pandemic (*M*=3.38, SD=.64) compared to use of individual religious coping prior to the COVID-19 pandemic (*M*=3.31, *SD*=.68). Additionally, no significant differences in use of community religious coping were noted (t(70)=1.349, p=.182) during the COVID-19 pandemic (*M*=2.79, *SD*=.66) compared to community religious coping prior to the pandemic (*M*=2.86, *SD*=.64).

Discussion

The COVID-19 pandemic has had significant impacts on daily life on the individual and community levels (Budamir et al., 2021). The closures of in-person worship services for churches and places of worship represent a major shift in community life and required adaptations of coping strategies for many individuals (Higgins, 2020; Okafor et la., 2022; Secon, 2020). This cross-sectional national survey sought to identify the impact of these types of precautionary measures related to the COVID-19 pandemic on congregants' use of coping strategies following the onset of the COVID-19 pandemic in the United States. Coping strategies for managing stress, especially in crisis situations, can be a protective factor against ongoing mental health concerns following disasters and aid in the development

of resilience (Budimir et al., 2021; Esterwood & Saeed, 2020; Lim et al., 2019). Communal coping practices increase both individual and community resilience, as well as promotion of post-traumatic growth (Aslam & Kamal, 2015; Mesidor & Sly, 2019; Rivera & Nickels, 2015; Stratta et al., 2015; Wlodarczak et al., 2016). The findings of this study identify several coping strategies employed by congregants during the COVID-19 pandemic as well as changes to coping strategies respondents noted they typically use in response to stressful life events compared to those they used following the onset of the COVID-19 pandemic.

The most common coping strategies respondents identified using to cope with stressful life events in general included active stress coping, individual religious coping, planning, positive reframing, and acceptance. Further analysis explored respondents' use of these most common coping strategies specifically and although some respondents identified more than one most common coping strategy, the frequency of these coping strategies amongst the sample were examined. Of these coping strategies, 44% (n=31) of respondents identified active stress coping as their most common coping strategy, and 37% (n=26) of respondents identified individual religious coping as their most common coping strategy. Planning was identified by 37% (n=26) of respondents as their most common coping strategy in response to stressful life events, and positive reframing was identified by 31% (n=22) as their most common coping strategy in response to stressful life events. Finally, acceptance was identified by 17% (n=12) as their most common coping strategy in response to stressful life events.

Following the onset of the pandemic, participants noted their most common coping behaviors included active coping 49% (n=35), individual religious coping 39% (n=28), planning 35% (n=25), positive reframing 25% (n=18) and self-distraction 23% (n=16). These results are in contrast to the most common coping behaviors identified through mean scores. A greater number of respondents noted the coping behavior of self-distraction as one of their most common coping behaviors, despite this not being identified through mean scores of the sample on these coping behaviors. This indicates significant use of the self-distraction coping behavior by a percentage of participants, but extremes were reported in the use of this coping behavior overall with others reporting very limited use of this coping behavior.

The main coping strategies identified by congregants in this study—active stress coping, religious coping, planning, acceptance, and positive reframing—have been grouped into the problem-focused coping strategy in previous literature (Stratta et al., 2015). The use of problem-focused coping is associated with reduced psychological distress, resilience, and the development of post-traumatic growth (Stratta et al, 2015). The participants' use of acceptance and positive reframing coping strategies aligns with several recent studies with various populations across the world who were

experiencing the COVID-19 pandemic (Aslam & Kamal, 2015; Mesidor & Sly, 2019; Stratta et al., 2015).

Religious coping was differentiated into individual religious coping and community religious coping in this survey. Individual religious coping was comprised of coping behaviors such as prayer, reading or studying of religious texts, and finding meaning and comfort in religious beliefs. Community religious coping included coping behaviors such as prayer with others; attending worship services or other group religious practices; or seeking counsel from religious leaders. These differentiated factors both displayed acceptable reliability and allowed for variation in scores, as demonstrated in the high levels of endorsed use of individual religious coping by respondents with reduced rates of community religious coping, especially following the onset of the COVID-19 pandemic.

Despite the reduction in respondents identifying community religious coping as one of their most common coping strategies following the onset of the COVID-19 pandemic as compared to general responses to stressful life events, there was not a significant mean score difference for either individual or community religious coping following the onset of the COVID-19 pandemic. This is notable considering the precautionary closures of many churches and houses of worship in the United States and the need to access faith communities through alternate means or with adaptations (Budimer et al., 2021; Coleman, 2020; Jiang, 2020). Individuals' use of religious coping behaviors are associated with meaning-making and feeling connected to a higher power (Ai et al., 2003; Aten et al., 2014, 2019; Shannonhouse et al., 2019). These types of positive religious coping behaviors are associated with reduced mental health concerns, such as depression and PTSD, and increased development of resilience in response to disaster and trauma (Chen et al., 2021; Ekanayake et al., 2013; Haynes et al., 2017; Okafur et al., 2022; Shannonhouse et al., 2019). Although many churches and places of worship were not available in the traditional manner, congregants' abilities to utilize individual religious coping behaviors despite widespread church and houses of worship closures highlights the importance of positive religious coping in response to crisis, stress, and change.

These findings also identify changes in participants' use of coping strategies during the COVID-19 pandemic. Changes in respondents' use of specific coping behaviors were assessed with paired-samples t-tests to evaluate the changes in mean scores from endorsed coping behaviors in response to general stressful life events compared to those utilized following the onset of the pandemic. The most significant coping strategy change was congregants' use of venting. The increase in the use of venting as a coping strategy had a large effect size. Alongside the increase in venting as a coping behavior was a decrease in positive reframing. This decrease in the use of positive reframing also had a large effect size. The decrease in the

use of positive reframing which is correlated to the decreased psychological distress and the increase in the use of venting coping behaviors are likely related to the drawn out and uncertain nature of the COVID-19 pandemic, as uncertainty in the context of disasters has been identified in previous literature to greater negative effect on individuals' mental health (Afifi et al., 2012; Afifi et al., 2021; Esterwood & Saeed, 2020).

Changes in respondents' use of the coping behavior of denial were also significant with an increase in the use of this coping behavior which had a moderate effect size. In previous literature the use of denial, along with behavioral disengagement and substance use, made up the avoidant coping strategy (Stratta et al., 2015). Self-distraction was also noted to have a significant increase following the onset of the pandemic, compared to usual coping behaviors prior to the pandemic, also with a moderate effect size. Although an increase in substance use was not noted in this study, which may be related to the study population and/or potential social desirability bias, these results may indicate a change in avoidant coping strategies among participants. The use of avoidant coping strategies has been shown in recent literature to be associated with depression, anxiety, and reduced psychological well-being (Budimir et al., 2021; Okafor et al., 2022).
Conversely, this study also found acceptance as a coping behavior also increased during the COVID-19 pandemic compared to general coping strategies prior to the pandemic. The increase in acceptance identified by participants had a small effect size. As acceptance is one of the coping behaviors identified in the positive coping strategies factor (Stratta et al., 2015), this result may indicate ongoing development of resilience and post-traumatic growth in the context of the first six months of the COVID-19 pandemic.

Implications

It is important for social workers to assess the use of avoidant coping strategies in individuals with whom they work to assess the impact of this risk factor on mental health, especially as it relates to the COVID-19 pandemic or other disaster situations (Okafor et al., 2022). As the COVID-19 pandemic has been long-term with uncertainty surrounding the duration of the public health crisis, the presence of positive coping strategies identified in the results is notable. The changes to daily life for millions also required changes to individuals' general manner of coping with stressors and crisis (Budamir et al., 2021). Stay-at-home orders and social distancing restricted the ability to utilize some coping behaviors in the usual way—for example, due to precautionary measures, many individuals did not spend time in-person with friends outside of their immediate family (Okafor et al., 2022; Scheffert & Ellor, 2023; Scheffert & Parrish, 2023. Despite the potential for increased distress related to the ongoing nature of

the pandemic, the prevalence of these positive coping strategies suggests the development of resilience among the majority of participants (Thompson et al., 2018). This finding highlights the potential development of resilience and post-traumatic growth developing during the COVID-19 pandemic.

Social workers working with Christian congregations will be aware of the ethical implications. Social workers who work with Christian congregations must be aware of the importance of knowing coping strategies that are taught in Christian congregations (for instance, bible reading, prayer, gathering together, and service to each other). Understanding the importance of the context of Christian congregations is vital to social workers who serve communities in their coping practices. The importance of code switching between the language of social work and Christian congregations is an essential skill for social workers in this context.

This research further identifies areas for practitioners to consider when working with clients and communities in the context of disasters. Tailored interventions focused on building skills in active stress coping, acceptance, and positive reframing have promise for increasing individuals' capacity for resilience in response to major life stressors (Godor & Van der Hallen, 2022; Thompson et al., 2018). Within religious communities, the findings of positive religious coping behaviors further identify areas for practitioners to consider when working with religious communities and Christian congregations. Positive religious coping behaviors are associated with meaning-making and feeling connected to a higher power (Ai et al., 2003; Aten et al., 2014, 2019; Shannonhouse et al., 2019). These types of positive religious coping behaviors are associated with reduced mental health concerns, such as depression and PTSD, and increased development of resilience in response to disaster and trauma (Chen et al., 2021; Ekanayake et al., 2013; Haynes et al., 2017; Okafur et al., 2022; Shannonhouse et al., 2019). The incorporation of religious coping supports into social work practice may increase resilience and reduce distress in response to disasters (Oxhandler, 2018). Through integration of clients' religion and spirituality into social work practices, social workers can support the use of religious coping for individuals impacted by disasters (Oxhandler, 2018). Social workers may also help to bolster the resilience of Christian congregations through education for churches and houses of worship leaders and lay leaders on the use of positive religious coping skills and ways to promote this in a religious community. While many churches and places of worship were not available in the traditional manner, congregants' abilities to utilize individual religious coping behaviors despite widespread congregational closures highlight the importance of positive religious coping in response to crisis, stress, and change. Countless examples exist of faith practices resourcing individuals' resilience in the midst of uncertainty or disasters. Further incorporation of individuals' spiritual and religious supports and

examination of ways to stay connected to existing church or house of worship community relationships provides vital connections to clients' existing support networks. Christian congregational leaders may consider offering multiple methods of relational connection and communication for congregants which will support the continuance of long-term relationships, as well as community building among congregational members (Seryczynska et al., 2021). While this study looked at disasters through the lens of the COVID-19 pandemic, the findings demonstrate the value in social workers understanding the impact of positive Christian coping skills for clients and communities.

Limitations

A limitation of this study was that the majority of respondents identified their relationship with their congregational communities as employment-based, as congregation leaders or paid church staff. Additionally, although efforts were made to increase the diversity of this sample by using a nationally representative sampling frame, one limitation of this study is the lack of racial diversity in the sample. The majority of responses identified their religious tradition as Christian. Within the Christian tradition, diversity of denominations of Christianity is present. The lack of African American/Black respondents in the sample is also a limitation, especially considering the unequal impact of the COVID-19 pandemic on minority populations (Abedi et al., 2020; Basset et al., 2020; Garcia et al., 2021). However, this survey's response rate and responses from 28 states across the United States and from a variety of denominations provides valuable insight into the impact of church and religious institutions closures during a disaster event.

Conclusion

This study has many implications for social workers to consider when working with individuals and Christian communities of faith in the context of coping and disasters. These findings identify Christian coping strategies used by individuals in response to a widespread and long-term disaster. The changes in coping behaviors highlight adaptations individuals made to their usual coping behaviors in response to specific disaster parameters. Further, these findings highlight the use of Christian coping behaviors associated with resilience and post-traumatic growth during the COVID-19 pandemic.

Despite the closures and restrictions in regular operations of churches and houses of worship, individuals used Christian coping behaviors and their communities of faith to respond to crisis, stress, and significant change. This is important for practitioners to consider as they potentially incorporate social work interventions when working with clients experiencing life stressors (Oxhandler, 2018). Given the vital context

of Christian congregations and houses of worship to individual and community well-being, especially in times of disaster or stress, social workers have the knowledge and skills to provide education and training to congregational leaders regarding mental health, coping, and methods to increase the resilience of a community through relational connection and community building (Seryczynska et al., 2021; Thompson et al., 2018). In addition to equipping congregational leaders, social workers may also make themselves available to consult with Christian congregations and congregational leaders for referrals for further assessment when that is warranted. While the COVID-19 pandemic is a unique disaster in the duration of uncertainty it has created for many clients and communities, it is important for social workers to consider the Christian coping strategies that have been reported from this study's findings. The implications and suggestions made here regarding positive coping and resilient practices suggest immense value in the on-going collaboration of social workers with congregational leadership, ultimately benefiting individual clients and the community. in 2020, 274 catastrophic. ❖

References

Abedi, V., Olulana, O., Avula, V., Chaudhary, D., Khan, A., Shahjouei, S., Li, J., & Zand, R. (2020). Racial, economic and health inequality and COVID-19 infection in the United States. *MedRxiv: The preprint server for health sciences*, 2020.04.26.20079756. https://doi.org/10.1101/2020.04.26.20079756

Afifi, W. A., & Afifi, T. D. (2021). Uncertainty and coping during COVID-19. In *Communicating COVID-19* (pp. 325-344). Palgrave Macmillan, Cham.

Afifi, W. A., Felix, E. D., & Afifi, T. D. (2012). The impact of uncertainty and communal coping on mental health following natural disasters. *Anxiety, Stress & Coping, 25*(3), 329-347. https://doi.org/10.1080/10615806.2011.603048

Ai, A. L., Peterson, C., & Huang, B. (2003). The effect of religious-spiritual coping on positive attitudes of adult Muslim refugees from Kosovo and Bosnia. *The International Journal for the Psychology of Religion, 13*(1), 29-47. https://doi.org/10.1207/S15327582IJPR1301_04

Aslam, N., & Kamal, A. (2015). Coping strategies as a predictor of psychological distress and post traumatic growth among flood affected individuals. *Journal of Alcohol and Drug Dependence, 3* (1), 181. doi: 10.4172/2329-6488.1000181

Aten, J. D., O'Grady, K. A., Milstein, G., Boan, D., & Schruba, A. (2014). Spiritually oriented disaster psychology. *Spirituality in Clinical Practice, 1*(1), 20. https://doi.org/10.1037/scp0000008

Aten, J. D., Smith, W. R., Davis, E. B., Van Tongeren, D. R., Hook, J. N., Davis, D. E., Shannonhouse, L., DeBlaere, C., Ranter, J., O'Grady, K., & Hill, P. C. (2019). The psychological study of religion and spirituality in a disaster context: A systematic review. *Psychological Trauma: Theory, Research, Practice, and Policy, 11*(6), 597. https://doi.org/10.1037/tra0000431

Bassett, M. T., Chen, J. T., & Krieger, N. (2020). Variation in racial/ethnic disparities in COVID-19 mortality by age in the United States: A cross-sectional study. *PLoS Med 17*(10): e1003402. https://doi.org/10.1371/journal.pmed.1003402

Budimir, S., Probst, T., & Pieh, C. (2021). Coping strategies and mental health during COVID-19 lockdown. *Journal of Mental Health, 30*(2), 156-163. DOI: 10.1080/09638237.2021.1875412

Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. *International Journal of Behavioral Medicine, 4*, 92-100. DOI: 10.1207/s15327558ijbm0401_6

Chen, Z. J., Bechara, A. O., Worthington Jr., E. L., Davis, E. B., & Csikszentmihalyi, M. (2021). Trauma and well-being in Colombian disaster contexts: Effects of religious coping, forgivingness, and hope. *The Journal of Positive Psychology, 16*(1), 82-93. https://doi.org/10.1080/17439760.2019.1663254

Coleman, J. (2020, April 12). All 50 states under disaster declaration for first time in US history. *The Hill*. https://thehill.com/policy/healthcare/public-global-health/492433-all-50-states-under-disaster-declaration-for-first

Davis, E. B., Kimball, C. N., Aten, J. D., Hamilton, C., Andrews, B., Lemke, A., Hook, J. R., Captari, L., Granqvist, P., Hook, J. N., Davis, D. E., Van Tongeren, D. R., Cattrell, E. L., Cuthbert, A. D., & Chung, J. (2019). Faith in the wake of disaster: A longitudinal qualitative study of religious attachment following a catastrophic flood. *Psychological Trauma: Theory, Research, Practice, and Policy, 11*(6), 578–587. https://doi.org/10.1037/tra0000425

Ekanayake, S., Prince, M., Sumathipala, A., Siribaddana, S., & Morgan, C. (2013). "We lost all we had in a second": Coping with grief and loss after a natural disaster. *World Psychiatry, 12*(1), 69–75. https://doi.org/10.1002/wps.20018

Esterwood, E., & Saeed, S. A. (2020). Past epidemics, natural disasters, COVID19, and mental health: Learning from history as we deal with the present and prepare for the future. *Psychiatric Quarterly, 91*(4), 1121-1133. DOI: 10.1007/s11126-020-09808-4

Garcia, M. A., Homan, P. A., García, C., & Brown, T. H. (2021). The color of COVID-19: Structural racism and the disproportionate impact of the pandemic on older Black and Latinx adults. *The Journals of Gerontology: Series B, 76*(3), e75–e80. https://doi.org/10.1093/geronb/gbaa114

Godor, B. P., & Van der Hallen, R. (2022). Investigating the susceptibility to change of coping and resiliency during COVID-19. *Scandinavian Journal of Psychology, 63*(3), 238-245.

Haynes, W. C., Van Tongeren, D. R., Aten, J., Davis, E. B., Davis, D. E., Hook, J. N., Boan, D., & Johnson, T. (2017). The meaning as a buffer hypothesis: Spiritual meaning attenuates the effect of disaster-related resource loss on posttraumatic stress. *Psychology of Religion and Spirituality, 9*(4), 446–453. https://doi.org/10.1037/rel0000098

Higgins, T. (2020, April 2). Churches allowed to stay open in states where millions are particularly vulnerable to coronavirus. *CNBC*. https://www.cnbc.com/2020/04/02/coronavirus-churches-can-stay-open-in-states-with-especially-vulnerable-populations.html

Jiang, I. (2020, March 31). Here's the difference between an "essential" business and a "nonessential" business as more than 30 states have imposed restrictions. *Business Insider*. from https://www.businessinsider.com/what-is-a-nonessential-business-essential-business-coronavirus-2020-3

Lim, J. R., Liu, B. F., Egnoto, M., & Roberts, H. A. (2019). Individuals' religiosity and emotional coping in response to disasters. *Journal of Contingencies and Crisis Management, 27*(4), 331-345. https://doi.org/10.1111/1468-5973.12263

Mahamid, F. A., & Bdier, D. (2021). The association between positive religious coping, perceived stress, and depressive symptoms during the spread of coronavirus (COVID-19) among a sample of adults in Palestine: Across sectional study. *Journal of Religion and Health, 60*(1), 34-49. DOI: 10.1007/s10943-020-01121-5

Mesidor, J. K., & Sly, K. F. (2019). Religious coping, general coping strategies, perceived social support, PTSD symptoms, resilience, and posttraumatic growth among survivors of the 2010 earthquake in Haiti. *Mental Health, Religion & Culture, 22*(2), 130-143. https://doi.org/10.1080/13674676.2019.1580254

Okafor, C. N., Bautista, K. J., Asare, M., & Opara, I. (2022). Coping in the time of COVID-19: Buffering stressors with coping strategies. *Journal of Loss and Trauma, 27*(1), 83-91. DOI: 10.1080/15325024.2021.1914987

Oxhandler, H. K., Narendorf, S. C., & Moffatt, K. M. (2018). Religion and spirituality among young adults with severe mental illness. *Spirituality in Clinical Practice, 5*(3), 188. https://doi.org/10.1037/scp0000164

Rivera, J. D., & Nickels, A. E. (2014). Social capital, community resilience, and faith-based organizations in disaster recovery: A case study of Mary Queen of Vietnam Catholic church. *Risk, Hazards & Crisis in Public Policy, 5*(2), 178–211. https://doi.org/10.1002/rhc3.12050

Roberts, S. B., & Ashley, W. W. C. (2008). *Disaster spiritual care: Practical clergy responses to community, regional and national tragedy*. SkyLight Paths Publishing.

Scheffert, A. H. M. & Ellor, J. (2023). Addressing the inequality of disasters: The role of faith-based organizations in disaster response and recovery. *Social Work and Christianity, 50*(2).

Scheffert, A. H. M., & Parrish, D. E. (2023). Social work students' experiences of loss and grief during the COVID-19 Pandemic: A mixed-method study. *Journal of the Society for Social Work and Research, 14*(1), 29-52.

Secon, H. (2020, July 9). An interactive map of the US cities and states still under lockdown—And those that are reopening. Business Insider. Retrieved July 26, 2020, from https://www.businessinsider.com/us-map-stay-at-home-orders-lockdowns-2020-3

Seryczynska, B., Oviedo, L., Roszak, P., Saarelainen, S. M. K., Inkilä, H., Albaladejo, J. T., & Anthony, F. V. (2021). Religious capital as a central factor in coping with the Covid-19: Clues from an international survey. *European Journal of Science and Theology, 17*(2), 67-81. ID: covidwho-1187622

Shannonhouse, L. R., Bialo, J. A., Majuta, A. R., Zeligman, M. R., Davis, D. E., McElroy-Heltzel, S. E., Aten, J. D., Davis, E. B., Van Tongeren, D. R., & Hook, J. N. (2019). Conserving resources during chronic disaster: Impacts of religious and meaning-focused coping on Botswana drought survivors. *Psychological Trauma: Theory, Research, Practice, and Policy, 11*(2), 137–146. https://doi.org/10.1037/tra0000420

Sipon, S., Nasrah, S. K., Nazli, N. N. N. N., Abdullah, S., & Othman, K. (2014). Stress and religious coping among flood victims. *Procedia - Social and Behavioral Sciences, 140*, 605–608. https://doi.org/10.1016/j.sbspro.2014.04.478

Smith, G., Cooperman, A., Martinez, J., Sciupac, E., Hackett, C. Mohamed, B., Alper, B., Gecewicz, C., Ochoa, J. C. E., Stencel, S., Lipka, M., Webster, B., Murphy, C., Sandstrom, A., Yoo, D., Rosenberg, S., Ritchey, K., Wormald, B., & Heimlick, R. (2015). America's changing religious landscape: Christians

decline sharply as share of population; unaffiliated and other faiths continue to grow. Pew Research Center. https://www.pewresearch.org/religion/2015/05/12/americas-changing-religious-landscape/

Stratta, P., Capanna, C., Dell'Osso, L., Carmassi, C., Patriarca, S., Di Emidio, G., Riccardi, I., Collazzoni, A., & Rossi, A. (2015). Resilience and coping in trauma spectrum symptoms prediction: A structural equation modeling approach. *Personality and Individual Differences, 77*, 55-61. https://doi.org/10.1016/j.paid.2014.12.035

Tabachnick, B. (2019). *Using multivariate Statistics*. Pearson.

Tausch, C., Marks, L. D., Brown, J. S., Cherry, K. E., Frias, T., McWilliams, Z., Melancon, M., & Sasser, D. D. (2011). Religion and coping with trauma: Qualitative examples from Hurricanes Katrina and Rita. *Journal of Religion, Spirituality & Aging, 23*(3), 236–253. https://doi.org/10.1080/15528030.2011.563203

Thompson, N. J., Fiorillo, D., Rothbaum, B. O., Ressler, K. J., & Michopoulos, V. (2018). Coping strategies as mediators in relation to resilience and posttraumatic stress disorder. *Journal of Affective Disorders, 225*, 153-159. DOI: 10.1016/j.jad.2017.08.049

Wlodarczyk, A., Basabe, N., Páez, D., Reyes, C., Villagrán, L., Madariaga, C., & Martínez, F. (2016). Communal coping and posttraumatic growth in a context of natural disasters in Spain, Chile, and Colombia. *Cross-Cultural Research, 50*(4), 325-355. https://doi.org/10.1177/1069397116663857

Zarrouq, B., Abbas, N., El Hilaly, J., El Asri, A., Abbouyi, S., Omari, M., Malki, H., Bouazza, S., Moutawakkil, S. G., Halim, K., & Ragala, M. E. (2021). An investigation of the association between religious coping, fatigue, anxiety and depressive symptoms during the COVID-19 pandemic in Morocco: A web-based cross-sectional survey. *BMC psychiatry*, 21(1), 1-13. DOI: 10.1186/s12888-021-03271-6

Aynsley H. M. Scheffert, PhD, MSW, LICSW, Assistant Professor of Social Work, Bethel University. 651-638-6305, Aynsley-scheffert@bethel.edu

Amanda Wilson Harper, PhD, MSW, MDiv, Assistant Professor of Social Work, Tarleton State University, 817-717-3324, wilsonharper@tarleton.edu

Gaynor Yancey, DSW, MSW, MRE, Professor and Lake Family Endowed Chair in Congregational and Community Health, Baylor University, 254-710-6424, Gaynor_yancey@baylor.edu

RESEARCH ARTICLE

A Qualitative Study to Assess a Catholic Ministry's Evidence-Informed Approaches to Intimate Partner Violence

Beata Debinski, Vanya Jones, Charles Dahm, Janice Bowie, Andrea Carlson Gielen, Caitlin Kennedy

Faith-based organizations (FBOs) are potential partners in the response to intimate partner violence (IPV). However, few studies have reported on such work in practice. We sought to describe implementation of IPV prevention and response in one U.S. Catholic diocese, and to analyze how activities aligned with the best evidence available per the Centers for Disease Control and Prevention's IPV technical package. We conducted sixteen key informant interviews with leaders from Archdiocese of Chicago Domestic Violence Outreach Ministry (ACDVO). Through analysis of interview transcripts, we found that ministry activities mapped onto three recommended strategies: to create protective environments, support survivors to promote safety and lessen harms, and teach safe and healthy relationship skills. The work of ACDVO also demonstrates that FBOs should consider more directly engaging congregation members in their IPV response. Social workers and other health professionals could support FBOs in intervention development and in evaluation for improvement and sustainability.

***Keywords*:** intimate partner violence, faith-based organizations, ministry, community engagement, interventions, qualitative, health promotion

DATA FROM THE 2015 NATIONAL INTIMATE PARTNER and Sexual Violence Survey show that contact sexual violence, physical violence, and/or stalking affect more than One in three women and about one in three men in their lifetime, while almost half of all

Social Work & Christianity, Vol. 50, No. 3 (2023), 239-262
DOI: 10.34043/swc.v50i3.316
Journal of the North American Association of Christians in Social Work

adults in the U.S. have experienced psychological aggression by a current or former partner (Smith et al., 2018). Experiencing intimate partner violence (IPV) has long-lasting mental and physical health effects (Gottlieb, 2008) and can predict future victimization or use of violence by the survivor and even witnesses (Niolon et al., 2017). The U.S. Centers for Disease Control and Prevention (CDC) has identified a series of risk and protective factors for IPV that span the individual, relationship, community, and societal levels of ecological models (National Center for Injury Prevention and Control: Division of Violence Prevention, 2020), and accordingly necessitate multi-level, multi-strategy prevention and response efforts. In 2017, the CDC released a technical package, *Preventing Intimate Partner Violence Across the Lifespan*, compiling the best available evidence about how to address these factors into six strategies to inform research and practice: teach safe and healthy relationship skills, engage influential adults and peers, disrupt the developmental pathways toward partner violence, create protective environments, strengthen economic supports for families, and support survivors to increase safety and lessen harms (Niolon et al., 2017).

Faith-based organizations (FBOs) are one type of community-based institution that is a candidate for executing multi-level and multi-strategy efforts. FBOs are important stakeholders that have supported numerous health and wellness interventions, including through offering a setting for recruitment and programming (e.g. DeHaven et al., 2004; Hou & Cao, 2018; Perez et al., 2013). The CDC's technical package identified FBOs as community organizations that are a necessary part of a comprehensive response to IPV. Further, religious engagement and spirituality have been found to be impactful and a source of strength to some survivors of abusive relationships and trauma (Anderson et al., 2012; Bhandari, 2018; El-Khoury et al., 2004; Potter, 2007; Rizo, 2016; St. Vil et al., 2017; Ting & Panchanadeswaran, 2016). FBOs are also seen as particularly important for reaching many immigrant communities in the U.S. and those who are less likely to access or lack access to traditional, secular services (Campbell et al., 2007).

Although FBOs have the potential to serve as valuable partners and collaborators to social workers and other health professionals, hurdles exist for establishing such partnerships. Studies have found mixed responses among religious leaders describing how they handle disclosure of abuse (Levitt & Ware, 2006; Tedder & Smith, 2018) or how they would respond to circumstances presented in vignettes (Behnke et al., 2012; Choi, 2015; Sisselman-Borgia & Bonanno, 2017); these responses have ranged from supportive and safety-promoting ones to those that emphasize sustaining the relationship above all else—including reinforcing patriarchal gender norms—which can continue to threaten a victim or survivor's safety. Similarly, one study of women survivors found mixed responses by religious

leaders when the women disclosed their abuse (Fuchsel, 2012), while others have found primarily negative responses and a lack of support afforded victims or survivors (Potter, 2007; Ting & Panchanadeswaran, 2016). Many religious leaders have, nevertheless, reported they believe their congregations should be addressing IPV and should be sources of support to those experiencing abuse, but feel unqualified, unprepared, and uncertain what to do or hampered in accomplishing it, and that they are in need of training (Brade & Bent-Goodley, 2009; Houston-Kolnik et al., 2019; Raymond et al., 2016; Shaw et al., 2020; Sisselman-Borgia & Bonanno, 2017; Skiff et al., 2008; Tedder & Smith, 2018; Zust et al., 2017). Yet very few examples of IPV interventions involving FBOs or faith leaders have been documented in the literature (Choi et al., 2018; Danielson et al., 2009; Davis et al., 2020; Drumm et al., 2018; Hancock et al., 2014; Jones et al., 2005).

The Catholic Church is one religious institution that has largely been absent from literature on IPV and FBOs, despite 20.8% of Americans identifying themselves as Catholic in 2014 (Pew Research Center, 2015). In 2002, national U.S. Catholic leaders—the United States Conference of Catholic Bishops—updated a 1992 publication entitled *When I Call for Help*, describing the burden of intimate partner violence, advising parishes and their leaders on how to respond in ways that are supportive of victims and survivors, and explicitly stating that "…we emphasize that no person is expected to stay in an abusive marriage" (United States Conference of Catholic Bishops, 2002). Implementation of these recommendations has been low—the National Study of Congregations in 2012 found that only 3.8% of Catholic parishes had a ministry addressing domestic or sexual violence (Houston-Kolnik and Todd, 2016).

We had the opportunity to examine one Catholic case that has been moving forward on the issue of IPV; Archdiocese of Chicago Domestic Violence Outreach Ministry (ACDVO, herein referred to as the "ministry" or "the organization") is the lead for IPV response in the Archdiocese of Chicago, Illinois. Our study aims are to: 1) describe the key components of ACDVO's work, 2) connect the work to the IPV technical package of the CDC, and 3) describe how the impact of these components is evaluated.

Methods

Study setting. The data for this analysis were collected as part of a larger case study of ACDVO (Archdiocese of Chicago, 2023b). The Archdiocese of Chicago (AOC) was identified by senior leadership of Catholics for Family Peace Research and Education Initiative—a national organization working on IPV issues—as an outlier in advancing how the U.S. Catholic Church addresses IPV (S. O'Brien, PhD, personal communication, Dec 19, 2017). Their director described the AOC as

having the greatest breadth of ongoing activities in responding to and preventing IPV, and we chose an extreme case to help us to understand the causes behind IPV response and prevention by a religious organization and its results more deeply (Flyvbjerg, 2006). Author CK has extensive methodological expertise in qualitative research and worked closely with the lead author BD, a PhD Candidate, on informing the study design. Authors VJ, JB, and ACG contributed their expertise in community-engaged research, working with faith communities, and IPV, respectively, to informing the study aims and design.

The AOC serves the area of Cook and Lake Counties in Northeastern Illinois. At the time the study was initiated, the diocese ministered to a population of about 2.2 million Catholics attending 344 parishes. Each parish comprises a pastor, or lead ordained religious leader, and sometimes additional priests. Some parishes have a deacon(s) – another type of ordained minister who supports church operations. Most also have some paid administrative staff, along with volunteer, lay leaders who serve the parish community in a variety of ways. Lay persons (or "laity") refers to anyone not a deacon, priest, bishop, or member of a religious order (e.g., a "nun" or "sister").

In 2016, about a quarter of masses celebrated each weekend in the AOC were conducted in a language other than English; the largest share in Spanish (17%) followed by Polish (6%) (AOC Office of Strategic Planning and Implementation, 2017). These data reflect a multi-cultural community and foreshadow needs to prepare communications in multiple languages and likely contend with cultural differences between parishes and communities in the diocese. At the start of the study, the AOC was in early stages of a multi-year process to study and then combine or close parishes based on factors such as community size, engagement, and available resources. By the start of 2020, when data collection for this study ended, the total number of parishes had been reduced from 344 to 316 and had further decreased to 216 parishes as of July, 2023 (AOC, 2023a).

Although ACDVO was not formally created until 2011, the IPV prevention and response activities within the AOC were initiated in 2008 when a local priest began to champion the issue and preach about it at parishes beyond his own. As pastor, he had helped develop a vibrant Hispanic parish-based domestic violence ministry ("HOPE") in response to parishioners coming forward and encouraging the importance of addressing violence occurring in their homes. The ministry had grown in size and scope over time driven by victims and survivors, eventually adding a batterer intervention program (Davis et al., 2020, 2019), receiving funding from the Chicago Department of Family & Support Services, and offering counseling and services by paid staff.

In the late 2000s, another parish in the AOC, inspired by the work of HOPE, began to pursue the possibility of developing a similar ministry. One of those parishioners secured the support of the diocese's leader—the archbishop, who in this case also served in the Pope-appointed senior role of cardinal—to make a concerted effort to address domestic violence in the AOC. The two parallel domestic violence prevention efforts came together, and in 2011 they formally established ACDVO. The priest who began preaching about DV in 2008 became its first director, and the number of parishes reached has since increased.

Data collection. We collected data through semi-structured, in-depth key informant interviews with leaders of ACDVO. A total of 18 eligible people were identified, beginning with the 14 members of the organization's steering committee, who we expected to have the benefit of perspective across the ministry and who were active in strategic planning of the IPV activities within AOC. Four additional people who were highly active in the ministry were also identified through snowball sampling. Author CD, the study's community partner, facilitated initial contact with eligible participants by email in September-October 2018, and fourteen were successfully interviewed. One participant also brought along a colleague involved in their own parish ministry resulting in a small group interview, for a total of fifteen participants in the study. In-person interviews were requested but phone interviews were accommodated. Two individuals also participated in second interviews in fall 2019 and winter 2020 for follow-up on initiatives that had been unfolding in the interim. All sixteen interviews were conducted by the lead author BD, a practicing Catholic with qualitative training and experience. Oral consent was obtained, and all interviews were audio-recorded with permission.

Using an open-ended interview guide that was pilot tested with and revised upon feedback from the director of Catholics for Family Peace, key informants were asked about the central IPV prevention and response components of the ministry, about how the ministry's components was being implemented, and about supporting parishes and other groups involved in implementation. Next, interviewees were asked to reflect on their personal perceptions about the priorities of their ministry, whether ACDVO was succeeding in its efforts or not, factors that were associated with implementation and success, sustainability of the organization, and changes they would like to see. This study was determined not to be human subjects research by Johns Hopkins Bloomberg School of Public Health Institutional Review Board.

Data analysis. The analytic process began with the lead author writing notes and reflections after interviews. Subsequent interviews then varied in their emphasis on certain areas; for example, they were

used to begin testing hypotheses or expanding on ideas introduced by previous interviewees. Interview recordings were transcribed in a standard intelligent format, including interviewer questions. We subsequently coded transcripts using NVivo qualitative data analysis software (QSR International Pty Ltd. Version 12, 2018).

We applied five deductive codes to all transcripts. These first included the three key components of the organization's mission: awareness, services, prevention. The fourth code applied was that of 'parish ministry activities' to highlight what was specifically reported on at the parish level. The final code used was 'impact,' for reflections on how impact was being evaluated and the extent to which the respondent believed ACDVO was having an impact.

Coded units were reviewed by code, with notes taken about justifications for activities within components, perspectives on how implementation was planned and executed, and specifically whether implementation was taking place at the diocesan or parish level. We then organized key activities into categories inductively. Next, the notes were used to generate integrative memos (Emerson et al., 1995) that considered how the key components and their activities related to the strategies and approaches in the technical package. Whether impact was known or perceived was also explored in the memos along with what data was used to inform these assessments. Coded units, notes, categories, and connections to the IPV evidence base were revisited as BD advanced new ideas, with additional memo-ing used for elaboration. Co-authors with expertise in interventions for violence prevention (VJ, ACG) then contributed additional analysis and input on interpretation of results.

Results

Interviewees were similar in demographic characteristics: about two-thirds were women, practicing Catholics, and non-Spanish speakers. The remaining interviews comprised a mix of individuals who met one or two of those characteristics, but not all three, though we do not provide counts of each here to limit identifiability of participants. Eleven interviewees (73%) had been active in the ministry at their home parish and were able to speak to activities at the parish level. Six participants (40%) had professional experience or training addressing IPV prior to getting involved with ACDVO in their roles as social workers, counselors, or nurses. As the ministry uses the term domestic violence (DV), it is used here synonymously with IPV. The results below are organized by the study aims, first presenting descriptions of ACDVO's work at both diocesan and parish levels and connecting it to the technical package, then followed by a summary of how the ministry evaluates the impact of its work.

We observed the work of ACDVO to be evidence-informed due to its use of materials from institutions such as the CDC or local domestic violence service agencies. Furthermore, several interviewees discussed the concept of "do no harm," and the importance of making sure that the work and content of ACDVO is correct and advances good:

> One of the things that we have to be very careful of, and I know this, and [the director] has said it-- when we are giving out information, we've got to make sure that the information is true and accurate.

We also assessed that the ministry's work relates to three IPV technical package strategies: *create protective environments, support survivors to increase safety and lessen harms, and teach safe and healthy relationship skills*.

Raising awareness, which creates protective environments. ACDVO has been establishing a foundation for addressing DV and raising awareness using three categories of diocesan-level activities (detailed below), which include creating and supporting parish ministries, offering education and training, and communicating via social media. We also describe below parish ministry activities that promote raising awareness among parish communities. This work has included a central goal of communicating to victims and survivors that the Church supports them and does not condone DV:

> You have to get the word out, that you are concerned about this and you're active on it, and you want victims to come to you. And you have to create that, because right now who would think about going to a Catholic church for domestic violence? Nobody.

We identified that ACDVO's awareness-raising efforts most reflect the CDC strategy, *create protective environments*, and particularly two strategy-specific approaches: "improving organizational policies and workplace climate," and "modifying the physical and social environments of neighborhoods." This is accomplished through both focusing on the organizational elements of parishes and how they are set up to respond to people experiencing DV, as well as through raising awareness among their members. The connection between all activities, strategies, and approaches is summarized in Table 1.

Creating and supporting parish ministries. Once ACDVO's director preaches at a new parish—either in English or in Spanish depending on the parish and mass—an announcement is made that there will be an interest meeting to establish a parish ministry. The director attends the

interest meetings along with a representative from the Parish Support committee—one of ACDVO's diocesan-level sub-committees—who is designated as a mentor to the new parish. Interviewees explained that the parish mentor model was adopted in order to alleviate concerns of parishioners that they could not initiate the ministry on their own. The mentor brings a printed copy of the online Resource Guide that includes background content and materials for activities that parish ministries can pursue, as well as a list of area and national resources:

> I said, "You could do this…you could do this…you could do this…you could do this…" and if you sit down and go over it with them…" "Oh, yeah! We could do all those things." So they just need somebody to say, "Try this…try that…You only have to do three or four things a year."

One goal of this initial meeting is to identify a leader for the group and to schedule the next meeting. Mentors then continue to participate for several meetings to help each ministry gain traction and stabilize, then remain available as a point of contact. Three Spanish-speaking parish mentors have supported parishes with predominantly Spanish-speaking members, but interviewees identified a gap in having a Polish-speaking mentor to be able to support the Polish-speaking parishes. As one mentor reflected:

> I would say me not being able to speak Spanish or Polish. I think that would've been helpful, if I had a different language... I think [what I've] been seeing is I think definitely you need to speak the language going in, because with domestic violence you just can't have a barrier of not being able to understand your clientele, you know?... I felt like I was an outsider, and being an outsider, I lose my effectiveness.

The Parish Support committee has also been working to network parishes across the diocese as well as regionally to foster collaborative initiatives and to pool resources:

> We have the South Side Consortium—and the person who started this tried to start with the North Side (North Shore and North Side)—where we meet every quarter and just discuss what's going on, any resources we can help each other with, anything we can do to help each other with.

ACDVO delivers information through a diocese-wide listserv, bi-annual meetings that bring together parishes from across the diocese, and higher-profile events including an annual mass for Domestic Violence Awareness Month and annual fund-raising gala.

Education and training. A second area of ACDVO's awareness-raising has been delivering education and training to parish ministry members, staff and clergy at parishes, deacons across the diocese, and seminarians, with a goal to increase the number of leaders and parishioners trained in DV. Each training was designed to provide key information about DV and to deliver basic tools and knowledge for how individual leaders and parishes should respond when somebody seeks help. For example:

> …[Parishes] get an hour and a half. Just background. Familiarity with the Bishops' letter "When I Call for Help." The topic of no one is expected to stay in an abusive marriage. The "Do No Harm." Don't go for [couples] counseling. That's not recommended, to go for counseling in an abusive situation. It can make it worse.

By January 2020, 72 parish ministries and 22 parish staff were reported to have been trained.

Social media communications. For awareness-raising via social media, ACDVO hired a dedicated coordinator to post content and track engagement on Facebook, Twitter, and Instagram about events and basic DV information. This communication channel was observed by interviewees to be less for the benefit of local partners and ministry participants, many of whom are older and do not use social media very frequently:

> So that's another way of telling at least if there's-- we're being reached. And what the numbers are. What the ages are of people. Because it's more of a younger demographic that would go on social media, for example.

Rather, social media are seen as ways to reach youth and serve to network across the country with an increasing number of other organizations or advocates who are involved in DV work and follow the ministry, particularly on Instagram. As a result, this activity also promotes the Catholic Church more broadly as a social institution that is intolerant of DV.

Parish ministry activities. The final category of awareness-raising activities by ACDVO that connects to the strategy of *create protective environments* encompasses a range of parish ministry efforts. Interviewees reported that the ministries distributed content in their parishes by putting it in pews, in female bathrooms, and in bulletins, or out in the community such as in libraries or at local businesses. Parish ministries have been encouraged to make these materials and information visible as regularly as possible:

> …[E]very week I wrote a column…Because somebody may not have needed my help that week or the next week, but if I'm in the bulletin they know where I am. They can get me… If you put a blurb, a statistic, a something in the bulletin… you put that logo and people will see it…Maybe you need to tell somebody a phone number of a center that's going to help them.

A few times a year, often aligned with October, Domestic Violence Awareness Month, some parish ministries have organized events that honored victims and survivors, provided prayer services, or tied purple ribbons around trees or fences on the parish campus. Some have even held interfaith events that brought more groups or FBOs together. At these events, representatives from DV services—including social workers or other professionals who work on the issue—have often been invited as speakers.

Connecting to services, to support survivors to promote safety and lessen harms. We observed that the services-oriented activities of ACDVO comprise three streams: parish ministry referrals, engaging with survivors and referrals by diocesan-level leaders, and direct services provided by Catholic Charities. We also found that these activities contribute to the second relevant CDC technical package strategy of *support survivors to promote safety and lessen harms*, and align with two strategy-specific approaches, 'victim-centered services' and 'treatment and support for survivors of IPV, including teen dating violence'. The evidence for these approaches comes from studying advocacy—here meaning assessing a victim or survivor's needs and supporting them in accessing the appropriate resources—and providing counseling, respectively.

Parish ministries as advocates: activities and referrals. In line with the 'victim-centered services' approach, the diocesan-level has been supporting parish ministries and parish staff in learning about available local services and agencies, such as shelters or mental health clinics. The goal is for parish representatives to share ways to connect with services and in some cases be ready to provide referrals to someone in need. ACDVO has also encouraged this approach for priests and deacons, so that instead of offering counseling themselves (if they are not qualified), their parish is aware of available resources and could appropriately refer someone seeking help:

> The ministries gather all that information, and we encourage them to keep looking for more, because it's not enough just having one agency. So their job will be to just gather as much information as they can, put it online or in a folder, give it to the secretary in the church. So when someone comes and

> says, "Is there help?" or "Can I speak to the priest?" the priest knows that there is help. They will know where to send them. They will ask them, "What are you looking for?" and then they will go to the information that they've gathered and give it to the victim…They have to have the national 800-number as well as just the hotline that [the local agency may] have, in case they're looking for shelter right away.

Parish events with speakers—introduced above—have also brought in service providers to educate the parish community about what types of services they offer. Thus, community members could be made aware of available resources, and interviewees noted that it was important for ministry members to be able to speak more competently about those options. Other speakers have included law enforcement to discuss response to DV calls, and lawyers to discuss how protective orders function and how to obtain one.

In a few instances, some parishes did either hire a counselor or set up a hotline, provided their ministry members were properly trained; however, in most cases, these efforts did not yield much activity and were discontinued. Interviewees reported hearing that some people were concerned that someone would recognize them and would rather go elsewhere for help than their own parish.

> I think that's when we started to refocus and realize that even with the hotline, there were very few calls that came through. We had heard through [Parish A], and I think it was [Parish B] that often the phone wasn't used. They felt that people were concerned they might be identified.

Some parishes have, however, continued to offer support groups for survivors based on local demand.

Diocesan-level leaders as advocates for providing victim-centered services. In the course of their work, ACDVO diocesan leaders have encountered many survivors directly. Some individuals have reached out to them directly from around the diocese or across the country. Interviewees also reported that some proportion of the attendees at parish ministry formation meetings are people seeking help. They specifically observed more victims coming to the meeting for help from the Hispanic community than from any other group, which was attributed to the Hispanic community having more confidence in the Church as a source of help.

The need for immediate help, however, was noted by interviewees to conflict with the intended function of the first meeting, making those meetings a challenge:

> It's hard…the first meeting that Father has, we get more of the people who are looking for help. And I don't – I think when they hear that the Church is here and the Church is going to listen, they go with hope that, "Okay, I'm going through this. Now I've learned that there is help, so I'm going to see what they can do for us." So it gets hard trying to tell them, 'Well, this is where you can go' versus, 'Well, we're here just to build a ministry, and they're going to help you later on.'

In turn, some were concerned that it was a lost opportunity because individuals' needs were not being adequately met at that meeting. Other interviewees did describe, however, that those who needed help have been acknowledged but asked to wait until the initial presentation finished so that someone could speak with them individually.

Treatment and support through Catholic Charities. In the third way that ACDVO's work connects to the CDC strategy to support survivors to promote safety and lessen harms, Catholic Charities has offered individual counseling to DV victims and primarily served as a stopgap in areas that do not have readily accessible, publicly funded services. In these locations, they have placed a counselor to meet peoples' needs closer to where they live, often using parish space for a limited time during the week. Counselors were placed in six parishes at the time of the study. To best spread their resources, Catholic Charities has coordinated with ACDVO to attend to parishes or areas where they can fill a need:

> Father tells us where he's going to speak. We know where the agencies are and where there are more challenges for people to get services either because of transportation or the agency isn't close by. We tend to end up in the neighborhoods and parishes where there are a lot of undocumented immigrants. It's also that population tends to be more comfortable going to their church for help. Sometimes that's the only place they can go.

More generally, the agency has ended up providing services in areas of Cook County that are underserved and/or impoverished, tending to reach parishes in communities of color.

Table 1.
Relating ACDVO Activities to the IPV Technical Package

ACDVO Mission Component	ACDVO Activities	Technical Package Strategy	Technical Package Approach
Awareness	(a) Creating and supporting parish ministries (b) Education and training (c) Parish ministry activities	Creating Protective Environments	Improve organizational policies and workplace climate
	(a) Creating and supporting parish ministries (b) Education and training (c) Parish ministry activities (d) Social media communications		Modify the physical and social environments of neighborhoods
Services	(a) Creating and supporting parish ministries (b) Education and training (c) Parish ministry activities and referrals (e) Diocesan direct referrals to survivors	Supporting Survivors to Promote Safety and Lessen Harms	Victim-centered services
	(f) Catholic Charities' counseling services		Treatment and support for survivors of IPV, including TDV
Prevention	(c) Parish ministry film screenings and discussions for youth (g) Dating Matters pilot program in Catholic schools	Teaching Safe and Healthy Relationship Skills	Social-emotional learning programs for youth

Promoting prevention, to teach safe and healthy relationship skills. The prevention activities of ACDVO have been closely tied to the CDC strategy of *teach safe and healthy relationship skills* to youth and young adults and to their parents, specifically the approach of 'providing social-emotional learning programs for youth.' To support activities of parish ministries, the ministry has purchased films or other media, or has linked to online content through their Resource Guide that varies in appropriateness for youth of different ages. ACDVO has also been

providing materials to help facilitate post-screening discussions, and/or parishes have invited professionals to lead seminars or discussions.

The most institutionalized step of ACDVO to address teen dating violence has been working with Chicago Catholic schools to deliver an evidence-based curriculum to middle-school aged students: "*Our goal is to get this into our Catholic schools and hopefully help support the spread to public schools in the state of Illinois*." As of January 2020, they had developed a pilot program for introducing Dating Matters (Niolon et al., 2019) into 6th and 7th graders in Catholic schools in the area, with assistance from key staff at CDC. They had also secured support from key individuals locally to implement the pilot and were working on identifying potential pilot locations.

Evaluating ACDVO's impact. Interviewees acknowledged both the importance and the shortcomings associated with evaluating their work. ACDVO is perceived by its leaders to be having an impact based on the active, sustained implementation of their key components and the assumption(s) tied to each part of their mission. However, measuring and quantifying the impact in addressing DV has been a challenge.

To begin with, interviewees assumed that raising awareness community-wide and repeatedly presenting information about DV to parishioners increases knowledge and raises the profile of the issue in the church. Outcome data to measure changes in knowledge and/or behavior—such as through pre-/post-tests or post-only assessments—have not been collected. Instead, process indicators have been used to demonstrate parish ministries' efforts, for example, getting content included in bulletins or in prayers during mass, and both the diocesan-level leadership and parish ministry leadership have counted attendance at events. There has also often been immediate affective feedback from audiences, who have generally responded to sermons about DV by applauding, or made comments following trainings about their positive experience, appreciation for the content, and/or recognition of its utility. Trainings have been evaluated using three questions: 1) "Was your time well spent?" 2) "What did you like most?" and 3) "What would you like to see improved?" and the responses used to make adjustments for the future.

Social media analytics are also used, such as engagement with posts and followers from the three channels: Facebook, Instagram, and "X" (formerly Twitter). However, some of these numbers are believed to underestimate the visibility of the content, in part because some people are viewing the content without having accounts or are less actively engaging because of the content area. One respondent noted, "…[S]ometimes you don't really know the impression or the reach you actually have because maybe people don't want to publicly show they're following your page just because of what it's for?"

A similar observation was also made about the level of participation at events being affected by people's perception of the topic:

> And another thing that happens, if you do have an event or a speaker—I have been told this—people are reluctant to go, because they don't want the public at large or their neighbors to think that they themselves have been in an abusive situation, so they're reluctant to go to hear a speaker on domestic abuse.

Other process measures that the leadership have tracked at the diocesan level begin with the number of parishes at which the topic is preached and the number of active parish ministries. As of January 2020, it was estimated that over 150 parishes in Archdiocese of Chicago had been reached, and about 80 of them were active in addressing DV to varying degrees.

ACDVO's second assumption underlying its work has been that by providing information about services and making referrals, people are accessing those services. The number of people who subsequently seek help is a tangible outcome, but as mentioned above, parish ministries have not had many people come to them directly for referrals. ACDVO tried to connect with local service agencies to figure out how to get feedback on whether people were accessing services as a result of its work, but it was not feasible to implement. On occasion, the ministry has received direct anecdotal evidence from people who share actions that they or someone they know has taken as a result of the ministry's work, or the leadership has learned about people accessing services when interacting with staff from some agencies. For example:

> I said, "[We were] just at the parishes near to you and… referring people," and she said, "Oh! Yes! I just noticed that we had this influx of people that just came to our agency, and I didn't know where they were coming from. And now I know, you sent them from these two parishes."

Those involved with parish ministries also reported their groups' efforts to get information about agency services posted in female bathrooms or on bulletin boards, noting that palm cards in bathrooms deplete rapidly.

For the final component of ACDVO's work—prevention—they have counted attendance at film screenings and discussions, but no data have been collected about changes in knowledge, attitudes, beliefs, or behavioral intentions, nor about experiences with teen dating violence prior to the event. Evaluation was built into the teen dating violence

prevention pilot program being prepared for Catholic schools, which leadership hopes will build the case for further expansion.

Discussion and Conclusion

In this study we conducted key informant interviews with leaders of a Catholic ministry in a large, urban metropolitan area to add to the limited literature that describes implementation of IPV-related work in U.S. Catholic churches. We found the efforts of ACDVO to respond to and prevent IPV—organized by their mission of awareness, services, and prevention—to be evidence-informed and to map onto three of the CDC's six IPV prevention best practice strategies.

ACDVO's awareness-raising activities connect to the strategy, *create protective environments*, because they have been focused both on raising awareness among parish leaders, community members and the Church more broadly, and on improving parishes' capacity to respond to victims and survivors. One strategy-specific approach from the IPV technical package that ACDVO's awareness work closely relates to was 'improving organizational policies and workplace climate.' The evidence for this approach was established by one virtual workplace intervention and evaluated using the Workplace Climate Towards Domestic Violence Scale (Glass et al., 2016; Niolon et al., 2017). The instrument assessed five areas that help define the workplace climate, which were training & policies, communication & confidentiality, information & resources, posting information, and work flexibility & positive response to IPV (Glass et al., 2016). ACDVO's work targets the first four of these areas, both demonstrating an alignment of their work as well as a possible tool that could be adapted for evaluating outcomes within the AOC.

Raising awareness consistent with the strategy of *create protective environments* has been common in other IPV-related interventions in FBO settings, particularly through providing education and training to religious leaders. Hancock and colleagues developed a resource guide and workshop for Latino Christian leaders in rural North Carolina, providing basic information about IPV and why religious communities should be responding (Hancock et al., 2014). Elsewhere, in a medium-size city in NC, a program focused on building self-efficacy of faith leaders to respond to IPV (Jones et al., 2005). Similarly, a training for Seventh-Day Adventist pastors in the Southeast U.S. (Drumm et al., 2018) and one for Korean American clergy in Georgia (Choi et al., 2018) led to significant improvements in knowledge and attitudes about various aspects of IPV. These studies all reported positive outcomes but were limited in the scope of their work and training audiences. Only one other article in the literature has focused on the development of a comprehensive IPV program in a large Christian church in Chicago. This ministry delivered

trainings and awareness-raising not only to religious leaders and lay leaders, but also to the general congregation, though no evaluation data were reported (Danielson et al., 2009).

The second strategy from the technical package reflected in ACDVO's work was *support survivors to increase safety and lesson harms*, such as through training advocates for victims or survivors and curating a resource list for referrals, as well as connecting individuals to services offered by Catholic Charities. Data from the National Congregation Study (Houston-Kolnik & Todd, 2016) indicate that other Catholic churches across the U.S. are also providing direct services of some kind to victims or survivors of sexual assault or domestic violence, as reported 3.8% of churches in the 2012 survey, though it is unknown what these services are and what their success has been. Other FBO interventions have had success in training religious leaders to refer to services and provide resources (Choi et al., 2018; Drumm et al., 2018; Hancock et al., 2014; Jones et al., 2005), which respond to the needs raised by leaders across faith traditions and denominations to learn how to advocate for those who seek their support (Brade and Bent-Goodley, 2009; Raymond et al., 2016; Shaw et al., 2020; Sisselman-Borgia and Bonanno, 2017; Skiff et al., 2008; Tedder & Smith, 2018; Zust et al., 2017). It is important, though, for community services to in turn be able to care for referrals, as, for example, a study of Black female clergy found a need for culturally tailored services that could also meet spiritual needs (Shaw et al., 2020).

At the same time, within ACDVO a visible challenge has been hotlines set up by parishes, which have received very few calls. This could be attributable to survivors using the posted resource information and contacting those services directly or, as reported anecdotally, because they sought advocacy support outside of their own parish for privacy reasons. Bender surveyed providers about screening for IPV in rural health clinics, and similarly found that respondents often reported being "personally or socially acquainted with their patients, further limiting their ability to ensure completed, objective confidentiality," (Bender, 2016, p. 390) and recommended that confidentiality concerns may need to be addressed more directly to facilitate disclosure. How ministries were assuring and promoting confidentiality measures was not probed upon in this study, but as parishes are small communities where many people are likely to know each other, those that may be interested in offering services or resources of any kind would benefit from clearly articulating how they handle confidentiality.

ACDVO's emerging work also aligns directly with a third strategy of *teach safe and healthy relationship skills*, particularly through seeking to implement the evidence-based curriculum *Dating Matters* (Niolon et al., 2019) in Catholic schools. Others have reported providing resources

about and training faith leaders in ways to promote building healthy family relationships (Drumm et al., 2018; Hancock et al., 2014), but did not directly reach youth.

One of the limitations of this study is that while ACDVO is a diocesan-based Catholic ministry and thus part of an institution that is organized similarly across the country and subject to the same guiding principles, it is nevertheless an extreme case. Thus, transferability of this ministry's work and model to other dioceses or Catholic institutions across the country may be limited if there are factors associated with the high level of performance of ACDVO that could not be replicated elsewhere. For example, the AOC is more densely populated and of smaller geographic size compared to most other U.S. dioceses. Moreover, ACDVO is formally part of the diocesan structure, so other locations will likely similarly need diocesan policies or commitments supporting IPV interventions as well as backing from clergy to pursue IPV prevention or response more broadly. However, by studying an exemplar, we were able to describe what could be possible for others to consider pursuing. By connecting this to the CDC technical package, we have also offered an approach for using an existing framework to interpret practice in FBO settings.

We feel that our interviews provided a complete picture of ACDVO programming. However, it is possible that we would have gained different insights from participants who were not represented in our interviews, specifically, priests who had chosen not to engage with ACDVO, parish ministry leaders who stopped participating in ACDVO activities, and leaders from predominantly Spanish-speaking parishes, where several interviewees noted having different experiences with IPV and ACDVO programming. Nevertheless, we did interview parish mentors with experiences from a range of parishes, as well as individuals who had been involved in the ministry from its formation.

With the world and religious practice changing overnight in early 2020 in response to the spread of SARS-CoV-2, another potential limitation of the study is that it describes and analyzes the work of ACDVO preceding the impacts of the COVID-19 pandemic. Activities or resources not already available online (e.g., the Resource Guide, mentoring available by phone or virtual calls) did pause or contract for some of 2020 and into 2021. Some parish ministry committees met online while some parishes suspended services for several months. Even when services recommenced, attendance was dramatically reduced. At the same time, ACDVO also moved more meetings and trainings to online platforms, building technical capacity and connectivity that, moving forward, has the potential to persist and bring together more individuals across the diocese. Furthermore, ongoing livestreams of events such as the annual diocesan mass for survivors, trainings, and meetings, enable people far

and wide to access them and hear about IPV from the church and the work of ACDVO. Of greatest concern, however, is that increased reliance on online activities can disproportionately impact and muffle families and victims or survivors who do not have reliable internet. Nevertheless, as local restrictions on gatherings have eased over time, in-person events, trainings, and homilies have resumed, following relevant guidelines on masking and distancing. A strength of the study is that the lead author is an "insider" as a practicing Catholic, so was able to readily understand the setting and language. At the same time, when participants asked about her motivation of the study, the lead author did not hide her interest in seeing the Catholic Church play a more positive role in addressing IPV than it has historically. In turn, she was cognizant of this perspective and reflected on it in memos throughout analysis to promote credibility of the findings. She also considered possible consequences or limitations of the organization's work beyond what participants raised.

In light of our findings, Catholic churches should be considered by social workers and other health professionals to be among partners for outreach and community-based initiatives. Not only have a growing number of pastors welcomed ACDVO to their parish but many lay members of the church in Chicago have been receptive to greater public acknowledgement of the issue. Findings from another study echoed this, reporting quantitatively that leaders of Christian congregations across a variety of denominations and their community members want to see the issue discussed publicly and from the pulpit (Zust et al., 2018). In particular, social workers and other health professionals could offer the capacity to rigorously evaluate initiatives in these settings and support disseminating findings more broadly in the field, something that organizations may not have the capacity to do themselves. ACDVO, for example, has primarily drawn on anecdotes for assessing impact and on process data to track implementation and inform adjustments in their programming, but they have internally lacked the resources to formally study different components and test outcomes.

In turn, future research should seek to measure the outcomes and impact of the current types of work of ACDVO and similar initiatives. For example, it would be valuable to test the outcomes of awareness-raising efforts among parish communities with parish ministries, particularly beyond active ministry members. The Workplace Climate Towards Domestic Violence Scale (Glass et al., 2016) could be adapted for parishes and administered to staff and to parishioners to describe parish climate. Process measures could be utilized as predictors (e.g., whether the parish staff were trained, how frequently IPV resources were shared), and comparing across time points or between parishes could test for whether certain activities are more effective than others, or even demonstrate what

intensity and regularity of information is necessary to ensure that it is fostering a more positive climate. ACDVO's planned evaluation of the *Dating Matters* pilot program will be critical for studying the effectiveness of an evidence-based intervention in a parochial school setting.

As was articulated by one informant and others have discussed as well (Allen et al., 2015), Catholic churches have the ability to reach many different people at one time, including in this context victims and survivors, their children, family or friends, people who use violence, and advocates. They are also able to reach people across the lifespan, and the church is set up to encounter people at key life stages. It thus has access to many audiences for different messages and for many potential points of intervention and/or for prevention. Our results demonstrate how one organization has been capitalizing on these features and also indicate further opportunities that dioceses and parishes could pursue. Notably, ACDVO activities did not map onto three strategies in the IPV technical package: *engage influential adults and peers, disrupt developmental pathways, and strengthen economic supports for families*. These strategies all contain approaches that can be framed as supporting families, parents, or youth with or without explicitly referring to IPV. Many parishes have social outreach committees that already focus on a range of issues or have other social- or community-building ministries, so there are myriad opportunities for Catholic Church collaboration on such activities, ranging from advocacy for paid leave policies, to teaching parenting skills.

Finally, ACDVO informants reported more willingness among Hispanic parishioners to seek assistance through the ministry compared to other groups. This is consistent with other literature that FBOs serve as trusted, primary sources of support for many different immigrant or ethnic communities (Bhandari, 2018; Campbell et al., 2007; Fuchsel, 2012; Gore et al., 2020), though the role and influence of cultural context should be investigated further, particularly as Hispanic members make up a growing proportion of U.S Catholics (Pew Research Center, 2015). Building capacity in Catholic churches or with other FBOs such as Catholic Charities could, however, lead to improved access for members of these communities.

The persistence and prevalence of IPV necessitates that social workers and other health professionals engage with diverse partners in order to have a broader, sustained impact. Archdiocese of Chicago Domestic Violence Outreach Ministry offers an example of evidence-informed prevention and response to IPV and calls for exploring this approach in other Catholic settings and assessing its acceptability and effectiveness with different faith communities and cultural groups. ❖

References

Allen, J. D., Tom, L. S., Leyva, B., Rustan, S., Ospino, H., Negron, R., Torres, M. I., & Galeas, A. V. (2015). Recruiting and surveying Catholic parishes for cancer control initiatives: Lessons learned from the CRUZA implementation study. *Health Promotion Practice, 16*(5), 667–676. https://doi.org/10.1177/1524839915582174

Anderson, K. M., Renner, L. M., & Danis, F. S. (2012). Recovery: Resilience and growth in the aftermath of domestic violence. *Violence Against Women, 18*(11), 1279–1299. https://doi.org/10.1177/1077801212470543

Archdiocese of Chicago. (2023a). Facts and Figures. https://www.archchicago.org/about-us/facts-and-figures.

Archdiocese of Chicago. (2023b). Domestic Violence Outreach. https://pvm.archchicago.org/human-dignity-solidarity/domestic-violence-outreach

Archdiocese of Chicago Office of Strategic Planning and Implementation. (2017). Data composite: Facts and figures for year ending 2016.

Behnke, A. O., Ames, N., & Hancock, T. U. (2012). What would they do? Latino church leaders and domestic violence. *Journal of Interpersonal Violence, 27*(7), 1259–1275. https://doi.org/10.117/0886260511425246

Bender, A. K. (2016). Using the consolidated framework for implementation research to increase provider screening for intimate partner violence in rural health clinics. *Women's Health Issues, 26*(4), 384–392. https://doi.org/10.1016/j.whi.2016.05.005

Bhandari, S. (2018). South Asian women's coping strategies in the face of domestic violence in the United States. *Health Care for Women International, 39*(2), 220–242. https://doi.org/10.1080/07399332.2017.1385615

Brade, K. A., & Bent-Goodley, T. (2009). A refuge for my soul: Examining African American clergy's perceptions related to domestic violence awareness and engagement in faith community initiatives. *Social Work & Christianity, 36*(4), 430–448.

Campbell, M. K., Hudson, M. A., Resnicow, K., Blakeney, N., Paxton, A., & Baskin, M. (2007). Church-based health promotion interventions: Evidence and lessons learned. *Annual Review of Public Health, 28*(1), 213–234. https://doi.org/10.1146/annurev.publhealth.28.021406.144016

Choi, Y. J. (2015). Determinants of clergy behaviors promoting safety of battered Korean immigrant women. *Violence Against Women, 21*(3), 394–415. https://doi.org/10.1177/1077801214568029

Choi, Y. J., Orpinas, P., Kim, I., & Ko, K. S. (2018). Korean clergy for healthy families: Online intervention for preventing intimate partner violence. *Global Health Promotion, 26*(4), 25–32. https://doi.org/10.1177/1757975917747878

Danielson, T., Lucas, P., Malinowski, R., & Pittman, S. (2009). Set Free Ministries: A comprehensive model for domestic violence congregational interventions. *Social Work & Christianity, 36*(4), 480–494.

Davis, M., Fernandez, B., Jonson-Reid, M., & Kyriakakis, S. (2019). Pathways to seeking help from a partner abuse intervention program: A qualitative study of voluntary and non-court-mandated Latino men's experiences. *Journal of Interpersonal Violence, 088626051988468*. https://doi.org/10.1177/0886260519884680

Davis, M., Jonson-Reid, M., Dahm, C., Fernandez, B., Stoops, C., & Sabri, B. (2020). The Men's group at St. Pius V: A case study of a parish-based voluntary partner abuse intervention program. *American Journal of Men's Health, 14*(1), 155798831989128. https://doi.org/10.1177/1557988319891287

DeHaven, M. J., Hunter, I. B., Wilder, L., Walton, J. W., & Berry, J. (2004). Health programs in faith-based organizations: Are they effective? *American Journal of Public Health, 94*(6), 1030–1036. https://doi.org/10.2105/AJPH.94.6.1030

Drumm, R. D., Thayer, J., Cooper, L. L., Mayer, S., Foster, T., Gadd, H., & Brayak, K. (2018). Clergy training for effective response to intimate partner violence disclosure: Immediate and long-term benefits. *Journal of Religion and Spirituality in Social Work, 37*(1), 77–93. https://doi.org/10.1080/15426432.2017.1363011

El-Khoury, M. Y., Dutton, M. A., Goodman, L. A., Engel, L., Belamaric, R. J., & Murphy, M. (2004). Ethnic differences in battered women's formal help-seeking strategies: A focus on health, mental health, and spirituality. *Cultural Diversity and Ethnic Minority Psychology, 10*(4), 383–393. https://doi.org/10.1037/1099-9809.10.4.383

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (1995). *Writing Ethnographic Fieldnotes*. The University of Chicago Press.

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry, 12*(2), 219–245. https://doi.org/10.1177/1077800405284363

Fuchsel, C. L. M. (2012). The Catholic Church as a support for immigrant Mexican women living with domestic violence. *Social Work & Christianity, 39*(1), 66–87.

Glass, N., Hanson, G. C., Laharnar, N., Anger, W. K., & Perrin, N. (2016). Interactive training improves workplace climate, knowledge, and support towards domestic violence. *American Journal of Industrial Medicine, 59*(7), 538–548. https://doi.org/10.1002/ajim.22601

Gore, R., Patel, S., Choy, C., Garcia-dia, M. J., Singh, H., Kim, S., Mohaimin, S., Dhar, R., Naeem, A., Kwon, S. C., & Islam, N. (2020). Influence of organizational and social contexts on the implementation of culturally adapted hypertension control programs in Asian American-serving grocery stores, restaurants, and faith-based community site: A qualitative study. *Translational Behavioral Medicine, 10*(6), 1525–1537. https://doi.org/10.1093/tbm/ibz106

Gottlieb, A. S. (2008). Intimate partner violence: A clinical review of screening and intervention. *Women's Health, 4*(5), 529–539. https://doi.org/10.2217/17455057.4.5.529

Hancock, T. U., Ames, N., & Behnke, A. O. (2014). Protecting rural church-going immigrant women from family violence. *Journal of Family Violence, 29*(3), 323–332. https://doi.org/10.1007/s10896-014-9581-x

Hou, S. I., & Cao, X. (2018). A systematic review of promising strategies of faith-based cancer education and lifestyle interventions among racial/ethnic minority groups. *Journal of Cancer Education, 33*(6), 1161–1175. https://doi.org/10.1007/s13187-017-1277-5

Houston-Kolnik, J. D., & Todd, N. R. (2016). Examining the presence of congregational programs focused on violence against women. American *Journal of Community Psychology, 57*(3–4), 459–472. https://doi.org/10.1002/ajcp.12055

Houston-Kolnik, J. D., Todd, N. R., & Greeson, M. R. (2019). Overcoming the "Holy Hush": A qualitative examination of Protestant Christian leaders' responses to

intimate partner violence. *American Journal of Community Psychology, 63*(1–2), 135–152. https://doi.org/10.1002/ajcp.12278

Jones, A. S., Fowler, T. S., Farmer, D. F., Anderson, R. T., & Richmond, D. W. (2005). Description and evaluation of a faith community-based domestic violence pilot program in Forsyth County, NC. *Journal of Religion & Abuse, 7*(4), 55–87.

Levitt, H. M., & Ware, K. N. (2006). Religious leaders' perspectives on marriage, divorce, and intimate partner violence. *Psychology of Women Quarterly, 30*(2), 212–222. https://doi.org/10.1111/j.1471-6402.2006.00283.x

National Center for Injury Prevention and Control: Division of Violence Prevention. (2020). *Intimate partner violence: Risk and protective factors*. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html

Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). Preventing intimate partner violence across the lifespan: A technical package of programs, policies, and practices. https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf

Niolon, P. H., Vivolo-Kantor, A. M., Tracy, A. J., Latzman, N. E., Little, T. D., DeGue, S., Lang, K. M., Estefan, L. F., Ghazarian, S. R., McIntosh, W. L. K., Taylor, B., Johnson, L. L., Kuoh, H., Burton, T., Fortson, B., Mumford, E. A., Nelson, S. C., Joseph, H., Valle, L. A., & Tharp, A. T. (2019). An RCT of dating matters: Effects on teen dating violence and relationship behaviors. American *Journal of Preventive Medicine, 57*(1), 13–23. https://doi.org/10.1016/j.amepre.2019.02.022

Perez, L. G., Arredondo, E. M., Elder, J. P., Barquera, S., Nagle, B., & Holub, C. K. (2013). Evidence-based obesity treatment interventions for Latino adults in the U.S.: A systematic review. *American Journal of Preventive Medicine, 44*(5), 550–560. https://doi.org/10.1016/j.amepre.2013.01.016

Pew Research Center. (2015, May 12). America's changing religious landscape. https://www.pewresearch.org/religion/2015/05/12/americas-changing-religious-landscape/

Potter, H. (2007). Battered black women's use of religious services and spirituality for assistance in leaving abusive relationships. *Violence Against Women, 13*(3), 262–284. https://doi.org/10.1177/1077801206297438

Raymond, J. L., Spencer, R. A., Lynch, A. O., & Clark, C. J. (2016). Building Nehemiah's wall: The North Minneapolis faith community's role in the prevention of intimate partner violence. *Violence and Victims, 31*(6), 1064–1079. https://doi.org/10.1891/0886-6708.VV-D-14-00156

Rizo, C. F. (2016). Intimate partner violence related stress and the coping experiences of survivors: "There's only so much a person can handle." *Journal of Family Violence, 31*(5), 581–593. https://doi.org/10.1007/s10896-015-9787-6

Shaw, A. R., Enriquez, M., Bloom, T., Berkley-Patton, J., & Vidoni, E. D. (2020). We are our sister's keeper: The experience of Black female clergy responding to intimate partner violence. *Journal of Interpersonal Violence, 1–23*. https://doi.org/10.1177/0886260520918574

Sisselman-Borgia, A., & Bonanno, R. (2017). Rabbinical response to domestic violence: A qualitative study. *Journal of Religion & Spirituality in Social Work: Social Thought, 36*(4), 434–455. https://doi.org/10.1080/15426432.2016.1250146

Skiff, D., Horwitz, S. H., LaRussa-Trott, M., Pearson, J., & Santiago, L. (2008). Engaging the clergy in addressing the impact of partner violence in their faith

communities. *Journal of Spirituality in Mental Health, 10*(2), 101–118. https://doi.org/10.1080/19349630802081046

Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M.-J., & Chen, J. (2018). The national intimate partner and sexual violence survey (NISVS): 2015 data brief -- updated release. https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

St. Vil, N. M., Sabri, B., Nwokolo, V., Alexander, K. A., & Campbell, J. C. (2017). A qualitative Study of survival strategies used by low-income Black women who experience intimate partner violence. *Social Work, 62*(1), 63–71. https://doi.org/10.1093/sw/sww080

Tedder, M. A., & Smith, D. E. (2018). A phenomenological study: Black clergy leaders' response to violence against women. *Pastoral Psychology, 67*(4), 429–442. https://doi.org/10.1007/s11089-018-0821-5

Ting, L., & Panchanadeswaran, S. (2016). The interface between spirituality and violence in the lives of immigrant African women: Implications for help seeking and service provision. *Journal of Aggression, Maltreatment & Trauma, 25*(1), 33–49. https://doi.org/http://dx.doi.org/10.1080/10926771.2015.1081660

United States Conference of Catholic Bishops. (2002). When I call for help: A pastoral response to domestic violence against women. https://www.usccb.org/topics/marriage-and-family-life-ministries/when-i-call-help-pastoral-response-domestic-violence

Zust, B., Flicek, B., Moses, K., Schubert, C., & Timmerman, J. (2018). 10-Year study of Christian church support for domestic violence victims: 2005-2015. *Journal of Interpersonal Violence, 1–27*. https://doi.org/10.1177/0886260518754473

Zust, B. L., Housley, J., & Klatke, A. (2017). Evangelical Christian pastors' lived experience of counseling victims/survivors of domestic violence. *Pastoral Psychology, 66*(5), 675–687. https://doi.org/10.1007/s11089-017-0781-1

Beata Debinski, PhD, MHS. Assistant Professor at Wake Forest University School of Medicine. Phone: (336) 713-9332. Email: bdebinsk@wakehealth.edu

Vanya Jones, PhD, MPH. Associate Professor and Assistant Dean of Community Engaged Research at Johns Hopkins Bloomberg School of Public Health. Phone: (410) 502-9932. Email: vjones@jhu.edu.

Fr. Charles Dahm, OP, PhD. Director of Archdiocese of Chicago Domestic Violence Outreach. Phone: (312) 371-7752. Email: cdahm13@gmail.com.

Janice Bowie, PhD, MPH. Professor Emerita at Johns Hopkins Bloomberg School of Public Health. Phone: (410) 614-6119. Email: jbowie2@jhu.edu.

Andrea Carlson Gielen, ScD, ScM. Professor Emerita at Johns Hopkins Bloomberg School of Public Health. Phone (410) 955-2221. Email: agielen1@jhu.edu.

Caitlin Kennedy, PhD, MPH. Profesor at Johns Hopkins Bloomberg School of Public Health. Phone (443) 287-8794. Email: caitlinkennedy@jhu.edu.

A Place for Christianity in Evidence-Based Treatment of OCD

Cali Werner

Obsessive-Compulsive Disorder (OCD) includes obsessive and intrusive thoughts (obsessions) followed by repetitive and ritualistic behaviors (compulsions) performed in an attempt to relieve anxiety from the thoughts. Evidence based treatment for OCD includes multiple forms of Cognitive Behavioral Therapy (CBT) known as Exposure with Response Prevention (ERP) and Acceptance and Commitment Therapy (ACT). Christian practices seem to have similar underpinnings with CBT, ERP and ACT in clinical practice. The following article provides insight into an idea of more clearly incorporating Christian faith for the enhancement of OCD treatment.

Keywords: Christianity, religion, OCD, mental health, evidence-based care

SOCIAL WORKERS ARE CALLED TO BE AGENTS FOR change when social injustice or oppression are brought to attention (Turner, 2017). Working to create improvements in mental health care falls under the role of a social worker. For instance, social workers may work to provide mental health resources to those with limited resources to pay for treatment (Zastrow & Hessenauer, 2022). They may ensure that those struggling with mental illness are connected to appropriate evidence-based practice. Finally, social workers are called not only to help patients in need by assessing their current problem at hand, but instead, develop a full understanding of each patient's bio-psycho-social-spiritual background which may largely include cultural upbringing and religious practices (Elliot & Richardson, 2014; Hunt, 2014).

Social Work & Christianity, Vol. 50, No. 3 (2023), 263-279
DOI:10.34043/swc.v50i3.368
Journal of the North American Association of Christians in Social Work

In an evidence-based therapy intake, a social worker may ask a patient about their spiritual and religious background, but this may be the extent of discussion on religion within the session. As social workers hoping to engage the most effective evidence-based care for those suffering, we should be further exploring the benefits of incorporating faith into mental health support. According to Hayes and Toarmino (1995), behavioral therapy should incorporate an understanding of diverse cultures and backgrounds to ensure the most effectively laid foundation for change. Faith is a variable included in diversity (Hayes & Toarmino, 1995; King & Franke, 2017). Most human beings live by moral or faith related standards (Durkheim, 2014; Jayyusi, 2014). Yet, often, this is not an essential part of therapy. In 2014, over 70% of U.S. occupants labeled themselves as Christians (Pew Research Center, 2015). Taking this statistic into account, should Christianity be interwoven into mental health practice to better meet the needs of the general population? Is it possible to intertwine Christian practices in therapy without pressing one's own faith on their patient, or is it essential?

The following article will review the underpinnings of Cognitive Behavioral Therapy (CBT) and Christianity in the treatment of Obsessive-Compulsive Disorder (OCD). CBT, specifically Acceptance and Commitment Therapy (ACT) and Exposure with Response Prevention (ERP), is the most effective treatment for OCD (Koran et al., 2007; Twohig et al., 2012; Twohig et al., 2015). Belief in a higher power correlates with a positive outlook on life, gratitude, and healthier ways of coping with hardships (Büssing et al., 2013; Sen et al., 2022). Meisenhelder et al. (2013) found having a belief in a loving God to be highly correlated to better mental health. Research has shown us time and time again the positive impacts belief in a higher power has on the bio-psycho-social-spiritual aspects of humanity. It is possible that combining Christian faith practices with CBT for OCD may further reduce OCD symptomology. An understanding of the overlapping commonalities between Christianity and CBT is a promising first step toward potential OCD treatment enhancement through the incorporation of Christian scripture and beliefs.

What is OCD?

Obsessive-Compulsive Disorder is a chronic and often debilitating disorder that may worsen with time when left untreated (Asken et al., 2007). OCD consists of obsessive and anxiety-inducing thoughts followed by repetitive or ritualistic behaviors labeled as compulsions performed to relieve anxiety caused by the thoughts (Asken et al., 2007). CBT is an evidence-based practice used to treat a variety of mental illnesses including OCD, eating-related disorders, substance abuse disorders, and depression (Butler et al., 2006; Lewin et al., 2014; Linardon et al., 2017;

McHugh et al., 2010). CBT treatment modalities include helping one understand how behaviors, thoughts, and feelings impact one another, and that recognizing and reframing distorted thinking patterns inadvertently affects how one feels and behaves (Beck, 2011; Craske, 2010). With the use of evidence-based care, CBT treatment may become more specialized depending on the mental illness being treated. For example, CBT alone for the treatment of OCD has been proven less effective than CBT with the incorporation of ERP for OCD (Hezel & Simpson, 2019).

Individuals with OCD tend to engage in obsessive thoughts, also often referred to as intrusive thoughts, by trying to find certainty or clarity for their obsession through a compulsion. The compulsion may be a mental ritual such as replaying a conversation they had with a friend to ensure they did not say something to offend the friend. However, the more someone struggling with OCD replays the thought(s), the more confused and uncertain they may become. After an intrusive thought is replayed numerous times, the details of what actually happened may become exaggerated leading to more discomfort.

There are different subtypes of OCD that include different obsessions and behaviors or compulsions that help to identify an OCD diagnosis. OCD subtypes include checking behaviors which may include excessively checking locks, stoves, and appliances for fear of being responsible for someone breaking into the home or starting a fire (Starcevic et al., 2011). Contamination OCD consists of excessive washing or cleaning rituals for fear of harming oneself or others with germs or other substances such as bodily wastes or fluids (Coughtrey et al., 2012). Just-right OCD involves engaging in repetitive behaviors in an attempt to obtain a just-right feeling (Belloch et al., 2016). Magical thinking includes fear of something bad happening unrelated to the task at hand such as wearing a certain color may cause fear of getting ill or stepping on a crack may injure a family member's back (Rowsell & Francis, 2015). Sexual intrusive thoughts involve unpleasant sexual thoughts such as picturing a parent naked when hugging them (Menzies et al., 2021). Harm OCD includes fear of harming oneself or others through violence or aggression (Rowsell & Francis, 2015).

The subtype of OCD most closely intertwined with one's faith values is known as Scrupulosity. This OCD subtype includes obsessions surrounding the need to do something morally correct out of fear that God may be mad, dismiss someone from heaven, or not forgive them if they engage in a behavior incorrectly or have a bad thought (Abramowitz & Hellberg, 2020; Rowsell & Francis, 2015). Compulsions in Scrupulosity may consist of excessively repeating prayers, over-apologizing, or excessive fear of sinning which can make one replay actions of their day repetitively to make sure they did not do anything wrong (Abramowtiz & Hellberg, 2020). An understanding of how faith, Christianity, and CBT

overlap is helpful regardless of the OCD subtype, but it is essential in the treatment of Scrupulosity as faith is the central focus in this OCD subtype.

Treatment Approach to OCD

When treating OCD, the purpose of combining two forms of CBT (Exposure with Response Prevention [ERP] and Acceptance and Commitment Therapy [ACT]) is to help teach an individual how to tolerate uncertainty and live within their values. In fact, Twohig et al. (2015) reports that the combination of ERP and ACT for OCD symptom reduction is more effective than ERP alone (Twohig et al., 2015).

Exposure with Response Prevention is an effective form of CBT used to treat multiple forms of anxiety-related disorders such as OCD, social anxiety, specific phobias, and perfectionism (Albakri et al., 2022; Cui et al., 2021; Dayan et al., 2017; Overholser & Dimaggio, 2020). According to Koran et al., (2007), ERP consists of confronting feared situations gradually while eliminating the compulsion or avoidance behavior usually completed in an attempt to relieve anxiety from the feared situation. The goal of ERP is to "weaken the connection between feared stimuli and distress…" by facing fears for a prolonged period of time and "allowing the anxiety or discomfort to dissipate on its own" (Koran et al., 2007, p. 39). For example, a clinical social worker or other mental health provider may work with a patient who fears germs, and therefore, excessively uses hand sanitizer after touching anything they deem as contaminated. The provider and patient may work together to eliminate hand sanitizer usage in increments. Perhaps, they start by having the patient touch a doorknob without using hand sanitizer or without avoidance of touching other items they do not want to cross-contaminate. This exposure slowly teaches the patient they can tolerate the distress they feel without engaging in a compulsion. With repeated exposure practice, the stress begins to dissipate when the patient touches doorknobs, leading to a trickle effect of lowered anxiety regarding other contamination fears.

When one struggles with OCD, living with uncertainty becomes challenging (Dugas et al., 2001). When engaging in ERP, the goal is to teach the individual they are capable of tolerating uncertainty by doing exposures (Brown et al., 2023). For example, someone with contamination OCD may struggle with touching doorknobs for fear of becoming sick. The uncertainty of being sick, or the uncertainty of hitting a bump in the road and fearing it may be a person (a form of harm OCD known as hit-and-run OCD) becomes too difficult to bear for the OCD sufferer. Therefore, a clinical social worker or other mental health provider may work on ERP with an OCD sufferer by progressing towards having them open a door without immediately engaging in a handwash afterwards. Additionally, a sufferer with hit-and-run OCD may be asked to continue

driving home without going back to check the bump in the road or ask for reassurance to allow them to see their anxiety go down naturally without obtaining temporary "certainty" with a compulsion. In summary, ERP for OCD helps an individual see they are able to tolerate the things their anxiety tells them they need certainty for (Brown et al., 2023).

Acceptance and Commitment Therapy is another form of CBT that often coincides well with ERP for anxiety-related disorders as the purpose of ACT is to promote psychological flexibility while living within one's values instead of letting anxiety or fear take control of their thoughts, feelings, and behaviors (Twohig et al., 2012). The combination of ERP and ACT includes the motivation of living in one's values through ACT-based core principals which include acceptance of change through cognitive diffusion, awareness, self as context, and committed actions, such as exposures (Twohig et al., 2012; Twohig et al., 2015). For example, a patient may struggle with the idea of engagement in ERP, and ACT can be used to promote motivation or buy-in. Let's say a patient no longer hugs their loved ones due to having sexual intrusive thoughts. Every time their five -year-old daughter turns to hug them; the patient may turn away. The patient may be deeply saddened by the fact that they can no longer hug their daughter and may further worry about how this avoidance is impacting their daughter's own well-being. Through ACT, a therapist can help a patient recognize and choose their values (i.e., caring for their child) over choosing their OCD (i.e., avoidance of their daughter to appease OCD).

Acceptance and Commitment Therapy (ACT) combined with ERP helps motivate individuals suffering by reminding them of why they are choosing to engage in exposures in the first place (Brown et al., 2023). ACT helps one to accept their intrusive thoughts as thoughts instead of trying to assess the thoughts for meaning while going on about their day. The central focus of ACT is to encourage one to move forward with a focus on their values instead of focusing on their OCD (Twohig et al., 2015). If a mother suffering from post-partum harm OCD was having intrusive thoughts about harming her baby, focusing on her OCD may make her feel a strong urge to avoid her baby. However, using ACT principles of change, cognitive diffusion, acceptance, and focus on the present moment along with ERP exposure work encourages the mother to resist urges to avoid her baby (i.e., compulsion), while moving towards her inner values of caring for a baby she loves (Twohig et al., 2015).

A Place for Christianity in Treatment

Cognitive behavioral theory is a modernized version of cognitive theory and behavioral theory that helps individuals struggling with negative thinking patterns to reframe or leave negative thoughts as captive.

According to Yarhouse et al. (1991),

> Perhaps no other therapy approach so closely mirrors a biblical balance of cognitive and action orientation as cognitive-behavioral therapy. Even a superficial reading of the pastoral exhortations of the New Testament epistles yields a clear theme of obedience in actions and in thoughts as the way to maturity (pp 218-219).

Research suggests that religiously centered CBT that integrates the patient's faith practices has proven more effective than CBT alone (Pearce et al., 2015). In fact, Pearce and colleagues (2015) report findings indicating that out of one thousand Americans, 83% reported their emotional wellbeing and faith beliefs were somewhat intertwined. Out of this group, 72% of the individuals reported desire to see a therapist that included their faith in treatment (Pearce et al., 2015).

Findings are also promising for a Christian-based CBT approach, but the research is outdated (Payne et al., 1992). Recognizing, labeling, and reframing cognitive distortions are common practices utilized in CBT (Beck, 1970; Robson & Troutman-Jordan, 2014). Through a Christian lens, Pearce (2016) highlights what the Bible says about some of these common distorted thinking patterns. Pierce references eight different distortions (i.e., overgeneralization, mental filtering, disqualifying the positive) utilized in CBT practice and intertwines scripture to indicate the importance of recognizing distorted thinking patterns without giving into them (Pearce, 2016). For example, overgeneralization is when one "sees a single negative event as a never-ending pattern of defeat" (p. 67). Pearce (2016) refers to the gospel of John and how Peter denied Jesus. Peter could have chosen to deem himself unworthy, yet after Jesus is resurrected, He shows Peter grace and trusts him to continue discipling. Pierce (2016) states "One failure didn't mean a lifetime of failure for him" (p. 67) (New Revised Standard Version [*NRSV*] Bible, 1989; Pierce, 2016). Although there is much overlap between Christian principles and Cognitive Behavioral Therapy (CBT), there is limited research exploring this avenue.

Christianity and evidence-based CBT for the treatment of OCD share common grounds in meaning and application of life. When a clinical social worker is working with someone of Christian faith on their OCD, pointing out the commonalities in treatment and how they live out their faith may contribute to an increase in motivation for therapy engagement. Nonetheless, providers should be assessing religion and spirituality of their patients at intake. Knowing a patient's faith background leads to deeper empathic connections, enhanced rapport, and clinical understanding of the patient (Shafranske & Cummings, 2013).

A common theme found among individuals who struggle with anxiety-related disorders is intolerance for uncertainty (Gu et al., 2020). Additionally, excessive worry highly correlates to intolerance of uncertainty whereas OCD tendencies are moderately correlated to intolerance of uncertainty (Dugas et al., 2001). Christian faith, itself, is an example of practice without certainty. One chooses to live in accordance with their faith daily even though they do not have 100% certainty that they are saved until they get to heaven. However, doubt and fear are eliminated due to faith. Teaching someone with OCD who struggles with uncertainty, that they actually choose uncertainty every day in some aspects of their lives (such as through faith practice) may help build motivation or hope that they can eventually be okay with uncertainty tied to their OCD behaviors.

In my own practice, I have found the implementation of Christian references for my Christian patients to be extremely beneficial. For example, comparing examples of leaning into Christian faith as similar to leaning into uncertainty, as one is supposed to do in OCD treatment, immediately creates a sense of buy-in for treatment, and builds trust between myself and the patient. In return, patients of Christian faith seem to build momentum quicker in therapy when they apply their faith to the CBT.

For my patients who are not Christian, I use a similar metaphor that, to me, is still rooted in Christianity. Before a patient is supposed to engage in an uncertainty exposure, I may ask them to reflect on a time they drove to the grocery store. I may then ask them to tell me what they thought of on their way to the grocery store, to which they usually respond something like "I thought of the list of things I needed to buy." I then point out, "That is interesting. You didn't think of getting in a car crash or having your life insurance set up on the way there?" The purpose of this exercise is to help patients reflect on the fact that they are capable of leaning into uncertainty with other aspects of life their OCD does not latch on to, and therefore, are also capable of leaning into the uncertainty that their OCD tells them they cannot lean into. If they fear dying because their hands were not washed long enough, we can reflect on the idea that they made the choice to drive to the grocery store, even though there was a chance they could die there. Yet, they still chose to live in their values, instead of in fear, and to me, that is the definition of what Christian faith is, even if my patients do not realize it themselves.

Christianity may be discussed in CBT therapy if a patient incorporates it into their discussion with their provider. A clinical social worker or other mental health provider may spend some time discussing faith if they recognize it as a core principle in their patient's life, or if they observe symptoms of Scrupulosity. Scrupulosity is the religiously affiliated subtype

of OCD where an individual has heightened anxiety tied to their faith. They may obsess about upsetting or disappointing the higher power in which they believe, being condemned to hell, or being morally incorrect. Therefore, they complete compulsions tied to their faith such as excessive prayer, apologizing, or re-reading of Bible verses. In my own experience of treating Scrupulosity, more time may be spent building rapport with the patient. If a provider rushes through psychoeducation when it is time to do exposure work of skipping a prayer before dinner, or not completing a prayer with "amen," a patient may fear that I am pulling them away from their faith. The provider often has to spend extra time teaching the patient the difference between fear driven by OCD as a deciding factor for their religious practices versus actively choosing to follow a faith practice every day due to their own desire and choice. Ultimately, the latter option leads to a healthier and stronger faith whereas the first option feeds OCD symptoms leading to more severe Scrupulous behaviors. After all, the Bible reminds us that we have not only the ability to choose our faith journey. According to Joshua 24:15,

> Now if you are unwilling to serve the Lord, choose this day whom you will serve, whether the gods your ancestors served in the region beyond the River or the gods of the Amorites in whose land you are living; but as for me and my household, we will serve the Lord (*NRSV*, 1989).

Anxiety takes that choice away, which prevents one from living according to the way of the word. Let us not forget the gift of God's sovereign grace if we fall and are trying to find our way again. According to Ephesians 1:5-6 "He destined us for adoption as his children through Jesus Christ, according to the good pleasure of his will, to the praise of his glorious grace that he freely bestowed on us in the Beloved" (*NRSV*, 1989).

Practicing a faith tradition links to positive mental health outcomes (Behere et al., 2013; Koenig, 2018; Schieman et al., 2013). Social workers are called to lead advocacy efforts and give a voice to the voiceless (Dhavaleshwar, 2016). If we have knowledge of Christian practices tied to evidence-based care for OCD, advocacy of this treatment approach should be spread to practitioners in the field. Additionally, Christianity has proven to be a component of resiliency for those engaging in Christian faith-based practices (Oxhandler et al., 2021; Tan, 2013). Oftentimes, social workers see back-to-back patients in one day with limited time to process their own emotions. Incorporating their own Christian faith practices into their personal growth and work with patients may allow for more space to process, heal, and help.

Christian practices overlap with that of engagement in CBT, ERP and ACT. One may believe that when the individual struggling with OCD

is able to recognize their thoughts as irrational or invalid, they would be able to tolerate the discomfort and go back to "normal." However, a fraction of doubt often lurks from the "what if" thoughts that follow the validation of the intrusive thought as irrational. These "what if" thoughts often prevent sufferers from being in the present moment and focusing on the aspects of life that matter. They get lost in their anxious thoughts by trying to fix or solve them, which in turn only makes the thoughts worse.

Matthew 6:34 states, "So do not worry about tomorrow, for tomorrow will bring worries of its own. Today's trouble is enough for today" (*NRSV*, 1989). When I was in my most fragile state with my own OCD, trying to comprehend how I would face the next hour when I had to drive to the store, let alone the next day, was unbearable. I was filled with panic thinking about what was ahead, such as having to go back to college after being home for Christmas break, spending copious hours on compulsions. I feared being around my teammates due to the intrusive thoughts that I may possibly cause them harm. The only way I could comprehend how to move forward was by reminding myself to take life one day at a time. Making it through another day was a success, and if I thought too far ahead, fear would consume me. This verse in Mathew reminds us to not only prepare mentally one day at a time but to also understand that we must relinquish control over our lives.

Anxiety makes it difficult for one to let go of control and live with uncertainty (Gold et al., 2016). The message in Matthew 6:34 along with the message in CBT, ERP, and ACT all emphasize the importance of letting uncertainty exist while one focuses on the important aspects of life in the present moment (*NRSV,* 1989). When one is focused on trying to get rid of an intrusive thought, the thought often comes back stronger, and they miss out on other aspects of life. The goal of OCD treatment is to let the disruptive thought be there while continuing to go on about the day. When one tries to solve or fix the thought, it only gets more out of control. When one lets the thought come and go as it pleases without attaching extra meaning to it, the thought is much more likely to become quieter and less disturbing.

Obsessive-Compulsive Disorder often goes left untreated. In fact, from the onset of symptoms, it takes an average of about 17 years for a sufferer to obtain the appropriate evidence-based care (Hohagen et al., 2014). OCD has been labeled one of the top four most commonly diagnosed mental illnesses (Obsessive Compulsive Foundation of Metropolitan Chicago, 2008). Therefore, it is essential to consider best practices for assisting the populations vulnerable to this painfully debilitating mental illness. Children with OCD may be viewed as abnormal by their peers and therefore, become mistreated or even isolated (Helbing & Ficca, 2009; Storch et al., 2006). The elderly population with OCD tends to

have poorer mental and social functioning skills and therefore, may find it more difficult to engage in structured ERP therapy (Klenfeldt et al., 2014). For believers, faith practices are often a part of daily life. With the incorporation of CBT into familiarized faith practice, such as reviewing distorted thinking patterns by utilizing messages from the Bible or leaning into uncertainty while engaging in ERP without worry (i.e., Matthew 6:34), it is possible that these practices may be more easily obtained for the younger and older populations. In fact, reading and sharing stories has been an effective method of teaching children for many years in therapy and in the classroom (Brandell, 1984; Mason, 2017; Porras González, 2010; Wright & McCatheren, 2012). As age of the elderly increases, the ability for sharing and interpreting stories declines; yet, faith promotes stronger mental health amongst this population (Juncos-Rabadán, 1996; Meisenhelder & Chandler, 2002). Therefore, it may be possible that the incorporation of faith into CBT practices for this population may be more easily retained.

Engaging in ERP is not easy. Motivation for exposure work is an important component for someone suffering from OCD to respond positively to ERP (Vogel et al., 2006). When we think of what a patient is asked to do in this work, we must remember that their instinct is to avoid anything that causes stress. For example, someone with contamination OCD may have a major fear of touching the floor. Their fight or flight response goes up when they think about their hands touching the floor. However, when they are in therapy, they may be asked to start thinking about touching the floor, or touch their shoes that touched the floor, and eventually sit on the floor all together. A motto of this therapy is the reminder that although the work is hard as one is doing it, one should remember that every time they lean into an exposure without avoiding the discomfort, they are getting closer to long term freedom. Motivation to push through the discomfort and do the exposures comes from acceptance that suffering through the exposures is worth it for the ability to no longer let fear rule future life choices. 1 Peter 5:10 shares a similar message in that "And after you have suffered for a little while, the God of all grace, who has called you to his eternal glory in Christ, will himself restore, support, strengthen, and establish you" (*NRSV*, 1989).

When an individual struggles with OCD, the need for certainty keeps them spinning in the obsessive-compulsive cycle. They may try to gain certainty about their hands being clean, if they are a bad person for the thoughts they are having, or if they hit a person while driving after going over a speed bump. Through my experience as a clinician, the more time someone tries to spend obtaining certainty, the more uncertain they become. Think of an individual struggling with Scrupulosity who has a fear that they may have offended someone. They may replay a conversation

they had with a person multiple times to try to be 100% certain they did not say anything wrong. However, by the third, fourth, or fifth time they have replayed it, the more elaborate their interaction with the other individual becomes in their head.

Hebrews 11:1 says, "Now faith is the assurance of things hoped for, the conviction of things not seen" (*NRSV*, 1989). OCD is an ego-dystonic disorder which means individuals usually have insight into their fears as irrational, but the anxiety overrules their thought process, making them doubt (Vaghi et al., 2019). Hebrews 11:1 reminds us that all aspects of life are uncertain but that we may hope for what is not seen while letting that be enough. OCD treatment works in the same way. With ERP and ACT, one is supposed to choose to move forward with their day without solving for certainty that they are unable to obtain anyway. The more they practice this exposure without trying to solve for certainty, the more at ease they become with uncertainty. In OCD therapy, one is supposed to re-learn that they can handle uncertainty with the things they feel they must be certain about.

From the perspective of my own clinical work, handling uncertainty does not mean accepting the worst fears as true. Instead, it means letting the doubt be at the back of the mind while choosing to move forward with the day anyway. When one tries to force doubt away, it only becomes more intrusive. Instead, letting those scary thoughts be there without giving them the response they want makes them lose their power. Confidence and clarity in taking charge of OCD comes when one stops trying to be certain.

A Call for Clinicians

In conclusion, social workers can raise awareness on the positive benefits of incorporating Christian faith-based practices into CBT treatment through educational opportunities and direct practice. Additionally, CBT clinicians may also enhance the understanding of CBT skills such as the understanding of distorted thinking patterns through examples referenced in the Bible (i.e., analogies and stories from books of the Bible used to identify cognitive distortions; Beck, 1970; Pearce, 2016; Robson & Troutman-Jordan, 2014). Mental health clinicians should be taking time to teach patients about CBT and scripture overlay that provides an opportunity for lived practice of OCD treatment through scripture. Alone, these practices have strong foundations for mental health healing (Koran et al., 2007; Beck, 2011; McHugh et al., 2010; Meisenhelder et al., 2013). Weaving Christian faith and CBT more clearly together in mental health practice by discussing similarities of evidence-based care and scripture with patients may enhance treatment proving a more significant symptom reduction. According to Koenig et al. (2012), spiritual well-being and understanding heavily influences mental health. Spiritual turmoil,

uncertainty, or misunderstanding may have the opposite effect (Koenig et al., 2012). Christianity provides a sense of deeper meaning and the Bible carries messages throughout that relieve angst and uncertainty (1 Timothy 6:17, 1 Thessalonians 3:5, Acts 2:14, Matthew 6:34; *NRSV*, 1989). Although all patients may not be Christians, clinicians practicing CBT may use Christianity as a compass for their therapy as both CBT and Christianity send the same message that one can tolerate uncertainty (Brown et al., 2023; *NRSV*, 1989; Yardhouse, 1991).

Those with anxiety-related disorders such as OCD, tend to struggle with an inability to tolerate uncertainty (Dugas et al., 2001; Gu et al., 2020). CBT helps patients to build resilience to uncertainty instead of trying to resist it, which only further enhances OCD (Koran et al., 2007). For patients who do not disclose Christianity as their faith, but have a specific faith practice, clinicians may point out the patient's ability to lean into faith as a healthy practice of uncertainty. Patients may recognize that they are capable of leaning into uncertainty due to their faith practices, and therefore, can work with the clinician to build confidence in their ability to handle the uncertainty tied to their anxiety as well. If the patient is a Christian, clinicians may be able to use specific verses to help the patient in their journey, by allowing them to further lean into scripture while also leaning into CBT and ERP practices of tolerating uncertainty. Finally, if a patient does not identify with a religious or spiritual practice, clinicians of faith may personally reflect on scripture to guide and enhance their own practice of CBT integration. Although CBT is considered ethically sound due to evidence that supports it, a Christian clinician who finds it to be biblically sound as well may display more confidence in their therapeutic approach. An individual who portrays confidence has been found to receive 30% higher levels of trust from others when compared to someone who does not portray confidence (Sapienza & Zingales, 2012). In turn, due to this portrayed confidence, patients may trust clinical advice and lean into therapy with less hesitation, which may result in more positive therapeutic outcomes.

Social workers can take action by tying Christianity into CBT more fluently in their direct clinical practice. Additionally, they can work to close the unknown treatment gaps by contributing to education and research on Christianity and mental health. ❖

References

Abramowitz, J. S., & Hellberg, S. N. (2020). Scrupulosity. In *Advanced casebook of obsessive-compulsive and related disorders* (pp. 71-87). Academic Press.

Albakri, G., Bouaziz, R., Alharthi, W., Kammoun, S., Al-Sarem, M., Saeed, F., & Hadwan, M. (2022). Phobia exposure therapy using virtual and augmented reality: A systematic review. *Applied Sciences, 12*(3), 1672. https://www.mdpi.

com/2076-3417/12/3/1672

Archibald, H. C., and Tuddenham, R. D. Persistent stress reaction after Combat: A 20-Year Follow-Up." Archives of General Psy. *Therapy, 45*(10), 2317-25. DOI: 10.1001/archpsyc.1965.01720350043006

Asken, M. J., Grossman, D., & Christensen, L. W. (2007). American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Publishing, 2013.

Beck, A. T. (1970). Cognitive therapy: Nature and relation to behavior therapy. *Behavior therapy, 1*(2), 184-200. https://doi.org/10.1016/S0005-7894(70)80030-2

Beck, J. S. (2011). *Cognitive behavioral therapy: Basics and beyond*. Guilford Press.

Behere, P. B., Das, A., Yadav, R., & Behere, A. P. (2013). Religion and mental health. *Indian Journal of Psychiatry, 55*(Suppl 2), S187. URL: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3705681/

Belloch, A., Fornés, G., Carrasco, A., López-Solá, C., Alonso, P., & Menchón, J. M. (2016). Incompleteness and not just right experiences in the explanation of obsessive–compulsive disorder. *Psychiatry Research, 236*, 1-8. https://doi.org/10.1016/j.psychres.2016.01.012

Brandell, J. R. (1984). Stories and storytelling in child psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 21*(1), 54. https://doi.org/10.1037/h0087530

Brown, V. M., Price, R., & Dombrovski, A. Y. (2023). Anxiety as a disorder of uncertainty: Implications for understanding maladaptive anxiety, anxious avoidance, and exposure therapy. *Cognitive, Affective, & Behavioral Neuroscience, 1-25*. DOI: 10.3758/s13415-023-01080-w

Büssing, A., Wirth, A. G., Humbroich, K., Gerbershagen, K., Schimrigk, S., Haupts, M., Baumann, K., & Heusser, P. (2013). Faith as a resource in patients with multiple sclerosis is associated with a positive interpretation of illness and experience of gratitude/awe. *Evidence-Based Complementary and Alternative Medicine, 2013*. https://doi.org/10.1155/2013/128575

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical Psychology Review, 26*(1), 17-31. https://doi.org/10.1016/j.cpr.2005.07.003

Coughtrey, A. E., Shafran, R., Knibbs, D., & Rachman, S. J. (2012). Mental contamination in obsessive–compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders, 1*(4), 244-250. https://doi.org/10.1016/j.jocrd.2012.07.006

Craske, M. G. (2010). *Cognitive–behavioral therapy*. American Psychological Association.

Cui, L., Dong, X., & Zhang, S. (2021). ERP evidence for emotional sensitivity in social anxiety. *Journal of Affective Disorders, 279*, 361-367. https://doi.org/10.1016/j.jad.2020.09.111

Dayan, A., Berger, A., & Anholt, G. E. (2017). Enhanced action tendencies in obsessive-compulsive disorder: An ERP study. *Behaviour Research and Therapy, 93*, 13-21. https://doi.org/10.1016/j.brat.2017.03.005

Dhavaleshwar, C. U. (2016). The role of social worker in community development. *International Research Journal of Social Sciences, 5*(10), 61-63.

Dugas, M. J., Gosselin, P., & Ladouceur, R. (2001). Intolerance of uncertainty and

worry: Investigating specificity in a nonclinical sample. *Cognitive Therapy and Research, 25*, 551-558. https://doi.org/10.1023/A:1005553414688

Durkheim, E. (2014). *The rules of sociological method: and selected texts on sociology and its method*. Free Press. (Original work published 1895)

Elliott, J. O., & Richardson, V. E. (2014). The biopsychosocial model and quality of life in persons with active epilepsy. *Epilepsy & Behavior, 41*, 55-65. https://doi.org/10.1016/j.yebeh.2014.09.035

Gold, M., Dunn, L. B., Phoenix, B., Paul, S. M., Hamolsky, D., Levine, J. D., & Miaskowski, C. (2016). Co-occurrence of anxiety and depressive symptoms following breast cancer surgery and its impact on quality of life. *European Journal of Oncology Nursing, 20*, 97-105. https://doi.org/10.1016/j.ejon.2015.06.003

Gu, Y., Gu, S., Lei, Y., & Li, H. (2020). From uncertainty to anxiety: How uncertainty fuels anxiety in a process mediated by intolerance of uncertainty. *Neural Plasticity, 2020*. https://doi.org/10.1155/2020/8866386

Hayes, S. C., & Toarmino, D. (1995). If behavioral principles are generally applicable, why is it necessary to understand cultural diversity. *Journal of Counseling Psychology, 28*(25), 257. URL: https://www.researchgate.net/profile/Steven-Hayes-5/

Helbing, M. L. C., & Ficca, M. (2009). Obsessive-Compulsive Disorder in School-Age Children. *The Journal of School Nursing, 25*(1), 15–26. https://doi.org/10.1177/1059840508328199

Hezel, D. M., & Simpson, H. B. (2019). Exposure and response prevention for obsessive-compulsive disorder: A review and new directions. *Indian Journal of Psychiatry, 61*(Suppl 1), S85. URL: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6343408/

Hohagen, F., Wahl-Kordon, A., Lotz-Rambaldi, W., & Muche-Borowski, C. (Eds.). (2014). *S3-Leitlinie Zwangsstörungen*. Springer-Verlag.

Holy Bible, New Revised Standard Version, (1989). NRSV Online. https://www.biblehub.com/

Hunt, J. (2014). Bio-Psycho-Social-Spiritual Assessment? Teaching the Skill of Spiritual Assessment. *Social Work & Christianity, 41*(4). https://www.proquest.com/docview/1655810190

Jayyusi, L. (2014). *Categorization and the Moral Order (Routledge Revivals)*. Routledge.

Juncos-Rabadán, O. (1996). Narrative speech in the elderly: Effects of age and education on telling stories. *International Journal of Behavioral Development, 19*(3), 669-685. https://doi.org/10.1177/016502549601900313

King, J. E., & Franke, G. R. (2017). Faith bias or religious expression: The real religious diversity challenge. *Journal of Management, Spirituality & Religion, 14*(1), 81-99. https://doi.org/10.1080/14766086.2016.1249396

Klenfeldt, I. F., Karlsson, B., Sigström, R., Bäckman, K., Waern, M., Östling, S., Gustafson, D., & Skoog, I. (2014). Prevalence of obsessive-compulsive disorder in relation to depression and cognition in an elderly population. *The American Journal of Geriatric Psychiatry, 22*(3), 301-308. https://doi.org/10.1016/j.jagp.2012.09.004

Koenig, H. G., King, D., & Carson, V. B. (2012). *Handbook of religion and health*. Oup Usa.

Koenig, H. G. (2018). *Religion and mental health: Research and clinical applications*. Academic Press.

Koran, L. M., Hanna, G. L., Hollander, E., Nestadt, G., & Simpson, H. B. (2007). Practice guideline for the treatment of patients with obsessive-compulsive disorder. URL: https://d1wqtxts1xzle7.cloudfront.net

Koran, L. M, Hanna, GL, Hollander, E., Nestadt, G., Simpson, H.B. American Psychiatric Association. (2017). Practice guideline for the treatment of patients with obsessive-compulsive disorder. *Am J Psychiatry.* 164(7 Suppl):5-53. PMID: 17849776.

Lewin, A. B., Wu, M. S., McGuire, J. F., & Storch, E. A. (2014). Cognitive behavior therapy for obsessive-compulsive and related disorders. *Psychiatric Clinics, 37*(3), 415-445. https://doi.org/10.1016/j.psc.2014.05.002

Linardon, J., Wade, T. D., De la Piedad Garcia, X., & Brennan, L. (2017). The efficacy of cognitive-behavioral therapy for eating disorders: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology, 85*(11), 1080. https://doi.org/10.1037/ccp0000245

Mason, J. M. (2017). Reading stories to preliterate children: A proposed connection to reading. In *Reading acquisition. (P. B Gough, L. C. Ehri, and R. Treiman, eds.)*. 215-241. Routledge. https://doi.org/10.4324/9781351236904

McHugh, R. K., Hearon, B. A., & Otto, M. W. (2010). Cognitive behavioral therapy for substance use disorders. *Psychiatric Clinics, 33*(3), 511-525. 10.1016/j.psc.2010.04.012

Menzies, R. E., Zuccala, M., Sharpe, L., & Dar-Nimrod, I. (2021). Are anxiety disorders a pathway to obsessive-compulsive disorder? Different trajectories of OCD and the role of death anxiety. *Nordic Journal of Psychiatry*, 75(3), 170-175. https://doi.org/10.1080/08039488.2020.1817554

Meisenhelder, J. B., & Chandler, E. N. (2002). Spirituality and health outcomes in the elderly. *Journal of Religion and Health, 41*, 243-252. https://doi.org/10.1023/A:1020236903663

Meisenhelder, J. B., Schaeffer, N. J., Younger, J., & Lauria, M. (2013). Faith and mental health in an oncology population. *Journal of Religion and Health, 52*, 505-513. https://doi.org/10.1007/s10943-011-9497-1

Obsessive Compulsive Foundation of Metropolitan Chicago. (2008). *OCD Facts: Facts about Obsessive Compulsive Disorder*. Retrieved October 15, 2008, from https://ocdchicago.org/

Overholser, J., & Dimaggio, G. (2020). Struggling with perfectionism: When good enough is not good enough. *Journal of Clinical Psychology, 76*(11), 2019-2027. https://doi.org/10.1002/jclp.23047

Oxhandler, H. K., Chamiec-Case, R., Wolfer, T., & Marraccino, J. (2021). Integrating social workers' Christian faith in social work: A national survey. *Social Work and Christianity, 48*(1), 52-74. https://www.nacsw.org/Publications/SWC/SWC48_1.pd#page=57

Payne, I. R., Bergin, A. E., & Loftus, P. E. (1992). A review of attempts to integrate spiritual and standard psychotherapy techniques. *Journal of Psychotherapy Integration, 2*(3), 171. https://doi.org/10.1037/h0101254

Pearce, M. (2016). *Cognitive Behavioral Therapy for Christians with Depression: A Practical Tool-Based Primer*. Templeton Foundation Press.

Pearce, M. J., Koenig, H. G., Robins, C. J., Nelson, B., Shaw, S. F., Cohen, H. J., & King, M. B. (2015). Religiously integrated cognitive behavioral therapy: a new

method of treatment for major depression in patients with chronic medical illness. *Psychotherapy, 52*(1), 56. https://doi.org/10.1037/a0036448

Pew Research Center. (2015). America's changing religious landscape [2014 Religious Landscape Study]. https://www.pewresearch.org/religion/2015/05/12/americas-changing-religious-landscape/

Porras González, N. I. (2010). Teaching English through stories: A meaningful and fun way for children to learn the language. Profile Issues in Teachers *Professional Development, 12*(1), 95-106.

Robson, Jr, J. P., & Troutman-Jordan, M. (2014). A concept analysis of cognitive reframing. *Journal of Theory Construction & Testing, 18*(2). https://www.proquest.com/docview/1629019978

Roemmele, M., Mardo, P., & Gordon, A. (2017, August). Natural-language interactive narratives in imaginal exposure therapy for obsessive-compulsive disorder. In *Proceedings of the Fourth Workshop on Computational Linguistics and Clinical Psychology—From Linguistic Signal to Clinical Reality* (pp. 48-57). 10.18653/v1/W17-3106

Rowsell, M., & Francis, S. E. (2015). OCD subtypes: Which, if any, are valid? *Clinical Psychology: Science and Practice, 22*(4), 414. https://doi.org/10.1037/h0101733

Sapienza, P., & Zingales, L. (2012). A trust crisis. *International Review of Finance, 12*(2), 123-131. https://doi.org/10.1111/j.1468-2443.2012.01152.x

Schieman, S., Bierman, A., & Ellison, C. G. (2013). Religion and mental health. *Handbook of the Sociology of Mental Healt*h, 457-478. https://doi.org/10.1007/978-94-007-4276-5_22

Sen, H. E., Colucci, L., & Browne, D. T. (2022). Keeping the faith: Religion, positive coping, and mental health of caregivers during COVID-19. *Frontiers in Psychology, 12*, 6487.

Shafranske, E. P., & Cummings, J. P. (2013). Religious and spiritual beliefs, affiliations, and practices of psychologists. In K. I. Pargament, A. Mahoney, & E. P. Shafranske (Eds.), American Psychological Association. https://doi.org/10.1037/14046-002

Starcevic, V., Berle, D., Brakoulias, V., Sammut, P., Moses, K., Milicevic, D., & Hannan, A. (2011). Functions of compulsions in obsessive–compulsive disorder. *Australian & New Zealand Journal of Psychiatry, 45*(6), 449-457. https://doi.org/10.3109/00048674.2011.567

Storch, E. A., Ledley, D. R., Lewin, A. B., Murphy, T. K., Johns, N. B., Goodman, W. K., & Geffken, G. R. (2006). Peer victimization in children with obsessive–compulsive disorder: Relations with symptoms of psychopathology. *Journal of Clinical Child and Adolescent Psychology, 35*(3), 446-455. Doi: 10.1207/s15374424jccp3503_10.

Tan, S. Y. (2013). Resilience and posttraumatic growth: Empirical evidence and clinical applications from a Christian perspective. *Journal of Psychology and Christianity, 32*(4), 358. https://counseling4christians.com/

Turner, F. J. (Ed.). (2017). *Social Work Treatment: Interlocking Theoretical Approaches*. Oxford University Press.

Twohig, M. P., & Crosby, J. M. (2012). Acceptance and Commitment Therapy for OCD and related disorders: Current research and future directions. URL: https://digitalcommons.usu.edu/psych_facpub/1693/

Twohig, M. P., Abramowitz, J. S., Bluett, E. J., Fabricant, L. E., Jacoby, R. J., Morrison, K. L., Reuman, L., & Smith, B. M. (2015). Exposure therapy for OCD from an acceptance and commitment therapy (ACT) framework. J*ournal of Obsessive-*

Compulsive and Related Disorders, 6, 167-173. https://doi.org/10.1016/j.jocrd.2014.12.007

Vaghi, M. M., Cardinal, R. N., Apergis-Schoute, A. M., Fineberg, N. A., Sule, A., & Robbins, T. W. (2019). Action-outcome knowledge dissociates from behavior in obsessive-compulsive disorder following contingency degradation. *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging, 4*(2), 200-209. https://doi.org/10.1016/j.bpsc.2018.09.014

Vogel, P. A., Hansen, B., Stiles, T. C., & Götestam, K. G. (2006). Treatment motivation, treatment expectancy, and helping alliance as predictors of outcome in cognitive behavioral treatment of OCD. *Journal of Behavior Therapy and Experimental Psychiatry, 37*(3), 247-255. https://doi.org/10.1016/j.jbtep.2005.12.001

Wright, L. A., & McCathren, R. B. (2012). Utilizing social stories to increase prosocial behavior and reduce problem behavior in young children with autism. *Child Development Research, 2012*. https://doi.org/10.1155/2012/357291

Yarhouse, M. A., Butman, R. E., & McCray, B. W. (1991). *Modern psychotherapies: A comprehensive Christian appraisal*. Christian Association for Psychological Studies Books.

Zastrow, C., & Hessenauer, S. L. (2022). *Empowerment series: Introduction to social work and social welfare: Empowering people*. Cengage Learning.

Cali Werner, LCSW, is a Doctoral student at Baylor University and Clinician at OCD Institute of Texas, 713-527-2851, Cali_Werner@Baylor.edu

Community Health Workers in Action: The Efforts of "Promotores De Salud" in Bringing Health Care to Marginalized Communities
Melvin Delgado (2020). Oxford University Press.

Melvin Delgado's latest publication relates to integration of faith in social work practice with an emphasis upon social justice topics. The author focuses upon special populations which included persons confronted with their age, race, youth, addictions, homelessness, criminal justice, health challenges, gender issues, and LBGTQ identities. As Christians, we are called to address societal needs in providing compassion and concern without judgement. As social workers we are called to be advocates with the gospel providing that foundation.

Social work practitioners will find Delgado's publication relevant to social work practice but will want to note that it was published in 2020, before the COVID-19 pandemic. When Delgado addresses health care topics, there is no mention of the 2020 global pandemic, but regardless, there is relevancy to ongoing health challenges faced in the United States. For example, the author does a remarkable job addressing the challenges faced in immigration procedures that have become a major social justice issue.

Delgado covers a wide area of topics starting with a firm foundation in recognition of the "close relationship between health and well-being across the life span" (p. 3) and carries this theme throughout. He specifically addresses the "graying of the nation's population" and how this necessitates "the development of initiatives to meet their complex health care needs that are increasingly financially costly" (p. 7). Special attention is given to the Affordable Care Act (ACA), the historic legislation that increased health care with a special focus upon mental health services throughout the publication as it relates to specific groups. Delgado discusses values as key principles that community health workers (CHW) should embrace in practice (p. 28). He then refers to the importance of culture and addresses it extensively in chapter 2. Reference is made to the effectiveness of CHW because of their focus on culture in association with values and practices found in communities. This chapter also tackled the present-day struggles of Latinxs, and their fear and resistance to seek out health care because of a perceived risk of deportation. Delgado also focuses upon medical personnel who are bilingual and as a result enhance their role as a CHW. The chapter closes with a solid definition of acculturation as it relates to the role of the CHW.

Interestingly, Delgado addressed the impact of previous pandemics

such as the Asian Flu, HIV/AIDS, and SARS without knowingly making a connection to how the United States would recover from the pandemic now known as COVID-19. He discusses the social justice analysis that must be addressed during a pandemic as it presents a higher level of barriers to marginalized individuals who are already facing challenges. Also, in this chapter, he addresses the term "US health care system" which is a misnomer as it is not an organized system but rather a system that has disparate parts and provides an unequal delivery of care across age and racial spectrums. Work related injuries are addressed as well noting that "workers of color…. are often overrepresented in occupations with high rates of injuries" (p. 50).

A unique phrase is found in chapter 4, in regard to addressing barriers in urban health care, "the nation is graying (getting older) and browning (diversifying ethnically and racially), setting the stage for a country that will look very different in the future from what it looks like today" (p 53). The *graying* of America refers to not only senior citizens but also their families who are often the primary caregivers. Awareness of the nation's graying is critical to community health workers because it represents a growing population getting older and thus relating to healthcare services associated to the aging process. The browning of America is related to the progression in the number of blacks, Hispanics, Asians, multiracial Americans and other non-white groups. The impact is that we no longer view Europe as the primary origin of immigrants to the United States. We are now transformed from a country with a majority of white people to a country of mixed peoples which presents a continued need for awareness on how health care challenges impact those who are marginalized due to race.

Foundation of health care values in chapter 5 addresses social justice, empowerment, cultural competency, and participatory democracy which lays the framework for a listing of eight principles related to CHW initiatives. Delgado touches upon the non-traditional environments in which communities can focus upon health care. One such example provided is houses of worship initiating health programs by hosting community health workers offering a free health clinic, a screening site for common illnesses or a vaccination site. Places of worship are viewed as ideal locations because community members have already established trust within these environments.

Delgado addresses the need for community health workers to be a profession that has legitimacy in order to earn consumer trust. This trust is acquired in a variety of ways, one of which is an academic degree and professional credentials acquired from a college education. "Achieving professional status also serves a gatekeeping function, keeping people in and out" (p. 12). This position relates to policies, guidelines, and standards that a community health worker brings with them to the

position because these principles were learned in a formal education. This reference to professional status is a critical element for academia to focus upon especially in the field of social work because one competency of those required by the Council on Social Work Education (CSWE) relates solely to policy.

Peer support for CHW is also referenced as a focus upon "shared understanding, respect and mutual empowerment" (p. 16) between people in similar positions. Addressing the need for peer support in practice is another critical factor that educators should address in their curriculum as way of preparing students for future roles.

As social work educators strive to promote the work of community mental health, it is important to address the various titles and roles that are used in order to understand this field. These descriptions are addressed in chapter 6. Defining the roles of CHW is dependent upon who is defining them, but focus should also be made upon the critical role the Affordable Care Act (ACA) has played in fostering employment in this area.

Christian foundational values of working with the poor and other oppressed populations continue to guide the social worker with a faith perspective. This publication provides an introductory practice perspective whereby integration of faith in practice for the Christian social worker is at the forefront. Strengths of this publication include the definitions, historical focus, and examples of community mental health workers and their role in reaching marginalized communities. As noted above, since the book was written before the Covid-19 pandemic, future editions could include the ongoing challenges that have been presented to community health workers. ❖

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

Development in Mission: A Guide for Transforming Global Poverty and Ourselves

Monty L. Lynn, Rob Gailey & Derran Reese (2021). Abilene Christian University Press.

The world is at an unparalleled moment in history. There are more existential threats than ever before, and they come from what seems like every angle. In addition to the age-old global and domestic manifestations of sin such as poverty, hunger, sickness, war, and displacement, we also have climate change, slavery still exists, though it is called trafficking, child labor, income disparity is ever increasing, globalization has led to both displacement abroad and unemployment at home, mental health services are a rapidly increasing need, and though this account is far from complete, it has arguably culminated in an increase of authoritarian politics and policies the world over as people search for ways to make sense of the complexity and havoc. There is hurt all around us, within us, and as a people, but especially as Christians, it is past time to act; it is time to catch up. *Development in Mission: A Guide for Transforming Global Poverty and Ourselves* presents a way contemporary Christians can practically engage to lessen global suffering on an individual level, but also offers a multitude of considerations for congregations of all sizes to more fully engage locally as well as internationally. Though the book is intended for a Christian audience, many of the concepts could easily be implemented within the context of other faiths or within secular organizations.

Authors Monty Lynn, Rob Gailey, and Derran Reese have combined their extensive educational backgrounds and years of mission experience to present, in three succinct sections, a comprehensive approach to the broad and complex field of mission work. Where this book appeals to both social worker and Christian alike is the authors' concept of holistic mission, which is essentially an entire embrace of the person/population within, and in relation to, their environment. From that lens then, Lynn et al. have come up with 15 sectors of mission work that churches have traditionally engaged in such as education, relief, and food security. Aside from providing a brief theological basis for each sector, the authors provide insight into the dynamic and often overlapping nature of mission work. If a congregation wishes to provide education to a remote population, what type of education will they provide? What is there a local need for? Is there other mission work nearby, such as medical relief, that will need trained medical professionals in the future? What has worked in the past with educational mission work and what has failed? Questions such as these are essential to successful mission work, but they are not nearly as important as simply listening to what a specific population has to say for itself. That is a point the authors frequently make and one all social workers should know.

The book does not have many weaknesses; it conveys its message. It is more a call to action and should be evaluated as such. What is consistently apparent is a massive need for prayer as well as action. The book is often overwhelming at times due to the complexities of global suffering, and one would understandably wonder where to even begin. Mission work is a broad field, holistic mission work even more so, and so this really serves as a sizable approach to either beginning or continuing to engage in mission work. The final section of Development in Mission addresses where to begin on a congregational level, and it provides insight and guidance for those looking to do so. It is vitally important, yet again, to pray and hear from all congregants in this regard as well. The book's excellent appendices align development organizations categorically and provide a list for further reading.

Perhaps the book's greatest feature is the persistent challenge it makes of the reader, namely, are they living a truly Christian life? The authors do not blatantly ask, rather the book is replete with quotes from Christians from around the world, Biblical references, and quite a few eye-opening statistics that have the composite effect of causing one to self-reflect. This book is not a how-to, rather it is a map showing the way for greater Christian engagement, advocacy, and a brighter future: a map which leads the reader down paths that should question morality, comfort, livelihood and more. As the authors state, "If those in poverty are the ones who are blessed, then we might have just as much, if not more, to receive as we do give" (p. 25). ❖

Reviewed by ***Nathan Edwards, MSW,*** *Mental Health Therapist, Eagle View Behavioral Health. Email: Nathan_Edwards1@baylor.edu.*

The Soul of the Helper: Seven Stages to Seeing the Sacred Within Yourself So You Can See it in Others
Holly Oxhandler. (2022). Templeton Press.

Holly Oxhander, PhD, LMSW, is an associate professor of social work at Baylor University's Diana R. Garland School of Social Work. Her new book, *The Soul of the Helper: Seven Stages to Seeing the Sacred Within Yourself So You Can See it in Others*, is written for any helping professional who is looking for spiritual and psychological healing and growth. Using Namaste Theory, Oxhandler encourages us to work towards our own healing so we might be able to heal others. Written as an autoethnography, Oxhandler weaves her own personal experience with her research, and presents a seven-stage journey to Namaste embodiment.

The book is divided into three parts: I. Spirituality and Mental Health, II. The Journey of Seeking the Sacred, and III. "So What?": Cultivating a Practice of Seeking and Serving the Sacred for the Journey Ahead. Part I briefly introduces the reader to Oxhandler's understanding and research on the intersection of mental health, religion, and spirituality together with her personal story of struggles and triumphs as they relate to her own mental health recovery journey. In Chapter two she writes:

> When we create space for our spiritual journey and mental health journey to coexist, we're better positioned to help those around us. When we allow ourselves the time to discern our views about our own deep spiritual beliefs, we can pay attention to and reduce imposing our assumptions, biases, and views of God onto those around us, including those we're helping. Without this kind of deep self-reflection, we may unintentionally hurt those around us (p. 35).

Part I closes with an introduction to Namaste Theory, which is the operating thesis of the remainder of the book—i.e., the idea that helping professionals must recognize the "sacred within themselves" to be able to then recognize "the sacred within their client" (p. 42).

Part II of the text walks the reader through seven stages of seeking the sacred. The 7 S's (each stage begins with the letter S) build off one another and end with Service to others through our individual circumstances and callings. Oxhandler writes:

> As we awaken to the Sacred within and see it in others, it's as though we're naturally drawn to serve the image of God within and all around us in whatever way our divine spark guides us (p. 162).

Part III closes the book in true social work fashion, with practical application. This section asks the question, "So what?" and provides three methods for the reader to reflect on their own journey of seeking the Sacred.

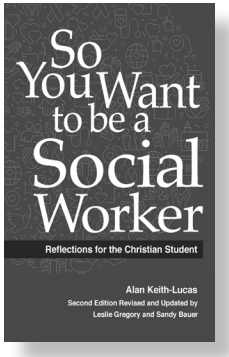
The Soul of the Helper is a practical guide that connects research, contemplative practices, and personal reflection to assist any person who is personally or professionally serving others. The book provides a solid overview of research surrounding the intersection of religion, spirituality, and mental health. Additionally, while its discussion of faith is from the context of Christianity, it is also applicable to a broadly religious audience. The book also offers practical solutions and examples for implementing Oxhandler's charge to care for oneself and others through the lens of Namaste Theory.

Some readers may find *The Soul of the Helper* to be a primer for contemplative living and mindfulness practices, and self-care. The author's primary thesis that a helping professional must be attentive to their own vulnerabilities and wounds will resonate well with social workers. Oxhandler admirably tackles subject areas that carry a considerable amount of abstraction. Indeed, understanding such abstract concepts will, however, be difficult for some readers, especially those unfamiliar with or even distrusting of her terminology. That said, the book pushes into important territory by challenging, and even charging, helping professionals to attend to their own spirituality and mental health as a means of effectively caring for others.

The Soul of the Helper is written for a wide audience and will be a great resource for any professional helper, regardless of context (e.g., mental health, clergy, educators, service workers) and may be especially appropriate for student social workers who are beginning field experiences. ❖

Reviewed by ***Jennifer Hollenberger, MSW, LCSW,*** *Assistant Professor of Social Work, Field Education Director, Grove City College. Email: hollenbergerjc@gcc.edu.*

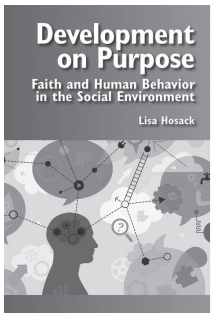
PUBLICATIONS AVAILABLE FROM NACSW



SO YOU WANT TO BE A SOCIAL WORKER: REFLECTIONS FOR THE CHRISTIAN STUDENT (2ND EDITION)

Alan Keith-Lucas, Leslie Gregory, and Sandy Bauer. (2021). Palos Heights, IL: NACSW. $14.95 U.S. ($11.95 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 is 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.



DEVELOPMENT ON PURPOSE: FAITH AND HUMAN BEHAVIOR IN THE SOCIAL ENVIRONMENT

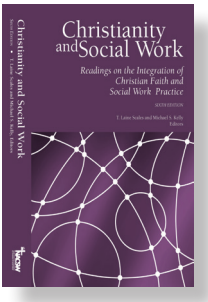
(2019) BY LISA HOSACK , MSW, PH.D.

NACSW. $25.50 U.S., $22.95 for NACSW members or orders of 10 or more copies. For price in Canadian dollars, use current exchange rate.

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 andthe 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.

To support the use of this book in the classroom and training environments, NACSW has developed a collection of online teaching resources for your use, which can be found at: www.nacsw.org/teaching_resources/hosack_developmentonpurpose.



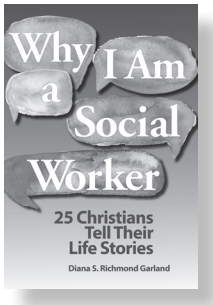
Christianity and Social Work: Readings on the Integration of Christian Faith & Social Work Practice (Sixth Edition)

T. Laine Scales and Michael S. Kelly (Editors). (2020). Botsford, CT:
NACSW. $64.95 U.S., $51.96 for NACSW members or orders of 10 or more copies. For price in Canadian dollars, use current exchange rate.

The 6th Edition of Christianity and Social Work (CSW6), edited by T. Laine Scales and Michael Kelly, and is written for social workers whose motivations to enter the profession as well as their approaches to helping have been inspired and informed by their Christian faith.

The 19 chapters and over 400 pages of CSW6 address social welfare history, human behavior and the social environment, social policy, and social work practice from a faith perspective at micro, mezzo, and macro levels. Four decision cases and an accompanying online instructor's manual provide rich teaching tools for the use of this material in a variety of social work and related classes. Especially useful in the classroom or social work trainings, CSW6 supports several major curriculum areas outlined by the Council on Social Work Education's Educational Policy and Accreditation Standards.

NACSW has also developed an extensive electronic resource tool, Instructor's Resources for Christianity and Social Work: Sixth Edition (2020) by Tammy Patton to support the use of the Christianity and Social Work in classroom and trainings environments, which can be found at: www.nacsw.org/Publications/CSW6/CSW6thInstructorsResourcesFinal.pdf.



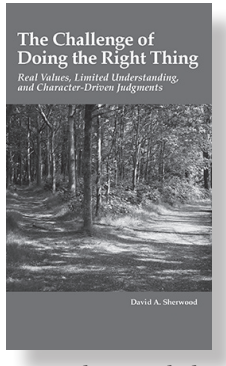
Why I Am a Social Worker: 25 Christians Tell Their Life Stories

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. 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. It addresses a range of critical questions such as:

- How do social workers describe the relationship of their faith and their work?
- 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?

The stories in Why I Am a Social Worker have strong themes of integration of faith and practice that will both challenge and encourage students and seasoned practitioners alike.

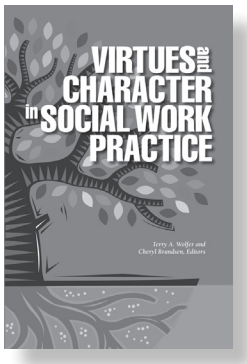


The Challenge of Doing the Right Thing: Real Values, Limited Understanding, and Character-Driven Judgments

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

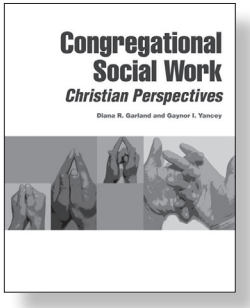
professional social work practice. In this book. Dr. Sherwood argues that in ethical decision-making, decisions frequently involve making judgments that functionally prioritize legitimate values that are in tension with each other. He contends that the mission of NACSW and *Social Work & Christianity* 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.



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.

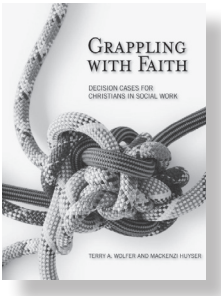
Virtues and Character in Social Work Practice offers a fresh contribution to the Christian social work literature with its emphasis on the key role of character traits and virtues in equipping Christians in social work to engage with and serve their clients and communities well.

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.

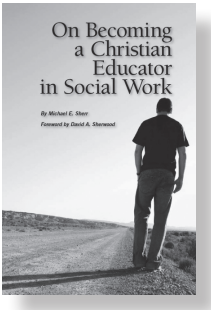
Congregational Social Work offers a compelling account of the many ways social workers serve the church as leaders of congregational life, of ministry to neighborhoods locally and globally, and of advocacy for social justice. Based on the most comprehensive study to date on social work with congregations, *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.

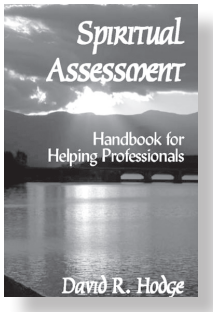
Grappling with Faith: Decision Cases for Christians in Social Work presents fifteen cases specifically designed to challenge and stretch Christian social work students and practitioners. Using the case method of teaching and learning, *Grappling with Faith* highlights the ambiguities and dilemmas found 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.

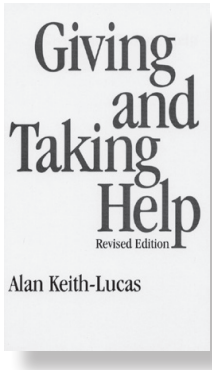
On Becoming a Christian Educator is a compelling invitation for social workers of faith in higher education to explore what it means to be a Christian in social work education. By highlighting seven core commitments of Christian social work educators, it offers strategies for social work educators to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

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

ONLINE OR ON-CAMPUS
BEHAVIORAL SCIENCE PROGRAMS
UNDERGRADUATE • GRADUATE • CERTIFICATES

Addictions Counseling
Criminal Justice
Human Services
Life Coaching
Social Work & more!

GET STARTED TODAY
866.498.4968
IWUeducation.com

INDIANA WESLEYAN UNIVERSITY

Classes starting monthly!

TOP ONLINE NON-PROFIT UNIVERSITY IN INDIANA | FAITH-INTEGRATED EDUCATION

North American Association of
Christians in Social Work
6601 W College Dr
Palos Heights, IL 60463

Change Service Requested

North American Association of Christians in Social Work

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

Its goals include:

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

NACSW
North American Association of Christians in Social Work