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Editorial: Exposing White Privilege by Two White Guys

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Stephen M. Marson, Ph.D., Editor and Paul Dovyak, MSW, LISW-S

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> A South politician preaches to the poor white man
> "You got more than the blacks, don't complain
> You're better than them, you been born with white skin," they explain
> And the Negro's name
> Is used, it is plain
>
> Bob Dylan
> Only a Pawn in Their Game

This editorial represents our conversations regarding the racial turmoil we followed through the media during the years 2019 to 2021. We awkwardly reminisced our youth during the turbulent 1960's and concluded that many similarities exist between the social revolutions of the 60's and today. Essentially this editorial is a recapitulation of our conversations. These conversations cycled through reactions of intellectualization, anger, irrationalities, irony, sarcasm, depression and embarrassment about being white. Assembling these fragments of ideas and feelings was a Herculean task. We spent as much time on this seemingly simple editorial as we would on a major research manuscript. Essentially, we have attempted to integrate our affective reactions with our intellect. In assembling these fragments of ideas we believe that we should start with some intellectualization. Thus, we begin with the assumption that to understand the concept of "white

privilege," it is critical to clarify how it intersects with the concept of "white supremacy."

White Privilege and White Supremacy

White supremacy is founded on a sociopolitical history of projecting biological determinates for which there is no known genetic basis. Social psychology and psychiatry might further trace through the Nuremberg Trials how societies interact to sustain the dynamics of domination and oppression. In fact, the biological and anthropological evidence suggests that racial superiority simply does NOT exist. Robert Merton would classify white supremacy as a manifest function. *Manifestly* and unambiguously, the position for white supremacy can be summarized as: "Whites are superior to everyone else [sic] because they dominate." Although there are a number of people who embrace this position, they lack scientific evidence to support their position. In some ways then, white supremacy may be the psychiatric strawman that can be easily knocked over with science principles. Thus, being contrary to the scientific substantiated reality, the existence of feelings of white supremacy becomes an issue for psychiatric intervention – perhaps pharmaceutical or electroshock therapy. White supremacy is a socio-political reality that sustains variant streams of social injustice to allow innumerable types of oppression.

White privilege is sociological (less psychiatric) in nature with an absence of biological and psychological principles. Unlike white supremacy which is clearly manifest, Robert Merton would envision white privilege as latent and deeply embedded within the social structure without conscious acknowledgement. Marxist scholars and feminist researchers would employ the concept "false consciousness" to define white privilege. Thus, white privilege is deeply embedded within our social infrastructure. White privilege is insidious. Thus, a white or Black person can truly believe that white supremacy is abhorrent, but simultaneously embrace white privilege without conscious awareness.

White privilege is better understood as an evolved rationalization for white supremacy. After generations of passive sociological denial, our country may be birthing an unwanted pregnancy. It is a Constitutional certainty that *white supremacy* was a founding principle of our country. Gerson (2021) describes the hesitancy of her colleagues to more fully embrace exposure and reminder of the stain of the Supreme Court Dred Scott decision (1857). The tortuous logic of our white AND male 'forefathers' to so fundamentally argue a 'three-fifths' human clause shames any revisionist publisher of our Constitution. Three Amendments were required to correct this imperfect union.

If the reader teaches race relations or social justice, Robert Merton's sociological concepts of manifest and latent and the Marxian concept of false consciousness are prerequisite concepts necessary to have an in-depth understanding of white privilege. These concepts lead us and our students to unambiguously acknowledge that white privilege is far more of a danger to society than white supremacy.

In examining white privilege and white supremacy, we concluded that white privilege is much more of a micro concept while white supremacy is macro. Based on our conversations, we developed a typology that may be helpful for teaching instructional purposes:

Characteristics	White Privilege	White Supremacy
Locus of Control	External / Passive/Aggressive	Internal / Aggressive
Origin	Sociological	Psychiatric
Consciousness	Subconscious	Grandiosity
Group Influence	Collective Unconscious	Collective Conscious
Feelings	Naivete	Agitation
Intervention	Policy & Laws	Deprogramming
Best Literature	Sociological Abstracts	Psychological Abstracts
Population Proportion	Majority	Loud Minority

Table 1: Typology of White Privilege and White Supremacy

The Emergence of White Privilege

What is the derivation of "white privilege"? White privilege is an extremely elusive concept. According to Smith, Crosthwaite and Clark (2014) white privilege originally emerged within Critical Race Theory (CRT) in conducting research on the courts' sentencing practices. Within the jurisprudence literature, the CRT position states that race-based preferences and biases are embedded in established law and policy. In terms of criminal justice, social workers are well-aware of a pattern of harsher sentences for the identical crime among Blacks when compared to convicted whites. In addition to harsher sentences, Blacks are more likely to be convicted whereas whites are less likely. The *Criminal Justice System* is the origin and the explanation of how the concept of white privilege came into existence.

Two Examples: Example 1

A further extension of white privilege to male privilege was displayed in the judiciary in the nomination and confirmation of Brett Kavanaugh to the United States Supreme Court. Kavanaugh was accused of the attempted rape of a 15-year-old girl while he was 17. During the Judiciary Committee hearing, the allegations boiled down to "he said, she said." The vote to confirm Kavanaugh fell into the hands of female Senator Susan Collins.

As stated within the definition, white privilege is embedded within our social structure in such a profound manner, it goes unnoticed by those who are hurt by it but are compelled to endorse it. Such a social environment is fertile soil for conflict theory's concept of "false consciousness." In fact, the concept of false consciousness is the foundation to enable white privilege to continue and thrive. To help her decide to endorse Kavanaugh, Senator Collins requested to have three meetings in which she interrogated him. On the surface this sounds reasonable. However, from the perspective of someone assessing the situation from a white privilege perspective, there is a problem here. Collins made no effort to meet with Christine Blasey Ford – the alleged victim. It is true that the standard protocol within the Senate bears

no necessity for a senator to request a private meeting with the opposition. The most notable aspect of the normal established protocol within the Senate is that it fits, like hand in glove, the definition of white privilege within the history of the judiciary. As stated earlier, preferences and biases are embedded in established law and policy. The concept of failing to interview Ford is normal. It is fundamentally dismissive. In terms of white privilege, legal norms must be challenged.

In fact, failure to consider interviewing Ford demonstrated the existence of false consciousness. We see that Collins acquiescing to white male superiority by denying Ford an equal opportunity to explain in her own words – unfettered by prying eyes – equal to the Kavanaugh interviews. We see a vision of male superiority and second-class citizenship for women because Ford and Kavanaugh *were not* treated equally. The rationale for excluding a Ford interview exists and is quite believable within our political framework. However, these political rationales are also the latent characteristics of white privilege. Among Republicans, there were cries that took the position that the rejection of Kavanaugh would be grossly unfair. We cannot deny a job to white man who has a lifetime of privilege. The pertinent question: Is it impossible to find a conservative white male judge that does not have a rape allegation? This question reinforces the notion of white privilege within a white male dominated judiciary. The key characteristic is: No one questioned the process.

Two Examples: Example 2

A second example of white privilege within jurisprudence is found in Judge Persky's disposition of Brock Turner's three felony convictions for the rape of Chanel Miller. Turner was convicted of sexual assault for which the maximum sentence was 14 years. The female prosecutor recommended six years. Judge Aaron Persky, a white male judge, ordered a six-month sentence for which Turner served three months – one month for each felony conviction.

Because the sentence was ridiculously light, Judge Persky felt compelled to offer six justifications to form the basis of this extraordinary light sentence (for all six see: www.theguardian.com/us-news/2016/jun/14/stanford-sexual-assault-read-sentence-judge-aaron-persky). Most of his considerations were founded on the amount of trauma in which Turner, the convicted rapist, would be subjected if he received a harsher imprisonment. Judge Persky's last rationale is quoted:

> "… adverse collateral consequences on the defendant's life resulting from the felony conviction. And those are severe. And they're severe in a couple of ways: One, with respect to the Penal Code section 290 registration that he'll be subject to for life; and, secondly, with respect to the media attention that's been given to the case, it has not only impacted the victim in this case, but also Mr. Turner. Where, in certain cases, there is no publicity, then the collateral consequence on those on the defendant's life can be minimized."

Although judges *must be given* latitude in sentencing, Judge Persky's final disposition of the Turner conviction received universal condemnation. In practical terms, a six-year prison sentence would mean three years in prison. Actually, a light sentence from the judge would have three years and in practical terms, he would serve a year and a half. Regardless of how one cuts the cake, the Turner rape case is a classic example of white privilege – a white judge disposes a ridiculously mild sentence to an upper middle-class white boy. Although Judge Persky had the support of the white male dominated stakeholders in California, great international protests emerged, and the people of California removed Persky from his judgeship. We can refer to the people's reaction to Judge Persky's sentencing as a "backlash."

White Privilege in Everyday Life

Employing white privilege outside the jurisprudence arena is stretching CRT to its limits of coherency. However, the popular press has done this. For example, Smith, Crosthwaite and Clark (2014) stress that two types of white privilege exist within our social structure. They envision white privilege as a

twofold triumph. First, *white* males face fewer negative consequences for violating social norms. Second, *white* males are afforded social opportunities that are limited and/or even denied to women and people of color. As one can easily observe, on the popular front, *YouTube* offers a massive trove of white social advantages:

https://www.youtube.com/watch?v=vksEJR9EPQ8&bpctr=1608648415
https://www.youtube.com/watch?v=q2h4CVt1f2I
https://www.youtube.com/watch?v=1PaZzKkGhtc&t=1s
https://www.youtube.com/watch?v=MktXtgJBiuE
https://www.youtube.com/watch?v=KqARrnQdcQM
https://www.youtube.com/watch?v=hdNKpnXnmGE
https://www.youtube.com/watch?v=N6xnoODRlBQ
https://www.youtube.com/watch?v=Nx5DxpNxDNY&t=2s
https://www.youtube.com/watch?v=j1mq1P8V_8s
https://www.youtube.com/watch?v=EZPJZkTmBi4
https://www.youtube.com/watch?v=IPubUIKLzsM&t=14s
https://www.youtube.com/watch?v=fbPzsREhrUA
https://www.youtube.com/watch?v=jEAHBl7OWBY&t=1s
https://www.youtube.com/watch?v=HtdLaIpLQ3M
https://www.youtube.com/watch?v=iQbq40WqQuc
https://www.youtube.com/watch?v=ODhNRyjJsl8&t=53s
https://www.youtube.com/watch?v=m7qk-5Cz0PI
https://www.youtube.com/watch?v=DaBAbxZGokY
https://www.youtube.com/watch?v=I-d8XtujC98
https://www.youtube.com/watch?v=LgaU1h0QiLo
https://www.youtube.com/watch?v=jNBeF2ByPu8
https://www.youtube.com/watch?v=cSzNB0-1R8A
https://www.youtube.com/watch?v=817n6l5mrkM
https://www.youtube.com/watch?v=KTAG50fqYIk
https://www.youtube.com/watch?v=43gm3CJePn0

These short videos that illustrate white privilege can be employed in the classroom to illuminate the concept of white privilege to students.

Personal Anecdote: Example 1

After attending a conference on white privilege in Canada, Steve found himself to be distressed. Among the participants, Steve got the distinct impression, as a white man, he was to be blamed for social injustice. He had two close friends with whom he attended the conference. One was a lesbian while the other was a Black male. With great finesse, they both gently told Steve that he didn't understand white privilege. They travelled together on the plane ride from Canada to the US where they would connect to different flights homeward bound.

When they arrived at the airport to transfer planes, all three were hungry and decided to eat at a fast-food restaurant. Upon arriving, the restaurant was total chaos. There were no lines and people were mulling around in a state of polite confusion. No one was getting their food! Without being prompted, Steve went to the counter and told everyone to form a line. Steve asked who the first person was to arrive then told her to get in line first then the second arrival and so on. In less than a minute Steve got everyone organized. When Steve returned to his two friends, they both glared at him and almost simultaneously said, "that's white privilege." Steve responded by stressing that they would have eventually done the same thing. Both responded with an emphatic NO. The social concept of white privilege finally clicked in his head and he immediately apologized for his reflex action of *taking over*. Once again, both responded with a "NO! They want him that way! otherwise they would have never had a chance to eat." This illustrates and shows us that white privilege can be a double-edged sword. Sometimes white privilege serves a social function. OR perhaps everyone should be entitled to have white privilege. OR white privilege is a normal social function, and everyone is entitled to it. OR, whoever is wearing the persuasive personality trait of the day floats as the leader!

Personal Anecdote: Example 2

Another personal example involves an application for a Ph.D. program. Steve received a reply from his application which reported that he was the type of candidate they were seeking. The university had an affirmative action policy. The Ph.D. program was obligated to enrol Puerto Rican applicants during that current fiscal year. When Steve got the rejection, he told this story to his Native American students who cheered at the outcome. They envisioned Steve as a white man of great privilege, and they were glad to witness his defeat. Steve's immediate response was, "I am not upset. I don't need help to get accepted and I know I'll eventually be admitted." His sincerity shocked his students, and silence emerged. If a pin dropped, you could hear it. He didn't tell them that he applied to three schools and was immediately accepted to the other two. We don't know if multiple applications for Ph.D. programs were the norm in the late 70's, but no one guided him to do so. Is that white privilege?

Personal Anecdote: Example 3

Girard and Steve travel to the gym at 4 AM every morning from their respective homes. It is an uneventful trip for Steve. However, Girard, on at least three occasions, was stopped by the police and searched without cause. During one of these three times, Girard walked from the door of his home to his car. Within these few feet of walking, Girard was stopped by police at gunpoint. Girard was emotionally shaken, but after the harsh police interrogation, he drove to work – late. Steve had been driving to the gym for over two decades (commonly over the speed limit) and has never been stopped by the police or anyone else. Since Girard is Black and Steve is white, the decisions made within the criminal justice system, constitutes white privilege.

Steve cannot be held responsible for the lack of social justice faced by his friend Girard. What can Steve do to address this social injustice? His first thought was to make the situation public by publishing a paper. You're reading it. If you have additional ideas, send them to smarson@nc.rr.com.

Academic Perspective

Lui (2017) writes, "white wealthy men use privilege as a means to access and gain power while white men in lower- and working-classes use privilege to build relationships and legitimize inequality" (p. 349). We find this conclusion perplexing. Wealthy people, regardless of their sex and race, have few restrictions to access in gaining more power and wealth. The fact is, people with wealth have social and legal privileges the rest of us do not. If OJ Simpson was poor, he would have been found guilty. Technically, this situation is outside of the realm of white privilege. More precisely, it should be labelled wealth privilege.

Heller (2009) seems to be suggesting that white privilege does not exist for working class whites. In the trades such as carpentry, auto mechanics, plumbing etc., a person's skill set (regardless of race or sex) is immediately recognized and rewarded. Historically, gaining admission to the journeyman's or other trade training for women and people of color is associated with executive orders from the U.S. presidency. Within political parties who demand small government, we notice a decrease of women and people of color enrolled in trade programs. Whereas political parties who believe that government can create an even playing field, we have an increase of women and people of color enrolled (Hunte, 2016). Thus, white privilege is governmentally regulated in predictable ways or as Merton would suggest, it is a latent social function.

White men who search for the truth are likely to experience cognitive dissonance. However, when requiring two books to be read, one immediately after the other, students regardless of their race, experience cognitive dissonance and will find the concept of white privilege elusive. The books are:

Connerly, W. (2007). *Creating equal: My fight against race preferences*. Encounter Books.

Suskind, R. (2005). *A hope in the unseen: An American odyssey from the inner city to the ivy league*. Broadway Books.

Both books are powerfully presented and take opposite views – both of which are objectively convincing. However, if the positions are truly opposite, both cannot be true?

Applied White Privilege

What level of credibility or legitimacy do two white guys have in addressing the topic of white privilege? We must acknowledge that our discussions focusing on white privilege were stirred during the tumultuous late spring of 2020. Thus, our narrative on the topic has persisted as a sidebar to the national drama's perfect storm. Pandemic begets racial strife begets economic shutdown. Our discussions were both an intellectual examination of the scholarly literature peppered with lifetimes of personal reflection. No matter what our conversations or rationales developed, we both experienced a state of awkwardness.

One issue emerged true: White privilege exists and is a product and fuel of our society and social structure. What can two white guys do about it? After reviewing the literature and examining our personal experiences, we see the strategy to overcome white privilege resting within the dialogue of white men confronting other white men. In fact, a most meaningful credibility and legitimacy to challenge white privilege rests in the words of the white men who are bold enough to denounce it. There are simple skirmishes that emerge within daily lives of white men. When white men are passive or silent when confronted with racist remarks, racism is strengthened. Enduringly painful offenses can be found within the posts on Facebook. Following is a typical example of a post found on a white man's Facebook:

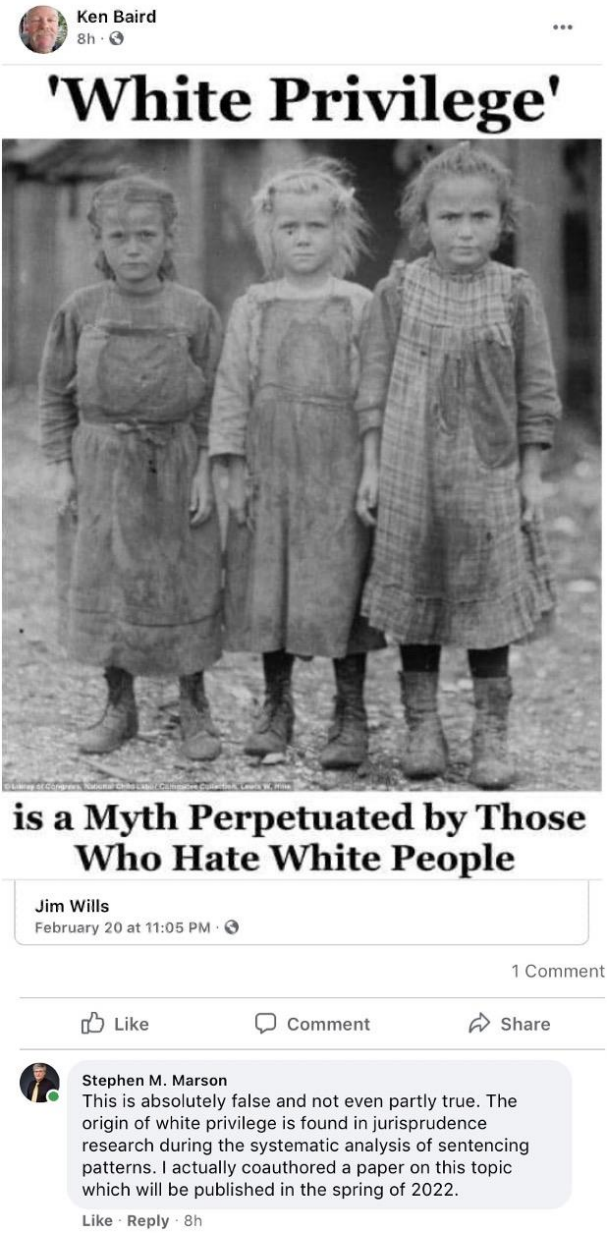

Figure 1: Facebook Post

Allowing this post to pass without critical comment does nothing but perpetuate white privilege and racism. That is its manifest intent. This post, and others like it, must face an unambiguous protest *from white men*. Such an objection to racist posts reaches its crescendo when the condemnation comes from another white males. "The only thing necessary for the triumph of evil is for good men to do nothing." Thus, when a white man does nothing in the midst of a racial slur, racism is strengthened and perpetuated. Here, we are approaching the border of unethical professional behavior. The battle of racism is a battle among white men. The question presumes: If a white male social worker fails to respond to racial slurs, that is, doing nothing – is this lack of action *unethical*?

You are encouraged to send your opinion regarding white privilege to mailto:smarson@nc.rr.com . Your commentary will be published and unedited.

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The Importance of Social Work Ethics and Values at a Time of Global Change

DOI: 10.55521/10-019-102

Rory Truell, Ph.D.

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Social work ethical principles have taken centre stage reaching multiple organisations that represent 100s of millions of people. The people's global summit that takes place in June / July this year is a ground-up process initiated by social work to develop a new agenda for an eco-social world that leaves no on behind. The many global partners that have committed to this process have embraced the social work values of holistic rights, human dignity, the right to self-determination, recognising/celebrating diversity and building solidarity.

These, now shared values, are inspiring widespread contributions on what direction the world needs to take as we emerge out of the pandemic. People from communities, governments, civil society organisation, professions as well as UN agencies are championing new policy ideas that effect every facet of life. Here is an example of some of some of the headline themes from social work that will be considered in the summit:

- *Economics*: From market driven economies to sustainable wellbeing societies
- *Environment*: From exploitation to recognizing the rights of nature for sustainable co-existence
- *Nationalism*: From national introspection to global citizenship
- *Business*: From independent markets to sustainable cooperation

- *Work*: From being undervalued to recognition and decent working conditions.
- *State responsibility*: From reactive public spending to public investment in wellbeing

The International Federation of Social Workers invites all readers of this journal to become actively involved in the summit discussions. The social work profession's grounded experience and insights into what values and policies enable people to sustainably thrive and what values and policies undermine them is critical information as we work towards co-shaping new agendas. As some of the non-social work partners in the summit have noted, 'social work was key in developing the New Deal following the great depression and social work was a significant force in the development of the International Declaration of Human Rights following the second world war'. At this moment in history with climate change, the failing global economy, increased military actions and a worldwide pandemic, it is again time for the profession to promote change based on our longstanding and tested ethics and values.

Some Notes on the Journal's New Features

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Pascal Rudin, Ph.D., Publisher

With IFSW being the new publisher, the name of the Journal has now been changed to *International Journal of Social Work Values* (i.e., the word "*International*" has been added) to reflect the increasingly global authorship and audience. This is also reflected in the new ISSN number 2790-6345 which has been linked to the former publication titled *Journal of Social Work Values*.

Against this backdrop, a number of new exciting features have been introduced. These include:

New Layout

The Journal comes in a completely new, modern and sleek design. In consultation with an external layout expert a number of optimisations have been introduced. These include:

- the format has been changed from A4 to A5, to optimise it for e-readers, tablets and even smartphones. With mobile devices now being the majority of Internet devices used across the globe, we wanted to optimise the Journal's design accordingly. This trend is further accounted for by HTML text that is fully responsive (i.e. it adapts to the screen size of any device).
- the colour palette has been derived from the well-established logo and website to ensure continuity.

- modern Google fonts have been used to optimise readability: *Oswald* font for titles and descriptions, as well as *Alegreya Sans* font for content.
- the Journal now comes in a one-column design to optimise both readability and accessibility.

DOI Identifiers

IFSW now assigns a digital object identifier (DOI) to all articles and book reviews published by the Journal as soon as the content is made available electronically. This is a unique numeric string to identify content and provide a persistent link to its location on the Internet (i.e. the Journal's website). In order to achieve this, IFSW became a member of CrossRef, where more than 80% of the global citation meta data of DOI indexed content are stored. Through DOIs, articles can more easily be identified both by search engines and databases.

IFSW's membership with Crossref increases the authenticity of this Journal and reflects the growing impetus for an international culture of citation using the DOI system. This approach increases acceptance of research data as legitimate and citable contributions to the scholarly record, which is important for both the Journal and authors publishing with us.

HTML Full Text

One of the requirements of the DOI system is to have a landing page for each content (e.g. article, book review). This page needs to carry the citation meta data of the relevant content item, such as author, date, file location etc. We go one step further and also publish the full HTML text of the relevant content item. This allows users to read articles without even accessing the relevant PDF. For smaller screens, such as smartphones, content will be better accessible due to the responsiveness of the Journal's website (i.e. the text will display differently in response to the screen size to optimise readability).

Automatic Translation

A further advantage of having full HTML content published is the ability to translate text into one's own language. Website visitors may choose the newly installed Google translate functionality to read content in their own language. While the quality of these translations has been improved over the past years and continues to improve, it remains an automatic translation with its specific limitations. Nevertheless, this functionality may help our increasingly global audience to read articles and book reviews in their own language.

Full Citation Meta Data

As mentioned before, each article and book review will come with its own landing page that also carries full citation meta data. Through this, website visitors may now use citation software such as EndNote, Mendeley or Zotero to download not only the full citation of a specific article or book review, but also the PDF *completely automatically* into their library at the ease of a click. No manual writing down of authors, date, Journal name etc. required anymore.

IFSW is delighted to present all these exciting features to our global audience and wishes everyone an interesting read!

Letters to the Editor

DOI: 10.55521/10-019-104

1

I read this post on the BPD listserv in the US. This refreshing post was submitted by my friend and colleague, Professor Bruce Thyer. He gave me permission to reprint it here:

Happy New Year!

Last week, by chance or divine providence, I heard references to several social workers in the national news.

First, the Dean of the College of Social Work at Florida State University, Dr. Jim Clark, was appointed to be the University's new Provost and Vice President for academic affairs. It is always good to see social workers having their competence as administrators recognized. FSU's gain is a loss for our college.

Then on Morning Edition on NPR, over two days, I heard the voice of NYU social work Professor Deborah Padgett on a segment dealing with homelessness, one of her many areas of expertise. And later that week Dean Luis Zayas of the University of Houston, was featured on an NPR segment focused on immigration issues. And two additional hospital social workers (sorry I did not catch their names) were also a part of NPR segments on homelessness. Very nice disciplinary recognition.

Bruce

https://news.fsu.edu/news/2021/12/13/social-work-dean-jim-clark-named-provost-of-florida-state-university/

2

Replies to: Editorial: Should the NASW Code of Ethics require Institutional Review Board (IRB) review of all social work research in the USA?

Dear Steve,

I agree with you on principle, but it is important that we specify "human-subjects research" under a NASW IRB mandate. I do a lot of Census and other existing database research, and do not do IRB for that. Although I am zealously complying with IRB in any other research.

Regards,

Elena Delavega, PhD, MSW
Professor & MSW Program Director
School of Social Work

Changes at IJSWVE and Thank You

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Stephen M. Marson, Editor, and Laura Gibson, Book Review Editor

We have an addition to our Editorial and Policy Boards. We haven't had a student member for about five years. I have been able to recruit an excellent addition. *Rachel (Ray) Mathew-Santhosham* is an BSW/MSW Candidate with The Ohio State University. Her family is from India. *Bettina Leibetseder, Dr. rer. soc. oec.* was recruited to our editorial board because of her background in macro practice, research, and statistics. Currently, she holds a professorship at University of Applied Sciences Landshut in Germany. *Jörgen Lundälv, Ph.D.* also is joining our editorial board. He is an Associate Professor of Social Work from the University of Gothenburg in Sweden. He specializes in disability studies. We are fortunate to successfully recruit three new members of our Policy Board. *Hassan Mousavi Chelak, Ph.D.* is the President of Iran Association of Social Workers. *Jane Shears, ProfDoc* is the Head of Professional Development and Education at British Association of Social Workers. *Céline Lembert, MS* joins our board to represent France. She is employed by the Public Mental Health Facility in Paris and is a member the Ethics and Deontological Commission of the High Labor Council.

A great deal of work goes into each issue of the *International Journal of Social Work Values and Ethics*. All work on our journal is completed by volunteers and *no one* — including our publisher IFSW — makes a financial profit from the publication. In addition, we have unsung heroes on our editorial board

who contribute to the existence of our journal. Because we have a rule that requires our manuscripts to be assessed anonymously, I cannot offer public recognition of their names. I thank them! However, I can publicly announce the names of our hard- working copy editors. Their work is not confidential. For their major contributions to this issue, I must publicly thank:

- Alison MacDonald
- Eric M. Levine
- Amelia Chesley
- Jan Summerson
- Donna DeAngelis
- Kathleen Hoffman

I also thank the book reviewers for the generous gift of their time to read and write thoughtful reviews:

- MaryAnn Thrush, PhD, MSW
- J. Porter Lillis, Ph.D.

Announcement: News for Authors and Researchers

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I want to encourage all past, current, and future authors of our journal to upload their articles on ResearchGate [https://www.researchgate.net]. If you are not connected to ResearchGate, I strongly encourage you to do so. When articles are posted on ResearchGate, more scholars are likely to read your work and our journal gains greater acknowledgement.

In an unrelated event but nevertheless important to researchers and authors, we have reformatted the archives – see https://jswve.org/archives/. The reformatting will also greatly improve searches in library databases and online searches for our publications with such tools as Google. The bottom line is: If you're an author, your article will become more accessible.

Re-stor(y)ing Trauma

DOI: 10.55521/10-019-107

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Abstract

Individualistic and disembodied trauma narratives that emerge effortlessly from dominant discourses like biochemistry and diagnostic nomenclature fail to address the effects of trauma in people's lives. Trauma could also be understood as a challenge to personal narratives of living in the face of exceptional experiences that stand far outside what is known and familiar. This invites personal accounts of values, purposes, skills, and acts of resistance which offer more possibilities for addressing the negative effects of trauma than descriptions from the cultural canon.

Keywords: Diagnoses, narrative, neuroscience, story, trauma

> If you label it this, then it can't be that.
>
> Tom Wolfe (paraphrasing Ken Kesey), *The Electric Kool-Aid Acid Test*

I crashed my car when I moved to the West Coast right after finishing up my MSW. I shouldn't have been focused on getting out to Oregon so urgently because there was a heavy snow and the roads were icing over. I was pulling a trailer behind my little Ford Escort with everything I owned tetrised inside. Just short of my final destination—50 miles to go in a 1,750 mile journey

(only 3% left!)—at the peak of a fold in the freeway along the Columbia River Gorge I looked down the highway and quietly mutter-swore as the clutter of cars all crumpled together in the depression below presented an image to my eyes and my pre-frontal cortex of a pool of metal and plastic settled into a trench. I pressed on the brake pedal with enough force to slow my descent down the frozen slope confident that I wouldn't sustain any major injuries in the imminent crash but fast enough to know with certainty that my car wasn't going to make out as well. At least two additional vehicles joined me in the basin confluence, ensuring I got it from all sides. The U-Haul trailer's feeble walls shredded, and my stuff scattered about the snowy road and blizzard wind like a sculptural Pollock interpretation.

My computer, one of the early internal hard drive consumer models, now had an external hard drive that wasn't supposed to be external. The turntable for my record player laid in the median like one of the assortments of hubcaps also present. My ten-speed street bicycle was now recumbent. I could see the cathode ray tubes from my first small color television, a high school graduation present from my parents. Both my acoustic and my electric guitars looked like Pete Townshend had taken to them. And the bright green pillow that comforted my head through six years of collegiate reading rested near the general location of where road stripes would have been if they were visible through the opacity. My car was wrecked too.

I started my professional social work career as a freshly minted 23-year-old MSW with few intact possessions. My clothes were fine. My books readable, if a bit damp. Despite their shattered cases, my stellar collection of Grateful Dead bootlegs survived. Pretty much all the rest of my things were in pieces. In my journal I wrote,

> A storm raged through Ronnie's life yesterday, leaving his treasured possessions ravaged on the surface of the freeway. This unusual event had far-reaching effects.
>
> The snow has melted away, rain and sun eroding the atmospheric residue. And I have grasped the intrinsic value of life and the impermanence from whence it comes. Not without a price, mind you. There is more to an acoustic guitar than all the screws and transistors and microchips that

> make up a computer, a stereo, or a television. I'll start my work as an MSW knowing I have a clean slate.

Seventeen years later I'm sitting at the dinner table with my nine-year-old daughter and she looks worried. She thinks I'm going to die.

I haven't been well for several weeks now. I've been having a lot of difficulty chewing my food into small enough bits to swallow comfortably; fearing that I am going to choke when I swallow because it's not only my mouth that gets tired but muscles needed to swallow, prevent choking, and make sure food goes into the right part of my body and not somewhere that could lead to pneumonia or other infections.

Exhausted bulbar muscles aren't just affecting my eating. My ability to speak has been compromised. I can't form a bunch of the sounds in the English language that require strong lips: B, F, M, P, V, W. Plus my voice has been going out on me because the larynx, the so-called "voice box," is also weakened by the disorder that recently emerged in my life. When my voice starts to go out I begin sounding nasally and constricted. If I don't stop talking very soon and rest those muscles, I won't be able to speak coherently at all. My family has come to call the nasally cadence "The Nutty Professor Voice" because I sound like Jerry Lewis as Professor Julius Kelp (and clearly not Buddy Love). I now carry around a card in my wallet in case I get pulled over to let law enforcement officers know that "sometimes these symptoms are mistaken for intoxication."

So we're at the dinner table together and my daughter has buried her gaze in her food and she looks worried. I had asked a question that pushed and strained and tore through stitches in our individual and collective narratives. I knew I wasn't going to die. I read all the peer-reviewed journal articles and book chapters written about this muscle disorder (which happens to be one of the 91 muscle disorders included in the research portfolio of the Muscular Dystrophy Association, whose Labor Day telethon host for 45 years was, of course, Jerry Lewis). Yes, some people do die from this, but most don't. Probabilities that have been calculated with strong statistical significance were in my favor. *Myasthenia gravis* wasn't going to kill me.

There had been moments when I imagined this, particularly when things first started to go downhill, but I didn't think much of it when the question catapulted from my mouth. Ignited by the lightning fast internal probe of *I know I'm not going to die from this, but I wonder if she does?* and without critical reflection, pause, or insight surged the query, "Honey, are you afraid that I'm going to die?" She looked down at her food. She looked worried. And she said "Yes."

This was my first time having a death-related conversation with my kid that was clearly more immediate and experience-near than the generic discussion about organisms, entropy, death and cycles of life. This was about me. Her father. This was a chasm between the world of the everyday and the numinous or perhaps spiritual; a crevasse in the seamless story I had generated about my very self, the world in which I go on, and the relationship betwixt and between. This was a trauma to the narratives of my life, my daughter's life, my partner's life, and our collective lives together.

Trauma discourse does not have to be based on a medical, biological, pathology-oriented way of thinking about illness, disease, and disorder. It can emerge from an understanding that problems like trauma effectively operate by limiting people's authority in their own lives; that is, being the primary source for narrative authorship in one's life. People's capacities, their intentions, their hopes and dreams, how they express what they give value to, and their ability for significant achievements given difficult circumstances are occluded by dominant trauma discourse.

These days trauma is frequently conceptualized materialistically and deterministically (Supin, 2016, Nov.). I understand that trauma can be described in relation to neurological effects. This perspective can be of tremendous help in liberating people, particularly young people and parents, from the sort of blame, shame, and guilt that comes along with failed attempts at navigating life's difficulties. Defining trauma in the context of neuropathways may provide helpful interventions for people who have directly experienced trauma as well as those that care for and support them professionally and personally. Yet there is risk in totalizing trauma as electrochemical. When trauma is localized in people's brains, real social and

cultural contexts related to trauma are rendered invisible, such as patriarchy, racism, homophobia, cisgender privilege, colonialism, ableism, and classism, to name a few. These are contributing elements of power structures that lead to disproportionate incidences of trauma that involve women, people of color, people who identify as gay, lesbian, bisexual, trans, and other gender identities, Indigenous Peoples, people living with disabilities, and people without enough money to get by (e.g., Harrell, 2017; Mani, Mullainathan, Shafir, & Zhao, 2013; McIntyre, Harris, Baxter, Leske, Diminic, Gone, Hunter, & Whiteford, 2017; Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010; Sacco, 2018; Williams, Metzger, Leins, & DeLapp, 2018). Trauma can certainly be understood in terms of the formation, deterioration, and reinforcement of neuropathways and the ways in which different sets of neurons fire simultaneously. But there are other options.

How do we make sense of events, whether intense and brief, or insidious and lengthy, that are located far from the everyday? The late Australian social worker Michael White (2004) described trauma as an experience or set of experiences that disconnects a person from what is known and familiar. Trauma is a subjective experience where the severity of a single event or the duration of multiple events has an individual effect. Though there are common, shared effects of trauma, the totality of effects are specific to a person. Trauma is an *exceptional* event or series of events that stand(s) outside our dominant narratives of the world, our selves, and our relationships with the world.

As language-using social beings we are constantly making meaning of the information, communication, and exchanges within which we swim. In general, it's fairly easy to make sense of so-called "everyday" events because their stories are everywhere to be found. They are embedded in historical, social, and cultural discourses (Foucault, 1982). (From a biology-based perspective, I'd say that the neuropathways for everyday experiences are well formed and firing quite regularly.) Descriptions, understandings, explanations, and sense effortlessly emerge from dominant discourse to render these experiences meaningful.

However, *everything* we experience has to be storied, including exceptional events such as trauma. Storying trauma events in ways that are consistent with existing personal narratives is extremely difficult because they are, well, *exceptional*. Jerome Bruner (1990) explained that we pull from the canonical stories of culture to make meaning when it's hard to story an experience or set of experiences. This approach to meaning-making limits other possible stories for living through trauma. People may make sense of trauma through easily accessible and readily available explanations such as, "I am not worthy," "I brought this on," "I deserve this," "I am crazy," and/or "I have PTSD."

These thin conclusions are obvious when we appreciate that the dominant, Western-European culture is filled with canons of individualism; personal responsibility; measurement, diagnosis, and scaling of normality; insurance codes; and institutional concerns of productivity, perfection, pulling yourself up, and just moving on. These narratives may offer help with making sense of traumatic experience but they overwrite stories that strengthen and protect us. People's preferences, their achievements, their values, what they stand for, and their demonstrations of resistance and resilience are subjugated despite often existing before the experience of trauma and exceptional distress. Canonical tenders of meaning for troubling events are generalized and universalized, rarely speaking to a person's particular trajectory of life and their unique experiences (Gergen, 2000). They promise to explain what's going on, sure, but not grounded in locally relevant, personal narratives (Geertz, 1973).

This understanding of trauma as a rift in the storyline of one's life and our discursive attempts to make sense of experience can explain why, though I was certainly shaken, I was not oppressed by the chattel-destroying car accident when I moved out West. I was able to story it with resilience (along with youthful pretentiousness): *I have grasped the intrinsic value of life and the impermanence from whence it comes*. The benefits I am granted via intersectional privileges helped as well (e.g., white privilege, cisgender privilege, male privilege). But when my daughter's potent and entirely reasonable fear that I would die landed on me while I was still reckoning with the

narrative turn myself, I struggled to story this exceptional set of events free from the canon of options for making sense of medical crises.

Nine years later now, when I lie down on the tray that inserts me into the CT machine to make sure the tumor that likely instigated the whole thing hasn't started to grow back, I can be flooded with intense thoughts, feelings, and memories. The canon might call this an "intrusion." I know I couldn't have prevented the muscle disorder's development…but maybe if I had only done *this*? (Eaten more kale?) Or not done *that*? (Tried pot in college?) These could be considered "distorted cognitions about the cause" of the disorder. I had problems with my concentration when there was a norovirus outbreak in local schools a few years ago and I didn't want to stay in crowds for very long because I don't want to get sick and have my immune system kick into high gear and target my neuromuscular junction while it neutralizes antigens. I am willing to go to great lengths to avoid getting sick because the last time I had a bad virus I couldn't swallow liquid without a good bit of it streaming out my nose and I sounded like Professor Julius Kelp much of the time. COVID? Oy vey. This could be understood as "avoidance." Intrusion symptoms, avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity are important criteria for a PTSD diagnosis (American Psychiatric Association, 2013). However, I don't want to make sense of my experiences using clinical criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, even if it is the newest, most accurate, most evidence-based fifth edition. This canonical narrative doesn't seem to yield opportunities for me to persist in the face of adversity that are consistent with what I hold precious and my personal commitments.

Contesting essentialist understandings of trauma is in no way dismissing or minimizing the very real effects of trauma. People diagnosed with PTSD frequently experience significant distress, which can be understood in physical, emotional, psychiatric, and spiritual contexts. Many people who meet the diagnostic criteria for PTSD deal with legal and economic challenges as well (Substance Abuse and Mental Health Services

Administration, 2014). Interrogating dominant ideas about trauma is not the same as doubting people's suffering.

What I am suggesting here is that there are narratives of people's lives—ways to make meaning—that emerge from people's lived experience before, during, and after trauma. Canonical narratives can help people make meaning but usually, maybe not always, these meanings render other powerful narratives invisible. Narratives that could be helpful in overcoming the troubling effects of trauma are pushed to the margins. Simply put, the diagnosis of 309.81 does not tell me very much about a person's lived experience, their personal commitments, what is dear to them, what they stand for, and what they have achieved. I don't think it does very much to assist people in addressing the difficulties they face either.

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Spirituality, Diversity, and Ethical Decision-making: The Inclusive Wesleyan Quadrilateral Discernment Model

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Abstract

Social workers and other helping professionals act as moral agents within society when faced with ethical dilemmas. Over the last three decades, there has been a proliferation of ethical decision-making models available to practitioners that range from the rational, centered on objective step-by-step actions, to the reflective, focused on the character and outlook of the practitioner. Responding to calls for a more integrative approach to ethical decision-making grounded in the virtue of moral courage, this article introduces the Inclusive Wesleyan Quadrilateral Discernment Model (WQ

Model). Drawing from a range of interprofessional literature, this model combines attributes of both rational and reflective models, with an emphasis on cultural humility and spiritual discernment. Unlike other integrative methods, the WQ Model applies a holistic bio-psycho-social-spiritual approach to understanding the practitioner as moral agent. Engaging the religious and spiritual dimensions of practitioners, this model centralizes each practitioner's unique sources of moral knowledge and contextual diversity experiences through application of the Wesleyan Quadrilateral. With an emphasis on spiritual discernment, the WQ Model places the Wesleyan Quadrilateral in dialogue with the moral principles of bioethics for resolving ethical dilemmas and reducing moral distress.

Keywords: spirituality, diversity, ethical decision-making, interprofessional, moral agency

Introduction

The Inclusive Wesleyan Quadrilateral Discernment Model (WQ Model) is an evolving bio-psycho-social-spiritual holistic and comprehensive ethical decision-making model for practice professionals that integrates diversity awareness and spiritual discernment into the process of resolving complex ethical dilemmas within helping professions. Although this model emanates from the field of social work, it is intentionally interprofessional, grounded in literature from several professions and disciplines. As McAuliffe (2019) has reminded us, the World Health Organization in 2008 strongly urged a shift from teaching within traditional academic silos towards more collaborative engagement across disciplines in the best interests of patient care for individuals, families, and communities. McAuliffe (2019) specifically advocated for teaching interprofessional courses for practice professional students, stating that "Where IPE (Interprofessional Education) comes into its own is in those courses that set up simulated situations in which students from different disciplines work together in a deliberative and collaborative way to problem-solve a clinical case involving a patient" (p. 391). The classroom is exactly the context in which this model was developed, over a fifteen-year period of team teaching a course in which

interdisciplinary groups apply the WQ Model to complex, practice-based cases involving culturally diverse and religious or spirituality oriented ethical dilemmas. This paper merely presents the model and does not focus on teaching; however, based on this teaching experience, we strongly support McAuliffe's (2019) premise and suggest that increased interdisciplinary scholarship can only strengthen such a shift.

The discipline of professional ethics, as Reamer (2019) has summarized, emerged in the 1970s from roots in moral philosophy, eventually developing its own ethical theories and practice models applicable to a range of ethical dilemmas. Reamer (2019) also clearly identified one of the central ongoing struggles within the profession as the effort to balance concerns regarding the inclusion of marginalized populations' unique experiences and perspectives with the need to uphold core values and best practice standards. The WQ Model addresses this question by providing a new process through which practice professionals decide who upholds what in which scenario, particularly when more and more diverse voices are included in the process of resolution.

Within the debate about process, identity, and standards, an aspect of the decision-making process that is gaining attention is the role of self-awareness of the decision-maker, the practitioner. In addition to seemingly more objective external sources of decision-making guidance from rationally focused theories and codes of ethics, the WQ Model emphasizes consideration of internal sources of influence through a process of self-reflection focused on spirituality and cultural humility. Building upon the bioethical foundations of applied ethics laid by Beauchamp and Childress (2013), the WQ Model is predicated upon the conviction that social workers, and most helping professionals, act as moral agents committed to engaging their whole bio-psycho-social-spiritual selves in the process of resolving ethical dilemmas.

For practitioners engaging their whole selves when examining ethical dilemmas, there is a need for timely self-awareness to help in comprehending the many internal as well as external factors at play. Increasingly recognized within most practice professions, cultural competence and cultural

humility are essential aspects of engaging one's whole self. Within both diversity discourse and contemporary dialogues about practitioners as moral agents, paying increased attention specifically to the roles of spirituality, religion, and spiritual discernment can be revealing and beneficial.

The WQ Model relies on Canda and Furman's (2010) original holistic definitions of spirituality and religion as foundational, providing a comprehensive and inclusive conceptualization for the model's emphasis on spiritual discernment. Canda and Furman (2010) have stated;

> I conceptualize spirituality as the gestalt of the total process of human life and development, encompassing biological, mental, social, and spiritual aspects…. The spiritual relates to the person's search for a sense of meaning and morally fulfilling relationship between oneself, other people, the encompassing universe, and the ontological ground of existence. (p. 66)

Canda and Furman (2010) have differentiated this primarily internal human experience from the more external manifestations of religion in the following way: "religion involves the patterns of spiritual beliefs and practices formed in social institutions and traditions that are maintained in a community over time" (p. 66). Spiritual discernment in the context of the WQ Model does not reference or favor any particular religious practice. Spiritual discernment refers to the more general act of reaching a decision only after reflecting, meditating, or praying upon the unique intersections of diversity characteristics and sources of moral knowledge that together inform how practitioners, as moral agents, understand and resolve ethical dilemmas.

Regarding diversity and inclusiveness, there is general acknowledgement that the U.S. is projected to become a majority-minority nation for the first time over the next few decades. Relevant to that shift, in 2015, the National Association of Social Workers (NASW) updated their *Standards and Indicators for Cultural Competence in Social Work Practice* document, which states:

> Standard 1. Ethics and Values
> Social workers shall function in accordance with the values, ethics, and standards of the NASW (2008) Code of Ethics. Cultural competence requires self-awareness, cultural humility, and the commitment to understanding and embracing culture as central to effective practice. (p. 4)

In addition to race, the NASW *Standards and Indicators for Cultural Competence in Social Work Practice* (2015) further identified the following categories of social identity and diversity characteristics:

> Diversity, more than race and ethnicity, includes the sociocultural experiences of people inclusive of, but not limited to, national origin, color, social class, religious and spiritual beliefs, immigration status, sexual orientation, gender identity or expression, age, marital status, and physical or mental disabilities. (p. 9)

Newer ethical decision-making models will need to be explicitly grounded in cultural humility and responsive to the changing demographics of the populations served without sinking into relativism. Already complicated ethical dilemmas become even more so when considering the multiple worldviews of all parties involved, including those of practitioners. Several steps of the WQ Model include clearly identifying social identity variables and their influences.

The WQ Model builds upon the Transcultural Integrative Model of ethical decision-making from the field of counseling. Garcia et al. (2008) have emphasized that "The need to be inclusive of cultural variables extends to the development of ethical decision-making models, which, to date, have not incorporated such factors systematically" (p. 21). Due to the WQ Model's emphasis on diversity and spiritual discernment, applying the Comparison Chart of Selected Ethical Decision-Making Models from Garcia et al. (2003) helps identify where the WQ Model fits into an increasing array of approaches to ethical decision-making in practice. Along with the Transcultural Integrative Model, the WQ Model is situated in the Integrative category of blending a rational approach with virtue ethics. Referring to their

own Transcultural Model, Garcia et al. (2003) have stated, "Because it combines rational and virtue ethics, users of this model focus on both the dilemma and the character of the counselor while considering contextual factors" (p. 271).

The most unique aspect of this new integrative model, however, involves using the Wesleyan Quadrilateral (an 18th-century decision-making framework in which scripture, tradition, reason, and experience intersect) to apply an emphasis on spiritual discernment to ethical decision-making. Informed by virtue ethics, the WQ Model presumes that the moral character and moral courage of the reflective decision-maker sheds light upon the pursuit of rational, right (correct) action by the practitioner. Towards these ends, this model places a significant emphasis upon self-reflection throughout the process of ethical decision-making, incorporating the concept and language of moral agency as described by Strom-Gottfried (2019) in the field of social work. Referring to practice as moral agency, Strom-Gottfried (2019) has provided a detailed description of moral distress and moral courage as aspects of self-awareness that help a professional identify additional components of ethical dilemmas as well as find the fortitude to choose and then act upon their resolutions. This review of the development and key components of the WQ Model requires considerable background information. It begins with literature regarding ethical dilemma decision-making models in interprofessional practice. This is followed by an explanation of moral courage terminology, the Wesleyan Quadrilateral sources of moral knowledge, the role of rational moral principles, and finally presenting the WQ Model.

Literature Review

In existing literature, the role of practitioner self-awareness in ethical decision-making has been often debated by ethicists from various practice fields. As Reamer (2019) pointed out, "Like philosophers, social workers disagree about the objectivity of ethical principles" (p. 15). In placing the emphasis on the process rather than the practitioner, currently dominant

ethical decision-making models in social work barely reference self-awareness or reflection.

In social work, two models have dominated the field: those of and Dolgoff et al. (2012) and Reamer (2013). While the two have significant differences, both are grounded in a scientific/rational approach to decision-making that assumes a good process in itself will lead to the best outcome. Such an approach dismisses virtue ethics as lacking in objectivity and favors a more mechanistic approach grounded in deontology, consequentialism, or both. In fact, Dolgoff et al. (2012) have stated that;

> Traditional models of ethical decision making offer some guidance as to what to do by providing principles and tools by which professional social workers may make ethical choices. In this book we place emphasis on rational, scientific, systematic, and less ambiguous decision-making processes instead of on the personal characteristics of the decision maker. (p. 64)

Both Reamer's (2013) and Dolgoff et al.'s (2012) models fit in the rational category of Garcia et al.'s (2003) ethical decision-making models comparison chart.

While not ignoring the importance of process and scientific rationalism, the WQ Model is grounded in a central tenet of virtue ethics: the practitioner matters as much as the process. Each actor in an ethical dilemma, whether client or practitioner, is contextually bound, with unique experiences, both individually and communally, as part of diverse communities with intersecting social identities and worldviews. As such, a bio-psycho-social-spiritual awareness of who the practitioner is becomes as important as the process they use to resolve an ethical dilemma. The WQ Model calls for both spiritual and cultural self-awareness by including multiple opportunities for objective factor identification as well as subjective reflection. Since the character of the actor becomes as important as the goodness of the action, applying the WQ Model relies on the incorporation of virtue ethics into decision-making, in alignment with ethics scholarship from multiple disciplines.

From psychology, Kitchener (1984) has addressed the lack of integrating self-awareness into ethical decision-making models. In the counseling literature, Stadler (1986) put forth a justified reasoning process in which practitioners are described as moral agents in comparison to ordinary citizens due to the roles they play in their clients' lives. Stadler (1986) stated:

> As moral agents with special responsibilities, we recognize the fallacy of thinking ourselves to be neutral, unbiased observers of the lives that pass before us…. We conscientiously endeavor to reduce the impact of our values on our clients by clarifying our own value expectations and by allowing clients to consider their own values and freely chosen goals. (p. 4)

In the social work literature, Mattison (2000) noted that ethical decision-making should rely on the profession's code of ethics, but also emphasized the importance of self-awareness. She stated:

> Yet the code does not specify which values or principles the social worker should consider primary in cases of competing interests…. Although systematic guides for resolving ethical dilemmas offer social workers a logical approach to the decision-making process, to some extent, the use of discretionary judgments is inevitable. (p. 203)

Nodding towards the influence of diversity issues, Mattison (2000) also noted that the value system and preferences of the decision maker affect every step of assessment as well as final outcomes.

Integrating Mattison's (2000) reflective approach and Garcia et al.'s (2008) transcultural one with the dominant rational process models of Reamer (2013) and Dolgoff et al. (2012), McAuliffe and Chenoweth (2008) introduced an Inclusive Model of Ethical Decision-Making. This model is one of the earliest efforts within the field of social work towards such integration. McAuliffe and Chenoweth (2008) have observed:

> From our work with practitioners and students, we identified a need for a model that was inclusive of both important concepts on which practice is based, and systematic steps to create a more comprehensive and robust model suited to many practice situations. The model also needed

> to be inclusive of the most important values that form the foundation of social work and human services. (p. 41)

More recently in social work, Barsky (2019a) has likewise challenged the strict rationalism of the dominant models through his "Framework for Managing Ethical Dilemmas," a step-by-step method that includes both a rational process for decision-making and a complementary emphasis on the practitioner as decision-maker, including a call to "reflect on one's own values, virtues, attitudes, beliefs, motivations, emotions, capacities, challenges, and social contexts" (p. 272). Elsewhere, Barsky (2019b) has proposed integrating Narrative Ethics more fully into social work, emphasizing cultural humility and starting where the client is through active listening. Barsky advocates that there may be more than a single story of what is right in any given dilemma.

Speaking from an Islamic perspective, Eltaiba (2019) further integrated these cultural and reflective elements, with a reminder that;

> Social workers bring to their practice their family structure, gender, experience, values, and cultural and religious affiliation—all of which would invite a range of interpretations of ethics for ethical decision making… the emphasis on critical thinking and reflection, when dealing with ethical dilemmas and making ethical decisions, is congruent with social work ethicality. (p. 290)

Eltaiba's (2019) work supports the bio-psycho-social-spiritual inclusive approach of McAuliffe and Chenoweth (2008), providing an Islamic case study to specifically illustrate how religious cultural sensitivity and reflection can be included in ethical decision making.

Synthesizing the themes from this interdisciplinary literature review, we argue for effectively reintroducing virtue ethics into ethical decision-making for practice professionals. By combining a concern for practitioner self-awareness with a rational process for resolving dilemmas, these theorists lay the foundation for the emergence of new integrative models, including this WQ Model.

In broadening the discussion beyond rational scientific analysis to include self-awareness and reflection regarding diversity and moral agency, the WQ Model proposes that a methodical approach to spiritual discernment can be of value. Few models specifically incorporating spiritual discernment to assist in ethical decision-making exist. Most of the models in this interdisciplinary review do not specifically emphasize spirituality when they advocate incorporating self-awareness. In contrast, the WQ Model intentionally introduces methodical spiritual discernment as a central aspect of self-awareness and moral agency. Like Beauchamp and Childress (2013) in bioethics as well as Stadler (1986) in counseling, Strom-Gottfried (2019) in social work has referred to helping professional practitioners as moral agents. Along with Kitchener (1984) from psychology, Stadler (1986) explained that "any time we think or act on what we believe to be right or wrong, good or bad, we are concerned with the moral dimension of life" (p. 2). Strom-Gottfried (2019) put forward moral courage as the virtue that moves individuals to act ethically even when their principles or values are short circuited by various barriers and they risk disapproval, isolation, or termination. She has pointed out that such barriers can be external and/or internal and that moral courage "is built and sustained through self-awareness about the personal barriers to action" (p. 68).

"Moral residue" as explained by Strom-Gottfried (2019) refers to the cumulative effects of moral distress, a concept first identified in the nursing field of the practice literature by ethicist Andrew Jameton in the 1980s. Wilkinson later expanded upon the concept in the nursing literature (Burkhardt & Nathaniel, 2014). In defining moral distress, Wilkinson (1987) described "the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision" (p. 16).

While Strom-Gottfried (2019) has focused more heavily on external constraints to a determined course of action, such as agency policy, she also refers to the possibility of psychological trauma experienced by the thwarted practitioner struggling with internal conflict when faced with an ethical dilemma. In describing moral distress as manifesting itself in both

physical and emotional symptoms, Strom-Gottfried has provided helpful terminology. The virtue of moral resilience can overcome moral distress and bolster moral courage: "While moral distress arises from and evokes feelings of powerlessness, moral resilience suggests flipping the narrative to focus on solutions and possibilities" (Strom-Gottfried, 2019, p. 69). Because practitioners act as moral agents in society, moral cowardice and disengagement need to be minimized in every helping profession by maximizing moral courage and resilience through increased recognition of moral distress internally and externally.

Strom-Gottfried (2019) proposed that a "fresh discourse" about moral distress factors and how to address them can contribute to the moral courage of practitioners. Eltaiba (2019) likewise suggested the need for "future dialogue" surrounding the role of spiritual reflection and cultural sensitivity in shaping moral agents' responses, noting "there is no training in how to link these thoughts and this spirituality to ethical issues and ethical decision-making" (p. 296).

The WQ Model begins to meet both of these author's concerns through an emphasis on practitioners' bio-psycho-social-spiritual self-awareness of themselves as moral agents who are equipped to manage increasingly complex ethical dilemmas. More specifically, the WQ Model pursues increased practitioner self-awareness through spiritual discernment which requires attunement to the spiritual dimensions of self. These efforts are undertaken only after the practitioner has entered a space of reflection, meditation, or prayer.

Wesleyan Quadrilateral

The Wesleyan Quadrilateral was identified in the twentieth century by Albert Outler, an academic and ordained Methodist Elder. When reviewing the writings of John Wesley, the English founder of the Methodist denomination in the 1700's, Outler (1985) noted Wesley's use of four sources of moral knowledge throughout his sermons:

- scripture

- tradition (beliefs and practices passed from generation to generation)
- reason (science)
- experience (both individual and communal)

Christian scholars continue to use this method of organizing information and evaluating the factors involved in any dilemma to develop contemporary theology and ethics (Thorsen, 2005; Salzman and Lawler, 2018).

The WQ Model opens up the Wesleyan Quadrilateral to use by practitioners, regardless of religious status or faith-based background, by encouraging them to interpret the four sources of moral knowledge broadly, as described in the sections below. The model encourages practitioners to engage in methodical spiritual discernment, reflecting upon their own unique sources of moral knowledge from their social identity characteristics as well as their religious or spiritual foundations. By making this examination explicit, the WQ Model encourages practitioners to ask themselves:

- What sources of moral knowledge do I bring to this dilemma?
- How does each act as resource for resolution, broadening my understanding of the dilemma?
- How do these sources act as barriers to resolution, creating biases within my worldview that need to be objectively negotiated?

Scripture

Scripture can be understood as those authoritative textual sources, often believed to have come from divine origins or to have been divinely inspired, that have shaped and may continue to serve as a resource for a particular practitioner. These include the Christian Bible, the Jewish Torah, the Muslim Qur'an, the Buddhist Tripitaka, The Vedas from Hinduism, and many other texts from any number of spiritual traditions. While the sacred passages a practitioner selects may not deal immediately with a specific issue, such as genetic testing or in vitro fertilization, they may still illuminate the

dilemma by highlighting particular values or themes. In exploring scripture, a practitioner might begin by asking:

- What light does scripture shed on the ethical dilemma, and how does that content inform my understanding of it?
- Are the passages I have selected consistent with the major themes of the sacred text or are the passages being proof-texted, cherry-picked, or used out of context?
- What were the cultural perspectives and intended messages of the writers of the passages being examined?
- What additional messages am I hearing today from my own vantage point?

In some cases, the scriptural prescriptions might be quite clear as in the Christian Ten Commandments or Jewish Kosher rules. In others, general narrative themes such as "love your neighbor" or "provide aid to orphans, widows, and strangers" may be more relevant to a particular case. And some religious prescriptions, such as stoning adulterers, are rarely implemented in contemporary societies.

Tradition

Religious tradition can be understood as an evolving set of shared beliefs and spiritual practices that have been transmitted by a community over time. Tradition is often formed from an array of diverse, even competing, foundations, including the examples of historical figures such as theologians or Christian saints, religious teachings such as in the Muslim Hadith or Jewish Midrash, or practices of particular religious communities such as the Jesuits or the Amish. Like scripture, traditions may have shaped and may continue to inform how a particular practitioner acts as a moral agent when faced with an ethical dilemma. In exploring tradition, a practitioner might ask:

- What light does this tradition have to shed upon the ethical dilemma and how does it inform my understanding of it?

- Can one say that a certain view has had significant support in the tradition over time, or are there alternative, countervailing traditions, such as in the cases of polygamy/plural marriage, child brides, or wearing a burkha?
- Is the tradition internally diverse (such as Reform vs. Orthodox Jew or traditional vs. progressive Catholics), with a variety of resources to draw upon?
- How much value is being placed on doing things a certain way because it has always been done that way and by whom is it valued?
- Are there other voices within the tradition that have not frequently been heard, such as those of women, people of color, or LGBTQ+ individuals?

Answering such questions can help practitioners understand some of the cultural factors at play within their traditions, opening space to consider potential discrepancies or tensions within the tradition - such as Christian support for slavery in the U.S. South or determining whether or not women should be allowed to drive in Saudi Arabia.

Reason

Reason can be understood broadly as the sciences, from the physical sciences to the social sciences, which play a major role in shaping how contemporary practitioners understand and resolve ethical dilemmas. In exploring reason, a practitioner might ask the following:

- What light does reason have to shed upon the ethical dilemma and my understanding of it?
- Is the issue being thought through in ways that are coherent and credible?
- Is there scientific inquiry or research that provides important information from the fields of social work, psychology, sociology, and medicine?

- How can questioning, probing, and attempting to use the best insights of contemporary science deepen spiritual beliefs and make them more meaningful today?
- In what ways is science playing a role in the dilemma that conflicts with spiritual or religious beliefs?

Exploring reason can help the practitioner to identify both best practices supported by empirical data—such as vaccination to prevent diseases like COVID-19—and practices that are not evidence-based, such as conversion therapy for persons who identify as LGBTQ+.

Experience

Experience can be understood as the broad constellation of individual and communal realities not captured in the previous three sources of moral knowledge. Experience centrally includes diversity concerns that may have been marginalized or erased from mainstream historical accounts, such as in cases of intimate partner violence, workplace harassment, police brutality against people of color, or the violence of the Holocaust. Practitioners, like all human beings, have been shaped by their experiences and worldviews, relying upon them consciously or unconsciously as they resolve ethical dilemmas. In exploring experience as a source of moral knowledge, a practitioner might ask the following:

- What light does my personal or collective experience shed upon the ethical dilemma and my understanding of it?
- What have been my personal experiences tied to this dilemma, and how might that both support and bias or limit my understanding of the issues at hand?
- What is the collective historical experience of this issue?
- Is the historical religious view consistent with contemporary experience regarding issues and events?
- Whose contemporary experience(s) have been centralized? Whose have been marginalized?

Considering these questions encourages cultural humility and helps a practitioner contextualize both themselves and the dilemma, understanding it historically from multiple perspectives and diverse worldviews.

According to Thorsen (2005), the Wesleyan Quadrilateral has been traditionally employed by Christians for religious purposes to explain how God is active in reality, calling forth right action. From Thorsen's perspective, Wesley intended for scripture to exert the strongest influence among the four sources. While he encouraged interplay with the other three sources, scripture would ultimately outweigh them (sola scriptura) if there was a conflict during ethical decision-making. Theologians Salzman and Lawler (2018) provide a solid theological grounding for de-prioritizing scripture, placing each of these sources upon equal grounding, through what they call perspectivism. This refers to examining how moral agents engage in the "Selection, Interpretation, Prioritization, and Integration (or SIPI) of these sources from a virtuous perspective" (p. 93). Salzman and Lawler contend that different SIPI configurations are required for different ethical dilemmas and that there is no one size fits all configuration. This flexibility provides a way to see how different practitioners may arrive at different yet equally valid conclusions, based on their unique SIPI configurations of the four sources in a justified reasoning process, as illustrated in Figure 1.

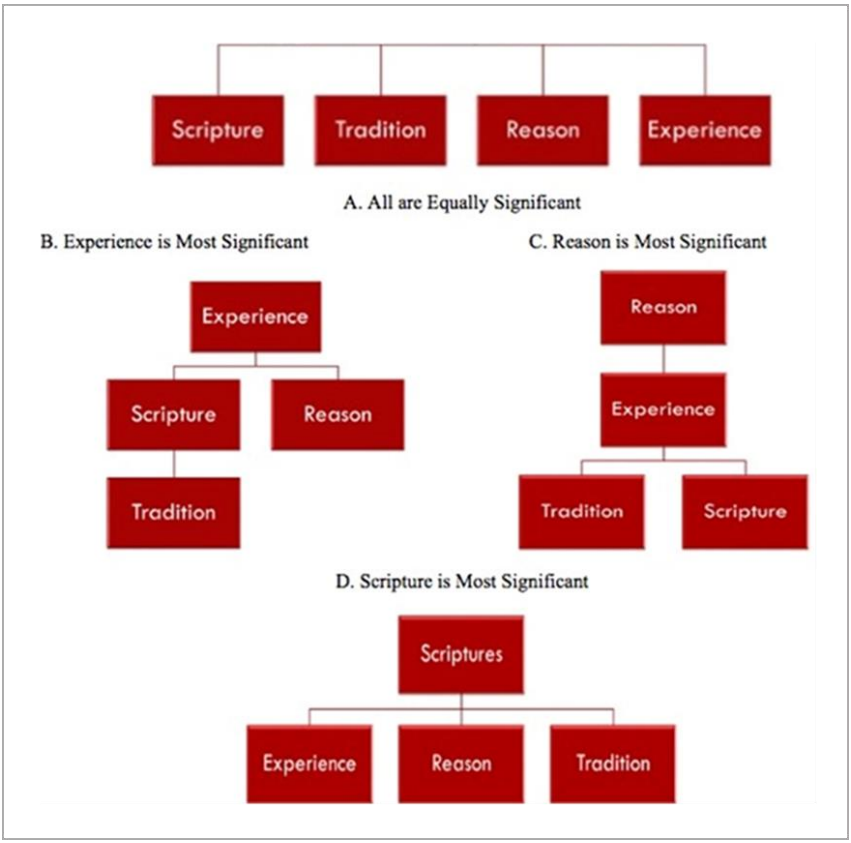

Figure 1: Possible SIPI Configurations for Diverse Practitioners and Ethical Dilemmas

Analyzing ethical dilemmas by considering one's SIPI constellation of these four sources of moral knowledge—scripture, tradition, reason, and experience—grounds the practitioner as moral agent in a methodology of spiritual discernment, helping one better understand the foundations of one's own ethical perspective, its strengths and limitations, and the critiques it faces. But recourse to the four sources is not a panacea. A Christian fundamentalist may only superficially consider tradition, reason and experience, evaluating them as inferior to the word of God in the Bible (See Figure 1, Model D). An agnostic or atheist may disregard scripture and tradition

entirely, deciding these do not influence their decision-making, despite the penetration of many religious beliefs and customs into the culture at large, such as the dollar bill stating "In God We Trust" (See Figure 1, Model B and Model C). Still, applying the Wesleyan Quadrilateral can help practitioners weigh the roles of these four sources in their analysis of a dilemma, each applying their own unique configurations, unique to the dilemma and unique to the practitioner solving it.

Engaging the WQ Model encourages practitioners in their roles as moral agents in society by helping them understand the spiritual contexts from which they are acting and making decisions. While the WQ Model asks for more conscious deliberation of factors contributing to a complete and justified reasoning process, it also has the potential to sort which of these factors contribute most to moral courage and resilience as a moral agent. Since these four sources collectively inform each practitioner's context and character, shaping the virtues that they bring to the dilemma, all four necessarily shape practitioner responses and eventual outcomes. The WQ Model brings to the forefront a more complete examination of conscious and unconscious competing values, virtues, and ethical claims.

Moral Principles

Considering the self as a moral agent within the context of an ethical dilemma, Beauchamp and Childress (2013), have contended that there is "a rough, although imperfect, correspondence between some virtues and moral principles" (p. 381). Rational moral principles can be explored concretely through specification, weighing, and balancing just like the four sources of moral knowledge of the Wesleyan Quadrilateral through Salzman and Lawler's (2018) SIPI approach (Beauchamp & Childress, 2013). As originally introduced by contemporary philosopher Rawls (1971), lexical ordering of one moral principle over another in practice would depend on the case, the client, and the practitioner. When an ethical dilemma arises involving competing moral principles and/or sources of moral knowledge, spiritual discernment can facilitate rank ordering.

Beauchamp and Childress (2013) proposed four core moral principles:

- nonmaleficence (derived from the virtue of nonmalevolence)
- beneficence (derived from the virtue of benevolence)
- autonomy (derived from the virtue of respectfulness for autonomy)
- justice (derived from the virtue of justice)

For helping profession practitioners, the WQ Model adds a fifth to the standard list of four moral principles:

- veracity (derived from the virtue of honesty)

Before further explanation of the WQ Model, each of the moral principles is briefly reviewed below, as understanding them plays an important role in the model's application.

Nonmaleficence: do no harm

Primarily a passive principle or negative injunction, nonmaleficence requires refraining from harmful acts, whether intentional or as a consequence of doing good, for example, such as refraining from engaging in dual relationships with clients or from practicing while impaired.

Beneficence: do good and prevent harm

As an active principle or positive injunction, beneficence requires actions that do good and intercede when harm can be prevented, such as preventing impaired colleagues from practicing or reporting suspected child maltreatment.

Autonomy: self-determination

This principle promotes self-governance, wherein a person is accorded the right to determine their own destiny even if these actions might bring them harm, such as in cases of assisted suicide or clients' refusing medical

treatment. Culturally, this principle is weighed considerably differently in Western vs. Eastern oriented societies.

Justice: be fair

This principle requires fair, equitable, and appropriate treatment with equals treated equally and unequal treated unequally, as illustrated in Figure 2. For instance, consider the Special Olympics or how students with Down's syndrome receive specialized education for math and science but are mainstreamed for physical education or music in schools.

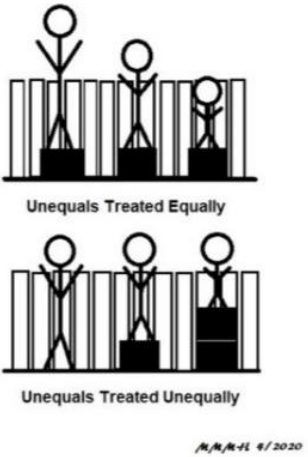

Figure 2: Justice as a Moral Principle

Veracity: be honest

In helping professions, in which communication and developing relationships are essential, truthfulness would seem to be foundational. And yet, that is not and has not always been the case. Conventions of practice have certainly changed over time regarding who gets to know what and when about an adoption. Or consider when a family is in a serious car crash; to promote the health of a survivor, when should the patient be told that the rest of the family perished?

In dialogue with the Wesleyan Quadrilateral, these moral principles provide a way to integrate virtue ethics with rational analysis. By providing moral agents with concrete concepts that can be weighed and ranked through spiritual discernment, practitioners are better equipped to evaluate ethical dilemmas and arrive at directional decisions that both reduce moral distress and determine right action.

Section I: Facts of the Case

Step A. Dilemma - Name the dilemma, introduce competing ethical issues
Step B. Facts - Clarify - Who? When? Where? What? Why? How? Whose worldview? Who is being marginalized?
Step C. Motives - Explain probable pertinent motives and intentions, clearly identifying which motives belong to whom
Step D. Person-in-Environment - Explain contextual and diversity factors (social, cultural, economic, legal and administrative context) and any quality of life issues - include relevant special circumstances (questions of competence, ethnic basis to conflict, minors involved, etc.)

Section II: Spiritual Discernment

Step A. Code of Ethics – Identify relevant aspects of appropriate code of ethics and other relevant documents (local/state/federal laws or regulations, institutional or agency mission/policies, other professional ethics codes)
Step B. Self-Awareness
1. **Values** – Identify and explain one's own personal values and worldview in relation to the ethical dilemma
2. **Spiritual Discernment & Wesleyan Quadrilateral** - Identify areas of moral distress. Reflect, meditate, pray, or engage in any activity that facilitates spiritual discernment as you weigh and evaluate the information above using the Wesleyan Quadrilateral as outlined below. How would you select, interpret, prioritize, and integrate these four sources of moral knowledge (SIPI)?
   a. **Scripture** - In what ways do scripture inform your understanding of this dilemma?
   b. **Tradition** - In what ways do religious and spiritual traditions inform your understanding of this dilemma?
   c. **Reason** - In what ways do reason and science inform your understanding of this dilemma?
   d. **Experience** - In what ways do contemporary experiences inform your understanding of this dilemma?
   e. **SIPI –** How would you prioritize and integrate these sources for responding to this dilemma?

Step C. Other Awareness
1. **Others' Values** - Identify important values and worldviews of client/family/employer/professionals key to the dilemma that influence outcomes
2. **Cultural Humility** - What aspects of cultural competence play a role and how?
3. **Marginalized** - How has listening to "truth from the margins" been taken into account

Step D. Moral Principles - Explain the relevance of each to all sides of the conflict
1. **Nonmaleficence** - Do no harm
2. **Beneficence** - Do good/prevent harm
3. **Autonomy** - Self-determination
4. **Justice** - Fairness
5. **Veracity** - Honesty

Step E. Consult
1. **Colleagues** – Peers, supervisors, especially those with diversity expertise
2. **Relevant professional experts** - Legal, cultural, medical, ethics, issue specific
3. **Higher power** - Religious and/or spiritual resources

Step F. Integrative Discernment - Reflect/meditate/pray/engage, continuing to be aware of areas of moral distress – summarize the results of the process and discuss how the values, quadrilateral, moral principles, consults, and pertinent worldviews influence each other in the process.
Step G. Rank - Moral principles and justify choices

Section III: Plan for Action

Step A. Hoped-for Outcomes – Identify hoped-for outcomes
Step B. Possible Courses of Action - Brainstorm possible courses of action. Explain short/long term consequences; benefits/burdens; possible cultural barriers/supports; effects on the most vulnerable for each.
Step C. Identify Competing Non-moral Considerations - Financial, cultural, relationship changes, potential political fallout, time factors, degree of sustainability, and other potential contextual consequences
Step D. Choose a Course of Action – provide justified reasoning for the chosen course of action.

Section IV: Take Action

Step A. Steps - Identify concrete steps to implement the plan, including culturally relevant resources/strategies
Step B. Act and Document – practice moral courage

Section V: Monitor Implementation & Evaluate Outcomes

Step A. Unanticipated Consequences
Step B. Additional Options/Opportunities
Step C. Moral Traces/Residue – Examine any remaining moral distress

Figure 3:Inclusive Wesleyan Quadrilateral Discernment Ethical Decision-Making Model

Inclusive Wesleyan Quadrilateral Discernment Model

As a holistic bio-psycho-social-spiritual approach, the WQ Model has five main sections with multiple sub-sections or steps within each. The following sections examine application of each step, as outlined in Figure 3 (see previous page).

WQ Model, section I: Facts of the case

In Section I, Step A begins like most ethical decision-making models, with naming the dilemma and identifying the competing ethical issues or claims. In Step B, the goal is establishing the facts of the case. Answering as many of the fact-setting questions as apply lays the foundation for analysis. This includes the usual who/what/when/where as well as identifying pertinent worldviews. These facts should be verifiable. In contrast, Step C involves explaining probable motives and to whom they belong. Although some guesswork may be involved here, intentions can also be fairly clear—possibly financial, power, relationship building, healing, revenge, or righting a wrong. Step D ends the first section with a review of contextual factors and special circumstances. Pertinent diversity characteristics should be identified here as well as administrative, legal, and quality of life matters. Including as much information as possible here often times is clarifying in and of itself and may result in the revelation of a heretofore unidentified resolution to the dilemma.

WQ Model, section II: Spiritual discernment

Section II is the most substantive and unique aspect of this model, with seven major steps, including a focus on awareness of self and others. Several forms and levels of consultation and spiritual discernment are key. Step A begins with consulting pertinent professional codes of ethics for guidance, ensuring that a sufficient answer is not to be found in an appropriate code before advancing any further. Codes from other professions can be helpful as well, especially in situations involving interprofessional teams. This is also where other clear answers might be found in searching for legal or

administrative rules. If no immediately clear direction for a decision is found, Step B, self-awareness, will guide the practitioner in evaluating what personal values and worldviews are playing a role in the dilemma or creating moral distress. The Wesleyan Quadrilateral's four sources of moral knowledge are selected, interpreted, prioritized, and integrated (SIPI), contributing to increased self-awareness regarding the roles of religion, spirituality, and diversity in shaping, and potentially biasing, the practitioner's understanding of the dilemma. Practitioners are asked to engage in activity that encourages spiritual discernment, such as meditation or prayer. This focus on self-awareness is followed by examining "other awareness" in Step C, identifying the worldviews, values, and biases of the others involved to the best of one's ability, as well as aspects of diversity that may be playing a role. Practitioners are asked to identify how listening to "truth from the margins" has been taken into account.

Step D of Section II involves applying the five moral principles and identifying the relevance of each to this dilemma. This is followed in Step E by consultation with colleagues and professional experts with relevant knowledge that might influence the outcome. For instance, beyond clinical consults, a case involving a teenager who enjoyed explosives might warrant that a fire marshal be consulted. Step F asks for an integrative spiritual reflection of Steps B through E, discerning how the values, Quadrilateral, moral principles, and consulted experts influence each other and address the moral distress involved. This includes again engaging in reflection through meditation and/or prayer, similar to Step B but now including the additional information gleaned from completing the steps in between. Finally, in Step G of Section II, the practitioner ranks the principles, makes a choice, and finds justification for it: why this choice rather than that choice? This, however, is only a choice of direction and not one of action.

WQ Model, section III: Plan for action

It is common to want to move straight into action once a directional decision has been made. Usually, however, there is more than one way to follow

through with a chosen direction. Section III tasks the practitioner with exploring options before acting. Both Step A, identifying hoped-for outcomes, and Step B, brainstorming the benefits and burdens of possible courses of action, reduce the "blinder effect" that can follow making a directional decision. A dilemma indicates two or more options that conflict but each option may have degrees of more or less favorable resolution. Discerning "favorable to whom" is an important part of a diversity-conscious benefits and burdens analysis. Identifying non-moral considerations in Step C that were not key in the conflict of the dilemma can be helpful as well. Will there be political ramifications? Is one choice more sustainable over time than another? Is the best choice unavailable to the client due to resources or geography? Section III ends with Step D: choosing a course of action and summarizing the justified reasoning for the choice.

WQ Model, section IV: Take action

In Section IV, the action plan is designed, with goals, objectives, tasks, and a timeline comprising Step A. Finally, the practitioner musters the moral courage to act and does so in Step B. Step B also includes documenting the action.

WQ Model, section V: Monitor and evaluate

Section V covers the ongoing implementation and assessment of the action plan, including measuring and evaluating the outcomes. Did the plan, as enacted, accomplish the goal? In Step A, the practitioner identifies any unanticipated consequences. Additional options or opportunities that presented themselves are described in Step B. And finally, Step C checks for moral residues or traces. That means going back to the original source(s) of moral distress, that tug that was the result of the conflicting or competing aspects of the dilemma. Does it feel resolved? What moral residue lingers that may still need attention?

Conclusion

This evolving model has been designed for both educational and practical settings. Although it has not been empirically tested on a specific population yet, the authors have found it very useful over many years of encouraging students to reflect on their characters as moral agents as well as learn skills of self-reflection, cultural humility, ethical analysis, and decision-making in an interprofessional classroom setting. Feedback indicates that the WQ Model provides a useful tool for assisting students and practitioners to identify and respond to numerous aspects of ethical dilemmas through a unique justified reasoning process. Understandably, real-world dilemmas often involve time constraints that limit a thorough application of this comprehensive model. Models that explicitly incorporate diversity concerns into a bio-psycho-social-spiritual approach are needed. Because spirituality and religion are aspects of diversity as well as foundations from which many practitioners and their clients operate, both warrant increased recognition in ethical decision-making. Controversial and often polarizing stances regarding the separation of church and state in the helping professions and practice settings point to the need for methodical ways to intentionally and explicitly consider how spirituality and religion interface in ethical practice.

The Inclusive Wesleyan Quadrilateral Discernment Model is grounded in the understanding that social workers and other helping profession practitioners are called to act as moral agents, often in interprofessional settings, when faced with complex ethical dilemmas. It builds upon an interprofessional body of literature with a foundation in virtue ethics that emphasizes the importance of holistic self-awareness and reflection for the practitioner with ethical concerns and dilemmas. The underlying assumption of this model is that, in the process of justified reasoning, it is important to make the unconscious conscious. Applying the Wesleyan Quadrilateral to the decision-making process provides a method for identifying and consciously monitoring elements of one's subjective social identity and the spiritual or religious biases that may be influencing decision-making processes. Importantly, using the model, constructs, and processes advanced in

this article can help practitioners find and maintain a sense of spiritual discernment and cultural humility, while reducing moral distress and increasing moral courage. Unique among ethical decision-making models, the WQ Model provides a holistic comprehensive reflective tool that empowers practitioners in their actions as moral agents with colleagues in interprofessional settings.

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Weight Stigma as a Violation of the NASW Code of Ethics: A Call to Action

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Abstract

Weight stigma is a violation of the Social Work Code of Ethics. Given that weight loss attempts have been shown to be harmful and ineffective and that they increase weight stigma, the National Association of Social Workers urgently needs to revise its response to weight loss endorsement. Social determinants of health, a robust indicator of population well-being, are ignored when interventions focus on decreasing the body size of individuals. When considering interventions, the field of social work has a responsibility to consider the evidence of what helps as well as what harms. As social workers, we need to examine our own attitudes for the biases that may harm the very people we are directed to help. The Code of Ethics gives us clear direction when applied to the topic of weight stigma.

Keywords: weight stigma, code of ethics, weight loss

The dominant discourse in our culture is the weight centered paradigm in which weight is considered a reliable measure of health, leading to the concomitant assumption that the pursuit of weight loss is a worthwhile goal that will lead to a healthier individual (Bombak, 2014). Considerable evidence refutes both ideas. The promotion of weight loss efforts contributes to weight stigma, which is associated with discrimination, oppression, and poorer health outcomes (Bacon & Aphramor, 2011). Further, the focus on changing individual body size is an effective distraction from the much larger work that needs to be done in improving social determinants of health, especially for marginalized and vulnerable populations.

Promotion of weight loss and diet culture are not common conversations in social work; however, the National Association of Social Workers (NASW) has supported programs that reinforce the weight centered paradigm (e.g., NASW, 2010: Panzer, 2020; see Figure 1), thus amplifying weight stigma. The purpose of the current paper is to explore how these efforts are a clear violation of the NASW Code of Ethics and provide recommendations for moving our field forward.

Figure 1: Example of NASW Promoting Weight Loss

Background

Conventional thinking about weight loss is grounded in misconceptions and inaccuracies. The myths concerning weight loss include: 1) Sustainable weight loss is achievable by anyone who tries hard enough to eat less and move more; 2) Thinner people are healthier than heavier people; and 3) Losing weight makes people healthier (O'Hara & Taylor, 2018). Taken together as true, the conclusion is that people should try to lose weight and that programs promising weight loss should be promoted by anyone interested in individual and community well-being. Based on untruths, these conclusions are actively harmful (Bacon & Aphramor, 2011).

A substantial body of literature suggests that weight loss attempts almost always fail, perhaps as much as 95% of the time (e.g., Rothblum, 2018; Tylka et. al., 2014). Dieting is not only ineffective, it causes harm. Restricted eating often results in metabolic changes that lead to long term weight gain (e.g., Neumark-Sztainer et al., 2006; Ochner, et al., 2015). Weight cycling, also known as "yo-yo dieting," is correlated to worsened mental and physical health, including body dissatisfaction, discrimination, eating disorders, death (O'Hara & Gregg, 2006), cognitive impairment, including difficulty concentrating or thinking clearly (Shaw & Tiggemann, 2004), and increased stress and cortisol levels, which are associated with heart disease, cancer, diabetes, impaired immune function and weight gain (Bangalore et al., 2017; Tomiyama et al., 2010). The assumption that weight loss results in better health outcomes is not supported by the literature (Bombak, 2014; Calogero et al., 2018; Mann et al., 2015). In fact, a compelling argument can be made that the widespread focus on losing weight and the increased stigma it engenders has contributed to the alleged "obesity epidemic" (Tomiyama et al., 2018).

Weight stigma can be defined as the devaluation and social rejection that derives from having a body that does not conform to predominant social norms or expectations regarding thinness (Tomiyama et al., 2018). It can also be thought of as weight bias, anti-fat bias or fat-phobia. It includes anything that devalues larger bodies or that shames or oppresses based on

body size. Even the terminology we use to talk about it is questionable. The term "overweight" implies that there is a given desirable weight, and one is "over" it. The term "obese" implies pathology and is often used as a slur (Meadows & Daníelsdóttir, 2016). The unquestioned promotion of weight loss as a positive outcome and the idealizing of smaller bodies directly reinforces weight stigma. Fat-shaming is seen as a useful motivation to help encourage someone to lose weight. However, weight stigma can be considered a public health problem in its own right (Blacksher, 2018). Weight stigma may be responsible for many, perhaps most, of the health problems that have been associated with higher weights (Puhl et al., 2013; Tomiyama, et al., 2014). In fact, weight stigma is associated with 60% higher mortality risk (Sutin & Terracciano, 2017).

Weight stigma contributes to lowered engagement in the practices that promote health. Behaviors such as participating in physical activity and eating more fruits and vegetables correlate with improved health regardless of body size (Matheson et al., 2012). However, when "success" is measured by the number on the scale, such behaviors may be abandoned when they do not lead to weight loss (Thomas et al., 2015).

Weight stigma is also linked to avoidance of medical care (e.g., Puhl & Heuer, 2009). People who have been shamed at a doctor's office because of their weight, or encouraged to embark on a weight loss effort regardless of their presenting problem, are less likely to access care in the future (e.g., DeShazo et al., 2015). Additionally, quality of care is compromised by unexamined weight stigma in medical professionals, further undermining health (Major et al., 2018).

Both anticipated and experienced stigma are associated with increased chronic stress and social isolation, and unhealthy behaviors changes (including disordered eating) which are linked with poorer health outcomes (Brochu, 2018; Hunger et al., 2018). Experiencing weight stigma is linked to hypertension, cardiovascular problems, diabetes, insulin resistance and overall impaired health (Major et al., 2013, Vartanian & Smyth, 2013). Thus, weight stigma leads to poorer health for individuals and for communities.

Children are particularly vulnerable to weight stigma, because they are growing and changing while being exposed to unrealistic images and messages in television, movies, print and social media. When well-meaning parents or others encourage youngsters to "watch their weight," children learn that their own bodies are untrustworthy and they may embark on a lifetime of disordered eating (Wansink et al., 2017). Overvaluation of body size is a precursor of eating disorders (Stice & Van Ryzin, 2019), as is dietary restriction (Golden et al., 2016; Neumark-Sztainer et al., 2006). Given that eating disorders have the highest mortality risk of any mental illness (Harris & Barraclough, 1998), exposing children to weight stigma is dangerous to their well-being.

Meanwhile, the promotion of ineffective approaches to weight loss is highly profitable. The 66 billion dollar a year industry includes commercial weight loss programs, meal replacements, low calorie entrees, weight loss surgery, pharmaceutical products, books, DVDs, apps and online programs, profiting from the desperation of vulnerable people (Marketdata Enterprises, 2017). When these approaches do not lead to long term reduction in body size, the failure is blamed on the participant, not the product.

Assigning pathology to people in fat bodies is not only inaccurate, but it also contributes to discrimination and perpetuates oppression. Weight stigma is reinforced by all messages and assumptions that smaller bodies are better, healthier or more worthy and valuable than larger bodies. Visible fatness takes on a moral quality than leads to behaviors that are shaming and blaming towards those in larger bodies (Greenhalgh, 2012). Bias and discrimination then become justified and socially acceptable. The economic burden falls more heavily on fat women, who are paid less than their thinner peers, are less likely to be hired, or promoted (Fikkan & Rothblum, 2012), to be encouraged to attend college, or to be accepted into graduate school (Major et al., 2018). Weight stigma leads to lower socioeconomic status and greater social disparities, especially for women.

Social workers are expected to be attentive to cultural and societal forces that can negatively affect individuals and communities, especially when they contribute to oppression and discrimination in vulnerable

populations. However, we are not immune to the widespread and unquestioned weight bias in our culture. Large body size is not commonly recognized as a stigmatized identity, because the concept promoted by those who profit from the dieting industry would have us believe that body size is controllable through individual effort, even though a wealth of evidence indicates that it is not (Calogero et al., 2016). Without awareness of our own unexamined assumptions, social workers with the best of intentions can inadvertently cause harm by promoting weight loss.

Social determinants are a much more robust predictor of health for individuals and communities, but are more difficult to address, involving policy, social change, funding and political will (Medvedyuk et al., 2018). The neoliberal viewpoint that weight is under individual control leads to the devaluing of large bodies and serves as a very effective distraction from addressing social determinants of health such as poverty, discrimination, oppression, housing, education, and opportunity. If we are truly interested in promoting health and well-being for individuals, families, communities and the society at large, we would do better to focus on improving lifelong learning, employment and working conditions, and minimum livable income, while addressing inequities in power, money and resources (Marmot, 2016). Decreasing disparities in access to education, employment and medical care while improving neighborhood safety and food security, for example, would be more much more beneficial than interventions focused on reducing body size.

Given the lack of quality evidence to support both the benefit of weight loss and likelihood of long-term weight loss, as well as the documented damage caused by weight cycling and stigma, ethical questions arise. The values of beneficence and non-maleficence require effective treatment benefit and an active awareness of avoiding harm, both of which are violated by promotion of weight loss (Bacon & Aphramor, 2011). A weight-centered paradigm is ineffective, harmful, and unethical (O'Hara & Taylor, 2014). There are no legitimate reasons to promote an intervention that has a history of poor outcomes and failure along with a high likelihood of iatrogenic results (Bacon & Aphramor, 2011; Bangalore et. al., 2017; Rothblum,

2018; Tylka et al., 2014). Additionally, anything that devalues larger bodies reinforces weight stigma. Support of intentional weight loss promotes the concept that smaller bodies are better, thus devaluing larger bodies.

Discussion of Ethical Considerations

The *Code of Ethics of the National Association of Social Workers* (2017) clearly delineates the responsibilities that social workers have to focus on improving well-being for individuals and society, with specific attention to those who are vulnerable, oppressed or living in poverty. In our focus on individual well-being in the context of society, we are especially aware of the forces in the culture and environment that can create or contribute to problems in living and our responsibility to recognize them and to address them when possible. We are charged to promote social justice by striving to end discrimination and oppression.

Weight stigma, which is implicit in any focus on weight loss, violates the Code of Ethics in a number of ways, including the core values of social justice and the dignity and worth of a person. The Code enjoins us to be aware of our own personal values and the impact they might have on ethical decision making, reminding us that our actions should be consistent with the spirit as well as the letter of the Code.

The Ethical Principles guide the work that we do, and contain several concepts to consider in the context of weight stigma. If we value the inherent dignity and worth of the person then we must consider the social injustice involved in the cultural belief that values thinner bodies over heavier ones. When weight stigma leads to discrimination, oppression and shaming, large people cannot live with dignity. If we, as social workers, are to behave honestly, responsibly and in a trustworthy manner, we must increase our knowledge in this area, learning about the evidence regarding weight and well-being instead of accepting the information that is promoted by those who stand to make a profit and promoting weight loss with our clients based on this misinformation. The Code already addresses these issues indirectly, but how do we apply the principles? The organization has a

responsibility to clarify these concerns for the members. The NASW is not responsible for the individual choices made by its members, but it sets the tone and provides guidance for ethical behavior. See Table 1 for NASW Code of Ethics principles, the impact of weight stigma, and suggestions for alternative responses.

The first Ethical Standard, 1.01 (NASW, 2017), regards our commitment to our clients and our responsibility to promote their well-being. If, as we have seen, attempts to lose weight, whether in pursuit of health or to become more socially acceptable, have overwhelmingly negative outcomes, then our commitment to our clients requires that we provide them with the information needed to make better choices. Informed consent, 1.03, obliges us to explain the risks involved with weight loss attempts. Even as we respect their self-determination, 1.02, we should be aware of serious, foreseeable risk and be adequately prepared to explain said risk. Self-determination relies on informed consent.

Standard 1.04, competence, reminds us to provide services only after we have engaged in appropriate study and training. Everyone we work with makes decisions about food and eating within a cultural context so we should strive to be familiar with the relevant research. In the field of helping professions, social workers place more emphasis on understanding culture, 1.05. We are uniquely qualified to recognize the cultural valuing of bodies that contributes to inequalities, inequities, and discrimination. The cultural value of thinness not only contributes to bias and oppression in society, but to internalized shame, body dissatisfaction and impaired quality of life in individuals and families (Brochu, 2018). Our understanding of the relationship between oppression and the nature of social diversity positions us, as a profession, to be particularly sensitive to these dynamics.

Standard 1.06, conflicts of interest, is written for individuals, but applies to the organization, as well. The NASW is in conflict of interest when it promotes (Panzer, 2020) or allies in any way with organizations that directly or indirectly profit from selling weight loss (e.g., its support for the profit-oriented businesses behind "National Obesity Care Week" in October 2018; see Figure 1). It should go without saying that we should not use derogatory

language, 1.12, regarding clients. However, disparaging comments about body size have become so common in our culture as to often pass unnoticed (Engeln-Maddox et al., 2012). We should be aware of, and careful about, remarks about bodies, whether the body belongs to a client, a coworker, or ourselves. Promotion or celebration of weight loss, in ourselves or others, contributes to weight stigma, as do disapproving comments about weight gain or larger bodies. Even jokes can be micro aggressions and should be avoided.

If we feel unable or unqualified to serve people in large bodies, or those with eating and body image concerns, we should refer to someone with more knowledge or expertise, per 1.16. When social workers are part of an interdisciplinary team, addressed in 2.03, we are responsible for bringing the unique social work perspective and ethics to discussion and decision-making in a way that is consistent with client well-being. Unexamined weight bias in other team members is potentially harmful to clients.

Administrators and supervisors, 3.07 and 3.08, are to advocate for adequate resources to meet client needs. This may involve continuing education and staff development to stay current with emerging knowledge regarding eating, health, body size, and weight stigma. Standards 3.09 d and e remind us that, as social workers in employment, we are expected to maintain the ethics and values of the profession by recognizing and addressing discrimination within the organization and its policies and practices.

We are reminded again in 4.01 and 5.02 that we are to stay current with emerging knowledge and base our practices on empirically tested information. When engaging in research or evaluation, we are to carefully consider possible consequences and ensure that consent is fully informed, 5.02 c and e. We must be especially vigilant regarding weight loss recommendations that focus on children, who are particularly vulnerable to the harm they can cause, and are not able to give their own consent. And, of course, we do not condone or participate in any form of discrimination, per 4.02.

Code Section	Principle	Weight Stigma Impact	Suggestions for Alternative Responses
1.01	Commitment to client's well-being	Pursuit of weight loss is potentially harmful	Offer accurate information about the possible harms of pursuing weight loss
1.02	Self determination	Client is influenced by advertising	Introduce alternate information about long term outcomes of weight loss interventions
1.03	Informed Consent	Pursuit of weight loss is recommended without explanation of risk	Explain evidence-based information about risks and benefits
1.04	Competence	Social workers may lack adequate understanding of the effects of weight stigma	Engage in ongoing study of applicable research
1.05	Cultural Awareness and Social Diversity	Cultural values of thinness contribute to bias	Recognize how weight stigma contributes to oppression at micro, mezzo end macro levels
1.06	Conflicts of Interest	Financial incentives contribute to decision making	Avoid involvement, as individuals and an organization, with those who profit from weight stigma
1.12	Derogatory Language	Weight stigmatizing comments are accepted as ordinary	Increase awareness of, and resistance to, weight stigmatizing language
1.16	Referral for Services	Interventions regarding weight and health require specialized knowledge	Refer to competent collogues when appropriate
2.03	Interdisciplinary Team	Client well-being is the focus of social workers' role on a team	Challenge unexamined weight bias in team members
3.07, 3.08	Administration, Continuing Ed., Current Knowledge	Administrators may not recognize that client needs may be affected by weight stigma	Ensure continuing education in the workplace about weight stigma and the natural diversity of body size
3.09	Obligations to Employers	Weight stigma can contribute to violations of the code of ethics in the workplace	Review policies and procedures in employment setting for weight stigma and suggest revisions
4.01	Competence	Social workers may be influenced by unexamined weight stigma	Maintain understanding of current, empirically based knowledge
4.02	Discrimination	Weight stigma contributes to discrimination	Consider the role of body size bias in discriminatory attitudes and practices
5.01	Integrity of the Profession	Decision makers within the profession can be influenced by weight stigma	Challenge organizational stances that promote weight loss
5.02	Evaluation and Research	Unexamined weight bias can lead to stigma and lack of informed consent in research	Evaluate research and research proposals for weight stigma; address the need for informed consent
6.01 6.02 6.04	Welfare of Society, Social Justice Public Participation Social and Political Action	Weight stigma contributes to the oppression and exploitation of vulnerable people.	Educate the public, especially those in decision making capacities, about the harmful effects of weight stigma. Challenge policies and programs that perpetuate a focus on individual weight loss instead of addressing the social determinants of health. Encourage respect for diversity.

Table 1: NASW Code of Ethics Principles, Weight Stigma Impact, and Suggested Alternative Responses

If the professional organization that represents us is acting in any way that promotes weight stigma, bias or discrimination, we are expected to speak out against it, 5.01b. As social workers, we have a commitment to promoting the general welfare of society in a way that is compatible with the realization of social justice, 6.01. This may involve facilitating the involvement of a well-informed public in shaping social policies and institutions, 6.02. If we are to promote social justice, we must encourage respect for diversity and difference in body size, ensure that all people have equal access to the resources they need to develop fully, and expand opportunity for the oppressed and those exploited by the weight loss industry, 6.04a, b and c.

Recommendations

Given the preponderance of evidence that body weight is not under individual control, that efforts to reduce body size carry considerable risk of harm, that weight stigma is a modifiable public health risk, that a focus on changing the body size of individuals distracts from more important social determinants of health, and that promotion of weight loss violates the NASW Code of Ethics, the following recommendations for the organization should be considered:

1) Divest any and all involvement with organizations that profit from promoting weight loss, or are funded by corporations that do.
2) Add "body size" to the list of protected categories "race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability," in sections 1.05c, 2.01b, 4.02 and 6.04d in the Code of Ethics. We accept that most of these categories, such as race, sexual orientation and age are not changeable through individual effort any more than body weight is.
3) Include the category of "weight stigma" in cultural diversity courses and ethics courses in schools of social work.

4) Promote continuing education courses that address the intersection of ethical issues, weight stigma, and cultural sensitivity.
5) Provide social workers with resources to address weight stigma when they encounter it in agency policies, treatment teams, and other employment settings as well as in themselves.
6) Develop training materials that can be used in employment and agency settings to address implicit and explicit bias based on body size.
7) Promote the use of resources to identify and address internal weight bias in ourselves and with our clients.
8) Carefully review existing organizational materials for weight bias and address accordingly.

Conclusion

Human bodies come in a variety of shapes and sizes. If we value human diversity in skin tones, ethnic background, gender, sex, and physical ability, we should not consider one type of body and size as more valuable or worthy than another. How do we, as individual social workers, reshape the environment for our clients to promote health, self- compassion, and self-worth instead of allowing weight stigma to mask social injustice? When we have the opportunity to influence or promote policies and interventions, we must ensure that they are compatible with the realization of equity and social justice for all people. The National Association of Social Workers and its members are uniquely qualified to stand against weight stigma. As Saleebey's seminal 1992 article about the person-in-environment perspective reminds us, we should not become, as helpers, part of the mechanics and metaphors of oppression.

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The Impact of Experiential Learning on Social Work Students' Application of the NASW Code of Ethics Post-Graduation

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Abstract

Experiential learning techniques have the ability to prepare social work students for practice by exposing them to real world challenges and allowing them to gain hands on experience. However, little is known about the direct impact such techniques have on students' social work careers post-graduation. This study aims to fill that gap. Qualitative interviews were conducted with graduates from an undergraduate social work program (N=20) who

had participated in an immersion learning course as part of their social work education. In part, this course focused on poverty, homelessness, and sexual exploitation of women. The six values of the NASW Code of Ethics and the principles based on these values were used as a framework to investigate the impact of this course. Interviews were analyzed by multiple investigators using Nvivo12. Findings indicate that experiential learning techniques, such as immersion learning, can have an impact on how students understand and apply each of the six ethical values of the Code with a generalist approach to poverty and homelessness post-graduation. Particularly, students reported an ability to better apply the values of social justice, dignity and worth of the person, importance of human relationships, and competence to their social work careers. These findings further inform social work education and reinforce the utility of experiential learning.

Keywords: Immersion learning, experiential education, BSW students, qualitative research, teaching research

Review of the Literature

According to Experiential Learning Theory (Kolb, 1984), knowledge acquisition heavily relies upon exposing the learner to concrete experiences. Through a process of reflective observation and abstract conceptualization, the learner can then develop an understanding of (or revise their current understanding of) that experience to which they can actively apply to future situations. This integrated process enables learners to develop critical thinking and self-awareness (Cleary, 2001). Roots of Kolb's Experiential Learning Theory can be traced back to John Dewey's pioneering work in active learning approaches. Dewey (1938) maintained that learning should be an experiential process in which students learn by doing, through active engagement in classroom experiences. As social work is an applied profession, experiential teaching approaches can be particularly useful in training future practitioners. Exposing students to real-world issues that challenge the social work profession, and facilitating the learning processes around those

experiences can facilitate and reinforce critical self-discovery and understanding of the profession (Milne & Adams, 2015; Pugh, 2014a).

Experiential learning, cultural competency, and job readiness

There is ample literature to support that experiential learning programs can be especially effective in developing cultural competency among students (Cramer et al., 2012; Dailey et al., 2016; Fineran et al., 2002; Maccio, 2011; Pugh, 2014b; Sanders et al., 2003). Saunders et al. (2015) describe cultural competence education as a journey that should be facilitated by both the social work student and the institution. Developing a strong sense of self-awareness is an integral step for students in their journey toward cultural sensitivity (Taylor & Cheung, 2010).

Schelbe et al. (2014) describe how service-learning activities can facilitate the cultural competency process and assist students in becoming more self-aware. Experiential learning activities can also assist students in discovering their own biases towards different population groups (Pugh, 2014b; Robinson, 2018), which can impact their overall perceptions of different groups (Carey, 2007; Sanders et al., 2003). In particular, Vandsburger et al. (2010) discuss a poverty simulation activity in which students (N=101) were exposed to real-life hardships faced by individuals experiencing poverty. Students who participated in this simulation gained a deeper understanding of poverty and an ability to analyze the effects of poverty, which impacted their overall perceptions of people living in such circumstances (Vandsburger et al., 2010).

Experiential learning programs have also demonstrated an impact on students' perceived personal and professional readiness for social work practice (Robinson, 2018). Such programs are often an extension of the traditional classroom-based experience for students and provide applied outlets to demonstrate knowledge and practice skills (Andron, 2013; Mitschke & Petrovich, 2011; Norris & Schwartz, 2009). Many experiential techniques in social work education focus on enhancing macro-practice knowledge among students, such as social policy (Anderson & Harris, 2005; Carey,

2007; Pierpont et al., 2001; Scott, 2008; Sather et al., 2007). These techniques have the potential to produce more socially aware students with skills in community organizing and advocacy (Dailey et al., 2016), as well as the overall ability to create social change (Fineran et al., 2002).

Application of the NASW Code of Ethics to experiential learning

While there is no literature that directly links all six core values of the Code of Ethics – service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence – to learning outcomes associated with experiential learning techniques, many studies directly or indirectly apply at least one of these values. For instance, Mitschke and Petrovich (2011) describe a service-learning activity that exposed social work students to a community health clinic serving a diverse group of clients. Their findings indicate that these students developed a strong sense of civic responsibility (i.e., *service*) and advocacy (i.e., *social justice*) through their participation. Additional literature supports the use of experiential learning techniques to impact students' ability or willingness to challenge social injustice (see Cramer et al., 2012; Dailey et al., 2016; Fineran et al., 2002; Scott, 2008).

Another service-learning program described by Donaldson and Daughtery (2001) promoted strong community collaboration between social work students and low-income residents in Washington, D.C. This progressive model focused on developing dignity and worth of community members through their partnership (i.e., *dignity and worth of the person*). Pierpont and colleagues (2001) focused on developing related values among a group of social work students engaged in a policy-related service learning assignment. Similarly, in the poverty simulation project previous described (Vandsburger et al., 2010) social work students gained a better appreciation for the *importance of human relationships*.

Finally, there is much literature (Anderson & Harris, 2005; Lemieux & Allen, 2007; Norris & Schwartz, 2009; Pierpont et al., 2001; Williams et al., 2002) that links experiential learning techniques to developing competent

social work practitioners (i.e., *competence*). For instance, a study examined social work students' use of self through a reflective/experiential project that aided in their overall feelings of competence in the field (Taylor & Cheung, 2010). In this course in which students were enrolled, they also reflected upon the use of self in application to various values and their derivative principles of the Code of Ethics. This demonstrates their ability to align themselves personally and professionally with the Code of Ethics and act in an ethical manner (i.e., *integrity*).

Gap in the literature

While the literature highly suggests the utilization of experiential learning activities in social work education to enhance overall knowledge and skills of students, to our knowledge there has been no research that has directly linked the use of such activities to the actual job readiness of students after they have entered the arena of social work practice. Therefore, the purpose of this study was to assess how an experiential learning program played a role in social work students' preparation for social work practice, once they have entered the workforce. The Code of Ethics was used to this guide analysis, whereas study findings are described in the context of each of the core values. We propose that utilizing the NASW (2021) Code of Ethics can be a meaningful method for gauging the impact of experiential learning programs, since these are the core values, principles, and ethical standards which we are expected to uphold in practice.

Methods

Description of the immersion learning course

Participants in this study had all completed a social work immersion learning course when enrolled as BSW students at a large Midwestern university. The purpose of this 15-week elective course was to explore social and political perspectives on racism, sexism, and classism as they pertain to poverty in the United States. The course prepared students for an intensive

immersion experience in Portland, Oregon, which involved learning about the long-term social and political effects of poverty, including issues of homelessness, youth runaways, welfare, drug addiction, sexual exploitation, and the long-term impact on children, families, and communities. The role of social workers in addressing the social injustices in this community was also explored. While in Portland, the students worked with and learned from the members of various organizations about the types of political and social advocacy work they were engaging in to address social issues in their community.

Ten social work and pre-social work students were selected to participate in this course each year. An application and interview process were conducted to select students. Students participated in three pre-trip and two post-trip seminars and were required to complete written assignments based upon course readings. Students also kept a daily reflection journal during their time in Portland.

While on the trip, students visited a number of community-based organizations, such as meal service programs, long-term drug rehabilitation centers, permanent housing agencies, street outreach programs, community organizing organizations, and a permanent tent city, to learn from the organizational staff and clients. Service-based activities, such as serving meals, distributing clothes and supplies, gardening, and assisting organizations in other tasks were also scheduled. Each evening was devoted to a large group reflection session of the students' experiences that day. These sessions were facilitated by the course instructors and would last anywhere from one to three hours, depending on the depth of processing required by the students. The primary investigator of this study and one of the co-authors were instructors for this immersion learning course between the years of 2013-2015 (Robinson) and 2011-2015 (Bobst).

Data collection

Semi-structured, one-on-one interviews were conducted with study participants. Interviews were conducted by a trained research assistant, who had

no prior involvement with the study participants nor the immersion learning course. Participants were recruited through a study flyer, distributed to former students who had completed this immersion course. Interviews lasted approximately 30 minutes and were conducted over the phone. Interviews were audio recorded and transcribed verbatim by a professional transcription company. Participants received a $20 gift card taking part in this study.

An interview guide was used to lead the question-asking process. This guide was informed by expertise of the study team, and prior teaching experience of the instructors for the immersion course. The interview guide included three sections of questions: 1) demographic and background information; 2) overall impact of the course; and 3) specific impact of the course on the participants' social work career. In part, interview guide questions inquired about how the immersion course had impacted the participants' short-term and long-term career path and goals. In addition, participants were also asked about how the course impacted their view and understanding of the Code of Ethics and how they adhere to these ethical values in their careers post-graduation.

Analysis

Transcribed interviews were entered into the qualitative analysis software, Nvivo12, and analyzed. As the Code of Ethics was used to craft interview questions, it was also used to guide the analysis process. Therefore, a deductive coding approach was used in this research (Elo & Kyngäs, 2008) whereas the six ethical values of the Code of Ethics were defined as initial codes. These values are: 1) Service; 2) Social Justice; 3) Dignity and Worth of the Person; 4) Importance of Human Relationships; 5) Integrity; and 6) Competence. Each transcript was coded by two trained researchers. Analysis was an iterative process, in which divergent coding was thoroughly discussed in a consensus building process to achieve strong interrater reliability. Cohen's Kappa was used to calculate interrater reliability, and at the end

of the coding process each code demonstrated strong interrater reliability (Range: 0.70-1.0), with an overall Kappa of 0.95.

To help ensure study findings were consistent with participants' experiences, member checking methods were utilized (Lincoln & Guba, 1985; Creswell, 1994). The results of this research were shared with three study participants for review. Individually, each of these participants stated that the study findings were consistent with their experiences while enrolled in the immersion course and the impact the course has had on their social work careers post-graduation. All study activities were approved by the university institutional review board prior to recruitment and data collection.

Results

Twenty participants completed an interview with the study team. Participants ranged in age from 22 to 42 years, and the majority identified as white (n=18, 90%) and female (n=15, 75%). All participants had participated in the immersion learning course between the years of 2011 and 2016. For most participants (n=16, 80%), this immersion course was the only immersion experience in which they had participated. For the other four participants, they had participated in other forms of non-social work immersion or service-learning opportunities prior to enrolling in this course. Of the participants, 13 (65%) had either completed or were working on completing their MSW degree at the time of their interview. Participants reported working in a variety of social work disciplines, including behavioral health services, grant writing and development, substance abuse counseling, domestic violence, medical social work, school social work, and case management, among others.

Participants were asked questions regarding the impact of this immersion learning course on their social work career, including how it has impacted their understanding and application the Code of Ethics in their careers. Therefore, findings from this study will be presented in context of the six ethical values of the NASW (2021) Code of Ethics.

Service

Nine participants (45%) identified that this immersion learning course had an impact on their understanding of and how they adhere to the ethical value of *Service*. Participants highlighted the importance of using their training in social work, as well as their privilege, to provide service to people in need. Many participants reflected upon volunteer work they performed while on the immersion trip (such as serving food or volunteering at a day shelter), and stated these experiences helped them understand the value of volunteerism outside of their paid employment.

For participants who do not currently work with individuals experiencing homelessness, this immersion course helped reinforce the many ways in which they could give back to and volunteer on behalf of this population. Some participants discussed volunteering at food programs and other homeless outreach programs during the evenings and weekends. For instance, one participant said that she began volunteering with a housing first program because "there are a few programs in the [city] area that are working towards housing first, and it's often getting shut down and the voices aren't being heard… so it's been my interest to get involved because it doesn't have enough support."

Social Justice

All 20 participants (100%) identified that this immersion learning course had an impact on their understanding of and how they adhere to the ethical value of *Social Justice*. The immersion learning course had a strong macro social work and social justice focus, therefore all the participants in this study demonstrated that they have been able to apply what they gained from the course, in terms of this ethical value, to their careers. One participant who works as a school social worker said, "Oppression is a huge piece of what people experiencing homelessness face. Why are the kids that I am working with experiencing this problem? It is not something that any 12-year old should have to worry about." Another participant who is employed as a therapist said:

> Everyone says, 'why don't they just get a job?' Okay, well, first of all the unemployment rate in general is pretty high. And you go fill out an application and they make you put your address on there, well you don't have an address and you don't have a phone. How are you going to get contacted? How are you going to get to the interview? How are you going to get new clothes?

Another participant said that she was able to better understand how social justice issues impact a person in their home environment. She talked about the immersion course helping her to understand this and apply it to her job. In part, she said:

> Something that I have noticed is, that I can work with a kid all day and I can make great changes and strides with the kid. And I send them home to that same environment, and they come back the next day, doing the exact same thing that we talked about and they worked through. You know? Because they're going back to that same environment. It helps me to understand why their environment impacts the way they are.

Dignity and Worth of the Person

Seventeen participants (85%) identified that this immersion learning course had an impact on their understanding of and how they adhere to the ethical value of *Dignity and Worth of the Person*. In fact, participants had a lot to say regarding this ethical value. In their interviews, many participants referenced the various social service agencies in which they visited while on the immersion trip. They talked about how these agencies served as a model for their current careers, in how they uphold this ethical value and regard their clients. One participant in particular, who was questioning his decision to enter the field of social work prior to the immersion course, discussed how these agency visits helped him understand just how much social service agencies care about their clients and value their clients' worth. These visits helped reaffirm his commitment to social work.

Other participants also discussed how this immersion course helped them realize their biases towards individuals experiencing poverty and

homelessness, and the judgement they unwittingly passed. One student in particular expressed how he did not realize his biases prior to enrolling in the immersion course, even though the topic was frequently discussed in his social work courses. However, now he believes that he is more self-aware in his job as a therapist.

Some participants also expressed how they were better able to understand the importance of client self-determination in their current work with clients. For many participants who completed this immersion course as a BSW student, they lacked social work job experience that highlighted the importance of client self-determination. It wasn't until the immersion trip in which they saw firsthand how empowering it can be for clients to have self-determination in their change process. One participant commented, "I would say that self-determination is a huge… because a lot of times people experiencing homelessness are not allowed to have that self-determination and they are just given handouts and expected to take what is given to them and not have a say."

And finally, other participants also talked about the importance of promoting dignity and worth of the person, through using person-first language. Using person-first language was encouraged in the immersion course and modeled by the course instructors. One participant said:

> In my professional world I think about [person-first language] on a weekly basis. I know to phrase my words differently, like as a whole, not just in certain circumstances. But since [the immersion trip], like for example, I only use person first language, so it is never a homeless guy, it's a man experiencing homelessness. I think that's a piece of cultural competency.

Importance of Human Relationships

Seventeen participants (85%) identified that this immersion learning course had an impact on their understanding of and how they adhere to the ethical value of *Importance of Human Relationships*. When speaking about this ethical value, there was much overlap in participants' responses to the

prior value of *Dignity and Worth of the Person*. For instance, one participant said, "People [experiencing homelessness] are really made to feel invisible by society, and that's not fair because they have so much to bring to the table. We can learn from them."

Participants widely discussed how building relationships with clients can strengthen the helping process and enhance overall client well-being. One participant commented about how she was able to apply this ethical value to her job as a behavioral health provider for children. She said, "I think that's been my number one goal with families, is like 'how do I make this relationship important and make them feel worthy, so they feel empowered to do these things and give them hope?' I think that is my role specifically, that's the biggest tool we have." Another participant commented:

> Relationship building, that's the most important thing. So, what if this kid isn't meeting his goal that I wrote down on paper? I mean, the fact that he's coming in and talking to me and feels comfortable sharing some of his struggles with me, I mean that is just the most important thing. It's that relationship piece.

Integrity

Nine participants (45%) identified that this immersion learning course had an impact on their understanding of and how they adhere to the ethical value of *Integrity*. For this ethical value, participants seemed to find difficulty in explicitly stating or finding examples of how they apply this value to their current career. However, they demonstrated their adherence to this value in how they responded to many of the interview questions. Many participants in general talked about how this immersion course helped build their awareness of the Code of Ethics, and how social workers abide by these ethics. A few participants discussed the importance of social work integrity in upholding client confidentiality. One participant in particular who is an HIV case manager discussed this, as well as self-determination of the client and how that relates to social work integrity. She said:

> I have had many times where I think, in my head, that this choice isn't going to turn out well for [my client]. But I can't change anything, I am not going to force them. I am not going to threaten them with no services. It's just their choice, they have to make it. And it's allowing them to have the freedom to do that. And continuing to work with them to help them overcome.

Competence

All 20 participants (100%) identified that this immersion learning course had an impact on their understanding of and how they adhere to the ethical value of Competence. Participants overwhelmingly discussed how being exposed to issues such as homelessness and poverty through an immersion course facilitated their competency in social work delivery. In general, participants seemed to appreciate the opportunity to learn outside of a classroom and apply what they had learned in a classroom setting to real situations of people experiencing homelessness. For instance, one participant commented, "So I think [the immersion course] just kind of solidified the things that we learned in the classroom." Another participant had similar thoughts:

> There really is no better way to learn than talking with the people experiencing those problems and seeing the organizations that are trying to assist these people. Hearing from organizations – this is what works for us, this is what doesn't, and this is what our clients want – you know. I think just exposure is the best way to learn.

However, some students talked about specific things they learned while enrolled in the immersion course and how they have used the knowledge in their current practice. One participant who has worked with at-risk youth since she participated in the trip said:

> It made me realize there is a lot of homeless youth out there as well, and a lot of them are runaways from, like, maybe problems at home. And it's not like they are bad kids. Like some might think they are bad kids, like what is wrong with them? But a lot of the times they have a lot of issues at home and that is why they just chose to be homeless rather than to

> live in an abusive relationship. That is one of major things that I learned that I did not necessarily know before.

Discussion

As the findings suggest, all students who participated in this immersion course experienced a strengthened understanding of the social justice value. The purpose of the structured activities and visiting the selected organizations provided an intentional set of meaningful guideposts to demonstrate social justice in action, in various forms. Therefore, the finding that the social justice value was strengthened for students is not surprising and further reinforces existing evidence (Cramer et al., 2012; Dailey et al., 2016; Fineran et al., 2002; Mitschke & Petrovich, 2011; Scott, 2008). However, participants' ability to apply that value post-graduation into their careers is very important. The majority of our sample currently works in micro-level practice settings, and all students reported an ability to apply this ethical value to their daily social work practice.

Similarly, dignity and worth of the person was highly emphasized in the course. Therefore, this finding is not necessarily surprising but lends insight on using immersion learning as a teaching mechanism to strengthen this value with our students. Since our participants are micro-focused in their careers, this is how they applied this ethical value to their careers and with their individual clients. Visiting the various organizations in Portland afforded students the opportunity to work and learn directly from individuals experiencing poverty, homelessness and sexual exploitation.

In addition, many of the organizations adopted a progressive model of social service delivery, which also promoted human dignity and importance of human relationships. An example would include a meal site which served patrons in a restaurant style, rather than a traditional soup kitchen line. These simple acts elevate the dignity and worth of every person. Removing the stigma and isolation that accompanies poverty and homelessness, the organizations and activities on the immersion trip focused on recognizing and enhancing the importance of human relationships. Exposing students

to these types of service delivery models provided insight to show how these values can be applied. The majority of our participants were not working directly or solely with individuals experiencing homelessness, yet through the immersion course, they had been instilled with a commitment to this population. Many know that they will likely come in contact with lower income or homeless clients in their social work careers, and this trip has armed them with tools and skills to effectively and compassionately deliver services to meet their needs. The use of progressive models to teach about social work delivery, especially through experiential techniques, has also been documented in the literature as an effective approach (Donaldson & Daughtery, 2001).

The finding related to competence was somewhat surprising to the research team. We did not expect to see perceived confidence in individual competence to increase with all students. Many students however, commented that this immersion course was their first exposure to social service models, individuals experiencing poverty, homelessness, and sexual exploitation, and even their first trip outside of their community. As the findings indicate, students being able to see core values and principles applied in the field created a stronger sense of competence. This level of preparation was significant for participants' growing skillset and confidence to practice in the field of social work. This finding underscores Kolb's Experiential Learning Theory (Kolb, 1984), in that the integration of concrete experiences with reflective observation assisted the students in developing a critical understanding and application of their experiences/skillset post-graduation. These results reinforce that immersion courses and other similar trips can be a valuable mechanism for strengthening competence among our social work students and their post-graduation careers.

While other studies have found an impact on students' sense of civic duty (e.g., Mitschke & Petrovich, 2011) due to experiential techniques, the value of service was not strengthened as significantly as the other five principles for our participants. This is unsurprising, given that the main focus of the immersion trip was geared towards social justice and addressing systemic and root causes of poverty and homelessness. However, some

participants did discuss that they were inspired to engage in volunteer work, outside of their paid employment, due to this immersion course. As for the value of integrity, similarly, it was not explicitly identified by all students as an area that was strengthened. Our research team believes if this value had been more explicitly explored during the immersion trip, participants' responses would have shown a strengthening of this value.

More BSW education programs should consider adopting immersion learning or other types of experiential learning techniques into their curricula. A particular focus on enhancing the six core values of the Code of Ethics will result in students feeling more prepared for the workforce. In addition, such programs can foster in-depth understanding of complex issues such as poverty, homelessness and sexual exploitation on behalf of students. This will also help improve and maintain the integrity of our profession. When students learn about a concept, see it in action, and understand it, they will apply that concept more readily in their future practice.

Limitations

This study is limited in generalizability due to the small sample size and geographic heterogeneity of the students enrolled in the immersion learning course. Students also self-selected into the study sample, which may have influenced the findings. For instance, students who gained more out of this immersion course may have decided to participate in this study, which would influence the findings on their understanding and application of the Code of Ethics. In addition, while this study attempted to control for investigator bias in multiple ways, the findings may still be subject to the interpretation of the study team.

Conclusion

This qualitative study examined the impact of an immersion learning course on social work students' understanding and application of the NASW (2021) Code of Ethics to their social work careers, post-graduation. Findings further reinforce the utility of such experiential learning programs for social work students to better prepare them for practice. We suggest that explicitly using the Code of Ethics as a teaching tool to help students apply knowledge to practice can help enhance their skill and adherence to these ethical values, principles, and standards.

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Reinvigorating Social Work's Focus on Perinatal Health

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Abstract

Perinatal health in the United States is plagued by persistent and pervasive racial and socioeconomic disparities. Although many researchers and health professionals have committed to eliminating these long-lasting disparities, not all women benefit from research and intervention efforts equally. The social work perspective, which emphasizes diversity, cultural competency, and healthy families, once served as a central force in combating structural inequities and associated perinatal health adversity. This article argues that, despite the fact that contemporary social work no longer places a heavy emphasis on structural barriers to optimal and equitable perinatal health, the profession's core values make social workers particularly well-equipped to champion maternal and infant health disparities. Given this potential, this commentary calls for social work to reinvigorate its focus and discusses the ways in which social workers can draw from their professional knowledge, training, and experience to help promote health equity for new mothers and babies.

Keywords: perinatal health; health inequities; social determinants of health; contemporary social work

Perinatal health, defined as women's and infants' health during pregnancy and the first year postpartum, is considered a critical indicator of a nation's overall wellness (Office of Disease Prevention and Health Promotion [ODPHP], 2020). Women and infants are experiencing a crisis within the United States, however, where the rate of pregnancy-related mortality and associated complications during pregnancy (e.g., cardiovascular conditions, hypertensive disorders, hemorrhage, and infection) is comparable to that of developing nations (Kassebaum et al., 2016). When women experience complications during pregnancy, their risk for additional pregnancy-related mortality and morbidities (e.g., preterm birth, low birth weight, infant mortality, and poor maternal health) is heightened (Goldenberg et al., 2008; Peterson et al., 2019). Rates of maternal morbidity and mortality are particularly dire within the US. For example, in 2018, there were approximately 17.4 deaths per 100,000 (Hoyert et al., 2020). For every maternal death, there are approximately 70 cases of severe morbidity (Fingar et al., 2018). Likewise, US infant mortality continues to remain far too high, ranking below 46 other nations (World Factbook, 2020).

Although all women can experience perinatal health complications, populations traditionally served by social workers are the most likely to be affected. Black and Native American women experience an unacceptable and disproportionate risk for poor perinatal health outcomes (Martin et al., 2018; Peterson et al., 2019). Among racial/ethnic perinatal disparities, the contrast between White and Black women's pregnancy-related mortality is the starkest of all, with Black women dying at three to four times the rate of White women (Howell & Zeitlin, 2017; Peterson et al., 2019). Women who experience socioeconomic stress, mental health and substance use conditions are also at a greater risk of experiencing perinatal health challenges (Blumenshine et al., 2010; Forray & Foster, 2015; Ross & Dennis, 2009). For families who experience multiple co-occurring marginalizations (e.g., an intersection of racial/ethnic minority status, low-income, and mental health and substance use conditions) the risk for experiencing poor health is higher (Chinn et al., 2021; Lopez & Gadsden, 2016). In particular, research indicates that the combined exposure to chronic maternal stress, greater likelihood

of poverty, and the effects of racism and discrimination have a notable influence on the disproportionate rates at which Black and Native American women experience poor perinatal outcomes (Bryant et al., 2010; Kozhimannil, 2020). Since families often experience poor perinatal health across multiple generations (Aizer & Currie, 2014), this pattern of risk places some of the most vulnerable families in a continuous cycle of reproductive health disadvantage.

It is important that the US health system enhance its capacity to address women's and infants' perinatal health needs. Several national organizations, including the Centers for Disease Control and Prevention (CDC), have prioritized improving perinatal health outcomes (CDC, 2015). Perinatal disparities and the need for reproductive justice have also received increasing attention from national media sources (Belluz, 2017; Frakt, 2020; Villarosa, 2018), sparked by a wave of advocacy led by persons of color (e.g., the JJ Way Model of Maternity Care; Black Mamas Matter Alliance; and the National Birth Equity Collective). In turn, interventions targeting perinatal health disparities have also become more prominent in state policies across the US.

Just as women and infants are not uniformly exposed to risk for poor outcomes, not all women and infants benefit from perinatal public health interventions uniformly (Thomas et al., 2011). This issue is complex. Although there are many interventions targeted toward medically vulnerable or underserved persons, interventions have historically focused too narrowly on the individual, without consideration for the larger system within which the individual exists (Jones et al., 2019). Multiple stressors on minoritized populations, along with medical mistrust, work to sustain existing disparities and make intervention a daunting contemporary health challenge. Broader system-level issues further complicate efforts to reduce perinatal disparities (Purnell et al., 2016). For example, disparities-oriented implementation science indicates that more research is needed to understand how interventions can effectively influence provider biases, enhance existing health resources, and address issues of care access and coordination (Purnell et al., 2016). Stark disparities persist in relation to a wide variety of

perinatal health conditions, including the disproportionate rates of unaddressed maternal mental and physical health conditions, preterm birth, low birth weight, and maternal-infant mortality (CDC, 2019; Goldfarb et al., 2018; Mukherjee et al., 2016; US Department of Health and Human Services Office of Minority Health, 2019). Continued perinatal health disparities, despite public health efforts, suggest the need for additional perspectives in order to close the gaps in perinatal health and wellbeing.

Effectively confronting perinatal health disparities will require increased attention from diverse stakeholders in order to identify gaps in interventions designed to enhance health equity (Purnell et al., 2016). The social work perspective can play a particularly valuable role in championing changes to a health system that has routinely failed some of its most vulnerable subpopulations. This commentary highlights ways that social work knowledge and values can contribute to the imagination of comprehensive intervention strategies that have the potential to erode the entrenched systems that foster disparities as well as roles that social workers can take on to aid in reducing existing disparities. It also presents ways that the social work profession can help to advance current progress within the perinatal health field. Given the profession's emphasis on advocating on behalf of underserved communities, its embrace of the person-in-environment perspective, and its strong support of strengths-based care provision, this article argues that social workers should enhance their purposeful attention to maternal and infant health equity.

Social Work and the Complex Landscape of Perinatal Care

Evidence of perinatal health disparities began garnering attention at the beginning of the 20th century, where Hull House social workers emerged as advocates for reducing high rates of infant morbidity and mortality, particularly among the very poor (Sherraden, 2015). Within their role at the Hull House, social workers such as Jane Addams and Julia Lathrop conceptualized strategies to address infant mortality beyond a need for enhanced medical care. These early social workers situated their concerns with

perinatal health in underlying conditions, including the "economic, social, civic, and family conditions" (Lathrop, 1918, p.1), such as adequate housing, education, food safety, sanitation, and the overarching issue of abject family poverty (Sherraden, 2015).

Today, Hull House efforts would be recognized as work to address social determinants of health (SDH). SDH, the "conditions that shape the ways that people are born, grow, live, and work" (Commission on Social Determinants of Health, 2008, p. 2), dictate how individuals experience social infrastructures that predict health and ill-health. Key contemporary SDH that influence perinatal outcomes echo the touchstones of Hull House workers, including education, employment, income, housing, and access to quality healthcare (ODPHP, n.d.). By continuing to emphasize these factors, contemporary perinatal health scholars and practitioners are able to explain how environmental conditions prime some families for poor health, while protecting others (Larson et al., 2017; Rust et al., 2012).

The risk and protective factors explained through SDH help to conceptualize the most effective strategies for promoting enhanced perinatal care and outcomes. When perinatal health providers integrate an SDH lens into service delivery, they have the potential to improve both direct treatment approaches and their ability to engage in prevention strategies. Unfortunately, while there are numerous social workers helping women address perinatal care needs across the US (National Association of Perinatal Social Workers, n.d.), the majority of social workers align themselves with clinical roles (Abramovitz & Sherraden, 2016) that limit their capacity for stemming structural inequities.

Though social workers have largely been replaced by other allied health professionals as the leading champions of community-centered practices that can promote perinatal health research and practice, the profession's role in addressing SDH offers an opportunity for new perspectives on persistent perinatal health challenges (Coren et al., 2011; Keefe et al., 2016; Rine, 2016). Social workers, whose professional role is to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are

vulnerable, oppressed, and living in poverty" (National Association of Social Workers, 2017, p 1), undergo explicit training to provide services that address individuals' social needs (National Academies of Science, Engineering, and Medicine, 2019). Through this training, social workers are poised to address clients' challenges and concerns from a person-in-environment, bio-psycho-social-based perspective, which allows the profession to frame individual or community experiences as expressions of social inequity, and to work towards social justice using a broad approach to solution-building.

Given their professional training and knowledge, social workers should strive to balance individualized medical care with community-based interventions (Abramovitz & Sherraden, 2016). Through this strategic balance, social workers can contribute in a variety of ways to developing interventions designed to address perinatal health care quality and accessibility while simultaneously addressing upstream factors that influence health outcomes. In particular, social workers can act as a critical source of support for enhancing communities' access to perinatal care. For example, social workers can 1) engage communities of women in conversations related to desired approaches to perinatal health care; 2) advocate for insurance options that enhance women's ability to access quality perinatal care; or 3) pilot health navigation strategies that allow perinatal care workers to actively help women to address barriers to care (Dominguez, 2011; Natale-Pereira et al., 2011; National Academies of Science, Engineering, and Medicine, 2019).

Social Workers' Role in Establishing Social Justice and Perinatal Health Equity

Perinatal health equity cannot be fully achieved without acknowledging the underlying predictors of inequity (Jones, 2018). Perinatal health workers invested in mitigating disparities must remain cognizant of the history of racism, discrimination, and bias, which shape differential access to key determinants of health. The disparities that characterize contemporary perinatal health are shaped by women's exposure to chronic racism and

discrimination, which have impacted African and Native American families' social experiences for generations (Prather et al., 2018).

Race-based discrimination pervades US health care settings, further sustaining and reinforcing existing health disparities (Forson-Dare et al., 2021). Social workers must approach perinatal health with an understanding of the values that permeate health care provision in the US, including the "myth of meritocracy" (Jones, 2018). The myth of meritocracy, first defined by Dr. Camara Jones, is the idea that "if you work hard, you will make it," despite the fact that working harder does not always equate to equitable outcomes (Crear-Perry et al. 2021). With respect to health, the myth of meritocracy fails to acknowledge the structural inequities that undergird disparate outcomes, and, as such, invalidates the experiences of persons who are exposed to health adversity. This myth can be further extrapolated to justify health as a privilege that can be earned or lost, rather than as a basic human right, thus shaping the ideals of which individuals are worthy of care and which individuals can be disregarded.

Meritocratic ideologies consistently disadvantage marginalized populations (Kwate & Meyer, 2010). By reinforcing a belief system that perpetuates the systemic and structural factors that underlie ill-health, these ideologies shift blame from public policies that negatively and disproportionately affect low-income communities and communities of color onto individuals who experience ill-health as a result of their systemic and structural constraints (Crear-Perry et al., 2021; Kwate & Meyer, 2010). Regarding perinatal health, women have experienced stigma related to their experiences of mental health conditions (Alderice & Kelly, 2019; McCauley et al., 2011), substance use behaviors (Terplan et al., 2015), and reproductive health practices (Cook & Dickens, 2014), which in turn shape the quality of the care that they receive. As a result, meritocratic ideologies have the capacity to reinforce negative stereotypes and can allow health workers to rationalize variable healthcare strategies based on demographic characteristics.

Work that addresses the perinatal health ramifications of racism and simultaneously critiques the existing myth of health meritocracy is greatly needed. Social work, which has prioritized issues such as healthy child

development, equitable health outcomes, cultural and linguistic care, and the amelioration of racially-driven barriers to equal opportunity and justice (Sherraden, 2015; Uehara et al, 2015), is well-suited to join forces with existing leaders in the reproductive justice movement to respond to this need. Social workers can apply their professional skills and foundational tenets to begin to mitigate racially driven inequities and existing ideologies related to health meritocracy. Social workers are called to engage in active listening with clients to understand how their clients' lived experiences relate to their overall health and wellbeing. Through active listening, social workers can identify, articulate, and protest mechanisms which prevent clients from obtaining optimal health.

Similarly, social workers are trained to identify client strengths and support their pursuit of resources in an effort to ensure clients' right to self-determination and sustained ability to experience optimal health. For example, social workers' strengths-based approach to solution-building can be a valuable skill in identifying examples of *positive deviance*, which highlights unique examples of alternative approaches to positive health outcomes. Within the perinatal health field, positive deviance, typically generated by individuals within affected communities, has emerged as a strategy for developing novel, potentially generalizable approaches to care (Rust et al., 2012). Social work's professional skills and tenets may offer an ideal constellation of knowledge regarding power and oppression as well as multisystemic strategies for perinatal health promotion.

Skills and Key Roles for Social Workers in Perinatal Health

Given social work's theoretical knowledge and foundations, the profession can challenge systemic and structural factors contributing to perinatal health disparities across the micro, mezzo, and macro systems. First, social workers can intervene at the micro level by assisting individual clients with addressing social, physical, and mental health concerns during the perinatal period. Examples of such support include facilitating communication between clients and their health providers, addressing symptoms of perinatal

depression and anxiety, establishing brief interventions to help mothers engage in health promoting behaviors, supporting mothers in their desired approaches to delivery, and problem solving around infant feeding during the postpartum period.

At the mezzo level, social workers provide support within communities and perinatal health practices to enhance perinatal health outcomes. Here, social workers play a primary role in patient-centered medical homes (PCMHs) and health navigation (National Academies of Science, Engineering, and Medicine, 2019). Social work knowledge, for example, is valuable within PCMH settings, which promote evidence-based strategies for implementing screenings and processes for utilizing community resources, including timely access to and coordination of care and overseeing electronic care management mechanisms (Institute for Healthcare Improvement, 2016; Stange et al., 2010). Health navigation shifts the burden of finding and coordinating specialty care from the hands of the client to professionals in the healthcare system (Valaitis et al., 2017). Social workers can use health navigation to help establish linkages across women's physical, emotional, and social care needs. Women's perinatal care needs may vary based on their personal and cultural preferences (Coast et al., 2016), and social workers, who are trained in person-centered, culturally-competent care practices, can use their professional knowledge to establish acceptable healthcare plans for patients while helping to educate nurses, physicians, and other allied health providers on best practices for patient-centered care. Through perinatal health provider education, social workers can broaden the likelihood that women receive care that aligns with their health needs and desires.

At the macro level, social workers can act as key players in social and health policy advocacy across several domains including (1) enhancing equity related to underlying SDH; (2) promoting access to *quality* health services, such as the Council on Patient Safety in Women's Health Care's patient safety bundle on reducing peripartum racial/ethnic disparities (2016); and (3) naming and calling for the dissolution of policies that promote health environments characterized by stigma and discrimination. In order

to promote equity across SDH, social workers can advocate in support of progressive social policies that promote quality education for all, reliable transportation, and access to affordable nutrition, housing, and childcare. As professionals who embrace the fit between individual and environment across a lifespan (Hutchinson, 2008), social workers are oriented to advocating for equity across numerous SDH domains.

Social workers should also advocate for increased access to healthcare services. Evidence suggests that Medicaid Expansion, which promotes access to affordable preconceptive care, has positive implications for women and infants during the perinatal period (Brown et al., 2019; Searing & Cohen Ross, 2019). It is equally imperative that families receive quality perinatal health services. Research, however, indicates that health resources remain racially and economically segregated (Chandra et al., 2017; Janevic et al., 2020; Yearby, 2018), with quality health services remaining more accessible to wealthier, White patient populations (Chandra et al., 2017). Social workers can help to ensure perinatal health equity by advocating in support of policies and funding mechanisms that ensure quality and allocate cutting-edge resources to perinatal providers and health institutions that serve low-income and racially-diverse communities.

Lastly, social workers are called to ensure that patients have access to perinatal health care that doesn't subject them to stigmatization and discrimination. As such, consideration of strategies to curb racially-driven criminal justice practices is necessary. During the perinatal period this may be particularly important, as the racial disparities in drug charges and sentencing may discourage pregnant and postpartum mothers with risky substance use practices from engaging in care (Lester et al, 2004; Stone, 2015). Although stringent perinatal substance use policies are designed to benefit children, studies show that children whose mothers engage in risky substance use practices receive suboptimal or delayed care due to mothers' fear of stigma and engagement in the child welfare system (Stone, 2015). Therefore, policies intended to improve health are further perpetuating the cycle of inadequate healthcare provision and enhancing the likelihood of poor intergenerational health outcomes.

Although social work is no longer a leader in promoting perinatal health equity, social work values affirming human worth regardless of racial identification, economic wellbeing, or behavioral health status make them ideal health professionals to address a wide array of women's perinatal health needs. Several models of health and social care have been inspired by social work's original values (Abramovitz & Sherraden, 2016), and social workers are already peppered throughout practices and programs in some states. Their critical skills and knowledge, however, demand that the profession reinvigorate its emphasis on community-based care and its attention to perinatal health.

Conclusions

Racial and socioeconomic disparities in perinatal health adversities are persistent and pervasive and are attributable to a host of negative repercussions for affected individuals, families, and communities. Although many health professionals are focused on closing the health gaps that occur during the perinatal period, stark inequities remain. In order to address the complex underlying factors associated with contemporary inequities, the perinatal health field is in need of a multi-systemic approach to solution-building. Social workers offer skills, perspectives, and a mastery of social care that lay a foundation for positively impacting the existing perinatal health crisis. Likewise, social workers place prominent value on curtailing racism, discrimination, and the inequities that emerge from socially unjust institutional structures, further driving the importance of social work's contributions to dismantling perinatal health disparities. Given the important role that social workers play in addressing health inequities during the perinatal period, it is essential that the social work profession reinvigorate its focus on perinatal health.

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Book Review

Raines, J. C. & Dibble, N. T. (2021). Ethical decision-making in school mental health (2nd ed.). Oxford University Press.

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Reviewed by MaryAnn Thrush, PhD, MSW
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Ethical Decision-Making in School Mental Health is a great book for anyone teaching an ethics course or for those making decisions for individuals with less standing/status. The authors begin this informative and well-written book by defining the term *ethics*. They suggest there are two pillars of ethics: the Golden Rule and fiduciary responsibilities. While all the major religions give credence to the Golden Rule, the authors suggest that it is necessary, but also, insufficient for a complete code of ethics. They posit that the Golden Rule serves as a moral basis, and fiduciary considerations serve as a legal basis. Together they provide a solid foundation for making ethical decisions.

The authors outline seven aspects of ethical decision-making that serve as a guide for ethical predicaments:

1. Know yourself and your responsibilities.
2. Analyze the situation.
3. Consider consultation.
4. Identify possible courses of action.
5. Consider clinical concerns.

6. Implement the decision.
7. Review and document the situation.

The first consideration, know yourself and your responsibilities, includes one's primary ethical orientation: deontological or consequentialist. Deontological ethics is based on duty and on moral principles. Consequentialist ethics posits that the right action is one that produces the best result. In Chapter 1, the authors deconstruct these ethical orientations, illustrating how they apply to the individual decision maker. The authors explore the pros and cons of each ethical approach and introduce two, more current, ethical theories: ethics of virtue and ethics of care. While ethics of virtue is based on duty, ethics of care takes into account emotions felt by the people involved. This latter theory seems to be particularly appropriate for social work professionals. Ethics of care has the potential to deepen the emotional bond between practitioners and clients and allows the practitioner to model and express unconditional positive regard.

Another aspect of the 'know yourself' element includes one's professional responsibilities. There is an expectation that the practitioner is able to use knowledge and skills consistently, in the service of the student. The authors also suggest that a commitment to self-care needs to be included in ethical obligations.

Chapter 2 describes the way to begin analyzing the situation in order to have a clear vision of the issue and of the people involved. Stakeholders, besides the student, might include parents, teachers, colleagues, other students, and administrators. Using the ethics of care theory, one might consider issues of loyalty and trust, but also, who benefits, who was harmed, and long-term consequences of a specific course of action. Analysis should also include the potential influence of stakeholders with different levels of power. When analyzing the situation, one needs to consider assent, given that students are minors, and that mandatory reporting is required for certain types of cases.

Chapter 3 considers the advantages of seeking consultation with other professionals, both legal and clinical. The authors list ten reasons to seek

consultation, most of which entail helping the practitioner look at the situation from different perspectives and consider possible unintended consequences. A good consultant is one with whom the practitioner has an ongoing relationship. A mature, experienced colleague offers a structured environment within which sensitive elements can be discussed. In addition to clinical consultations, legal consultations may be helpful and sometimes necessary.

After analyzing the situation and consulting with appropriate professionals, the practitioner is ready to begin identifying various courses of action. Five factors need to be considered at this stage: primary goals, including costs and benefits; going beyond *either/or* options; consideration of tension among various stakeholders; projection of outcomes and consequences (both negative and positive); and consideration of the moral principles of the profession.

Chapter 5 goes into detail about managing clinical concerns, both for the practitioner and others involved. The risk of suicide underscores the importance of having a competent team in place in case a crisis occurs. Consideration of warning signals, level of danger, location, whether the student needs to be hospitalized, responding to the family's culture and ethical values, consideration of the student's level of development and competency, all need to be well-thought-out ahead of time.

As action plans are implemented, Chapter 6 stresses remaining empathic and maintaining positive regard for the student and stakeholders while focusing on managing, rather than solving the dilemma. Additionally, the practitioner needs to continue to anticipate unintended consequences from both the therapeutic and the legal perspectives.

The final chapter considers the ethics of recordkeeping, discussing the three goals: improving client treatment, social conditions, and the practitioner's critical thinking skills. By keeping records that maintain confidentiality and the client's privacy, the practitioner details ethical and fiduciary accountability. Additional considerations are record accuracy; who has access; and how the information is communicated, documented, and ultimately destroyed.

Ethical Decision-Making in School Mental Health has multiple strong elements; however, perhaps the most important is the way the authors deconstruct ethical decision-making. The book is a thorough discussion of the factors that go into ethical decision-making and the fiduciary responsibility of school mental health practitioners. This book is not limited to school practitioners but can serve as a good foundation for anyone who makes decisions regarding individuals with less standing, such as persons served by our criminal justice system, persons hospitalized, and elders, to name a few. Finally, in addition to making ethical decisions for others, *Ethical Decision-Making in School Mental Health* serves as a guide for making personal decisions concerning ethical dilemmas.

Book Review

Renaud, M., & Schweiker, W. (Eds.). (2021). Multi-religious perspectives on a Global Ethic: In search of a common morality. Routledge.

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Reviewed by J. Porter Lillis, Ph.D.
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The book is an edited collection of essays by scholars of religion who consider the *Global Ethic* from specific religious traditions. The book begins with a primer on the history and development of the *Global Ethic*, an international effort at creating a worldwide (global) understanding and agreement on universal moral norms, common to both secular and religious traditions. This undertaking was begun at the behest of the Parliament of the World's Religions, based on initial work by the Swiss theologian, Hans Kung. The project was set in motion by leaders of the Parliament when they heard Kung lecture at the University of Chicago. The *Global Ethic* is based on universally held moral commitments found in the world's religions that are "purportedly held by people throughout the world…" (p. 1). Kung knew that religions have been the cause of violence, but he also held that they provide strong moral norms that shape and inform morality. Religions teach morals and ethics, and their rich texts and teachings are resplendent with stories and parables that shape and inform behaviors. "These…resources give the religious traditions a unique ability to shape the moral ethos of billions of practitioners" (p. 3).

The essays are written in secular terms, and they engage the *Global Ethic* by asking questions, testing assumptions, and in sum, providing a diversity of religious and scholarly perspectives on what the *Global Ethic* gets right as well as wrong, and where it could go. This collection has almost too many key terms and potential audiences to list them all. There are philosophical, humanistic, ethical, and theological audiences for whom this would work as a reader; it could be a companion for specific religious and moral perspectives, and for some undergraduates or graduates, as a text. There is a hope here, as well as a challenge. We are asked to re-contemplate the *Global Ethic* and are reminded that there is a common ground shared by the different religious traditions as well as the secular moral systems. The essays go beyond the general understanding of the *Global Ethic* that there are shared, universally held societal norms, and it investigates some of the arguments, minutiae, and aspects not covered by the broad strokes.

The essays share the uniqueness of the different cultures and religious perspectives. Some essays support the idea that there is, or could be a shared ethical commitment; others question, and even deny this is possible.