Emerging research on religion, spirituality, health, and mental health has begun to catch the attention of helping professionals. Some clients are expressing a desire for their health and mental health practitioners to initiate discussion of their religious or spiritual beliefs as they relate to their case. Social workers are the most represented group among personnel providing mental health services, so it is important to understand their attitudes, views, and behaviors regarding integrating clients’ religion and spirituality (RS) into practice. Few studies have assessed such an integration; those that are available focus primarily on practitioner characteristics and use of specific helping activities to integrate clients’ RS in treatment. This article discusses how RS have been integrated into social work practice and education and reviews instruments used to assess such practices. In addition, the findings from previous studies examining social workers’ integration of clients’ RS are compared with those of other helping professions. Finally, implications for education and practice are discussed.

KEY WORDS: education; practice; religion; social work; spirituality

A growing body of evidence on spirituality, religion, and health suggests religious or spiritual practices contribute to positive outcomes across a wide range of health and mental health issues (Koenig, King, & Carson, 2012; Koenig, McCullough, & Larson, 2001). Clients have also expressed a preference for health care providers to initiate the discussion of their religious and spiritual beliefs, stating such integration supports their healing process (Koenig, 2005; Stanley et al., 2011; Tepper, Rogers, Coleman, & Maloney, 2001). In addition, religious struggles or coping mechanisms may emerge in practice (Pargament, 1997), so it is important that practitioners address the religious dimension of life challenges and traumas.

Currently, social workers are the largest group of clinically trained professionals in mental health services, accounting for 45 percent of personnel (Substance Abuse and Mental Health Services Administration, 2010). Despite research showing the importance of considering clients’ religion and spirituality (RS) in health and mental health treatment, 65 percent of social workers report not having received education on how to integrate clients’ RS in practice, and 25 percent do not have the skills to assist clients in RS matters (Canda & Furman, 2010). Among the other 75 percent, the quality of their skills is not known.

This article presents a review of the literature on three areas concerning RS: (1) issues and considerations in health and mental health treatment, (2) the degree of integration in social work practice and education (including assessment, discussion of clients’ RS in practice, and use of empirically supported practice behaviors that integrate clients’ RS), and (3) prior attempts to measure social workers’ integration of RS in practice. In addition, social workers’ views and behaviors around integrating RS will be compared with those of other helping professions, implications for education and practice will be discussed, and suggestions for future studies will be made.

RELIGION AND SPIRITUALITY IN HEALTH AND MENTAL HEALTH TREATMENT

Defining Religion and Spirituality

Definitions of RS vary across helping professions. Hill et al. (2000) identified that both terms involve “feelings, thoughts, experiences, and behaviors that arise from the search for the sacred” (p. 66). Religion is defined as an institutionalized, systemic pattern of values, beliefs, symbols, behaviors, and experiences shared by a community (Canda & Furman, 2010)
that relies on a set of scriptures, teachings, moral code of conduct, and rituals (Koenig, 2008). Spirituality is a fundamental human quality (Canda & Furman, 2010) that involves a personal search for the sacred (Pargament, 2007) and “moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness” (Summit on Spirituality, as cited in Miller, 2003, p. 6). Further, positive spirituality is “a developing and internalized personal relation with the sacred or transcendent that is not bound by race, ethnicity, economics, or class and promotes the wellness and welfare of self and others,” integrating both religion and spirituality (Crowther, Parker, Achenbaum, Larimore, & Koenig, 2002, p. 614). Although these terms can be differentiated conceptually, they are often interconnected in practice. RS can be integral to many clients’ lives and is important to consider in social work practice, much like culture. In fact, Canda and Furman (2010) defined religion, and Robbins, Chatterjee, and Canda (2012) defined culture as both being shared by a community or social group, transmitted over time, and including a pattern of values, beliefs, and behaviors. The NASW’s Code of Ethics (2008) includes religion under the umbrella of diversity topics requiring cultural competence, and NASW’s (2001) Standards for Cultural Competence in Social Work Practice “require culturally sensitive and culturally competent interventions [that] include addressing . . . the importance of religion and spirituality in the lives of clients” (p. 8). Clients’ RS beliefs will vary, and social workers should consider them an aspect of client diversity.

### Prevalence of Religion and Spirituality within the United States

Social workers are trained to be culturally competent, to maintain a holistic perspective, and to remain mindful of where a client is (Saleebey, 2009). It is important to consider salient aspects of a client’s life, including his or her RS. According to a recent survey, 80 percent of U.S. adults view religion as being at least somewhat important (58 percent view it as very important) (PEW Forum on Religion & Public Life, 2012). Over the last five years, the percentage of the overall population that are unaffiliated with a religion increased by 4.3 percent, yet a third of this group report religion as at least somewhat important, over half consider themselves either “religious” or “spiritual but not religious,” and 68 percent believe in “God or universal spirit” (PEW Forum on Religion & Public Life, 2012). Therefore, even those unaffiliated with a faith tradition are not completely secular. Today, many of us value private, individualized faith (Achenbaum, 2012; Wuthnow, 2010), with over half experiencing weekly spiritual peace and well-being, and a third claiming to have experienced divine healing or receiving monthly answers to prayer requests (PEW Forum on Religion & Public Life, 2008).

### Integrating RS into Practice

Various helping professionals integrate RS in health and mental health treatment by using standardized assessment tools, such as the CSI-MEMO (Comfort, Stress, Influence, Member, Other) (Koenig, 2002) or FICA (Faith and Belief, Importance, Community, Address in Care) spiritual history (Puchalski & Romer, 2000), or by discussing forgiveness, gratitude, mindfulness, presence, hope, meaning, connection, spiritual transformation, ultimate reality, and positive and negative spiritual coping mechanisms with clients (Hodge, 2006; Kabat-Zinn, 2003; Koenig, 2005; McCullough, 2000; Pargament, 1997, 2007). Particular effort has been made to integrate clients’ RS into cognitive–behavioral therapy by using religious or spiritual images or words during progressive muscle relaxation (PMR), deep breathing, or cognitive restructuring (Armento et al., 2009; Barrera, Zeno, Bush, Barber, & Stanley, 2012; Hodge, 2006; Rosmarin, Pargament, Pirutinsky, & Mahoney, 2010). Roger’s (1951) client-centered therapy and Allen’s mentalization (Allen, Fonagy, & Bateman, 2008) also support RS in practice. A recent meta-analysis of 31 studies on spiritually oriented psychotherapies found an overall moderately high effect size (.56) across a variety of clinical issues (for example, depression, anxiety, stress), suggesting spiritually integrated therapies benefit clients with these clinical issues (Smith, Bartz, & Richards, 2007). Likewise, Wachholtz and Pargament (2008) found that those randomized to practice spiritual meditations (“God is good”) 20 minutes per day for 30 days had fewer headaches, less anxiety, and higher pain tolerance than those who practiced internal secular meditations (“I am good”), external secular meditations (“Grass is green”), or PMR.

Recently, Rosmarin et al. (2010) had 125 participants (77 percent female, with an average age of 42 years), who self-identified as Jewish, randomized to

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an Internet-based spiritually integrated treatment (SIT), a PMR program, or a waitlist (WL) group; participants completed all assessment points of the study. At six to eight weeks posttreatment, those in the SIT group had significantly lower levels of worry, stress, depression, and intolerance to uncertainty compared with the PMR and WL groups. The effect sizes for SIT, PMR, and WL were as follows: stress (−1.90, −1.10, −0.88), worry (−1.90, −1.10, −0.04), depression (−0.89, −0.65, −0.65), and intolerance to uncertainty (−1.40, −0.47, −0.39). The effect sizes across treatment conditions (SIT, PMR, WL) for positive religious coping were 0.60, −0.24, −0.05, respectively (Rosmarin et al., 2010).

CURRENT INTEGRATION OF RELIGION AND SPIRITUALITY IN SOCIAL WORK EDUCATION AND PRACTICE

RS had not always been included in the social work curriculum. The professionalization of social work (1920s to 1970s) paralleled a trend toward its separation from other helping professions. As related helping professions moved toward a scientific, medical model to practice, and with RS material not being scientifically grounded at the time, RS content was removed from social work’s curriculum guidelines (Canda & Furman, 2010; Marshall, 1991; Russel, 1998). However, a resurgence of interest in spirituality in the 1980s resulted in the Counsel on Social Work Education’s (CSWE) 1995 guidelines, which returned attention to RS as a part of client diversity (Russel, 1998). Currently, three policies from CSWE’s (2008) Educational Policy and Accreditation Standards mention RS, encouraging learning from diverse sources of instruction (policy 3.1), honoring the role culture (including religion) plays in one’s identity and life experiences (policy 2.1.4), and understanding spiritual (along with biological, social, cultural, and psychological) development (policy 2.1.7).

To date, many social work programs do not offer a course on RS, but weave religious traditions into the human behavior in the social environment content and textbook readings. However, due to RS being more experiential in nature, some have argued that a specialized course is needed to help foster an understanding of the role RS has in clients’ lives (including positive and negative coping strategies) that may not be obtained solely by required readings or in one or two brief lectures (Hodge & Derezotes, 2008; Canda & Furman, 2010). Clients’ RS may greatly influence health care decisions (Ehman, Ott, Short, Ciampa, & Hansen-Flaschen, 1999; Silvestri, Knitting, Zoller, & Nietert, 2003), further making it important for social workers to learn to assess and discuss clients’ beliefs and practices. In 1998, only 17 of 114 (15 percent) social work programs had a course on spirituality (Russel, 1998); in 2005 Canda reported an increase to 75 of 190 (40 percent). In 2011, a CSWE clearinghouse emerged to disseminate RS teaching strategies (Sherr, Land, Canda, Husain, & Sheridan, 2011). Despite these efforts, the degree to which these changes are actually affecting current social work education and reaching practitioners is limited. As a result, curricular content has not kept pace with pathbreaking research, which shows important connections between RS and health (Koenig et al., 2001; Koenig et al., 2012). In addition, it is important to examine how RS interfaces with social work education, especially because some students have reported experiences of religious discrimination in the classroom (Thyer & Myers, 2009), which may stifle their learning process.

Under NASW’s (2008) Code of Ethics, religion is mentioned in the purpose statement and under five standards (1.05, 2.01, 4.02, 6.04, and 1.06). These guidelines advise practitioners against discrimination, to respect diversity, and to avoid conflicts of interest (for example, practicing to further religious interests). Social workers are expected to understand social diversity (including religion) under standard 1.05, but understanding client diversity is not the same as knowing how to appropriately apply and integrate such knowledge into practice. Further, spirituality is not discussed in the Code of Ethics (NASW, 2008), though it is mentioned in NASW’s (2001) Standards for Cultural Competence in Social Work Practice, which acknowledges the importance of spirituality for many clients and notes potential use of relevant support systems (for example, spiritual leaders). Assessing for and understanding this area of clients’ lives better positions social work practitioners to identify and address both the positive and negative impact that RS may have in clients’ lives.

For current practitioners, the evidence-based practice (EBP) process is one of the most widely recognized decision-making processes. EBP identifies and integrates “best research evidence with clinical
exploring. and integration of RS into practice are worth their practitioner. Because clients prefer to discuss their RS beliefs at their practitioner’s initiative, social workers’ views and integration of RS into practice are worth exploring.

Current Social Work Practitioners’ Integration of Clients’ RS

To date, few studies have sought to understand social workers’ views and integration of clients’ RS into practice. Upon reviewing the social work literature, three scales appeared to have been developed and used to specifically measure social workers’ integration of clients’ RS in practice, though others may exist. These scales are the Role of Religion and Spirituality in Practice Scale (RRSP) (Sheridan, Bullis, Adcock, Berlin, & Miller, 1992), the Religion and Prayer in Practice Scale (RPPS) (Mattison, Jayaratne, & Croxton, 2000), and the Spiritually Derived Intervention Checklist (SDIC) (Canda & Furman, 1999, 2010). Previous studies have primarily examined social workers’ use of RS helping activities or interventions (for example, praying or meditating with a client) and whether the social worker agrees that the activity is appropriate to use in practice. RRSP, SDIC, and RPPS are described in the following sections.

Role of RPPS. In 2008, Sheridan noted that “practitioners and students are utilizing a substantial number of spiritually based interventions, . . . that there is no evidence of adherence to specific ethical guidelines, and that the majority of social workers receive little or no instruction on religion and spirituality” (p. 99). This disconcerting observation came 13 years after CSWE’s renewed emphasis on RS and 16 years following the development of the RRSP (Sheridan et al., 1992).

The RRSP is a 19-item scale (alpha = .81) designed to assess attitudes toward RS in practice, practitioners’ ideology, past and current religious affiliation, extent of and satisfaction with education and training in RS, and certain clinical practice behaviors (for example, “Know clients’ religious or spiritual backgrounds,” “Pray privately for a client”) (Sheridan et al., 1992). In the original study, Sheridan et al. (1992) found that compared with social workers and psychologists, licensed professional counselors (LPCs) had the highest involvement and affiliation with organized religion and higher attitudes and use of RS in practice, and were more likely to report that their clients presented issues involving RS. In 1994, Sheridan, Wilmer, and Atcheson surveyed social work educators using the RRSP. Results indicated high scores on the RRSP and a majority of educators supporting a course on spirituality, but four years later only about 15 percent of programs offered such a course (Russel, 1998).

Despite the wealth of information provided by this scale (Sheridan, 2004; Sheridan & Amato-von Hemert, 1999; Sheridan et al., 1992; Sheridan et al., 1994), the RRSP is limited by not having demonstrated criterion or factorial validity and is unidimensional, only measuring attitudes toward the role of RS in practice. Although this dimension is important, by itself, it does not assess a comprehensive understanding of practitioners’ views and integration of clients’ RS by overlooking potentially relevant practice behaviors, self-efficacy, and the question of whether such integration is even feasible.

SDIC. The 21-item SDIC was developed to survey NASW members’ use of specific religious or spiritual helping activities with clients, and whether the helping activity was appropriate in practice (Canda & Furman, 1999, 2010). Many of the items mirror those in the RRSP (for example, use or recommendation of religious or spiritual books or writings, recommendation of participation in a religious or spiritual support system or activity) (Canda & Furman, 1999, 2010). The SDIC assesses attitudes (specifically toward how appropriate the helping activity is) and behaviors related to RS in practice. Three subscales emerged in the study conducted in 1997 (Canda & Furman, 1999); these subscales were replicated in 2008, including religion items (alpha = .97), spirituality items (alpha = .97), and RS items (alpha = .98) (Canda & Furman, 2010). In both studies, more respondents agreed that each helping activity was appropriate in practice than those who had actually done the activity. Although the SDIC has provided much information (Canda & Furman, 1999, 2010), it does not shed light on why more practitioners feel certain RS helping activities are appropriate for practice but do not engage in these helping activities. Measuring self-efficacy or perceived feasibility of engaging in the activities may help to fill this gap.
RPPS. In 2000, Mattison et al. developed the RPPS (alpha = .80). Like Canda and Furman (1999, 2010), they asked NASW members if the indicated religious or spiritual practice activities were appropriate and whether they had used the activity with clients. Activities included discussing religious beliefs with client, praying with client at client’s request, requesting client to pray with you, using serenity prayer, initiating laying of hands as a technique, and recommending a religious form of healing. The activity that social workers felt was the most appropriate (34 percent) was the use of the serenity prayer, with the least appropriate (3 percent) being requesting the client to pray with you. Most interesting, although only 14 percent felt “discuss your religious beliefs with client” was an appropriate helping activity, 45 percent had done this activity at least once. This study corroborates Sheridan’s (2008) observation that a practitioner may view an activity as inappropriate in practice but still engage in the activity. It is not clear, however, what the reasons are for the disconnect between what is perceived appropriate and what is actually done, and how to address them.

Considering that allied helping professions often face similar practice issues, it is useful to examine whether other professions have identified important ideas or approaches for integrating RS into practice settings. As research and practice move toward an interdisciplinary approach to treatment, understanding how psychologists, therapists, counselors, and other related professionals handle RS issues is critical.

INTEGRATION OF CLIENTS’ RELIGION AND SPIRITUALITY IN SOCIAL WORK AND IN RELATED PROFESSIONS

Social work is not the only profession that wrestles with the role of RS in practice. It is only within the past few decades that RS has reclaimed helping professionals’ attention, despite their common roots in ministry (Koenig et al., 2001). Recently there have been various attempts to better understand practitioners’ views and integration of RS in practice.

RS in Allied Professions

Like social work, each helping profession has its own code of ethics. Religion is often woven into the topic of discrimination in most ethical codes, including those under the American Psychological Association (APA) (2010), the American Association for Marriage and Family Therapy (AAMFT) (2012), and the American Counseling Association (ACA) (2014). The ACA Code of Ethics also mentions consideration of RS during client assessment, to recognize clients’ RS social support, and as a valued component of counselors’ professional self-care (ACA, 2014). In addition, the American Nurses Association (ANA) mentions it under treatment planning (ANA, 2001). Although most helping professions include some attention to this area of clients’ lives, the level of clarity and degree of importance vary.

Psychology and Counseling. A number of studies have assessed psychologists’ integration of RS in clinical practice. Although most studies show psychologists to be less religious than the population they serve and only one in four believe RS is relevant to practice, research suggests that psychologists are more open to this topic in practice. For example, half report asking clients about their RS during assessment, and an overwhelming 82 percent believe a positive relationship exists between religion and mental health (Delaney, Miller, & Biondo, 2007; Shafranske & Cummings, 2013). Psychologists have also expressed the importance of being aware of the role RS has in clients’ lives and in their own lives (Crook-Lyon et al., 2012).

MFT. Studies have found that many marriage and family therapists express interest in incorporating RS in therapy (Carlson, Kirkpatrick, Hecker, & Killmer, 2002; Prest, Russel, & D’Sousa, 1999), regardless of their religious orientation (McNeil, Pavkovic, Hecker, & Killmer, 2012). Similar to Crook-Lyon et al. (2012), McNeil et al. (2012) found that marriage and family therapists report that awareness of their RS beliefs is important and tend to have positive views toward integrating RS in practice. Using an adapted version of the RRSP, Carlson et al. (2002) found that a majority of AAMFT members agreed that asking clients about their religion was appropriate. Half felt that talking with the client about God was appropriate, and 17 percent felt it was appropriate to discuss their own religious beliefs—a number similar to the 14 percent of social workers in Mattison et al. (2000). Qualitative data revealed that marriage and family therapists should “let clients know that we are willing to talk about their spiritual lives” (Carlson et al., 2002, p. 168), matching clients’ desire for practitioners to bring up the topic of RS (Koenig, 2005; Stanley et al., 2011).
**Nursing**. Despite its religious roots, the nursing profession has not consistently integrated clients’ RS into practice. In 2000, the Joint Commission on Accreditation of Healthcare Organizations (now known as the Joint Commission) began requiring a spiritual history on every hospital, nursing home, or home health care patient (Koenig, 2008), with nurses often collecting such information. Today, ANA’s Code of Ethics includes clients’ RS in treatment planning. With regard to current practice, 29 percent of nurses offer spiritual counseling, 71 percent had offered, suggested, or provided prayer to patients, and nearly all would offer, suggest, or provide spiritual help to patients who had requested it and were about to die (Grant, 2004). Nurses have described spirituality as a source of strength, connection, and a supporting practice that promotes health (Cavendish et al., 2004). Nurses also report using RS for personal coping, stating that RS provides meaning to their work and serves the function of protecting them from job-related stress (Ekedahl & Wengstrom, 2010; Pesut, 2013)—an insight not widely examined by other helping professions.

**Comparing Social Work with Other Helping Professions**

Because social workers account for almost half of all mental health personnel (Substance Abuse and Mental Health Services Administration, 2010), understanding current social workers’ orientation toward integrating clients’ RS into practice is important. Across studies, certain practitioner characteristics appear to affect practice behaviors. For example, more religious or older practitioners are more likely to consider religious activities to be appropriate for use in practice, hold positive attitudes toward RS, and make greater use of interventions that integrate clients’ RS in practice (Larsen, 2010; Mattison et al., 2000; Sheridan, 2004; Stewart, Koeske, & Koeske, 2006), findings that echo the evidence from studies of psychologists and marriage and family therapists. In addition, there is a common thread across professions, with practitioners desiring more discussion of RS in their training (Canda & Furman, 2010; Crook-Lyon et al., 2012; Prest et al., 1999).

Few studies have compared helping professions on their views and use of RS in practice. In Bergin and Jensen’s (1990) study, marriage and family therapists were the most religious, with beliefs similar to those of the general public, as compared with psychologists, psychiatrists, and social workers. Regarding integrating RS into practice, LPCs had the most positive attitudes, compared with social workers or psychologists (Sheridan et al., 1992). Although a growing discourse is apparent in social work literature, the profession has much to learn about integrating clients’ RS, especially because most social work practitioners have not received education on this topic (Canda & Furman, 2010) and may not know what to do when faced with a majority religious population.

**DISCUSSION AND NEXT STEPS**

Social workers’ attitudes and use of specific religious or spiritual techniques in practice are coming into focus, but further study is needed. Existing studies have examined practitioners’ use of specific RS behaviors in practice, yet for some of these practice behaviors (for example, touching clients for healing purposes) there is little evidence to support their use. In the spirit of the EBP process, using the best research evidence available, future studies might assess how practitioners can best integrate RS within this widely recognized decision-making process. For example, it would be worth knowing if practitioners are reading about evidence connecting RS and health (for instance, using standardized RS assessment tools, empirically supported practice behaviors previously mentioned, or empirically supported interventions such as the one used in Rosmarin et al.’s 2010 study) to guide their practice decisions. Likewise, because few social workers have received this content in their education, it may be worth identifying where (and if) practitioners are learning how to ethically and effectively assess for and discuss clients’ RS in practice, such as by reading research articles, through continuing education, or through supervision. Future studies may also assess whether practitioners involve clients in deciding if their RS beliefs should be integrated into treatment, especially considering that the EBP process includes integrating appraised evidence with practitioner expertise and clients’ culture and preferences (Sackett et al., 2000).

Social work research has not thoroughly assessed other factors, including practitioners’ perceived feasibility and self-efficacy with integrating RS into practice, which may affect social workers’ orientation to this area of practice. For example, agency support (or lack thereof) and time constraints may
influence whether practitioners feel it is even feasible or acceptable to ask about clients’ RS, or how their RS relates to treatment. In addition, with few social workers having received training on RS, their self-efficacy may be affected, potentially affecting engagement with this area of practice. If a practitioner has not received adequate training on assessing for or discussing this area of clients’ lives, or has received negative or discriminative messages in his or her graduate program about RS (Thyer & Myers, 2009), how likely is that practitioner to engage in these practice behaviors? Likewise, practitioner knowledge (or lack thereof) on how to address clients’ RS struggles or coping methods (either positive or negative) may also affect treatment planning and outcomes (Pargament, 2007).

Meanwhile, social work practitioners who have not received this content in their graduate training may consider seeking continuing education, supervision, or peer consultation on strategies for ethically and effectively integrating clients’ RS into practice. In addition, much in the way that personal biases with regard to cultural differences are explored in MSW programs, social work practitioners are encouraged to continuously explore their perceptions of working with a variety of RS belief systems. Practitioners may also want to consider having a list of spiritual leaders to refer clients to, if the client desires. Finally, it is recommended that practitioners consider the EBP process (Sackett et al., 2000) for identifying current, empirically supported methods for integrating clients’ RS in practice. Such methods include standardized assessment tools, manualized interventions, empirically supported practice behaviors that are appropriate with client characteristics and preferences, and evaluating client outcomes.

CONCLUSION
Exchanging practitioners’ integration of clients’ RS in practice is a complex undertaking, and there is still much to learn. There appears to be a need to empower practitioners to ethically and effectively assess for and address any issues related to RS in practice. As research on RS and health emerges, with social workers being the largest group of clinically trained helping professionals, and with a majority of the population reportedly religious or spiritual, it is important for the social work profession to understand social workers’ views and behaviors around integrating RS in practice to inform future training and educational efforts. SW

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