Personal and Professional Values: Relationships Between Social Workers' Reproductive Health Knowledge, Attitudes, and Ethical Decision-Making

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Abstract

Many social workers practice within organizations where sexual and reproductive health are relevant and important topics. However, there is currently a dearth of research investigating social workers' attitudes about sexual health, and ethical decision-making concerning sharing reproductive knowledge and resources with their clients. This study surveyed MSW students (N = 443) to explore further how perceived abortion knowledge and anti-abortion attitudes are related to their perceptions of ethical decision-making around reproductive health. Results indicate students' greater endorsements of anti-abortion attitudes are significantly associated with higher perceptions of reporting an inability to help clients who are considering reproductive health decisions with which they personally disagree. Conversely, students' perceived abortion-related knowledge was not associated with their perceptions of ethical decision-making pertaining to reproductive health. The implications are discussed.

Keywords: social work, social work education, MSW, reproductive health, ethical decision-making

Introduction

The Council on Social Work Education (CSWE) 2015 Educational and Practice Standards (EPAS) do not require social work programs to include sexual or reproductive health related competencies within either classroom or field placement curriculum (CSWE, 2015). Even though many social workers practice in organizations where discussions about sexual health are relevant, there is currently a scarcity of research investigating social work practitioner/social work student attitudes about sexual health, and ethical decision-making of social workers concerning sharing reproductive and

sexual health knowledge and resources with their clients. This study explores, more narrowly, how perceived abortion knowledge and anti-abortion attitudes of MSW students in the United States are related to their perceptions of ethical decision-making about reproductive health.

Social work values and ethics

According to the National Association of Social Workers (NASW), "every individual, within the context of her or his value system, must have access to family planning, abortion, and other reproductive health services" (NASW, 2015, p. 117). Additionally, the NASW *Code of Ethics* includes foundation practice values of social justice and dignity and worth of a person, both of which strongly support the rights of individuals to access education and services connected to sexual and reproductive health, as does the social work ethical principle of client self-determination (NASW, 2008). These core professional tenets are further cited as the primary logic that was used in the development of the NASW's aforementioned official policy statement on family planning and reproductive health (NASW, 2015). Moreover, within the 2015 EPAS Competency #2, CSWE states that social work students should "apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies" (CSWE, 2015, p.7). However, as CSWE does not explicitly require sexual and reproductive health education to be included in social work education curricula, it is evident that social work's professional organizations may support clients' overall access to reproductive health services, including abortion, yet perhaps do not overtly emphasize further educating and training social workers regarding these topics.

Review of the Literature

Abortion is a common medical procedure in the United States, with over one third of women having an abortion by the age of 45 (Finer & Henshaw, 2006). Although there are assumptions with regard to the personal characteristics of women who have abortions, research has shown that women of all races, ethnicities, socioeconomic classes and other demographics have had abortions (Henshaw & Cost, 2008). Despite the common nature of abortion procedures in the U.S., attitudes regarding abortion vary. In a study of 13-29-year-olds, 74% supported abortion, but support for abortion varied based on circumstance (Altshuler, Storey, & Prager, 2015). This is consistent with adult abortion attitudes. In a study of U.S. adults, 7.2% identified as anti-abortion and 31% pro-choice regardless of the reason, with most of US adults somewhere in the middle (Smith & Son, 2013).

According to Ely, Flaherty, Akers, and Noland (2012), "social workers may be the first point of contact for a woman facing an unintended pregnancy" (p. 36). Given that many potential social work clients may be faced with the need to make decisions regarding abortions and reproductive health care and that social workers may often be the people clients turn to when considering abortion services, social workers must be knowledgeable about this topic, the profession's values and broader stance on abortion, and how discussions and decision-making pertaining to abortion may arise in practice. Ely and Dulmus (2010) call for the field of social work to do more regarding access to reproductive health care and abortion for vulnerable populations, regardless of individuals' personal beliefs, because of the foundational social work value of social justice that is connected to access to choice about an individual's body. As such, a better understanding of social workers' personally- and professionally-held values and ethics regarding abortion will help to better consider how social workers aid clients in their abortion knowledge and resource acquisition, and ultimately, client's abortion decision-making. .

However, despite this need for social workers to be prepared to serve clients regarding topics of reproductive health, and particularly abortion, there is a scarcity of research in the social work field exploring how these topics are discussed as well as how social work students and practitioners make

decisions surrounding these issues (Begun, Kattari, McKay, Ramseyer Winter, & O'Neill, 2016; Flaherty et al., 2012). Extant research suggests that complex sociodemographic identities of individual social work students, such as political affiliation and religiosity, are highly associated with their attitudes toward abortion and birth control, as well as the extent to which they endorse sexual permissiveness (Begun et al., 2016). Other research indicates that the amount of sexual health information and training a student receives in the classroom or field placements, particularly pertaining to topics such as abortion and birth control, is positively associated with their views of sexual health as important to the field of social work (Ramseyer Winter, O'Neill, Begun, Kattari, & McKay, 2016). Beyond these burgeoning studies, additional research is warranted to further understand the complex relationships between social workers' identities, values, and decision-making pertaining to reproductive health issues, including ones that are notably controversial and value-laden, such as abortion.

In the past 15 years, there have been a large number of social work researchers and scholars committed to exploring issues related to sexual health and demonstrating the need for a more conspicuous focus within the field (e.g. Auslander et al., 2002; Ballan, 2008; McCave, Shepard, & Ramseyer Winter, 2014; Begun, 2015; Begun & Walls, 2015; Begun et al., 2016; Brennan, Emlet, & Eady, 2011; Dunk, 2007; Flaherty, Ely, Akers, Dignan, & Noland, 2012; Kattari, 2014; Begun, 2014; Ramseyer Winter et al., 2016; Mitchell & Linsk, 2001; Russell, 2012; Thompson & Auslander, 2011). Most recently, scholars have called for the inclusion of sexual health information in social work education curricula as a human rights issue, suggesting that based on the values and ethics position indicated by NASW, as well as the fact that social workers frequently engage with diverse and often vulnerable individuals/communities that may have a plethora of needs for sexual and reproductive health information and resources, social work as a field should move to facilitate education, policies, and research that support the sexual rights of *all* individuals (WRamseyer Winter et al., 2016).

The current study seeks to further contribute to this gap in the literature by answering the following research question: Among MSW students, what is the relationship between anti-abortion attitudes and perceived abortion knowledge with perceived ethical decision-making about reproductive health, while controlling for political affiliation, MSW program region, religiosity, sex, and sexual orientation? We hypothesized: 1) Participants with higher anti-abortion attitudes will be more likely to indicate an inability to serve a client who is seeking to make a reproductive health choice he/she personally disagrees with; and 2) Participants with lower levels of perceived abortion-related knowledge would be more likely to indicate an inability to serve a client who is seeking to make a reproductive health choice he/she personally disagrees with.

Method

Procedures

The survey was designed by a group of 10 sexual health social work scholars in 2014. Survey data were collected using Qualtrics after obtaining IRB approval. A combination of convenience, snowball, and purposive sampling techniques were used to recruit the sample in the current study. Each of the scholars disseminated the survey link to social work students at their respective institutions and social work faculty from other institutions also agreed to circulate the survey link. Some participants anecdotally reported forwarding the survey link to additional social work students, and the survey link was posted on a reproductive justice social media page and website. When students clicked on the survey link, they were invited to take a survey about their experiences with sexual and reproductive health topics in social work education. The survey was both anonymous and confidential. Data were collected for approximately seven months in 2014.

Measures

Anti-abortion attitudes

Informed by existing literature (Begun & Walls, 2015; Walls, 2005), anti-choice attitudes were measured with 5 items on a 4-point scale (1

= strongly disagree; 4 = strongly agree). Sample items include: "State laws should require parental consent before a teenager under 18 can have an abortion" and "Decisions to terminate a pregnancy should be a matter between a woman and her doctor". As applicable, items were reverse coded and then averaged for each participant to create an anti-abortion attitudes continuous score. A higher score reflects greater anti-abortion attitudes. The internal consistency of the anti-abortion attitudes scale among the current sample is high (α = .93).

Perceived abortion knowledge

Perceived knowledge about abortion was measured with one question with responses of 1 (strongly disagree) to 4 (strongly agree): "I feel I would know how to help a client who requested information about abortion (e.g., resources for where to learn more about the topic, where to obtain, cost, legality/rights; etc.)."

Perceived ethical decision-making regarding reproductive health

Perceived ethical decision-making regarding reproductive health was measured with one question with responses of 1 (strongly disagree) to 4 (strongly agree): "If confronted with a client seeking to make a reproductive health choice I personally disagreed with, I would be unable to serve that client."

Prior to answering this question in the survey, participants were provided with the following definition of reproductive health:

> A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (United Nations, 1994, para. 7.2a).

Due to a lack of variance in the data required for multinomial logistic regression, this variable was dichotomized so that participant responses of any amount of agreement, including slightly disagree, were combined (0 = strongly disagree; 1 = slightly disagree, slightly agree, or strongly agree).

Covariates

All analyses controlled for political affiliation, religiosity, age, and sex.

Political affiliation. Participant political affiliation was measured with one item: "Politically, I tend to think of myself as…" There were five response options: Conservative, independent, liberal, moderate, and not politically-affiliated. The variable was dummy coded with liberal as the reference group.

Religiosity. Participants' religiosity scores were determined via 3 questions, which were informed by prior research efforts (Begun & Walls, 2015; Walls, 2005). The 3 items included: "In my daily life, I would say religion provides me with…" Response options were: 1 = no guidance, 2 = little guidance, 3 = some guidance, 4 = quite a bit of guidance, and a 5 = a great deal of guidance. Participants were also asked, "I attend religious services…" Response options included: 1 = more than once a week, 2 = once a week, 3 = once or twice a month, 4 = a few times a year, and 5 = never. The third item asked participants, "Outside of attending religious services, I pray or engage in spiritual meditation…" Response options were: 1 = several times a day, 2 = once a day, 3 = a few times a week, 4 = once a week or less, and 5 = never. As relevant, items were reverse coded so that highest numerical

responses depicted highest religiosity. The internal consistency for the religiosity scale variable among the current sample is high (α = .88).

Sex. Sex was measured with one question: "My sex is…" Participants were given three response options: Female, male, or intersex. None of the current sample identified as intersex; thus, the variable was dichotomous with female as the reference group.

Age. Age was measured with one question: "My age (in years) is…" Age was included as a continuous variable.

Data analysis

Data were analyzed using IBM SPSS Statistics Version 23. Descriptive analyses were examined to determine the characteristics of the sample and logistic regression analysis were performed to test the aforementioned hypotheses.

Results

Participants

For the purposes of the current study, the original sample (N = 504) was narrowed to only include MSW students (n = 443). The participants were enrolled in social work programs across the country, with 35.2% from the Rocky Mountain region, 21.7% from the Midwest, 15.6% from the South or Southeastern U.S., 10.8% from the Western part of the U.S., 8.8% from Mid-Atlantic U.S., and 7.9% from the Northeast. The majority of the participants identified as liberal (70%), straight/heterosexual (82.4%), White (81.0%), and female (86.0%). The mean age of the sample was 28.47 (SD = 5.40). For a full list of sample demographics, refer to Table 1.

Descriptive statistics

The majority of the sample (82.3%) strongly disagreed that they would not be able to serve a client seeking to make a reproductive health choice he/she did not personally agree with, yet only 10.1% strongly agreed that they would know how to help a client who requested information about abortion. The mean anti-abortion attitudes scale score was 1.60 (SD = 0.85) on the 4-point scale with higher scores representing greater anti-abortion attitudes, and the mean religiosity scale score was 2.27 (SD = 1.05) on the 5-point scale with higher scores indicating higher levels of religiosity. Refer to Table 2 for a complete list of descriptive statistics.

Logistic regression analyses

Hypothesis 1 was that participants with higher anti-abortion attitudes would be more likely to indicate an inability to serve a client who is seeking to make a reproductive health choice he/she personally disagrees with. Anti-abortion attitudes were regressed on perceived ethical decision-making regarding reproductive health, political affiliation, religiosity, sex, and age. The generated model was significantly different from the constant-only model, $X^2(8) = 103.01$, $p < .001$. Additionally, the model correctly predicted 79.7% of those who strongly disagreed and 72.6% of those who slightly disagreed, slightly agreed, or strongly agreed, for an overall classification rate of 78.6%. Anti-abortion attitudes were significantly related to perceived ethical decision-making while holding other variables constant (OR = 3.78, $p < .001$, CI = 2.29-6.24). Thus, we found support for Hypothesis 1, as higher endorsements of anti-abortion attitudes were related to a greater likelihood of students' perceptions being unable to help clients seeking to make reproductive health decisions with which the student(s) personally disagreed. In addition, age was significantly related to perceived ethical decision-making. Higher age was associated with greater perceptions of being unable to serve clients (OR = 0.94, p = .044, CI = 0.88-1.00). Refer to Table 3.

Hypothesis 2 was that participants with lower levels of perceived abortion-related knowledge would be more likely to indicate an inability to serve a client who is seeking to make a reproductive health choice with which he/she personally disagrees. Knowledge about abortion was regressed on perceived ethical decision-making regarding reproductive health, political affiliation, religiosity, sex, and age. The generated model was significantly different from the constant-only model, $X^2(10) = 81.88$, $p < .001$. Additionally,

Table 1: *Participant Demographics (n = 443)*

Characteristic	*N*	%
Sex		
Female	381	86.0
Male	62	14.0
Race/Ethnicity		
White	359	81.0
Black/African American	22	5.0
Latino(a)	21	4.7
Asian/Asian American/Pacific Islander	11	2.5
Native Hawaiian/Alaska Native	11	2.5
Multiracial	19	4.3
Political Affiliation		
Conservative	33	7.4
Independent	30	6.8
Liberal	310	70.0
Moderate	41	9.3
Not politically-affiliated	29	6.5
University Location		
Northeastern US	35	7.9
Mid-Atlantic US	39	8.8
Southern or Southeastern US	69	15.6
Midwestern US	96	21.7
Rocky Mountain US	156	35.2
Western US	48	10.8
Sexual Orientation		
Straight/heterosexual	365	82.4
Bisexual	15	3.4
Gay	11	2.5
Lesbian	19	4.3
Pansexual	3	0.7
Queer	14	3.2
Questioning	3	0.7
Other	11	2.5
Characteristic	***M***	***SD***
Age	28.47	5.40

Table 2: *Descriptive Statistics (n = 443)*

Item	Strongly Disagree *n* (%)	Slightly Disagree *n* (%)	Slightly Agree *n* (%)	Strongly Agree *n* (%)
Perceived abortion knowledge				
I feel I would know how to help a client who requested information about abortion.	78 (17.6)	121 (27.3)	209 (47.2)	35 (7.9)
Perceived ethical decision-making				
If confronted with a client seeking to make a reproductive health choice I personally disagreed with, I would be unable to serve that client.	370 (83.5)	44 (9.9)	18 (4.1)	11 (2.5)
Anti-choice attitudes				
Late-term abortions should be illegal in the U.S. in all circumstances.	286 (64.6)	71 (16)	39 (8.8)	47 (10.6)
Decisions to terminate a pregnancy should be a matter between a woman and her doctor.	18 (4.1)	33 (7.4)	42 (9.5)	350 (79)
The government should NOT cover the medical costs of abortions for women who cannot afford the procedure.	322 (72.7)	58 (13.1)	23 (5.2)	40 (9)
Abortion should be legal under all circumstances.	39 (8.8)	57 (12.9)	63 (14.2)	284 (64.1)
State laws should require parental consent before a teenager under 18 can have an abortion.	273 (61.6)	68 (15.3)	63 (14.2)	39 (8.8)

Item	*M*	*SD*
Anti-choice attitudes scale score	1.57	0.838

Table 3: *Logistic Regression Results-Anti-Abortion Attitudes (n = 443)*

Variable	*B*	*Exp(B)*	*95% CI Exp(B)*	
(Constant)	-1.42	0.24		
Anti-abortion attitudes	1.33***	3.78	2.29	6.24
Religiosity	-0.16	0.85	0.60	1.22
Age	-0.07*	0.94	0.88	1.00
Political Affiliation				
Independent	0.13	1.14	0.27	4.68
Liberal	-0.61	0.55	0.15	1.99
Moderate	-0.52	0.60	0.17	2.14
Not politically-affiliated	-0.16	0.98	0.25	3.94
Sex				
Male	-0.41	0.67	0.24	1.87

* < .05; *** < .001
Reference categories: Conservative (political affiliation); female (sex)

the model correctly predicted 73.2% of those who strongly disagreed and 72.6% of those who slightly disagreed, slightly agreed, or strongly agreed, for an overall classification rate of 73.1%. Regarding knowledge about abortion, compared to those who strongly disagreed, those who reported that they slightly agreed that they would know how to help a client seeking information about abortion were significantly more likely to report some level of agreement on the perceived ethical decision-making variable while holding other variables constant (*OR* = 0.34, $p = .006$, *CI* = 0.16-0.73). The other responses regarding knowledge (slightly disagree and strongly agree) were not significantly related to perceived ethical decision-making, when compared to strongly disagree. Thus, we found partial support for Hypothesis 2. In addition, age (*OR* = 0.92, $p = .019$, *CI* = 0.87-0.99) and identifying as liberal (*OR* = 0.10, $p < .001$, *CI* = 0.03-0.32) or moderate (*OR* = 0.22, $p = .016$, *CI* = 0.06-0.75) were significantly related to perceived ethical decision-making. Higher age was associated with greater perceptions of being unable to serve clients. When compared to participants who identified as politically conservative, identifying as liberal or moderate was associated with lower perception of being unable to serve clients. See Table 4.

Discussion and Implications

Examining a nationally representative sample of MSW students ($n = 443$), the current study sought to understand relationships between students' perceived abortion knowledge and anti-abortion attitudes and their perceptions of ethical decision-making about reproductive health. On the whole, results suggest that students' endorsements of anti-abortion attitudes are significantly associated with their reporting of being unable to help clients who are considering reproductive health decisions with which they personally disagree. However, students' perceived abortion-related knowledge showed more nuances in relationship to their perceptions of ethical decision-making pertaining to reproductive health.

Table 4: *Logistic Regression Results-Abortion Knowledge (n = 443)*

Variable	*B*	*Exp(B)*	*95% CI Exp(B)*	
(Constant)	2.32	10.20		
Perceived abortion knowledge				
Slightly disagree	-0.57	0.57	0.26	1.23
Slightly agree	-1.08**	0.34	0.16	0.73
Strongly agree	-0.62	0.54	0.18	1.64
Religiosity	0.26	1.29	0.94	1.78
Age	-0.08*	0.92	0.87	0.99
Political Affiliation				
Independent	-1.14	0.32	0.09	1.15
Liberal	-2.26***	0.10	0.03	0.32
Moderate	-1.52*	0.22	0.06	0.75
Not politically-affiliated	-0.91	0.40	0.11	1.49
Sex				
Male	-0.55	0.58	0.21	1.56

* < .05; ** < .01; *** < .001

Reference categories: Strongly disagree (perceived abortion knowledge); conservative (political affiliation); female (sex)

The finding that for some students—particularly those who endorse anti-abortion views—may prioritize adherence to their own personal abortion viewpoints in their interactions with clients is important. Abortion views that are more broadly espoused by the social work profession advocate for aiding clients in achieving ends of self-determination and social justice, goals that specifically include upholding unimpeded access to the full range of reproductive and sexual health knowledge and services, including abortion (NASW, 2015). This professional stance makes social work somewhat unique and progressive. As a profession, social work has not formally enumerated "exceptions" to aiding clients in achieving such ends, akin to physicians and pharmacists, who are at times empowered with "conscience clauses" or "rights of refusal" which allow them to not provide patients or clients with information or services with which they personally disagree (e.g., abortions, emergency contraception, etc.). Social work education efforts should seek to further emphasize this aspect of professional values and ethics, such that students may be made more aware of what their professional values require of them, and if they are unable to adhere to such, what their next course of action by necessity must ethically include (e.g., referral of client to another social worker, etc.).

In addition, it is interesting that students' perceived knowledge of abortion was nuanced in relationship to their perceptions of being able to help clients with reproductive health decisions with which they personally disagree. In comparison to students who "strongly disagreed" with the notion that they possess adequate knowledge about abortion resources and information, students who "slightly disagreed" demonstrated significant and negative associations with regard to their perceptions of being unable to help clients who were seeking to make reproductive health decisions with which they personally disagreed. Yet, no significant associations were found among students who slightly or strongly agreed as having adequate abortion related knowledge and ethical decision-making. This finding may illustrate an interesting aspect of how tensions between subject familiarity, personal ethics, and professional values may be grappled with at the individual level. Students who noted that they do not know much or enough about abortion resources and information were thus perhaps paradoxically the most likely to actually help clients considering a reproductive health decision with which they personally disagreed. Although this cross-sectional sample cannot confirm causation, this is an interesting finding that merits further future research.

Moreover, these findings may have some connotations with regard to the degree to which a person's beliefs on issues of reproductive health and decision-making are dogmatic. The measure of ethical decision-making, at first consideration, seems to imply that the reproductive health decision with which the social worker might disagree is one that is typically thought of as the contentious option (e.g. abortion). However, particularly among the students who noted strong knowledge of abortion resources, these respondents may be most inclined to view abortion as the reproductive health decision that they believed to be best for their client, with the client in disagreement in perhaps the reverse-order from how this question may be initially interpreted. Just as social workers' attitudes regarding reproductive health decision-making, values, and ethics are not monolithic, neither are the beliefs of the diverse clients served by social workers. Regardless of which sentiments are held by the client versus the social worker, the "end goal" of these interactions should nonetheless include that social workers do not play a role in providing "misinformation" to clients (intentionally or unintentionally) who come to them in need of reproductive health knowledge and resources, and that clients are armed with resources to act with self-determination and knowledge of all relevant resources.

Furthermore, while over half of the students (n = 244; 55.1%) either strongly agreed or slightly agreed that they would know how to help a client seeking information about abortion, such perceptions may be inaccurately estimated, particularly as it is evident that most of their knowledge likely did not come from formal social work education, which is not currently required to teach any aspects of sexual

or reproductive health as part of formal curricula (CSWE, 2015). As such, the degree to which MSW students truly know accurate, evidence-based facts pertaining to abortion and other reproductive health topics should be the focus of continued investigations.

In terms of other sociodemographic related findings, in the perceived abortion knowledge model, liberal and moderate political identities were significantly and negatively associated with not being able to support clients who were considering reproductive health decisions with which they did not personally agree. This finding is not entirely surprising, as other studies have found significant predictors between political ideology and level of support for access to abortion and other reproductive health services (Smith-Osborne & Rosenwald, 2009). However, this is another indication that there may need to be more transparent, even challenging social work classroom discussions that acknowledge that social workers and the clients they serve are multi-dimensional individuals, with a myriad of political and personal belief systems. This diversity is, in many ways, what makes social work the great profession that it is, and a group that has the greatest potential to advocate for the many types of people and lived experiences it seeks to serve. However, with this diversity in personal belief systems, social workers still must be able to adeptly navigate what is required of them from a professional standpoint, and this may mean referring to other social workers and/or setting "the personal" and/or "the political" aside in favor of "the professional."

Notably, in both models, higher age was also significantly associated with greater perceptions of being unable to help clients with reproductive health decisions with which the social worker personally disagrees. In extant research, age has typically not been significantly associated with anti-abortion attitude endorsement (Carlton, Nelson, & Coleman, 2000; Esposito & Basow, 1996; Hess & Rueb, 2005), but as "reproductive health decisions" may be interpreted many ways (e.g., abortion, contraception, fertility, non-marital sex, etc.), future research would benefit from further dissecting associations between respondent characteristics and these more specific aspects of reproductive health and decision-making.

Additionally, students' religiosity was not significantly associated with ethical reproductive health decision-making. Although the reason for this is not entirely clear, it is possible that since more than a quarter of students in the sample (n = 121; 27.3%) noted they are 'spiritual but not religious,' religiosity may have captured aspects of meditation and engagement in spiritual activities that are not tied to various formal religious entities that take anti-abortion or less supportive stances on abortion and reproductive health. As such, the inclusion of this category as a religious identity, and thus the activities associated with the identity as potentially forming one's religiosity, may have served to obscure results that may most often be conceptualized as religiosity or religious doctrine.

Limitations

Several study limitations should be noted, including sampling bias, especially regarding participants who were made aware of the survey via the social work and reproductive justice website and Facebook page. Such participants may endorse open views regarding reproductive access and rights inherently by way of being linked with the webpage and/or social media group. In addition, the survey did not ask participants how they heard about the study, making such sampling concerns challenging to examine. While the study was created with goals of attracting a diverse national sample of social work students, there were uneven response distributions across sociodemographic identity categories. The sample was predominantly politically liberal, heterosexual White females. Just as these characteristics may in fact be fairly representative of the social work field and social work education programs in general, the likelihood exists that more evident differences in views within various groups were not reflected in the results due to the homogenous sample composition. Additionally, we did not measure perceived ethical decision making about abortion only, but reproductive health, although comprised of many topics, includes abortion. However, this is not a pure measure of

perceived ethical decision-making about abortion. Although these limitations are usually present in survey research, a more representative sample may have produced different results.

Conclusion

The issues of reproductive healthcare and abortion continue to be politically charged and highly debated issues in the United States. Individuals, including clients and social workers, may have strongly held beliefs regarding reproductive healthcare and abortion. Learning to develop self-awareness and self-regulation to better navigate the world of personal beliefs and supporting client self-determination is a foundation of social work education and included within the 2015 EPAS. Social work students need to be provided the opportunities to explore the potential ethical dilemmas that may arise when working with clients who have differing values and beliefs systems and lived experiences than their own. Social work students prepare to work in a variety of professional arenas, including direct client work, policy development, agency management, and research. Providing *all* social work students with accurate information regarding sexual and reproductive healthcare will better prepare them as social work professionals. Unfortunately, this preparation is not currently mandated by the CSWE 2015 EPAS. This study provides exploratory data that can be used to encourage curriculum inclusion of sexual and reproductive healthcare and further research on social work education and practice, both in the micro and macro arenas.

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