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Tiffany Adams
A Channel of Peace: The Role of
Clinicians' Spirituality in Their
Clinical Process

ABSTRACT

This qualitative study examined how experienced clinicians who self-identify as spiritual perceive the role their spirituality has in their clinical practice. The specific research question was: How do clinicians incorporate their own spirituality into their clinical practice? This study was undertaken because of the limited amount of research exploring the relationship between clinicians' personal spirituality and the influence it has in their clinical practice.

Given the limited amount of research in the area, a phenomenological approach was used. Thirteen licensed mental health clinicians who self-identified as spiritual filled out a questionnaire and were interviewed. The professions the participants belonged to were: clinical social worker (8) marriage and family therapist (1) psychiatric nurse (1) and licensed professional counselor (3). The spiritual beliefs and religious affiliations participants ascribed to are listed in table 1 in the findings section.

In line with a phenomenological approach, thematic analysis of participants' responses was done. The findings were that the clinicians' spirituality played multiple roles in their clinical practice: (1) clinicians' spirituality provided them with support and guidance; (2) clinicians' spiritual beliefs influenced the way they interacted with or perceived clients; and (3) clinicians used concepts of mindfulness for themselves and their clients.

Make me a channel of your peace
Where there is hatred, let me bring you love.
Where there is injury, your pardon, Lord.
And where there's is doubt, true faith in You.

Oh Master, Grant that I may never seek
So much to be consoled, as to console,
To be understood, as to understand
to be loved as to love with all my soul.

Make me a channel of your peace,
Where there's despair in life, let me bring hope,
Where there is darkness, only light,
And where there's sadness, ever joy. . .

-Prayer of St. Francis of Assisi

**A CHANNEL OF PEACE:
THE ROLE OF CLINICIANS' SPIRITUALITY IN THEIR CLINICAL
PROCESS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Tiffany Adams

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Northampton, Massachusetts 01063

2011

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CHAPTER I

Introduction

The purpose of this study is to examine the role clinicians' spirituality plays in the therapeutic process. The research question is: How do clinicians incorporate their own spirituality into their clinical practice? Specifically, this study explores the methods clinicians use to incorporate their spirituality into their professional practice, their reasons for doing so, as well as the perceived benefits. This study also investigates how clinicians understood potential drawbacks of bringing their spirituality into their work as mental health professionals.

The role of spirituality in mental health care has been a matter of heated debate. Historically, the debate about spirituality, as well as research on the topic, has focused on the client's spirituality. There has been limited exploration of the role that a clinician's spirituality has in his or her clinical practice. During the rise of psychoanalysis, clinicians aspired to be "blank slates," allowing no parts of themselves to influence the clinical process. The clinician's personal spiritual beliefs and practices were seen as something harmful to or outside of the therapeutic process. The ideal of a "blank slate" has continued to serve as a standard for how clinicians approach the therapeutic relationship. This concept could explain why there is such limited amount of research into clinicians' use of their own spirituality in the therapeutic practice.

The cultural competency movement, however, challenged the concept of therapist as a blank slate. The movement encouraged clinicians to acknowledge the ways which elements of their culture, including their individual spirituality, may affect their practice. Current codes of

ethics for social work, psychiatry, counseling and psychology include cultural-competency statements that encourage clinicians to reflect upon how their beliefs may affect their perceptions of their client's beliefs. This push for greater cultural competency was intended to increase awareness of the limits of clinicians' objectivity and neutrality. It does not, however, address how clinicians' own spirituality may play a role in the therapeutic process.

This study will address this dearth of information by interviewing clinicians who self-identify as spiritual about their incorporation of their spirituality into the therapeutic process. This research is unique in its focus on how a clinician's spirituality is incorporated into his or her clinical decisions and processes. Given the limited amount of research in this area, an exploratory, qualitative study was used. A phenomenological approach was taken in an effort to capture the clinicians' experiences. In total, thirteen clinicians were interviewed.

For the purpose of this study, a "clinician" is defined as a licensed mental health professional working in a clinical setting. This includes, but is not limited to, psychiatrists, psychologists, social workers, marriage and family therapists, counselors, and psychiatric nurses. This expansive definition allows for the representation of perspectives from many different mental health disciplines. The term "spirituality" is defined in the literature review.

This thesis is organized into five chapters. The first chapter, the introduction, establishes the research question, purpose of the study, and rationale for the study. The second chapter is the literature review. That chapter covers: (1) a brief historical overview of the relationship between religion/spirituality and mental health; (2) a definition of spirituality; (3) the role of spirituality in clinical practice; (4) a discussion of clinicians' spirituality; and (5) ethical considerations of spirituality in clinical practice. The third chapter, methodology, provides information on the study's design. This includes information on sampling methods and the data analysis used in this

study. The fourth chapter is the findings chapter in which the results of this study are presented. In the fifth and final chapter, the discussion chapter, the findings are summarized, and the relationship the findings have to literature are discussed. Potential future research and the implications for social work are also discussed.

It is the hope of this author that the study provides valuable information to the mental health field by furthering the understanding of how a clinician's spirituality is used in therapeutic relationships. Understanding this particular element of the clinician's process will deepen our understanding of the therapeutic relationship in general, helping us to be more effective. Additionally, this study could encourage clinicians to reflect on possible connections between their spirituality and their clinical practice. The findings could also lead to further research into what influences clinicians' practices and the way spirituality shapes therapy.

CHAPTER II

Literature Review

Introduction

The purpose of this study is to examine the role clinicians' spirituality plays in their clinical practice. The specific research question is: How do clinicians privately incorporate their personal spirituality into their clinical practice? Mental health care and religion/spirituality have a historically tenuous relationship. In the last two decades, however, there has been a swell of interest in better understanding this relationship, as well as addressing how religion/spirituality relates to mental health care.

The majority of the research related to religion/spirituality has focused on the client's spirituality/religion and its role in therapy. The ethical concern of including religion/spirituality in the therapeutic relationship is one area of continual focus for discussion. The literature addressing clinicians' use of their own spirituality is usually limited to the effect it has on the client's process. Little research has focused on clinicians' covert use of their spirituality. This study will focus on identifying clinicians' personal use of their spirituality within their clinical relationships.

The following literature review covers research involving clinicians, social workers, therapists, psychologists and other mental health professionals. For consistency and clarity the term "clinician" will be used throughout most of the review, in reference to all disciplines. If necessary for a specific research study, the clinician(s) may be referred to by their specific title.

This literature review will focus on the five following areas, as not all of the information discussing the relationship between spirituality and mental health is relevant to this study. These areas are: 1) a brief historical overview of the relationship between religion/spirituality and mental health, 2) a discussion of how spirituality is defined, 3) the role of spirituality in clinical practice, 4) clinicians' spirituality, 5) ethical considerations of spirituality in clinical practice. The conclusion will again summarize the relationships between all of the elements reviewed that have led to the proposed research question.

Historical Overview of Religion and Spirituality in Mental Health

The mental health profession has always had an ambivalent relationship with religion. The Latin term "psychologia" was first defined in 1524 as "concerning the human spirit" within the "science of spiritual being," (Vande Kemp, 1996, p.72). Founders of psychology such as James William, and G. Stanley Hall were intrigued by the implications religion had on one's well being (Weaver, Pargament, Flannelly, & Oppenheimer, 2006). As the mental health care profession progressed to psychoanalysis and behavioral paradigms, the founders of these theories sought for psychology to be defined as a hard science. Psychology was criticized as not being scientific because "its subject matter was unquantifiable and it mired in a metaphysical morass" (Coon, 2002, p. 121).

In their desire to be seen as scientific, mental health professionals resisted being intimately involved with topics involving spirituality and religion. They tried to disentangle the profession from its metaphysical and theological roots. For example, prominent figures such as Freud and Skinner distanced themselves, portraying religion in a negative way (Miller, 2003; Plante, 2007).

Toward the end of the twentieth century religion and spirituality became more accepted topics for research and treatment. In the beginning when religious themes were researched, the focus was on measurable elements. The spiritual/religious beliefs of a person were quantified by attendance, practices, and actions taken. It was not until the late 20th century that more intangible, subjective material became widely researched. The term spirituality, a more abstract concept than religion, began to be investigated. Between the years 1960 and 2000, the number of scientific studies of spirituality in the health and social science fields quadrupled (Weaver, Pargament, Flannelly, & Oppenheimer, 2006). The American Psychological Association first published books on the topic of religion/spirituality in clinical practice in 1996 (Richards and Bergin, 2000). Multiple text books, manuals, and scholarly books discussing the relationship between religion/spirituality and the mental health field have followed (Richards and Bergin, 2000; Weaver, Pargament, Flannelly, & Oppenheimer, 2006).

A rise in sensitivity to cultural diversity in the late 20th century is often credited for the inclusion of religion and spirituality into mental health practice. National Association of Social Workers (NASW) Code of Ethics Standard of Cultural Competence (2001) defines cultural competency as:

the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each (p. 9).

Several professional organizations acknowledged for the first time in their ethical guidelines that religion is an important part of a person to address (American Counseling

Association, 1995; American Psychological Association, 1992). This movement led to a more holistic approach to an individual's treatment. Religion/spirituality began to be viewed as an essential element of a person, to be included and considered in therapy. The acknowledgement of diversity also led to exploration of other paradigms such as positive psychology, and eastern psychology that make use of religion and spirituality in treatment (Pargament & Saunders, 2007). The cultural diversity movement, as it relates to the practices of the clinician, are further defined and addressed below.

Definition of Spirituality

Within the mental health field there is considerable variance in the definition of spirituality. Some researchers (Post & Wade, 2009) used spirituality and religion interchangeably. Others (Hill et al., 2000) conclude that religion and spirituality are both are necessary for the complexity of the topic to be explored. Nonetheless, most researchers agree a clinical definition of spirituality is needed to offer consistency in practice and research. Currently no such agreement on a definition has been reached.

In the past, religion was the predominant term used to describe all elements of a connection to a god or higher power. Over time, the definition of religion has narrowed to focus on structured and institutional elements of one's beliefs and practices. Now, religion is commonly defined as a "fixed system of ideas or ideological commitments" (Hill & Pargament, 2008, p. 64).

The term spirituality is currently used to express the more personal, private, subjective side of one's beliefs (Hill & Pargament, 2008). Richards and Bergin (2000) stated that "spiritual and spirituality suggest a closeness, harmony, or connection with a god or transcendence, whereas a religious practice or experience may not necessarily include this connection" (p. 5).

Using the term spirituality allows those who do not ascribe to traditional religions to express their beliefs and practices. The definition of spirituality when defined separately is usually along the lines of a “search for the sacred” (Hill & Pargament, 2008, p. 64).

Weaver, Pargament, Flannelly, and Oppenheimer (2006) conducted a review of empirical research of the trends in the scientific study of religion, spirituality, and health between 1965 and 2000. They found a steep increase in the amount of studies conducted on spirituality and a decrease in the study of religion. They concluded that

Over the past 35 years, there has been a dramatic increase in the number of empirical studies that focus on the broad domain of religion, spirituality, and health. However, our analyses reveal that the resurgence of interest is almost entirely attributable to the attention devoted to the construct of spirituality. While studies of spirituality and health increased sharply over the 35 year period, studies of religion and health decreased significantly over this same span. They supported the premise that spirituality as a more inclusive term has become more widely accepted (p. 211).

Still, several authors argue that the concepts are truly too complex and interwoven to be defined without inclusion of one another. Hill et al. (2000), in their extensive review of the definitions, concluded both terms were necessary to fully address the relationship and practices one uses. Both terms are important to consider as they highlight different parts of faith practices. Doing so also allows inclusiveness of belief systems that fall inside and outside of traditionally organized religious systems. Jacobs (2010) explored the definition of the two terms in her article. She outlined some of the perils of separating the two and polarizing them as spirituality being all inclusive and religion being rigid and structured (Jacobs, 2010). Her premise was that

both are needed to understand and incorporate clients' beliefs and faith practices into the therapeutic relationship.

The area of overlap between the definitions of spirituality and religion exists in the connection to and actions taken in relationship to a god or higher power. The focus of this study is to understand how clinicians' personal, private connection to a god or higher power is incorporated into their clinical practice. For the purpose of this study, the operational definition of spirituality will be: one's practices, beliefs, and actions in relationship to a higher power and use of it within one's life. It is acknowledged that this is a limited definition as only select elements (the connection, beliefs and actions in relationship to a higher power) of spirituality and religious practice are being examined.

Spirituality in Clinical Practice

An important reason for including spirituality into mental health care is that spirituality is a significant part of many American's lives. 80 percent of Americans agree with the statement that religion is very or fairly important in their lives (Gallup, 2010). The spiritual aspects of a person's life are an influential element and therefore important to include in mental health care

The health benefits are another reason to include spirituality into mental health care. An estimated 500 studies between 1980 and 2000 have confirmed a positive relationship between a patient's spirituality, and his or her mental health, physical wellbeing, and reduced substance abuse (Koenig, 2004, as cited by Wiggins, 2009). Although the benefits have been identified, further exploration of this beneficial relationship is absent from most of the literature. Hill and Pargament (2008) identified the following reasons for the underutilization: spirituality is viewed as outside the scope of scientific study; it is a less important area than others to research; and it is (falsely) seen as less important in a scientific age (p. 65). Clinicians being less spiritual and a

dearth in spirituality-related training (Pargament & Saunders, 2006) are also often cited as reasons for not including spirituality in treatment. These reasons will be discussed in the ethics section below.

How clinicians can effectively include spirituality in therapy is an ongoing discussion. Manuals have recently been developed to guide practitioners in the use of spirituality. Examples include: *The Handbook of Mental Health; Spiritual Assessment: A Handbook for Helping Professionals*; and *Spirituality and the Therapeutic Process: A comprehensive Resource from Intake to Termination*. These manuals suggest different techniques and approaches for including and using spirituality in therapy. Some examples of how to incorporate spirituality are including spiritual rituals such as prayer or meditation during a session, or using scriptural texts (Aten & Leach, 2009). A spiritual genogram is another tool suggested. A genogram is a diagram outlining the history of a behavioral pattern, in this example spirituality, of a family over several generations (Wiggins, 2009).

As mentioned earlier, the literature that does address the use of spirituality usually focuses on clients' spirituality and whether or not clinicians include it in therapy. A study conducted by Wade, Worthington and Vogel, (2007) found an important factor in effective use of spirituality is the client expressing an interest in incorporating spirituality. Almost all researchers and clinicians agree that the client's desire is an essential element for efficacy of its use. A client's spirituality can be used in therapy as a way to make sense of his or her experience in the world, as a source of strength, or a tool for coping (Aten & Leach, 2009; Jacobs, 2010; Wiggins, 2009). Further discussion of clients' spirituality in the therapeutic process, is important but outside the scope of this literature review.

Use of Clinician's Spirituality

Mental health professionals have historically been seen as less religious than the average person. Multiple studies such as those by Bergin and Jenson (1990), Curlin et al. (2007) and Delaney, Miller and Bisono' (2007) have concluded that different mental health professionals at different times in history are consistently less religious. The findings of these studies are further discussed below. This is one of the reasons offered for why clinicians may neglect spirituality in mental health care.

Bergin and Jenson (1990) surveyed the religiosity of psychotherapists. They found that psychotherapists identified less with traditional religions than the general public. For example, 35 percent of psychologists (not all psychotherapists) compared to 72 percent of the public agreed with the statement, "My whole approach to life is based on my religion." Delaney, Miller and Bisono (2007) did a comparison study of psychologists to see if their religiosity had changed over time. They found the psychologists were no more or less religious than those surveyed two decades ago. They concluded that psychologists were still less religious than the general public.

Researchers mainly offer only speculation as to why mental health professionals are less religious. Curlin et al. (2007) found that psychiatrists are less religious than other medical physicians in the United States. They speculated that the historical exclusion of religion from psychiatry may attract less religiously inclined people. A full discussion of all the possible reasons is important, but outside of the scope of this literature review.

The assertion that clinicians are less religious was challenged when spirituality was distinguished from religion in the more recent studies and reviews. More clinicians identified with spirituality, as a way to describe their belief system. For example, in the Delaney, Miller and Bisono (2007) study, the majority of psychologists indicated that spirituality was very

important (52%) or fairly important (28%) to them. A study by Bilgrave and Deluty (2002) found that psychologists differentiated between spirituality and religion. When religion was defined as participating with an organized religion, 21% strongly or totally endorsed it. When spirituality was defined as belief and participation in some transcendental realm, 50% strongly or totally endorsed it. This change in definition lessened the gap between clinicians and the general public in how they identified their beliefs.

Smith and Orlinsky (2004) researched the religious and spiritual experiences of clinicians in New Zealand, Canada and the United States. They concluded that the religious and spiritual experiences of clinicians are more complex than previously reached conclusions which viewed clinicians as secular and critical of religion. They felt further exploration was needed to examine the meaning of spirituality as it is used by clinicians, and what it means to be a religious or spiritual clinician. This is the intent of this paper's examination of how spiritual clinicians use their spirituality in clinical practice.

Historically, within the therapeutic community, clinicians' use of any aspect of themselves was discouraged. Within the psychoanalytic paradigm the analyst was supposed to be neutral, so as not to interfere with the client's process (Aron, 2004). Clinicians' spiritual beliefs and practices, as a part of their personal life, were not to affect the therapeutic process. Aron (2004) concludes that religion/spirituality is the last taboo topic of psychoanalysis, especially as it relates to the clinician's beliefs. This concept could be why there is such limited amount of research on clinicians' use of their own spirituality.

The cultural competency movement, however, felt it was important for clinicians to acknowledge the way their culture, including religion, affects their practice. This element of cultural competency is defined by NASW in their Code of Ethics Standard of Cultural

Competence (2001) as “having the beliefs, knowledge, and skills necessary to work effectively with individuals different from one’s self” (para. 3). Beliefs include “awareness of one’s heritage, values, limitations, and biases as well as respect and sensitivity to differences” (para. 3). Cultural competency encourages clinicians to examine their own spiritual beliefs as a way to identify the influence such beliefs could have on the therapeutic process.

The clinician’s spirituality is commonly considered only in relation to the client’s. For example, studies have examined whether clinicians who identify as spiritual use spirituality more in practice (Shafranske, 1996). Research has examined whether clinicians pray with clients, meditate with clients, or use scriptural text in sessions with clients (Jacobs, 2010; Stirling et al., 2010). Spirituality is included in treatment because of the client’s request for it to be included. The emphasis is on the clinician’s use of spirituality in relation to the client’s spirituality. It does not focus on the clinician’s private, personal use of his or her own spirituality in clinical treatment.

One study that addressed clinicians’ use of their spirituality explicitly was conducted by Jacobs (2010). She interviewed clinicians in focus group format about their spiritual and religious beliefs and how they used them in practice. She asked the clinicians how they use spirituality and how spiritual interventions relate to or interact with their clinical practice. What she found was that clinicians sometimes use not only their own spirituality, but, also borrow from other religious practices (Jacobs, 2010). For example, they may use mindfulness practices with clients, but it may not be a part of their own spiritual practice. The study did not examine the clinician’s private use of spirituality in clinical treatment as the study of this paper proposes to do.

Bilgrave and Deluty (2002) conducted a study that suggested psychologists spiritual beliefs did influence their practice. They found that 63% of psychologists interviewed endorsed that their religious or spiritual beliefs influenced their practice to a moderate or great level. The way in which their spiritual beliefs were influential was not specified. Another finding was that psychologists who followed fundamentalist or conservative Christian ideology were likely to use cognitive behavioral perspective in practice. Those with a humanistic perspective were likely to be associated with eastern or mystical beliefs. They proposed "psychologists may inform their work with world views and values derived from multiple cultural domains outside of science, domains such as religion and politics" (Bilgrave & Deluty, 2002, p. 256).

By being aware of their own spirituality, clinicians can become more attentive to interactions between their own spirituality and that of their clients (Hagedom, 2005). Clinicians' beliefs may influence the therapeutic relationship, but, by examining their own beliefs they can be attentive to this influence. Given the nature of the therapeutic relationship if this influence is unattended to it may result in non-obvious biases, or other indirect and unanticipated influences upon the therapeutic process (Plante, 2007). It also helps them to navigate the effects of their own spiritual beliefs and practices on the client's process. This need for awareness of the interaction is acknowledged as important, but the precise way in which it affects the clinical relationship is less studied in literature.

This study will address this gap by examining more precisely how clinicians' spirituality influences their practice. It will then examine how they personally and privately use these beliefs and practices in their clinical work. Examples of the personal, private use of spirituality that will be examined are: using spiritual practices to prepare for meeting with clients, praying for clients privately, and seeking spiritual guidance when making clinical decisions.

Ethical Considerations

The ethical considerations of the use of spirituality in therapy, and its effect on the therapeutic relationship have consistently been topics of discussion. Commonly cited ethical concerns are that it is outside the scope of clinical practice and clinicians have inadequate training to address spirituality. Another concern is how the clinician could have a negative influence on the client because of the clinician's own beliefs, convictions or counter transference.

A common reason for why spirituality is not addressed in therapy is that spirituality is seen as outside of the scope of practice (Gonsiorek, Pargament, Richards, & McMinn, 2009; Gubi, 2009). The proponents of this view believe spiritual issues need to be left to religious and spiritual leaders. They feel clinicians are not trained to address the spiritual aspects of a person. While this is a relevant concern, to not address a person's spirituality limits the treatment provided in light of culturally competent practice. One conclusion to reach from this argument is that more training is needed, so clinicians are competent to help with spiritual concerns.

A study by Hage, Hopson, Siegel, Payton, and Defanti (2006, cited in Post & Wade, 2009) researched multi-cultural training in religion and spirituality. They surveyed training directors and program leaders in counselor education, clinical psychology, counseling psychology, rehabilitation psychology, as well as in psychiatry. These participants reported student receive minimal training and education on the topic of spiritual diversity and interventions.

Another ethical dilemma is the transference and counter transference that could occur. A clinician could allow his or her own bias, convictions, or avoidance of spirituality to negatively influence therapeutic relationships. For instance, if a clinician disagrees with the religious

practices of his or her clients, he or she could avoid exploring the client's beliefs and miss an important insight or experience of the client (Aten & Worthington, 2009). Gubi (2009) suggested that incorporating spirituality can change the power dynamic between the therapist and client. Gubi (2009) conducted a qualitative study of the possible ethical dilemmas of using prayer in therapy. He found that clinicians felt that if only the clinician prayed, then “he [the clinician] could be elevated in some way” (p. 116), changing the way the client sees the therapist.

Conclusion

This chapter reviewed the definitions of spirituality and gave the definition that will be used for this qualitative study. The historic relationship between religion and spirituality was summarized. An overview of the use of spirituality in clinical practice was discussed. A brief review of the literature relevant to clinicians’ use of their own spirituality in practice was presented. The ethical considerations of the use of spirituality in practice were reviewed as well.

There are multiple limitations to the research available on the topic of spirituality. One limitation of the research stems from the subjectivity in the topic. The variety of ways which spirituality has been defined within the literature has led to divergence in interpreting the results. The existing research mainly focuses on major western religions/spirituality. Many of the studies available pull from small sets of people who are already spiritually inclined. The diversity of the groups discussed in the literature is inadequate. Ethnicity, race or gender of the participants is rarely identified or examined for the influence it may have. The spiritual practices of practitioners belonging to diverse populations have been minimally researched.

Mental health has moved to accept spirituality as a dynamic element in therapy. This study will further research by its investigation of how clinicians' spirituality is integrated into

their clinical practice. This study will go beyond just acknowledging that clinicians' spirituality plays a role in therapy; it will seek to address specifically how they privately, personally use their spirituality in their clinical relationships. This is an area identified as lacking in research (Smith & Orlinsky, 2004). The research question will be: How do clinicians privately incorporate their personal spirituality into their clinical practice?

This study will use phenomenology theory as its theoretical construct. Phenomenology is defined by Rubin and Babbie (2009) as "a philosophical paradigm for conducting qualitative research that emphasizes a focus on people's subjective experiences and interpretations of the world" (p. 218). It is a descriptive study of how individuals experience a phenomenon. Phenomenological research also searches for commonalities between the experiences of those interviewed. The theory was chosen because it focuses on gathering the experiences of individuals. This will offer understanding of how clinicians privately incorporate their personal spirituality into their clinical practice. This flexible format for gathering and interpreting information is appropriate for such an underexplored topic.

CHAPTER III

Methodology

The purpose of this qualitative study is to examine the role clinicians' personal spirituality plays in their clinical practice. The specific research question is: How do clinicians incorporate their own spirituality into their clinical practice? As the literature review revealed, there is a gap in literature exploring the relationship between clinicians' personal spirituality and their clinical practice. Given the limited amount of research in the area, a qualitative study focusing on exploration was used. This chapter summarizes the research methods used in this study and will describe the sample, data collection methods, and data analysis procedures.

Sample

The inclusion criteria for participation in this study was: self identification of being spiritual, a Masters or Doctoral level degree in a mental health related field, licensure to practice mental health care independently, and at least five years of experience within that field.

A snowball email approach was used for recruiting participants. Clinicians known by this author who met the criteria outlined were contacted to begin the process. This study therefore used a non- probability, convenience sample. Interested participants were sent a screening email (see Appendix B) to confirm their participation, and adherence to the criteria. Next the participant received an informed consent form and a questionnaire (see Appendix C and D). This approach was chosen for its practicality.

The sample size was 13 participants. Participants included: one Caribbean, three African-Americans, and nine Caucasians. There were three men and ten women. The

professions the participants belonged to were clinical social work (8), marriage and family therapy (1), psychiatric nursing (1), and licensed professional counseling (3). The spiritual beliefs and religious affiliations participants ascribed to are listed in table 1 in the findings section. The representativeness of this sample was limited by the self selection nature of snowball sampling.

Data Collection

This study employed two research methods, namely a questionnaire and a semi-structured interview. This research project was presented to and approved by the Human Subject Review Board (HSRB) at Smith College School for Social Work before data collection began (see Appendix F). This project followed all the federal regulations for the protection of human research subjects to ensure that the privacy and rights of all participants were protected. Prior to their involvement in the study, participants read and signed an informed consent form. The consent form outlined all elements of participation and the benefits and risks of being involved in the study. A signed copy was kept by the researcher and one was offered to the participant. Any writings or publications are presented in the collective format. Any quotes used for illustrative purposes do not contain identifying information. The information gathered, including surveys, recordings, transcriptions, notes, and signed informed consent forms, will be kept in locked storage for a period of three years, as required by federal guidelines.

After reading and signing the informed consent form, participants filled out a questionnaire about their beliefs and practices. The questionnaire also asked demographic questions of ethnicity and gender. After this was complete, six interview questions exploring the way in which the clinician's spirituality interacted with his or her clinical work were asked (see appendix E). When appropriate, follow up questions were asked for more understanding of the

participants' responses. For example, if a participant answered affirmatively to a question about seeking support from a higher power, follow-up questions explored how this occurred. The questionnaire and interview questions were written by this researcher. The combination of these two components provides a panoramic view of the role clinicians' spirituality plays in their clinical process. The strength of the semi structured interview method is the breadth of information received, which as a qualitative project focused on exploration, is a great asset.

The interviews were recorded on an audio recorder, and the researcher took written notes. The interview lengths ranged from 12- 50 minutes. All interviews were conducted between February 23rd, 2011 and March 30th, 2011. The interviews were transcribed by the researcher.

Data Analysis

Phenomenology is the theoretical framework chosen for this study. Rossman and Rallis (1998) provide a concise definition of phenomenology:

Phenomenology is a tradition in German philosophy with a focus on the essence of lived experience. Those engaged in phenomenological research focus in-depth on the meaning of a particular aspect of experience, assuming that through dialogue and reflection the quintessential meaning of the experience will be reviewed. Language is viewed as the primary symbol system through which meaning is both constructed and conveyed (Holstein & Gubrium, 1994). The purposes of phenomenological inquiry are description, interpretation, and critical self-reflection into the "world as world" (Van Manen, 1990) Central are the notions of intentionality and caring: the researcher inquires about the essence of lived experience. (p. 72)

Phenomenology was founded in the philosophy of Edmund Husserl (1859-1938). He is considered one of the most influential philosophers of the 20th century. Husserl believed that

“imaginative variation, the acceptance of descriptions of the experience exactly as related by study participants, assisted researchers’ efforts to grasp the essence of an experience” (Phillips, Strunk & Pickler, 2010, p. 67).

Phenomenology is an applicable theoretical framework for this study because it focuses on studying an aspect of an individual’s experience, like spirituality, in a particular setting. This framework emphasizes the meaning and “essence” of an individual’s experience. This is important when discussing a term such as spirituality that has multiple meanings, definitions, and personal distinction.

Since the topic of clinicians’ use of their spirituality in practice has minimal research, studying individual’s experiences offers valuable insight into the topic. Husserl believed that phenomenological research could further understanding of an experience by identifying meanings and central themes from participants’ experiences. Phenomenology continues its furthering of knowledge by searching for commonalities between the experiences of the participants.

To begin analysis, following transcription of the interviews, the researcher reviewed the transcripts several times. In line with Phenomenology approach, content theme analysis coding was performed, next. While reviewing the data, the researcher identified themes that emerged. Themes in the content of individual interviews were first identified. Overarching themes that were common among the participants were identified, next. These themes were then clustered together by conceptual similarities and labeled with a descriptive term.

CHAPTER IV

Findings

Introduction

This qualitative study examines the role clinicians' spirituality plays in their clinical practice. The specific research question is: how do clinicians incorporate their spirituality into their clinical practice? As discussed in the literature review, there is limited literature exploring the relationship between clinicians' spirituality and their clinical practice. There has been a growing amount of research exploring the use of spiritual practices in mental health and the influence of clients' spirituality on mental health. However, little attention has been given to the topic of how clinicians' spirituality influences their clinical practice. This qualitative study examines how experienced clinicians who self-identify as spiritual individuals perceive the role their spirituality has in their clinical practice.

For this study, thirteen clinicians were interviewed. Participants included one Afro-Caribbean, three African Americans, and nine Caucasians. Three participants were men and ten were women. One participant was located in Oregon, and the other twelve were located in Colorado.

Participants varied widely in their professional disciplines and workplaces; however, all worked in individual treatment settings. Four clinicians were in private practice; two of those practiced equine therapy. Seven worked in a public outpatient mental health clinic. One worked in a non-profit trauma center. One did not specify her current place of work and in the interview referred to past work in a hospital based setting. The participants included: eight clinical social

workers; one marriage and family therapist; one psychiatric nurse; and three licensed professional counselors. Their length of time in practice ranged from 10-35 years. Table 1 below provides participants' self-descriptions of their spiritual beliefs.

Table 1

Participant's Self Description of Spiritual Beliefs.

<u>Participant</u>	<u>Self-Description of Spiritual Belief</u>
Clinician 1	"Christ follower"
Clinician 2	"Spiritual with many different influences"
Clinician 3	"Presbyterian background, open spirituality now"
Clinician 4	"Tibetan Buddhist"
Clinician 5	"Nichiren shoshu Buddhism"
Clinician 6	"Christ follower"
Clinician 7	"Member of the church of Jesus Christ of Latter-day Saints"
Clinician 8	"Spiritual with Christian and Buddhist influences"
Clinician 9	"Spiritual"
Clinician 10	"Catholic"
Clinician 11	"Spiritual-connection to my own inner self"
Clinician 12	"Spiritual- Forces that are unexplainable"
Clinician 13	"Kadampa Buddhist"

This chapter presents a thematic analysis of participants' responses, in keeping with a phenomenological research approach. It discusses three major themes, each with subthemes. These three themes reflect the ways participants described the influence of their spirituality on their clinical practice: (1) clinicians' spirituality provides them with support and guidance; (2) clinicians' spiritual beliefs influence the way they interact with or perceive clients; and (3) clinicians use concepts of mindfulness for themselves and their clients. These themes were multidimensional (non-exclusive); each clinician may be a member of multiple themes and subthemes.

Before describing the three major themes in detail, it is important to note one universal perspective shared by all interviewees. All clinicians expressed that it was imperative to respect their clients' beliefs regarding spirituality. Each emphasized the need for clients to introduce and lead any direct conversation related to spirituality. As Clinician Number Three stated, "If they discuss their spiritual beliefs then it is something that I bring in to the session. If they don't then I don't." Clinician Number Nine echoed this sentiment, saying, "I am very open to exploring the role clients' spirituality has, but it needs to come from them."

Clinicians' Spirituality Provides Support and Guidance for Themselves

A significant majority of clinicians in this study (n=11) reported that their spirituality provided a source of personal support and guidance in their work. This support and guidance was internal, and not shared with clients. The exact nature of the benefit derived from the clinician's spirituality varied among clinicians but can be categorized in the three sub-themes. These subthemes are as follows: (1) clinicians use their belief in a god, or higher power to help them cope with the challenges of the job; (2) clinicians seek guidance and support specifically when

working with challenging clients; and (3) clinicians seek assistance from their spirituality to be effective in their work.

Clinicians use their belief in a god or higher power to help them cope with the challenges of their work. Ten clinicians stated that support from a god or higher power was important to them in that it helped them cope with their work in a variety of ways. Clinician Number Seven remarked on how belief in a higher power helped him to feel less alone in his work:

This sounds a little self serving, but it adds a sense of comfort and support from my viewpoint because I have a backup so it is not all on my shoulders. Part of my spiritual belief is that God knows more than I do, and He understands me as well as the person I am meeting, better than I do and so if I have access to that knowledge and inspiration than I can be more, it, I would be more. He calms me, I have more of a back up . . . if you do have a sense of spirituality you have got that sense of backing, peace and sometime serenity, then you are able to deal and cope. You have the different perspective than someone who isn't spiritual who does deal with some of the things we hear.”

Clinician Number Three explained how praying to a god helped her feel less overwhelmed in her job, and process the difficult information her clients shared in the course of a session:

I don't think I would have picked trauma or been able to work in it for 20 years without having a large spiritual component as part of my self-care plan. And whether or not I am using that, it is what preserves me and moves me forward...Using prayer with a client as a tool in counseling isn't something I would do, but using prayer as part of counseling to help myself is what I do. I think that it really helps me to stay present in the moment with people, without being overwhelmed by the type of things they are sharing or what I

am doing. It helped keep my anxiety down. I think it's more of what I use to be able to do in my clinical practice, but the focus is more on strength in myself to do it, ability to have boundaries, ability to let go of things.

As mentioned before, clinicians in this subgroup used their belief in a god or higher power to feel less overwhelmed or hopeless. These clinicians' belief in a god or higher power allowed them not to feel solely responsible for the care of their clients, helping them to feel supported and preventing burn-out.

Clinicians seek guidance and support specifically when working with difficult clients. Six clinicians identified that they sought spiritual guidance when feeling stuck or working with a difficult client. According to these clinicians, these situations - more than others - prompted them to seek assistance from a god or higher power. This subtheme ties into the first subtheme: both subgroups used spirituality or spiritual practice as a way to alleviate difficult feelings. However, clinicians in this subgroup used their spirituality in specific situations, instead of throughout their clinical work. For example, Clinician Number One said, "Sometimes when I am really hung up with a client, stuck, I will pray about it. I might even anonymously ask others to pray about it." Clinician Number Six stated:

I find myself, when preparing for clients that are really tough, or that I have negative counter transference towards, that I really ask for help in that. I ask that I would see them the way God sees them. To see them as children of God, that I can help them deal with some obstacles or very difficult experiences, a lot of the things they deal with are much harder than we think.

While the clinicians above found support from a god or higher power, others found support from their spiritual practice itself. Clinician Number Thirteen spoke of his Buddhist

spirituality: “Well, between sessions I might say certain prayers too, if I had a particularly difficult patient. I may dedicate any merit that I may have incurred from helping people to help them.” This clinician explained that in Buddhism, one earns merit when one does good deeds for another person; this merit may be transferred to others in order to bring benefit to those other people.

Clinicians seek assistance from their spirituality to be effective in their work. The third subtheme consisted of clinicians who sought support from their spirituality to gain a greater sense of efficacy. Clinicians spoke of starting their day with spiritual affirmations, and prayers. For example, Clinician Number Ten stated, “Often in the morning on my way [to work], I will say a prayer that I am able to really provide insightful assessments.” Other clinicians used spirituality within sessions to improve their clinical capabilities. Clinician Number Two stated that her spirituality helped her to gain clarity and direction. She reported, “When you are talking to people, with interventions, my spirituality helps clarify, crystallizes where to go from here and what to do with this, even if it means I don’t know, let me get back to you .”

This theme identified an important role that a clinicians’ spirituality has in their clinical work. It shows that clinicians use their spirituality for support and guidance in many stages of the clinical practice. Subtheme three identified those clinicians who described a proactive spiritual practice aimed at improving their clinical care. This is distinct from the behavior identified in subtheme one, which describes clinicians who use their spirituality to reactively cope with the impact of clinical work. In subtheme two, clinicians pointed out that their spirituality has a specific role when they face difficult clients in their clinical work.

Clinicians' Spiritual Beliefs Influences the Way They Interact with or Perceive Clients

Twelve of the thirteen clinicians stated that their spiritual beliefs influence either how they saw their clients or how they interact with their clients. These twelve clinicians fell into one of two sub-thematic groups. (1) The first group described spirituality as totally encompassing of their perceptions of the world, including their clients. (2) The second group reported that they use spirituality to actively improve their perceptions of clients' situations.

Spirituality totally encompasses clinicians' perceptions of the world, including their clients. Clinician Number Two articulated this subtheme when she answered the interview question, "What led to the decision to incorporate your spirituality into your practice?" She answered:

It is the whole reason why I do it. To take the spiritual practices out my work would be like taking the water out of my body and say, "Ok now function without the water." That is just not going to happen, cuz I would be just a pile of powder and dry bones...it is the reason why you are able to pick up on things, intuitively the reason why you are able to pick up on energies they omit from their bodies. [Spirituality] is the reason why you are able to align yourself with a particular person who is different than you or very similar to you, for a lot of very different reasons.

In the above quote, Clinician Number Two noted that her spirituality was not only an integral part of herself, but an essential part of being able to do therapy. Clinician Number Two described her spirituality as a crucial element to all of her interpersonal interactions. Her therapy represented a particularly focused personal interaction and therefore her spirituality was an essential part of the interaction.

Clinician Number Four shared a similar sentiment in her response to the question, “How does your spirituality influence your clinical work?” She stated that she could not have chosen to separate her spirituality from her clinical practice:

I think it is a way of living. I don't think there is much of a separation between spiritual paths, my spirituality, the way I do counseling, the way I live my life. It is all of me, a way that I engage in relationships and my work. It is really hard questions because I feel like it influences all aspects of my life - who I am as a wife, therapist, it is all the same.

Clinicians in this subtheme saw their spirituality as an intrinsic part of who they were as people. It was not an element they believed they could separate from their life or their work, but an intimate part of themselves that was present in every interaction. As such, it played an essential role in the therapeutic work that they did.

Clinicians use spirituality to actively improve their perceptions of clients' situations.

Clinicians reported a variety of specific ways in which they used spirituality to improve their perceptions of their clients. Some cited underlying tenants of their spiritual beliefs as significant in their view of clients. For example, Clinician Number Six stated that she sought to feel care and concern for all people because her god cares for all people. Clinician Number Five related her clinical viewpoint to her Buddhist spiritual beliefs:

I pray for the people I have in clinical therapy, I pray for them to develop the wisdom they need to move forward in their life, I don't necessarily believe I have the answers for people. I believe fundamentally that people have the power to change their lives instead of thinking their lives control them, or making your decisions, I wouldn't call them negative decisions people have made that have caused negative circumstances for themselves, have to always control their lives. So it is at the bias of my clinical work that

I believe people have the power and the insight and wisdom or can develop that to make changes in their lives.

Other clinicians found that their spiritual beliefs shaped their views of clients' spiritual identities. For example, some clinicians who did not ascribe to specific belief systems felt that their spirituality made them able to discuss spirituality without the bias because they did not belong to one religion. Clinician Number Two, for example, stated that because she does not belong to any religion, but has a more global spirituality, she is able to better understand clients' perspectives. Here she explains this view:

The particular way that I express my spirituality is that I am not in any particular religious circles. Whether it is an indigenous African religions or non-African religion . . . once you step out of those closed systems . . . you have a different vantage point than if you are in one yourself. It really does help you to sort of get what people are saying in a more unique way, because you are not embedded or entrenched in, say, Islam or Catholicism or Daoism, and then you see everything through those respective lenses. . . It just accords a unique vantage point for hearing people's stories.

Instead of their spirituality influencing their perspective because it is an intrinsic part who they are, like those in subtheme one, those in subtheme two use their spirituality as a flexible tool. In both subthemes, clinicians stated that their spirituality plays a role in their clinical work by positively influencing the way they interact with and perceive their clients

Clinicians Use Concepts of Mindfulness for Themselves and Their Clients

Ten clinicians, representing a wide range of spiritual beliefs, found clinical value in the application of practices which they described as: meditative, present, mindful, grounded and centered. This group was separated into two distinct subgroups: (1) clinicians used their

spirituality to be more present, centered or grounded *themselves*; and (2) clinicians who shared these spiritual practices with their clients as helpful tools. Some clinicians occupied both subtheme groups. Clinician Number One, for example, reported that she taught meditation to her clients and used it for herself. She stated:

I feel like [spirituality] centers me, grounds me, helps me to be focused and to be a conduit for the Holy Spirit. I think also that the practice of meditation that I use heavily in my [spiritual] practice often times keeps me centered and grounded as well as it does my clients when I teach it to them.

Clinicians used mindfulness concepts for themselves. Clinicians in this sub-theme group indicated their spirituality helped them to be present, grounded, or centered and thus more readily available to their clients. They indicated using this “grounded-ness” in preparation for meeting with their clients, as well in session with their clients. For example, Clinician Number Four talked about how she would center herself before meeting with clients. She stated:

The time I take before my sessions there is glimpse of that when I really sit and check in with myself and felt that sense of “okayness.” Okay, I am here, what am I feeling, that there is kind of centering to how I feel.

Clinician Number Nine also demonstrates, with the following statement, how clinicians use their spiritual practice as preparation:

I used to take the time to reflect on each client and try to prepare a space of welcome which I think is a very important space to have for each client. I have to use my spiritual practices to, in the past, to really create that space. When I do prepare that space, it helps to create a calm more relaxed, like I said a welcoming space. Clients really sense that they really sense when they coming into a space where you are present you are at ease

and you are wanting to make a connection with whatever you they are bringing into the office or the space.

Clinician Number Three, who works primarily with trauma victims, described how she used her spirituality to help her become present while in sessions with clients. She elaborated on how she uses spirituality by saying:

When I am talking with someone, and I am dissociating with the information or not focusing, I use [spirituality] as a way to refocus myself to join in the conversation and to be present... It really helps me to stay present in the moment with people, without being overwhelmed by the type of things they are sharing or what I am doing.

Clinician Number Eight described using grounding and meditation in both preparation for and during sessions:

I think the biggest help for me is mindfulness, the grounded-ness to really prepare myself for the individual clients, again the spaciousness of allowing the unseen to come in and the spaciousness of not being “I’m not putting out a product.” I think that piece allows me to work with them more effectively. So using my mindfulness and meditation skills allows me to help ground them and breath and helps me personally when there is a crisis when there is a lot of trauma in the room, when they are suicidal or whatever, to ground myself so I can help ground them.

Clinicians used concepts of mindfulness with their clients as helpful tools. Five clinicians said that one way they overtly use their spirituality within the context of the therapeutic relationship is by teaching techniques like meditation and mindfulness to clients. For example, Clinician Number Eleven said, “We talk about meditation as a tool. We actually do some in session, as part of centering, in terms of PTSD reducing hyper arousal symptoms.

Meditation can be part of that.” Clinician Number Four stated that she uses mindfulness and grounding techniques as an essential part of her equine therapy practice. She said:

Usually at the beginning of my practice we have a mindfulness awareness exercise, so I will start off, “Put your hand on the horse and breath and notice what is in your body.” Or it might be, “We are going to do some yoga exercises, and do a couple of poses and breathe and get into your body.” In that place of whole awareness of what is going on inside [yourself], that is where integration can happen. . . . So [we use the techniques] to help people to get to that place of grounding and awareness, to allow the change to happen at the beginning.

Conclusion

This chapter has presented the findings of thirteen semi-structured interviews with clinicians who identify as spiritual. Despite the variety of spiritualities represented, clinicians’ responses could be categorized by a number of salient themes. These themes demonstrate the multiple ways that clinicians’ spirituality can influence the therapeutic process. The clinicians interviewed felt that the inclusion of their spirituality was very helpful in the clinical work they did. It benefited them personally in multiple ways and was also beneficial to their clients. It contributed to their motivation in doing the work, their abilities and skills, as well as their sense effectiveness in what they did.

The generalizability of this study is limited. The limitations stem from a small sample size, a small geographical range and the ambiguity of the definition of spirituality. Because it was a qualitative phenomenological study the sample size was small. This approach provides an in depth look at some clinicians’ perspectives, but does limit the applicability of the results to clinicians in general. Future research could build upon this study by expanding the limited

sample size and geographical region. This researcher chose not to provide the clinician with a definition of spirituality, but allowed them to define the term. While this approach allowed for the representation of many different perspectives, it may have limited the cohesiveness of the responses and themes. This research does provide a launching point for further inquiry into the role clinicians' spirituality has in the clinical process.

CHAPTER V

Discussion

The purpose of this study was to examine the role that clinicians' spiritualities play in their clinical practices. While the literature review laid the foundations for this project, the research itself focused on new areas of inquiry, which are reflected in themes explicated in the findings section. This section seeks to find areas of connection between the literature review and the findings gathered from participants.

Definition of Spirituality

Prior literature indicates that definitions of spirituality include many different concepts (Post & Wade, 2009; Richards & Bergin, 2000). Clinicians in this study were not provided with a definition of spirituality, but were instead asked to articulate their description of their spiritual beliefs and practices. This was done in an effort to gain better comprehension of clinicians' definitions of spirituality. In keeping with the literature, participants in this study varied in terms of how they described spirituality. Each clinician defined his or her spiritual beliefs and practices differently.

Despite variation in definitions of spirituality, the literature review notes that spirituality tends to refer to a feeling of closeness and connection to the sacred, to a god or to transcendence (Hill & Pargament, 2008; Richards & Bergin, 2000). This commonality of definition was reflected in the findings of this study. All but one of the participants in this study stated that they held a belief in a "higher being" – a god or power greater than themselves – and described this element as central to their spirituality. For example, when Clinician Number Five described her

Buddhist beliefs, she said: “We do believe that there is a higher power . . . It is a tranquil relationship. . . We do believe in a higher power with Buddha who does have a greater influence in our lives.” Clinician Number Eight, who conducted equine therapy, when describing her spiritual beliefs, said, “I have belief in a larger being that works through us, and through the horses or whatever, in helping our clients and ourselves grow and develop.”

Distinctions Between Religion and Spirituality

Weaver, Pargament, Flannelly, and Oppenheimer (2006) found that “spiritual” was a preferred term – in comparison to religion – because of its greater inclusiveness. Consistent with the literature, clinicians in this study did prefer to refer to themselves as spiritual rather than religious. For example, Clinician Number Eleven said, “My spirituality is more a sense of having a deep connection to my own inner self and a kind of a more spiritual connection to the world, but not in a religious sense.” Clinician Number Two said, “I think spirituality is very different than religiosity. I think again being [in a] closed system [such as organized religion], you have a bias, it can’t not be a bias.”

Those who did belong to organized religions described their religious practices as an important part of their spirituality, but downplayed the structural components of religion, emphasizing instead their spirituality. This is consistent with a shift in terms in the literature. Earlier literature defines religion as encompassing spirituality (Weaver, Pargament, Flannelly, & Oppenheimer, 2006). Later research defines religion as pertaining to practices and prescribed and proscribed actions, while spirituality denotes personal beliefs (Hill & Pargament, 2008).

The distinction between religion and spirituality was especially important to clinicians in this study when discussing self-disclosure with clients. Clinicians who identified as religious hesitated to identify their religion to their clients, and two clinicians refused to tell clients at all,

because of biases or negative associations the client might have in response. They preferred to say only that they were spiritual, or had a faith, thereby avoiding these negative associations and any alienation clients might feel. For example, Clinician Number Six stated:

Well, I hate to use that global word but, I am a Christian, a follower of Christ . . . that doesn't mean the same thing to everybody, so a client may have an idea of what that is but they don't know what it is for me specifically. . . I think I might just disclose that I rely on prayer and meditation myself, or that I am spiritual, believe in a God- but again only down the road after I have developed a relationship with them.

Furthermore, seven of the thirteen clinicians did not identify with a particular religion. The literature review reflects a trend of clinicians preferring to identify with the term “spiritual,” rather than naming a specific religion (Delaney, Miller and Bisono, 2007). This preference for the term spiritual among participants could be due to a self-selection bias. A self-identification as “spiritual,” was a requirement for participation in this study, while religiosity was not explicitly mentioned. Clinicians that chose to participate in this study may be more inclined to participate because of their preference of the term spiritual.

Clinicians' Concern About the Influence of Their Spirituality in Clinical Practice

Previous author s have remarked on the potential for spiritual beliefs to bias clinicians (Miller, 2003). The majority of clinicians interviewed in this study had considered and were concerned about the how their own spiritual beliefs may affect the clinical process. These clinicians explained two methods that they used to managed these concerns. First, many clinicians stated that they discussed spirituality only upon the clients' request or with their permission and were very discerning about when and how they shared their own beliefs. This was consistent with literature including the study conducted by Wade et al. (2007) who found

that an important factor in the effective use of spirituality is the client's expressed interest in its incorporation into therapy. Clinician Number Four stated, "I don't want to impose my own beliefs and say that a client should or shouldn't feel a certain way about anything. . . . I won't lead a client, I don't want to lead them with my own." Clinician Number Five stated, "I don't tell them I am Buddhist, or tell them to be Buddhist. . . . You don't use your belief system to manipulate them."

These clinicians and others stated that promoting their own beliefs within the therapeutic relationship would be unethical. In the words of Clinician Number Six:

You don't want to prejudice your clients, and again whatever kind of experience they had with Christianity or spirituality sometimes is very damaging and hurtful. I think, you know, in some ways there is no place for that. This is a protective environment, where if I were going to a Muslim therapist I would not appreciate them proselytizing me in any way shape or form. And so I want to totally respect that.

Multiple clinicians responded to the question, "Do you share your spiritual beliefs with your clients?" in a way similar to Clinician Number Seven's response:

It is not just when someone asks me what my religion is. That doesn't necessarily mean I am gonna say, I will after I have established a relationship with them and we have been working together for quite some time and I have a pretty good feel from listening to them and talking with them and they are expressing some spirituality in their lives, how it applies to them, that I would say [what my beliefs are] and only if I feel that it has a therapeutic value in mind,-not for any reason for self serving or harm.

The second way in which clinicians responded to their concern about including spiritual practices was through exercising caution and deliberation. Some clinicians included only the

spiritual practices that supported clients' own religious or spiritual identities. As Clinician Clinician Number Five stated, "I work with them to pray twice a day every day for a while to be specific in their prayer, to use their study of their religious preferences to, whatever the philosophical belief is." This clinician drew upon clients' own spiritual practices and religious texts to create connection and meaningful interventions.

Another approach, used with spiritual techniques such as meditation, was to remove any spiritual element to the practice. Clinician Number Eight explained:

I do use meditation, but it is not always incorporating in spiritual elements. Often times it is, if I feel like it is going to be helpful or we have talked about it and I have gotten consent from them to do that, so often times, yes, I do incorporate it.

Clinician Number Four explained, "I will definitely give them some information, about like education about mindfulness and why we are doing those things. I don't use the word spiritual unless they use it as it a part of therapy." Clinician Number Five stated, "Well, I don't necessarily tell my clients what my spirituality is, but I use the fundamental tenants of my [spiritual] practice."As in this latter quote, some of their responses reflected hesitancy and caution about exerting their own spiritual influence over their clients' spiritual identities.

Four of the clinicians were not concerned about the influence their spirituality might have on their clinical process. The reason for this belief varied. Two clinicians choose to not include their spirituality in any direct way with clients and thus felt it could not have any negative effect. The other two felt that their spirituality was based on openness and thus did not make them biased. Clinician Number Two stated:

If being a spiritual person has a bias it really has to do with the bias being open to people's stories, and no need to make it into something Baptist or Lutheran or something.

It just is what it is, you don't have to do anything particular about it. I think biases get used differently by people who are spiritual, I think biases tend to be more strategically used rather than something that is a hopeless handicap.

Her comment indicates a belief that by not belonging to one religion, she could be open and accepting to all religions and belief systems. Clinician Number Five explained why she was not concerned about how her spirituality might affect the therapeutic process

Yeah, not with my spirituality, because Buddhism is so global. It is really hard to get entrenched and become opinionated to the point that you don't express acceptance of people. You know, there are some people who can be so entrenched in their spiritual path you just don't feel okay talking to them.

Lack of Professional Support for Issues Relating to Spirituality

Many clinicians in the study, as discussed above, expressed a strong level of concern about the effect of their spirituality in clinical practice. This level of concern, as well as their lack of consistent ideas of how to manage it, suggests that clinicians in this study may be feeling a lack of professional training and support around clinician spirituality. Moreover, the variability in level of concern across clinicians in this study suggests a lack of clarity about the therapeutic implications of incorporating spirituality.

The literature reviewed found that clinicians do lack in training and education around spirituality in therapy (Post & Wade, 2009). This was true for the clinicians in this study. Only three out of the thirteen had any training specifically about religion/or spirituality and the clinical process. Clinicians did not attend any trainings that discussed their own spirituality's role in the clinical practice.

Clinicians also lacked professional support around spirituality in their agencies.

Clinicians in agency settings expressed feeling limited in their ability to include spirituality in the clinical process. They often expressed that their caseloads were too full to be able to engage in their spirituality in the way that they wished. They also felt that their agencies were not supportive of the inclusion of spirituality. Clinician Number Six said, “I think we have real limitation in this setting to express our spirituality. . . I really saw this as a place to come where there are certainly not a lot of Christians in and certainly not something you would lead with or share openly among staff.” Thus, to the extent that clinicians incorporated spirituality into their practice, they did so with a sense of hesitancy, because of a lack of professional collaboration and support.

On the other hand, clinicians in private practice were more comfortable and frequently felt at liberty to address and include spirituality in private practice. They utilized it for themselves and clients. While they may see this as beneficial, clinicians in a private setting work without daily professional collaboration or agency policies. Without any guidelines on the use of spirituality, clinicians inclined to view spirituality as beneficial may be biased towards using it more liberally. Future research could further explore this division between private practice and agency setting and investigate the development of policies around spirituality in clinical practice.

Spirituality as a Part of Cultural Competency

Proponents of the cultural competency movement, as noted in the literature review, emphasized the importance of clinicians to acknowledge the way their culture, including religion, affects their practice. This element of cultural competency is defined by NASW in their Code of Ethics Standard of Cultural Competence (2001) as “having the beliefs, knowledge, and skills necessary to work effectively with individuals different from one’s self” (para. 3). Beliefs

include “awareness of one’s heritage, values, limitations, and biases as well as respect and sensitivity to differences” (para. 3). Cultural competency encourages clinicians to examine their own spiritual beliefs as a way to identify the influence such beliefs could have on the therapeutic process.

Many clinicians interviewed in this study had not thought about how their spirituality influenced their clinical practice. Clinicians in this study often said it was not something they had thought much about before. They described their actions as a habit, or a choice they made unconsciously. They had not considered how much they had relied upon their spirituality or how it might influence their clinical process. This finding reinforces the argument that clinicians need more training and examination of their own spiritual beliefs to become more culturally competent in their practice. Thus, the concept of cultural competency may naturally lead to a need for further understanding of-and guidance on-the impact of clinicians’ spiritualities on therapeutic processes.

The level of clarity clinicians had in their ability to define their spirituality seemed positively correlated with their understanding of how their spirituality affected their clinical practice. Those who were more ambiguous in the definition seemed to have more difficulty defining the role their spirituality had in therapy. This reinforces the concepts of cultural competency which encourage clinicians to identify their own beliefs so as understand the role it has in clinical practice. A study that further investigates clinicians’ definitions of spirituality may be warranted to better understand the variance of definitions and how these definitions affect the impact clinicians’ spirituality had in the therapeutic process.

New Findings

As demonstrated in the literature review, there are few studies that examine clinicians' use of their own spirituality in the clinical process. The findings of the two studies in the literature that did address clinicians' spirituality were consistent with the results found in this study. One study done by Bilgrave and Deluty (2002) concluded that clinicians' spirituality did influence the clinical practice. The other study, by Jacobs (2010), found that clinicians did incorporate elements from their own faith and other faiths into their clinical study.

This study also revealed several new findings. These findings reflect the ways participants described the influence of their spirituality on their clinical practice. It was found that the clinicians in this study used their spirituality in one of three ways: (1) clinicians' spiritualities provided them with support and guidance; (2) clinicians' spiritual beliefs influence the way they interact with or perceive clients; and (3) clinicians use concepts of mindfulness for themselves and their clients.

All the clinicians interviewed shared how the inclusion of their faith was significant source of support and self-care. Seven clinicians expressed the feeling that they could not do the work they did without incorporating their spirituality as a form of self-care. Clinicians expressed that including their spirituality made them better clinicians, and guided them at times when they were struggling or feeling overwhelmed. Spirituality helped them to have a more positive outlook in their work and changed the way they viewed their clients. Clinicians credited their spirituality for the success they have in their clinical work. Every clinician mentioned that their spirituality helped them to be more present, centered, mindful or grounded. These skills from mindfulness practice they shared with their clients.

Future Areas of Research and Discussion

More research is needed to better understand the findings of this study. Clinicians' spiritualities could be affecting the clinical process in an important way for all clinicians, just as it had for clinicians in this study. More research could help clinicians to tap into this resource and explore possible ways to use a clinician's spirituality in clinical practice. Potential areas of further research are detailed below.

First of all, several issues regarding ethics require further exploration. It is important to examine the potential negative effects of clinicians' use of spirituality. Future research could explore issues of bias and possible unethical application of one's beliefs. Another area of ethical research could be, is it ethical to pray or seek guidance from a higher power for your clients? To explore this thought further, one could research whether it is ethical to seek assistance and guidance from a god or a higher power without your client's knowledge or permission.

Clinicians in this study identified spirituality as beneficial to their therapeutic work, but further investigation is needed to fully understand the nature and extent of this positive impact. Possible research questions could include: What are the benefits clinicians see in incorporating their spirituality into mental health care? How is spirituality used as self-care for clinicians? What benefit do clients derive from having a clinician who identifies as spiritual, if any?

Finally, this study indicates – as is consistent with prior research – confusion regarding terminology applied to spirituality. Further research could investigate the variance of definitions of spirituality and spiritual practice among clinicians. The research presented in this study could potentially guide further exploration of how clinicians' understanding of their own spirituality leads to differing roles for spirituality in the therapeutic process.

Implications for Clinical Social Work Practice

As discussed earlier, this study identifies a serious need for more training, acceptance and understanding of the relationship between mental health care and spirituality. This study has shown that the clinicians' spirituality – whether it is acknowledged in professional training or not– is affecting the clinical relationship. It is important that we increase our understanding of clinicians' spirituality so as better understand how to use it effectively, and what exactly we need to be cautious about.

Up until recently, the clinician has been seen as an ideally spiritually neutral being who can make use of the client's spirituality. However, the results of this study show that examination of the clinician's spirituality could positively influence the therapeutic process.

Based on the clinicians in this study it is a beneficial for a clinician's spirituality to have a role in clinical practice. Clinicians believe their practice is improved by inclusion of spirituality. For one thing, it enables better use of areas of resilience and strength in the clinician, helping them to cope with the challenges and emotional difficulties of the work. It offers support and reassurance when faced with unsolvable questions and situations. It offers every clinician in one way or another sense of peace, or centeredness. Given the clear evidence of these positive benefits, the reality of this impact in current practice, and the potential pitfalls of misusing one's spirituality in clinical practice, it can be soundly concluded that clinicians' spirituality role in therapy is an important area of consideration and in need of further deliberation.

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Appendix A
Recruitment Email

Dear Clinician,

My name is Tiffany Adams. I am a Masters student at Smith College School for Social Work. I am seeking participants for a qualitative research study on clinicians' spirituality and the role it plays their clinical practice. The study seeks to better understand how spiritual clinicians incorporate their spirituality into their clinical practice.

The participants will be mental health clinicians who self identify as being spiritual. They must have a Masters or Doctorate degree in a mental health field and have been licensed, practicing clinicians for more than five years.

Participants will fill out a questionnaire prior to being interviewed over the phone. The questionnaire will be emailed to each participant. The questionnaire should take no more than ten minutes to complete. The interview will last approximately 30-45 minutes.

The data from this study will be used in my Master's thesis and may be used for future presentations or publications. Identifying information obtained through this research study will be kept confidential.

If you are interested please email or call me at your earliest convenience. If you know any other practitioners who may be interested in participating, I would greatly appreciate you passing this email along to them or you can refer them to me and I will contact them.

Thank you for your time, and for considering my request.

Sincerely,

Tiffany R Adams

Appendix B
Screening Email

Dear Clinician,

Thank you for your interest in participating in this study of the relationship between clinicians' spirituality and clinical practice. Please take a few moments to answer the following questions:

What degrees do you hold in a mental health field?

What professional licenses do you hold?

How many years of clinical experience do you have?

Do you consider yourself to be a spiritual person?

Please provide me with your mailing address when you reply to the questions above. I will send you a consent form, and a stamped self addressed, return envelope. A questionnaire will be included as well. After I receive your consent form and questionnaire, I will email you to arrange a time for the interview.

The interview will take approximately a half hour to forty five minutes to complete and will be recorded. Please let me know which of the following times you would be available for the interview. I am available Monday through Wednesday 12-2pm or after 4pm.

If you have any questions, please feel free to contact me.

Thank you again for your interest!

Tiffany R Adams

Appendix C

Informed Consent Form

Dear Participant,

My name is Tiffany Adams and I am a Masters student at Smith College School for Social Work. I am conducting a research study on clinician's spirituality and its relationship to their practice. The purpose of this study is to better understand how self identified spiritual clinicians integrate their spirituality into their clinical practice. The data from this study will be used in my Master's thesis and may be used for future presentation or publication.

You are being asked to be a participant in this study because of the interest you expressed in participation. Participants need to be mental health clinicians who self identify as being spiritual, have a Masters or Doctorate degree in a mental health field and have been practicing clinicians for more than five years. Participation will include a questionnaire about your spiritual practices, and a 30 to 45 minute interview consisting of open-ended questions. Demographic information regarding ethnicity and gender will also be gathered for this study. The interview will be audio taped and transcribed by the researcher of this study. The interview will contain questions regarding your spiritual practice and how you use it in the work you do with clients.

There is minimal risk associated with participation in this study. The potential benefits of participation are self exploration through reflection upon your spiritual practices. The questionnaire and interview may offer a new perspective and insight into the relationship between your beliefs and your clinical practice. You will also be adding valuable information to other providers. There is no compensation for your participation in this study.

Confidentiality will be maintained throughout this study. All identifying information will be kept confidential. Your name will not appear on any papers or tapes, but rather codes will be assigned to your information. The researcher and her thesis advisor will review and analyze this data together. All identifying information will be removed from any quotes used for illustrative purposes. The consent form and any other identifying information will be kept locked and separate from the research materials. The information gathered (surveys, recordings, transcriptions, notes, and signed informed consent forms) will be locked for a period of three

years, as required by Federal guidelines. After that period, all data will be safely stored or destroyed if longer needed.

Your participation in this study is voluntary. You may withdraw from the study at any time during or after the study until April 15th, 2011 and you may refuse to answer any questions. If you choose to withdraw, all information related to your participation will be destroyed.

Please contact me at the agency number or email stated below if you choose to withdraw from the study, or if you have any questions regarding this process. If you have any concerns about your rights, or about any aspect of this study, please contact myself or the Chair of the Smith College School for Social Work Human Subjects Review Committee at 1 (413) 585-7974.

Please print, sign, and mail this form back in the envelope provided.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____ _____ _____ _____
(Participant Signature) (Date) (Researcher Signature) (Date)

Please keep a copy of this form for your records.

Thank you for your participation in this study.

Contact information:
Tiffany R Adams

Appendix D
Questionnaire

Please answer the following questions and return it with your signed consent form.
Thank you for your participation!

1. Have you attended any professional training regarding your spirituality?
2. What is your gender?
3. What is your ethnicity?
4. Does your spirituality include spiritual activities or practices, such as prayer, meditation, and/or religious reading?
5. If yes, please describe your spiritual practices.
6. If yes, how frequently do you perform your spiritual practices in any given month?
7. Do you participate in religious or spiritual gatherings (i.e, church)? If so how often in any given month?
8. Does your spirituality influence your daily living, if so how?
9. Do you believe in a being greater than yourself, such as a god or a higher power?
10. If you do, what is it you believe in?
11. If you believe in a being greater than yourself do you seek support from it in your daily life, if so how?

Appendix E

Interview Questions

Can you please describe your spiritual beliefs and practices?

Do you use your spiritual beliefs and practices help you prepare for your clinical work with clients?

Do your own spiritual beliefs or practices influence your clinical process with clients?

Do you not incorporate your own spiritual belief and practices into your clinical practice with clients?

(Whether yes or no) Could you please share more about that decision?

If you do incorporate your spiritual practices into your clinical process with clients, how do you do this?

Do you seek support from a god or a higher power when making clinical decisions?

Do you have any concerns about your spiritual bias in relation to your client?

Appendix F

Human Subjects Review Approval Letter

February 18, 2011

Tiffany Adams

Dear Tiffany,

Your revised materials have been reviewed and they are fine. We have but one small request. In the Informed Consent, please delete the third sentence in the paragraph about the voluntary nature and withdrawal. Those reassurances are really not necessary. We are glad to give final approval to your study and ask that you send Laurie Wyman (lwyman@smith.edu) a copy of the revised Consent for your permanent file.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Marian Kaufman, Research Advisor