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The intersection of religion and spirituality in clinical practice : bridging the gap between outpatient therapy and pastoral counseling : a project based upon an investigation at Hartford Hospital, Institute of Living mental health center, Hartford, Connecticut

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ABSTRACT

The purpose of this study was to explore how the themes of religion and spirituality emerge in the clinical setting and how we can assess whether our current approach truly serves the needs of the clients. Recent literature has demonstrated an increasing exploration of these themes in research, while outcome analyses are slowly emerging. This suggests a tremendous opportunity to use scholarly work to bolster all working professionals in mental health who engage patients in discussions around potential religious or spiritual dimensions in their lives. Through the use of a focus group and two subsequent individual interviews, I wanted to gain the insight of working professionals who either engage primarily as outpatient therapists or who minister to individuals in a pastoral care setting. Themes of prior training on religion and spirituality, perceived relevance of these topics in mental health, religiosity and resilience or coping skills, clients' representations of religiosity (both adaptive and maladaptive), as well as views on religion or spirituality as a tool in social work were discussed. Findings revealed that both groups viewed religion or spirituality as appropriate and integral to a person's intrinsic views and belief systems. The points of divergence were in regards to the collaboration (or potential for collaboration) between outpatient clinicians and pastoral care workers, the training or education required for staff on these themes, and how respect for these themes can be translated into sensitive practice with patients.

THE INTERSECTION OF RELIGION AND SPIRITUALITY IN CLINICAL

PRACTICE: BRIDGING THE GAP BETWEEN OUTPATIENT THERAPY AND

PASTORAL COUNSELING

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CHAPTER I

Introduction

Research has demonstrated a greater attention in recent years on the intersection of

human behavior and mental processes with religion. For instance, since almost three-fourths of

18 to 29 year olds consider themselves spiritual **(**Grossman, 2010), it is very likely that youth

with spiritual beliefs will enter the therapy room. Nevertheless, some in the field of social work

believe this area has largely been neglected due to the profession's continual "quest for

professionalization and scientific respectability" (Canda, 2002, as cited in Praglin, 2004). I have

explored the literature for studies that sought to identify the correlation between positive mental

health and a faith perspective, and conduct my own research, because spirituality appears to be

an immense resource for clients. For example, Paloutzian and Park (2005) argued, "rather than

encouraging denial, religion promotes reinterpretations of negative events through the sacred

lens" (p. 481). Despite a growing body of literature on religion and mental health, a focus on

religion and spirituality is not ubiquitous across the social work graduate programs (Barker,

2007). Accessing a client's religion or spirituality can therefore be observed as an underutilized

intervention. This is a disheartening realization given that the field of social work has long held a

history of incorporating a holistic approach; "the concept being that an individual's well-being is

best understood in context" (Crisp, 2011).

My research problem developed from this early review of literature; I wanted to explore

how religion and spirituality are currently being addressed in clinical settings. My aim was to

observe the culture of two groups of mental health care workers—adult outpatient therapists and pastoral care staff—in order to gain insight about how conversations manifested regarding religion and spirituality, as well as how they affected the course of patient treatment. I wanted to know if patients were bringing up these themes in mental health care settings and, if so, what role did clinicians and pastoral counselors play in these interactions. Did the clinicians and pastoral counselors find religion and spirituality relevant and appropriate to address with a patient? Were they confident in having these conversations and, if not, what would help to build up their confidence?

Before discussing this further, I will first define these concepts of religion and spirituality because they often are ambiguous constructs, especially when used interchangeably (Barker, 2007). Barker posited that "spirituality" in the field of social work is essentially "the human attempt to find meaning and purpose in life through relationships with self, others, a higher power, and/or the cosmos" (p.148). Barker built upon this definition by the additional view that religion is both a "dynamic and evolutionary process" and therefore infers a developmental component (p. 148). On the other hand, religion can be defined as that which is both distinct and intersecting with spirituality (Barker, 2007). Nevertheless, a widespread definition is "an institutional community pattern of beliefs, rituals, and values relating to spiritual concerns" (Barker, 2007, p.148). A unifying concept within these explanations for religion is "organization and structure" (Barker, 2007, p. 148). Above all, Barker (2007) has made a strong argument that we, as clinicians, need to hold the fact that these two concepts are both separate entities and interlocking elements; all major religions grapple with spiritual issues.

<center>**CHAPTER II**</center>

<center>**Literature Review**</center>

Guiding Theories

Barker has written that it is important to expose social work students to spirituality and religion in their education because our profession was created from Judeo-Christian principles, as well as the social gospel movement of the late 1800s (2007). Whether the clinician fully embraces this history in their practice or not, the social work curriculum should at the very least expose students to this rich material which demonstrates the foundational values of this helping profession (i.e. multi-tiered approach)(Barker, 2007).

Multicultural theory. According to Fellin, a theory which can be useful in understanding the intersection of religion and spirituality is multicultural theory or cultural pluralism (as cited in Barker, 2007). Cultural pluralism is the "inclusiveness of all groups defined as cultures, the recognition of many distinct cultural groups in the United States (Barker, 2007, p. 151). As opposed to traditional notions of ethnicity and culture, cultural pluralism allows the space for spiritual and religious diversity that does not always fall under the categorization of culture. Cultural pluralists pose the argument that since religion and spirituality can be observed as part of one's culture, then in order to be a culturally competent therapist, one must be instructed on these issues because they will certainly enter the clinical encounter (Barker, 2007).

Spiritual development theory. In contrast with diversity or multicultural theories, the spiritual development perspective addresses the concept of spirituality from a human development perspective; Straughan stated that it is a "foundational attempt to honor holistic

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personal development from a bio-psycho-social-spiritual framework" (as cited in Barker, 2007, p. 153). What is also inferred is that an individual's capacity for spiritual matters is not stationary or fixed, but a fluid process which conveys change, adaptation, and growth (Barker, 2007). Within this understanding of spiritual development, there emerges another term, "faith development." The idea is that through one's faith or religion a person constructs a meaningful narrative, as well as explores and establishes links within experiences and events (Barker, 2007).

Transpersonal theory. Barker (2007) offered a third theory which can shed some additional insights on religion and spirituality: *transpersonal theory*. This theory utilizes a general, non-religious conceptualization of spirituality and argues that spirituality is essential for achieving the ideal level of human functioning. Transpersonal theorists recognize that religion can be a venue for spiritual expression, but posited that this type of expression is not exclusively tied to organized religions. This theory promotes a positive outlook on human nature (i.e. people want personal growth) and most importantly, encourages the participation of non-religious individuals who also reflect on the meaning of life and their connection to other people.

Barker (2007) also responded to the apparent increasing trepidation of social work students about the scarcity of material regarding religion and spirituality in social work education. She reviewed empirical literature on this topic including the field's history, diversity or multicultural theories, spiritual development theories, and transpersonal approaches to better understand these issues. This article's strength is the extensive range of viewpoints evaluated from the trajectory of this type of literature. One limitation is that the research does not adequately address ethnical or racial differences in the studies, nor does it mention how diverse the study's participant sample was.

Religion as a Resource

There are multiple scholarly articles which support the need for further exploration. Lee (2007) has argued that more research needs to focus on how religious and spiritual coping affects the well-being of an individual because this is a foundational element of the need for revised social work graduate curricula. While the relationship between stress and depressive symptoms has been investigated extensively, this dynamic has not been observed in light of religious coping strategies. To test his theory, Lee used quantitative measures (i.e. questionnaires) with 127 MSW students at a northeastern university in 2003. His findings were that religious or spiritual coping significantly decreased the influence of stress on depression. Given the complexity of terms such as religious and spiritual coping, further investigations are needed to tease out Lee's findings. While he made use of quantitative measures (i.e. Religious/Spiritual Coping Scale form or RCOPE) and sought to demonstrate a connection between spiritual interventions and positive coping mechanisms, the study was limited. For example, Lee did not provide demographic details regarding his participants, but did indicate that for future studies the need to include a larger age range (e.g. from young adults to the elderly).

In addition to looking at the perception of students, clinicians, and religious professionals, Crisp (2011) posited that "promoting wellbeing requires a holistic approach to social work practice" (p. 663) and, therefore, it follows that the role of religion should be addressed in the clinical setting. She further argued that religion should transfer into the individual level, as well as the agency or institutional level. Furness and Gilligan highlighted that "there has been a tendency to ignore religion unless it is somewhat exotic or problematic, and even then it tends to be considered as an issue in which cultural competence is required rather than understanding a person's religion as a potential resource" (as cited in Crisp, 2011).

Religion and Spirituality in Social Work Curriculum and Practice

Anderson and Young (1988) offered encouragement in this research domain because they found that by addressing spirituality with a patient, a clinician is opening an often untapped resource for healing. They argued that two questions can be easily incorporated into an assessment:

(a) Are there any religious concerns or experiences that you want to tell me about that relate to your coming into our program, your illness, or your recovery? And (b) Are you affiliated with any church, synagogue, or religious group that is or has been important to you? (p.529)

They also argued for a crucial component to any new intervention; "staff attitudes and anxieties are the target of any educational program" (p. 532).

Canda and Furman (1999) conducted a national study in which they surveyed 8,000 practicing social workers who were members of the National Association of Social Work (NASW) about their professional approach regarding religion and spirituality. These researchers used a 105-item questionnaire and found that 50% of social workers they surveyed were using spiritual or religious interventions in clinical work, but 73% of the sample had no formal training in this arena. Canda and Furman also found that "Christian clinicians were more likely to discuss the topic of religion with clients than are agnostics or atheists" (p. 318). Therefore, the strong percentage of Christian clinicians—approximately 70% of their sample—led to a more predictable outcome for their responses and limited their findings. The Christian social workers generally responded more positively to addressing religion and spirituality in their practice.

Sheridan and Hemert (1999) hypothesized that religion and spirituality served a significant role in social work education and approached this topic by surveying students on their

views and experiences. Their study involved interviewing 208 students from two schools of social work, and their results revealed an overall positive position on the role of religion and spirituality in clinical practice. Also, they found that the students generally promoted spiritually oriented interventions with clients. This was the case despite of little exposure these students had to such topics in their formal education and training.

Praglin (2004) shed some light on how to frame an interdisciplinary dialogue in regards to the connection between spirituality, religion, and social work. She argued that social work scholars and clinicians have generally approached this question of integration in one of four ways: "1) resistance or avoidance; 2) an overly-generalized syncretism; 3) radical separation of the terms *spirituality* and *religion*; or 4) a genuinely interdisciplinary conversation between the disciplines of social work and religious studies" (p.72). She also noted that even with the social work profession's religious roots, religion and spirituality have largely been disregarded given social work's continual mission to prove its professionalism and scientific respectability. While Praglin noted social work profession's oversights, she also highlighted the progress which has been made for our field as well. For example, there is now a Society for Spirituality and Social Work. Finally, Praglin cautioned but did not dissuade future researchers from exploring these themes of religion and spirituality, given specific logistical factors. For example, Praglin stated that a lot is embedded in why religion and spirituality have not always been included in dialogue; some social work professionals fear "pathological consequences of religious expressions, such as passivity, excessive guilt, or gender inequality" (p.69). Agencies may fear that attention to these themes will cost them their funding (i.e. mixing Church affairs with State capital).

Heyman, Buchanan, Marlowe, & Sealy (2006) explored how religion and spirituality can play a role in clinical practice. Their study was cross-sectional and examined social workers'

views on religion in practice primarily in the state of New York. These researchers utilized

survey questionnaires and mailed them to 400 randomly selected members of the New York

State Chapter of the National Association of Social Workers (NYSNASW) excluding members

in New York City. They found that only one-third of participants had taken coursework in

spirituality (those who did have spirituality coursework took, on average, two courses); 46% of

social workers indicated an interest in taking such courses, and on average, 68.5% of respondents

demonstrated positive attitudes on the inclusion religion in practice. However, there are two

limitations to this study. First, it was only administered to one northeastern state and—given

their unexplained exclusion of New York City—the validity of the data could have been

compromised due to their failure to reach out to one prominent city in their designated sampling

pool. In addition, approximately 84% of participants identified religious or spiritual affiliation. It

is possible that the participants who identified a religion or spirituality were more likely to take

the time to respond to the questionnaires. Nevertheless, this study exhibited strength by

reevaluating a topic that deserves more attention.

Hodge and Derezotes (2008) reviewed literature on this topic and their analysis concurred

that interest in incorporating content on spirituality into social work education has increased

substantially. Their examples of how this is being accomplished include specialized courses

being offered on religion and spirituality, general course content, and social work accreditation

standards. For example, Miller noted that in 1990 only a few graduate programs offered elective

courses on spirituality (as cited in Hodge & Derezotes, 2008). By 1995, the number increased to

17 programs (p. 103). In 2000, at least 50 programs offered courses on religion and spirituality

(Miller, 2001). Canda (2005) concluded the timeline for the movement by his data revealing that

in 2005 approximately 75 programs offered courses on these themes. While the work from

Hodge and Derezotes' article is in sync with prior literature framing the basis of the argument that there is a gap in social work curriculum (i.e. religion and spiritual education and training), what scholars should be dialoguing and researching now is the type of information to teach within these broad domains and how this content should be taught. Hodge and Derezotes suggested that, overall, the best frame of mind to have in these academic efforts involves acknowledging that "education in spirituality is a lifelong endeavor" (p. 116). Let this serve as a launching pad for exploring a new way to engage in dynamic work and healing with patients and not allow it to be an unsurmountable barrier any longer.

Gallichio (2009) conducted research similar to my study, which entailed interviews with four focus groups including social workers, psychologists, and psychiatrists in three different geographical locations. The author found that the clinicians believed that including spirituality in practice benefits the client in both secular and sectarian ways. The application of spiritual practices by participants varied widely. The majority of participants in this study reported the use of mindfulness and meditation based clinical modalities in their practice. Only a minority of participants reported formal education and training on the use of religion and spirituality in clinical practice and thus builds the case for more training and education for clinicians in these domains.

Jacobs (2010) conducted a qualitative study that expanded the literature on regional perspectives on the topic of religion and spirituality in clinical practice. The six regions she utilized were Western Massachusetts; the Bay Area of Northern California; Albuquerque, New Mexico; Atlanta, Georgia; Chicago; Illinois; and Colorado (Boulder and Denver). Participants were recruited through email correspondence and word of mouth from Smith College School for Social Work alumni affairs office. Participation involved a demographic questionnaire and a 2-

hour audio-recorded focus group session. Overall, Jacobs conducted eight separate focus groups with 40 participants in total. Results indicated several themes: "paying attention and listening, the importance of meditation or prayer-based practice for the clinician and the need for clinical supervisors to provide contemplative practices for staff in clinic and hospital settings" (p.113-114). While this study utilized a broad sample and highlighted an underutilized intervention (supervision) in relation to religious or spiritually-based clinical practice, there were a few limitations. For example, three of the focus groups had fewer than five participants. A second limitation was that the participants were predominantly alumni of the Smith College School for Social Work. The combination of these two factors limited the reliability and validity of this study's findings.

Harr, Openshaw, and Moore (2010) argued that religion and spirituality should be addressed in social work curriculum because of the likelihood of a social worker having to interface with religious chaplains, specifically in healthcare settings. If a social worker does not have exposure to the intersection of religion and spirituality in their graduate studies, how equipped or informed will they be to collaborate on a team with staff who utilize spiritual interventions? Proceeding from this question, the researchers conducted a mixed methods study using both qualitative and quantitative methods to survey chaplains' views on the working partnership between themselves and social workers. They utilized a 30-item survey with a 5-point Likert scale (i.e. never=1, always=5) and open-ended qualitative questions on positive aspects as well as difficulties experienced with working with social workers, as well as participants' suggestions to improve the partnership. The researchers found that chaplains and social workers generally have a positive experience collaborating on spiritually-inclusive treatment. The findings indicated that when a chaplain perceived that a social worker had a better

understanding of spirituality, their relationship with the social worker was more likely to be positive. A strength of this study was the mixed methods design, and the authors demonstrated a concrete way for the social work profession to show commitment to an interdisciplinary and 'holistic' approach to the individual client (e.g. through partnerships with chaplains). However, the demographics do highlight a trend of disproportionate racial and gender ratios (65% were male and 80% identified themselves as white).

Moon and Shim's (2010) exploratory research on Pastoral Counselors' clinical response to Intimate Partner Violence (IPV) also highlights an interdisciplinary approach with clients. These researchers posited that IPV is both a relevant and underreported issue in the United States. Additionally, they noted that some victims chose not to disclose this matter to secular authority figures (i.e. social workers, police officers).They felt that reevaluating who provides victim empowering counseling is necessary to best serve the needs of clients. Data were collected through semi-structured interviews and utilized Strauss and Corbin's Grounded Theory methodology. Grounded theory is a constant comparison research method, which includes examination of one incident that occurred in an interview and comparing it to another element within the same interview dataset or another one (i.e. another interview). Their findings revealed the pastors' perceptions that IPV was very prevalent in middle aged women and ranged from emotional, verbal, as well as physical abuse (Moon & Shim, 2010). The study's results also indicated that pastors were generally reluctant to confront perpetrators and the perpetrators' ambivalence surrounding engaging in divorce counseling. Therefore, while this study demonstrated the greater need for collaboration between religious professionals and social workers on relevant and intimate issues such as IPV, there is also a significant need for increased education for both groups who will encounter individuals in need of mental health support.

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While the implications exhibited a strength, the small sample size (7 participants) does limit generalizability from the findings, and more investigation is necessary.

Bhagwan (2010) added to this discourse by surveying students at South African universities. In order to assess whether religion and spirituality are resources in social work practice and, therefore, need to be included more in social work training, Bhagwan asked current students on their views regarding these two matters. His study involved the distribution of questionnaires to final year social work students at schools of social work. He found that over 80% of participants reported involvement in an organized religious or spiritual group, almost 50% of participants reported little to no inclusion of religion or spirituality in their curriculum, almost half of the sample supported religion and spirituality courses becoming requirement in their social work education. While these are exceptional findings, there were a few study limitations. For example, this study was conducted in another country which could suggest low validity of its conclusions as they relate to students in the United States. Other limitations included the low percentage of gender or racial diversity in the sample; 84% of participants were female, while 68% were Black African. While one could argue the relevance of this study to American social work graduate programs, the fact that no such university in the United States has published such an article speaks volumes.

Barker and Floersch (2010) conducted a study which also conveys an understanding of the connection between spirituality and social work education. Their study utilized a qualitative approach by interviewing 20 social work practitioners on how they define spirituality and how these definitions might highlight areas to address in future social work education. Their findings were that clinicians addressed issues of spirituality in treatment for a multitude of reasons, but primarily consistent with a conceptualization developed by Ortiz, Villereal, and Engel (2000);

that spirituality is "an essential dimension of human life" (p. 22). Their study's findings argued that spirituality can often be "a way of knowing" (p. 357). By fostering spirituality, a client is applying a lens for how they view everything from relationships, people, and the world they live in (Barker & Floersch, 2010). If a therapist's job is to help a patient make meaning out of live experiences, it stands to reason that they will likely encounter spiritual clients whose purpose in life is embedded in a belief system beyond the physical realm. Overall, we as clinicians need to address what is important to the client and explore what purpose those values serve to them, whether positive or negative.

Religion and spirituality has also entered social work practice in the setting of couple's therapy. Nelson, Kirk, Ane, and Serres (2011) conducted a study to examine the relationship between religious and spiritual values and moral commitment in marriage in order to better inform marriage and family counselors about the nature of committed relationships. Their sample consisted of 163 graduate and undergraduate students from counseling departments at two universities in the southwestern United States; their participation was primarily through use of an internet survey and telephone interview for those who agreed to be contacted for further clarification of responses. Findings revealed that participants characterized themselves in one of six groups regarding their observations of how their spiritual and religious values influenced their view of commitment in marriage. These six categories include "[a] commitment is related to religious beliefs, [b] commitment has little or no connection to religious beliefs, [c] commitment is related to spiritualty, but not to religion, [d] commitment is a promise to God or to a spouse, [e] commitment is abiding by God's guidelines, and [f] commitment is related to the notion of determinism or God's will" (p. 237). The percentages related to each categorical response varied, but what is significant to note is that 52% of participants reported that

commitment was tied to religious beliefs. Though this is a high percentage, this study had its

limitations. Despite earnest efforts to diversify the sample, the majority of participants were

Christian and from a predominantly Christian area in the Southwest. In addition, these

researchers failed to recruit individuals of diverse age cohorts; "more than 40% [of participants]

were over 40 years of age" (p. 243). Therefore, the findings are limited as they come from a

more limited scope of sampling.

Hook, Worthington, Davis, and Atkins (2014) built on Nelson et al. 's work by looking at

the strategies utilized in couple therapy, the degree in which clients enhanced communication in

their relationship over the course of therapy, as well as the degree in which client's religiousness

impacted his or her improvement. The researchers recruited therapists who knew of interested

couples just beginning therapy by advertising their study on forums of the American Association

of Christian Counseling and the Christian Association for Psychological Studies. At three

different points in the therapy, the couples completed questionnaires on relationship satisfaction,

the developing relationship with the therapist, and overall satisfaction with the therapy;

completed questionnaires were mailed to the research team without the therapists' viewing them.

Overall findings were that "clients in therapy with religious couples therapists improved over

time in relationship satisfaction and working alliance, and reported a high level of satisfaction

with therapy" (p. 99). Given Hook et al.'s research focus on religious or spiritual couples'

therapy highlights the need for greater scholarly attention; there are limitations of their study.

One limitation can be found in their decision to recruit solely from Christian Associations, which

filtered into their narrow definition of "religious therapy." Their recruitment limited not only the

study's scope, but also the validity of their findings. Assessing for *religious effectiveness* within

only one subculture of religion (Christianity) resulted in bias within the conclusions drawn from

this study. Future research should incorporate a more diverse participant sampling, especially as it relates to religious or spiritual orientation.

Religion and Vulnerable Populations

Williams (2004) contributed to the literature by her selection of an understudied population: runaway and homeless youth. She conducted a qualitative study of the impact of religion and spirituality on this vulnerable population through interviews with 19 participants, where she observed how these youth experienced spirituality as they coped with challenges in their lives. Williams identified five themes related to spirituality: a belief in divine intervention, having a personal relationship with a nonjudgmental higher power, use of prayer, participation in traditional and non-traditional religious practices, and finding meaning and purpose in life. Overall, her findings indicated that the majority of her participants were connected to a sense of spirituality in their lives; however their spirituality was completely independent of any formal treatment they were presently engaged in. It seemed that for these participants a belief in a God served as a vital substitute for the parental guidance that had been missing in their lives. Ultimately, Williams' findings support the argument for greater inclusion of religion and spirituality in clinical encounters with homeless and runaway youth because such inclusion creates "a context for reframing adversity into an opportunity for personal growth and learning" (p. 62). For vulnerable populations that social work students will encounter, such as runaway or homeless youth, bolstering their internal coping resources is essential.

Farley (2007) added to the discussion of serving our clients better, through conducting a qualitative study on how the application of religious or spiritual practices can bolster the development of *resiliency* traits, particularly in clients with traumas inflicted by one's family. The clinical settings for this study ranged from non-profit family counseling departments to

psychiatric hospitals. Farley offered a few definitions of resiliency, such as "the ability to bounce back despite exposure to severe risk" or "people's push toward growth, self-healing, and health" (p. 4). Farley defined trauma as "an event that overwhelms the person's coping skills," such as natural disasters or physical abuse (p. 5). Ultimately, through their interviews, Farley identified six spiritual elements which enhance the resiliency of an individual: insight, independence, relationships, initiative, creativity or humor, and morality. Her findings suggest that these traits indicate positive coping mechanisms and clinicians can help cultivate or strengthen them in service of helping the client better manage their presenting issues.

Farley's is one of several studies which speak to the role of religion in the lives of vulnerable populations. Raghallaigh's (2011) qualitative study of unaccompanied minors produced findings which suggest that religious faith and practice emerged as a source of continuity in their often chaotic lives. She concurred with Williams' finding that religious coping was not only relevant in the lives of potential clients, but also essential for reaching some vulnerable populations who could not always change their external world. Siedmahmoodi, Rahimi, and Mohamadi (2011) also contributed to the dialogue with their study investigating the relationship between resilience and religious orientation and how this dynamic contributes to post-trauma growth. They found that individuals who had an intrinsic or religious orientation, were more optimistic, which demonstrated a greater flexibility in coping strategies which, in turn led them to adapt better to adversity in their lives. This study was conducted in Iran, and speaks to the need for replication here in the United States.

Religious beliefs and spiritual values have been widely identified as contributors for the large proportion of students who decide to study social work, but the profession has not always acknowledged the significance of spirituality in the lives of clients, or for the clinicians

themselves (Crisp, 2009; Lindsay, 2002; Murdock, 2005).Crisp (2009) noted changes that have occurred in the last decade show there may be greater recognition of this issue. For example, spirituality has entered the dialogue at conferences on an international level such as in 2004 at the International Federation of Schools of Social Work (IFSW), and in the *Global Standards for the Education and Training of the Social Work Profession* spirituality was identified as essential knowledge which should be required for social workers in order to fully understand human development and behavior. Crisp pointed out there is a lack of shared understanding in how these "spiritual factors" should be addressed and explored in clinical practice. Crisp offered some practical suggestions for how spiritual dialogue can be framed in order to elicit dynamic work with patients.

Crisp discussed a framework of spirituality as a lived experience for clinicians with or without a religious background or affiliation. Within this framework, he identified four dimensions: life rituals, creativity, sense of place, and social action. This last dimension coincides beautifully with the NASW Code of Ethics' guidelines (National Association of Social Workers, 2008); social action is promoted and encouraged for all social workers given their committed efforts to reach out to vulnerable populations. Furthermore, social action can be a passionate pursuit stemming from one's spirituality; it is how their practice what they preach. The only limitation to this study was that no interviews were explicitly conducted and cited within the article and I recognize that since 2011 the perceptions of social workers could have changed.

As the research stands now, whether it is through believing that religion and spirituality are part of the make-up of a potential client, or by embracing the practicality of working in healthcare settings with chaplains, these themes will emerge for future clinicians. The question

remains if we are doing an adequate job at training students to meet these likely challenges. In light of all these findings, with the complexity inherent in dialogues on religion and spirituality comes a greater need for and attention to research on these dimensions of clinical practice in order to best equip future social workers who wish to embrace all aspects of the individual. From my review of literature thus far I have observed great disparity in the demographic features of the participants, primarily of race, gender, and religious affiliations. I have also noticed significantly small sampling; all of these factors exert a role in the limits that research has played in the examination of intersection of religion and social work practice. Therefore, I have designed my study to attempt to address some of this disparity, as well as to contribute to the research on this issue because it is all in service of our clients.

As Jacobs (2010) suggests, particular themes were selected to frame this study's design of a focus group with adult outpatient clinicians and pastoral care workers. These four themes were the definition of religion and spirituality, intake and assessment, explicit and implicit use of religion, and potential negative and positive impacts of attending to religious or spiritual issues (Jacobs, 2010). While these themes helped formulate the questions I asked in the focus group, I was open to any insight offered by participants as it related to the general topic of the study (time permitting). Above all, my aim was to elicit the expertise in the room from working professionals involved in the mental health treatment of patients who face themes of religion and spirituality in practice.

CHAPTER III

Methodology

Overview

This qualitative research was designed to tap into clinicians' and pastoral care workers' thoughts regarding themes of religion and spirituality as they emerge in the realm of therapy. This quantitative design involved one focus group and two individual interviews on a psychiatric hospital campus in the Northeast United States. I audio recorded each research setting (i.e. focus group and both interviews). I recruited from two different departments at the hospital: Adult Outpatient Clinicians and Pastoral Care Staff. The focus group session occurred over the lunch hour in a conference on the hospital's campus so as to best align with my participants' hectic work schedules. In the focus group session there were eight participants. Following the focus group and the limited attendance of eight participants, I also conducted two subsequent individual interviews. The first interview was with the Director of Adult Outpatient Psychiatry who is also in charge of the Psychiatry Residents. The second interview was with a consultant for the Pastoral Care Department, but also a veteran in the field with 44 years of experience. While I had not originally intended to schedule these interviews, both participants had scheduled vacations for the time of the group. Therefore, I decided to meet with them at a later date, since their input would be very important for my findings.

Sample

The inclusion criteria for this study included being an Adult Outpatient Clinician or Pastoral Counselor for at least two years (not necessarily with this particular Hospital), English-speaking, willingness/ability to attend one focus group session for duration of one hour, consent to be audio recorded in the one group session, as well as willing to engage in an informal, non-threatening discussion of religious and spiritual themes in clinical practice with adult patients. As long as these criterions were met, no participant was turned away. The participants in this study consisted of ten individuals; six of whom worked as clinicians in an Adult Outpatient unit of a mental health hospital, and four staff members in the Pastoral Care Department of the same hospital. There were seven females and three male participants. With the exception of one African-American female, racial identification of all other participants was Caucasian. For participants in the Adult Outpatient clinic, the number of years of experience in the field ranged from 10 to 30 years. For the individuals in the Pastoral Care Unit, the number of years in the field ranged from 4 to 44 years.

The demographic information was collected prior to the start of the focus group or individual interviews by the use of a pre-session questionnaire (Appendix E) and would not elicit any identifying information regarding that particular participant. I asked their age, gender, general department they worked in, how long they have been in their chosen field, graduate level degrees (if held), and what their primary language spoken was (given that focus group and interviews were held in English). Recruitment was facilitated by an email (Appendix D) to the department head of each of the two teams: Adult Outpatient Clinicians and Pastoral Care Workers. The department heads then passed along the email to their staff.

Data Collection

Participants were asked to complete a demographic or pre-session questionnaire just prior to the start of the group (Appendix E), engage in a one hour long, audio recorded focus group session, and complete a post-session feedback form (Appendix F) following their participation. All of the materials and forms used in this study were approved by the review board of the hospital where the study took place.

In order to conduct this study, I needed to submit a formal application through Hartford Hospital's Institutional Review Board (IRB). As part of the application process I needed to recruit a Hartford Hospital (HH) employee to act as the research supervisor or "principle investigator." Dr. Salma Malik, MD, an HH Psychiatrist, agreed to fulfill this role. She was the liaison between the HH IRB and myself during all correspondence related to my research study. After amending my methodology to utilize audio recording instead of video footage of my focus group or interviews, my application was approved.

The focus group took place in a conference room on the campus of a mental health hospital in the Northeast. Given that no identifying information was collected, participants only needed to verbalize their consent to being part of study (Appendix B) and received an information sheet (Appendix C) on the purpose of the study, as well as verification of its approval by the hospital's Institutional Review Board (Appendix A). I also distributed a list of approved discussion questions (Appendix G) and participants were advised to choose one or two which he or she would be most interested in exploring as a group in order to best utilize the limited time frame of the dialogue. If participants brought in any relevant case work during the focus group, they were advised not to disclose any identifying information from the material.

Data Analysis

For this study conducted a qualitative thematic analysis of the narratives from the focus group and two individual interviews based on an instructional video by a Swedish Researcher, Kent Löfgren (2013), who specializes in quantitative and qualitative methodologies. First, I transcribed all three separate conversations. Next, I coded data by identifying key issues that emerged from the dialogues. I then prioritized the most relevant issues by creating thematic categories that grouped many of the overlapping issues that were observed. Finally, I assessed data for a hierarchy among the thematic categories and chose the ones that elicited substantial feedback from participants to facilitate the data analysis. Quotations were taken directly from the data to illustrate themes as they emerged in the study.

CHAPTER IV

Findings

The purpose of this study was to explore how the themes of religion and spirituality emerge in the clinical setting and how we can assess whether our current approach truly serves the needs of the clients. I was interested in finding out whether or not these themes can serve as clinical tools and, if so, how we can collaborate with pastoral care professionals to utilize these potential areas in treatment. The participants in this study consisted of ten individuals; six of whom work as clinicians in an Adult Outpatient unit of a mental health hospital and four are staff members in the Pastoral Care Department of the same hospital. There were seven females and three male participants. With the exception of one African-American female, racial identification of all other participants was Caucasian. For Adult Outpatient clinic participants, the number of years of experience in the field ranged from 10 to 30 years. For the individuals in the Pastoral Care Unit, the number of years in the field ranged from 4 to 44 years.

The majority of the data from this study came from a focus group involving two mental health teams: adult outpatient clinicians and pastoral care workers. In addition to the focus group, data were also collected from two individual interviews. This chapter is organized by the seven categories or themes which emerged in all the discussions on the intersection of religion and spirituality in clinical practice. The themes include meaning-making, religious or spiritual resource, pathology vs. culturally sensitive practice, provider self-awareness, student education and training, presence and permanence, and collaboration.

Meaning- Making

   The focus group began with an instruction for participants to peruse the distributed sheet of research questions (Appendix G) and choose one which he or she was particularly interested in exploring during the discussion. One male participant initiated the discussion by stating that in his 19 years as a clinical social worker working in an Adult Outpatient treatment setting, themes of religion and spirituality have emerged most often in the context of a client's existential crisis of some sort. He had found that while patients would describe life events, loss and trauma as it pertained to their story, would elicit a dialogue on that which is considered "spiritual." He reported, "These individuals may have lost faith in God per say, but the concept of spirituality and being connected to force beyond them is strong." While the terms "religion" and "spirituality" can often be used interchangeably, there was an unspoken consensus among the group that "spiritual" was far more inclusive and therefore was used more by participants in the focus group.

   With this recognition of life events and their potential to serve as a "cross walk" into a conversation on religion and spirituality, the definition of the term spirituality emerged. A female pastoral counselor identified spirituality as it was communicated by a patient: "Spirituality is some connection with people or community." A male outpatient clinician remarked: "It is recognition of a force or forces beyond us." This was represented as the consensus of the group as evidenced by the simultaneous nodding and verbal assent. This apparent omission of the term religious in the focus group was not just present in the group, but also identified by patients that with whom both pastoral staff and outpatient clinicians interact. A female pastoral worker presented a remark she often finds voiced by patients, "I am not a religious person, but I am spiritual."

These themes of religion and spirituality were identified also by the families of patients; in particular the desperation which can emerge as patients' families attempt or struggle to understand their loved ones' suffering in light of their religious or spiritual views. Examples of this offered by participants included use of exorcisms, themes of "casting out the demon," and refusal to incorporate medications as recommended by clinician as part of the treatment plan.

Participants also recognized that within the meaning-making process where providers assessed patients' worldviews and their utilized constructs for understanding morality, these themes of religion and spirituality would surface. Participants identified topics such as trust, hope, resilience, and understanding the purpose of their suffering; these would often speak to one's "spiritual path." Focus group members reported varied responses from patients, including remarks such as, "Why would they want me to do this suffering?" Patients were also reported to say, "This is my cross to bear. This is my burden to bear. This is what is expected." Overall, the participants observed the role that religion or spirituality played in the patient's life directly impacted how they understood their struggles, as well as how they engaged in treatment planning.

Religious or Spiritual Resource

The majority of participants discussed how patients would come in to treatment with internal resources for coping with their illness and those resources very often involved a religious or spiritual value system. For patients with a sense of religion of spirituality, positive coping stemmed from a sense of community and solidarity. A nurse practitioner responded, "There is an internal protective factor [of religion/spirituality] in particular with depressive patients that helps feel that they're not alone and gives them hope." Outpatient clinicians and pastoral care workers had observed this was most evident in patients suffering from depression or anxiety. They

identified that religion and spirituality could exert a calming influence in their life. Spiritual or religious belief was also identified as a source of positive coping in the context of couples therapy. The female psychiatrist noted:

> One patient and her spouse felt this was best suited at their church, they felt it needed to stay within their church community, that it wasn't appropriate outside of the church and I think I have heard this more than once.

Participants also observed, through their work with patients, that religion and spirituality often served as an internal protective factor during risk assessments for suicidal or homicidal thoughts or behaviors. For example, members of both teams cited instances during intake sessions where a patient openly admitted that they would not engage in self-harm due to their religious or spiritual belief that they would not be admitted to an afterlife. The psychiatrist noted:

> I ask patients if they believe in God, if they pray to God, what do they pray for [and] if patient says, 'my religion is against suicide,' I've been taught that that's a powerful deterrent for people. So yea I use all of that in my risk assessment. A patient's religion or spirituality is just one piece to the whole, but yea I use it all.

The group identified religion and spirituality were also coping resources for patients when it came to healing from or making sense of a recent loss. Participants reported patients' experience of spirituality or religion varied from praying to a "force beyond us" to seeing a shadow of their loved one while at a cemetery and feeling their presence.

Pathology vs. Culturally Sensitive Practice

Both teams agreed that being sensitive to a patient's particular religious beliefs or spirituality was a desired goal in the treatment process as a part of their commitment to ethical practice. However, both groups acknowledged the inherent challenges in teasing out pathology

traits from vital, but different views and beliefs held by patient. One recommendation offered by an outpatient clinician was to include the family or religious or spiritual community in assessing what is appropriate or expected within that patient's identified culture or spirituality identity. An outpatient clinician and nurse practitioner highlighted a distinction between "comforting and distressing" in terms of when a patient remarks that he or she is hearing voices; do the voices bring comfort or distress to a patient's life? The nurse practitioner reported:

> The patient in particular that I can think of…her family saw that her being able to hear voices based on their faith were welcomed except that they caused so much distress for this patient and they were in and out of the hospital and couldn't function. [It] was when we learned we had to educate the family around you may see this as a blessing, as a gift, as a whatever, she [patient] does not. So there was a lot of education that had to happen around she felt like she was letting her family down, she felt like she was letting her spiritual network down, you [outpatient staff] want take this away from me…Your family might believe this [hearing voices]is a gift, but it is not a gift for you. You can't function and you keep telling us you can't function.

In terms of clinically assessing these situations, both teams agreed that symptoms of pathology can be more effectively teased out when one is examining, for example, how the patient responds to voices that only they hear. Are these voices telling the patient to kill her husband? Or are these voices the calming voice of a recently deceased relative and occur occasionally in the evenings? A male pastoral care worker noted that many people can identify with God as the father, particularly if they lose their own father at an early age. Furthermore, patients can pray to this God and earnestly believe that they are speaking to their deceased relative. This was the case for a patient the male pastoral care worker counseled, and the worker

offered this example as a way to caution clinicians to avoid making rash conclusions while evaluating a patient's mental status.

The female nurse practitioner noted a second distinction which could aid clinicians as they assess for pathology in a patient's religious or spiritual –themed narrative: external versus internal. She advised asking the question: "Are these voices internal or external to you?" She also reported, "Clarification is important; is it your conscience or a hallucination? Is it a belief system versus a maladaptive thinking pattern?" A male outpatient clinician stated that framing the behavior is also good practice. For example, he cited that if a patient continues hearing voices that prevent him from holding a job or completing simple tasks such as going to the grocery store, these disruptive signs in daily functioning could suggest symptoms of psychosis. A male pastoral care worker also noted that the "culture" of the setting in which they see patients—a hospital—factors into the assessment and diagnosis of patients who convey religious or spiritual undertones in their presentation.

This worker cited that as recently as two years ago the mental health hospital had been operating from a medical or rehabilitative model and this often contributed to a rigid understanding of what is "wrong" in a patient. The emphasis was on finding a practical cure. He reported, "Now it's about recovery; what can we do to help you get back on your feet and live a productive, meaningful life?" He recalls a time when social work "had to fight to be valid on the team." He argued, "moral treatment is back en vogue." He attributed this change to the greater representation of social workers in hospital settings, particularly on inpatient units. He stated, "When a discipline is represented in the team, there's more use of that discipline. Once you had a social worker in there, you were like wow this is really gonna help us with families." According to this worker, religion and spirituality are slowly becoming more accepted in medical settings

just as social work transitioned in. He concluded, "It helps us see the social context of the patients; you get a broader understanding of who the human being is."

A male pastoral care worker noted he used a more tangible tool for teasing out pathology from a person's religious or spiritual framework: a spiritual assessment. He noted that this tool was typically utilized in the intake process and was made up of four distinct categories: spiritual resources, spiritual concerns, spiritual distress, and spiritual despair. A female psychiatrist noted that she would assess for the potential of psychosis when religious or spiritually-themed conversations with patients involve persecutory remarks. For example, "the patient has a right to [his or her] own beliefs, but when behavior becomes persecutory, like about the devil, wanting to get him or hurt him [patient], that is a clue for me." In addition to persecutory themes in dialogue, a female nurse practitioner also noted that a challenging situation occurs when a patient's belief system is in complete opposition to the provider's beliefs. She noted, "This can make it very difficult to treat patients." Particularly, she noted that this can lead to the patient's refusal of the medications the clinician feels will help with a patient who is suffering from schizophrenic symptoms.

Provider Self-Awareness

Many participants noted that in order to be as effective as possible in exploring themes of religion and spirituality, a provider must be aware of their own religious, spiritual, or moral views, as well as their comfort level on these matters. The female psychiatrist identified that "I am sure residents in their training are uncomfortable about asking about it [religion]." She noted that things that are different from ourselves can very well make us uncomfortable. Many participants agreed and, in particular, a pastoral care worker, who stated, "A provider's value system influences his or her judgment on treatment options for a patient." A male outpatient

clinician noted that this self-reflection, on the part of the provider, demonstrated humility as one grappled with the inevitable "not knowing" when discussing fundamental themes such as religion or spirituality. The other clinicians in the room agreed that as one develops in their profession, one often finds that they speak less and acknowledge their own humanity and limitations.

Nevertheless, there seemed to be a distinct difference in this area between the teams represented in the group. Overall, the pastoral care staff openly admitted what they did not have, in particular, a sufficient knowledge of mental health treatment and practice. On the other hand, the outpatient clinical staff believed that the rich spiritual history of their institution served as evidence to their sensitive practice in regard to themes of religion and spirituality. While an outpatient clinician noted that transparency was a familiar concept to social workers, the outpatient staff did not comment on the extension of this conceptual framework in relation to a provider's awareness of their religious or spiritual history while the pastoral care team was discussing it.

Student Education and Training

From the pre-session questionnaires completed by participants just prior to the focus group's discussion, the outpatient clinicians disclosed they had minimal to no exposure to themes of religion and spirituality during their education and training. Only one outpatient clinician identified having one class that spoke to these matters. The psychiatrist stated that in her psychiatry residency program, students are trained to be "culturally sensitive" when interviewing patients. She did not identify concrete measures taught in the curriculum to engage the students in this process. Participants reported there are no required texts for staff, or collaboration with the pastoral care department within the hospital. In significant contrast, the pastoral team

identified a more integrative perspective for students in their chaplaincy program, citing an attention to "psychology, psychiatry, social sciences, world religions, and practices that are spiritual." All of the pastoral care staff in the focus group was either ordained ministers or hospital chaplains, or both. They all noted an attention to all faith denominations in their training.

In addition, pastoral care staff outlined their approach to *bracketing* as an essential component to their training of chaplaincy students. Bracketing is "an act of suspending judgment about the natural world to instead focus on analysis of mental experience" (Moran, 2000). The director of pastoral care stated that this bracketing skill allows "chaplaincy students to hear and be present with someone who is suffering or experiencing trauma." Outpatient staff agreed with this perspective. One male outpatient clinician stated, "Stay away from opinions and debates when talking with patients." There was a consensus that a provider should operate from a position of curiosity or exploration, not judgment.

There was general consensus among both the pastoral team and outpatient clinicians, who all acknowledged their ambivalence about discussing matters of religion and spirituality with patients. Nevertheless, there was also a consensus regarding the relevancy to treatment of these contextual factors which emerge in the life of a patient. As one pastoral care worker stated, "Just ask the question; if we don't ask, we're not going to find out. A patient will think that the docs or staff is asking the important questions so I'll just give them that information."

While pastoral care participants indicated that for chaplaincy students in pastoral education program the program identified a strong emphasis on learning about the various faith denominations, the adult outpatient staff identified they had minimal exposure to education about faith denominations in their graduate training. Two outpatient clinicians identified instances where they searched a particular patient's religion or spirituality on the internet to educate

themselves. However, a commonality in the training of both the mental health team and pastoral care workers was the attention to a "point of distress or disruption" in daily functioning that might suggest a potentially negative manifestation of a religious or spiritual theme. Another similar consensus from both teams was in regards to the appropriate response to a patient's concern that is a potentially psychotic report. For example, a chaplaincy student recalled a distinction between joining with a patient regarding a negative belief (e.g. her husband is the devil) and condoning this cognitive presentation, and listening to a patient while affirming their dignity as a person. She replied, "To me, there's not an easy answer." Nevertheless, she expressed that the better response was to listen and affirm the patient's dignity, and all of the members of the focus group nodded in agreement with her.

In terms of vital questions to ask a patient, as it was communicated to them in training, both teams agreed that a provider should ask, "What are your beliefs and practices?" Also, "what are your and your family's views on mental health and the use of medications?" They agreed that both the participation in a belief or value system rooted in a religion or spirituality and their community engagement (including family) were key in assessing a beneficial treatment plan which both patient and his or her family would "buy into."

A male pastoral care worker also spoke to the role of a chaplain and how 50 years ago their approach was more directive (i.e. I am going to give patient resources or skills from my own worldview or religion). He cited this as a typical Christian/Protestant Evangelization approach. Now a chaplain "is there to provide support to the patient and to draw, when applicable, from the constructive spiritual resources that they have in their life." Furthermore, he remarked, "If they chose to develop some, it's good for them to let us know, not for us to tell them [patients] what they are."

Presence and Permanence

A pastoral care worker mentioned the concept of *presence and permanence* as it relates to their department's mission to share the intersection of religion and spirituality in clinical practice on campus of the mental health hospital. He noted, "It's like this unspoken acceptance of spirituality as being relevant in treatment of psychiatric patients." According to this worker, this was evidenced by the presence of his chaplaincy students in the adult inpatient units. Furthermore, the pastoral care staff had positive experiences with their spirituality discussion group that occurs weekly on the inpatient units. While this team acknowledged there was room to grow regarding their visibility at the hospital, they cited a goal of their staff becoming full-time fixtures as a potential "opening door" to this budding partnership. Pastoral care staff also accounted for the resistance they sometimes experience as a result of the inconsistent efforts of hospital staff to orient their teams to the role of pastoral care workers. As one pastoral team member noted, "they are fine with us chaplains, but to them we're strangers." Overall, the pastoral care workers sensed a mild respect for their field, but not a universal recognition that they were an essential component of the team.

Collaboration

Among all the participants in the group, there was a consensus regarding the relevancy of religion and spirituality in mental health. However, translation of this shared view into practice led to varying responses. At the conclusion of the focus group, a pastoral care worker− in fact the director of the department− polled the group regarding the possibility of having an on-going group similar to the focus group to continue this type of dialogue across the various domains of mental health treatment within the institution. The outpatient clinicians in the room all fell silent and declined to respond, while the pastoral group nodded in agreement. The participants

discussed other ways in which the two teams could work together. An outpatient clinician commented that the outpatient setting was not an appropriate "fit" for working with pastoral care. She noted, "In outpatient settings we see our patients for 20 minutes, once every three months. " However, two outpatient staff recommended a monthly spirituality discussion group or couples therapy group facilitated by pastoral care staff in the outpatient clinic. She and the other outpatient clinicians suggested that the Intensive Outpatient Programs or day treatment programs might be good settings for collaboration with pastoral staff, given the frequency in which they meet (3 times a week).

A psychiatrist in the outpatient clinic noted that there was not a systematic approach to making referrals for patients and therefore, when it came to religious or spiritual resources for a patient, clinicians were generally ill-equipped to share external resources. One nurse practitioner and clinician noted that very rarely she will communicate with a religious or spiritual leader in the surrounding community on behalf of a patient. The majority of the outpatient clinical staff was unaware that the hospital even had a pastoral care department before the focus group was underway. However, a pastoral care worker identified that through their work they constantly interact with religious or spiritual networks in the surrounding community, whether because of their ordination responsibilities, training, or through their contact with patients who request more information.

Pastoral care staff shared a goal for future collaboration among the two disciplines−outpatient psychiatry and pastoral care services. This goal is to have the spiritual dimensions of a patient's life be considered as an essential part of a "valid" assessment. One pastoral care worker stated, "There are so many dimensions [on intake form] that we say is a part of understanding who the patient is and this [religious or spiritual assessment] can be an important part." They

reported that the spiritual assessment which pastoral care staff utilizes on inpatient units directly impacts the treatment planning which follows an intake. One pastoral team member noted, "Religion and spirituality are not just important aspects of one's life, but also to their treatment. There's a wide variety of things people can do to contend with the mystery and darkness of their life." Case examples were also identified as potential components of curricula to bolster education in both departments. As one pastoral care worker stated, "These themes come up, just a matter having a conversation with people." He mentioned that paring the right provider to a patient is complex, and only through strengthening the presence of pastoral care will help shed some light on how they can contribute to the clinical team. He noted, "That's the value of having a chaplain around; I find out things that the treatment team didn't know."

Overall, outpatient staff cited their setting as a culprit contributing to minimal to no communication with the pastoral care department. They remarked that between the minimal time they see patients and the scant space in their day-to-day schedules, there was not much room for a systematic implementation of education on these themes for both patients and providers alike.

CHAPTER V

Discussion

The purpose of this study was to explore how the themes of religion and spirituality manifest in the clinical setting and to assess whether our current approach truly serves the needs of the clients, as well supports the mental health care professionals who may face these issues in the clinical encounter. Through the use of a focus group and two subsequent individual interviews, I wanted to gain the insight of working professionals who either engage primarily as outpatient therapists or who minister to individuals in a pastoral care setting. Through these two groups who are both involved in mental health care treatment, I addressed the themes of prior training on religion and spirituality, perceived relevance of these topics in mental health, religiosity and resilience or coping skills, clients' representations of religiosity (both adaptive and maladaptive), as well as views on religion or spirituality as a tool in social work. I assessed if these mental health care workers who currently work in the field have embraced these themes of religion or spirituality and, if so, how these themes may manifest in the assessment or treatment of a patient, as well as why these themes can be neglected.

From this study, I found that overall both groups viewed religion or spirituality as relevant, appropriate, and integral to a person's intrinsic views and belief systems. The points of divergence were in regards to the collaboration (or potential for collaboration) between outpatient clinicians and pastoral care workers, the training or education required for staff on these themes, and how respect for these themes can be translated into sensitive practice with patients.

An intriguing finding involved the theme of meaning-making as it related to the terms

religion and *spirituality*. During the focus group, there appeared to be an unspoken consensus

among the group that the construct of "spiritual" was far more inclusive and therefore was used

more by participants. In the two individual interviews, the two terms were used frequently in the

dialogue. A pastoral care worker supported a focus on the relevancy of these terms to the patient

in the conceptualization of the term while engaging with that individual. For example, she cited

how some patients do not relate to the term religious, but only identify with a type of spirituality.

Awareness of this and embracing it through the provider's language in session can be highly

supportive of a strong therapeutic alliance with that particular patient. An outpatient clinician

brought up the level of intimacy required to have such a conversation surrounding religion and

spirituality and suggested a continual "check –up" on these themes over the course of treatment.

There was agreement among the pastoral care team on this matter: their view was that the role of

religion and spirituality can change dramatically all at once or it can change gradually over time

depending on various contextual factors (i.e. an increase in emotional or physical pain, trauma,

or loss).

Another key finding was the concept of *"bracketing"* shared with the focus group by a

pastoral education director. Bracketing occurs then the clinician "suspends judgment" and

instead focus energies on how that patient experiences themes of religion and spirituality in his

or her daily life. The concept echoes a similar concept used in strengths-based approaches to

psychotherapy (Moran, 2000). Bracketing allows for an honest, patient-driven dialogue where

the patient is treated as the expert of their own narrative. While many participants nodded in

agreement to this in the group discussion, one can only speculate to how well this belief is

translated into each participant's practice given the enduring struggle to work through a

clinician's own biases. The group did also speak to the theme of *provider awareness*, not discrediting it as insignificant, but emphasizing the requirement of intentional consideration for the time and place of this reflective process. It is interesting to note that while the participants were not directly asked to identify their religious or spiritual affiliations, all of the pastoral care staff openly identified theirs to the group, while none of the clinicians did. Nevertheless, there is a stark contrast between the training of an outpatient therapist and pastoral care worker; namely, there is a conscious attention to and a critical value placed on the religious or spiritual histories of pastoral care staff. For the outpatient team, their failure to disclose affiliations to the group could have been due to the unfamiliarity with the people in the room or it could suggest an oversight in the outpatient setting on bolstering a provider's self-awareness of their own experiences and beliefs regarding religion or spirituality. However, given the potential impact of these histories on a provider's assessment or plan of treatment, greater attention to this issue could be addressed in formal education for social workers or even during supervisory time (Gallichio, 2009).

While there was a wide range of experience in the field among the participants in the study, only one outpatient team member had encountered a course on religious or spiritual themes in their social work education. Nevertheless, among this participant group, there was an overall high rating of 9 or 10 for the level of confidence held by that worker to speak on these themes with a patient. It brought up the -question: is formal training on these areas is necessary prior to entering clinical practice? Is this part of the "not knowing" inherent in a relational, patient-driven approach to therapy or is this an unethical exploration which could harm the work with patients? As mentioned in the findings, some outpatient clinicians are resorting to the internet for resources on how to have these conversations with patients. This could suggest a

need for some academic framework or in-service training for outpatient clinicians on how best to broach a potentially significant dimension of a person's life.

In this study, participants' conceptualizations of religion and spirituality confirmed what previous researchers have posited. Within the narrative data, themes of meaning-making, relationship, and a higher power emerged as the potential roles of spirituality in a patient's life confirming Barker's findings (2007). In terms of religion, participants conveyed this term represented a more overt structure and organization, but that ultimately it was a dynamic process that changed over time, as Barker found as well.

Various theoretical perspectives regarding the matter of religion and spirituality were also confirmed by this study's findings. While all participants agreed with a spiritual development perspective or understanding that a valid assessment of a new patient should stem from a bio-psycho-social-spiritual framework, the pastoral care staff disagreed that the last component, spiritual, was truly embraced as part of a holistic approach to the personal development of a patient (Barker, 2007). Transpersonal theory was also evident in the responses by participants; this study's findings suggested that while religion can be a vessel for the expression of spirituality, spirituality itself is not limited only to the realm of organized religion (Barker, 2007). Several participants noted case examples where a patient was interested in exploring mindfulness techniques (which was derived from Buddhist study) such as meditation to cope with their anxiety, but did not identify with a particular religion.

In regards to interventions made with patients on these themes of religion and spirituality, the study's findings confirmed the previous literature (Dwyer, 2008). Participants expressed an unspoken, at times unconscious, approach; both outpatient clinicians and pastoral care staff indicated a tendency to have the patient direct any religious or spiritual intervention made

(Canda & Furman, 1999; Lawrence-Webb & Okundaye, 2007). The participants noted that the only exception to this would be during an initial intake with a patient where religious or spiritual themes were more directly addressed by the treatment provider, but always in an open-ended manner where patients had the choice to respond or not.

The majority of participants had no formal education or training on the intersection of religion and spirituality in clinical practice. This coincides with the current literature (Kvarfordt & Sheridan, 2007; Canda & Furman, 1999).Given the potential that this theme could serve as the foundation to a patient's belief and world view, some exposure to this topic prior to entering the field could better inform new clinicians' culturally-sensitive practice with patients. This is demonstrated by the example from this study where a director of psychiatry residents searched within an outline of the residents' curriculum, but reported none of the courses directly address the areas of religion and spirituality. While this is an area for improvement regarding collaboration between fields of religion and spirituality and social work, this study's findings do demonstrate a slow, but steady attempt to bridge the gap as evidenced by the pastoral care director advocating for an ongoing focus group similar to the one in this research design (Praglin, 2004). However, the silence by the outpatient staff on this idea suggests barriers of time, agency politics (such as those at institutions, including hospitals), as well as a tolerance versus integration dynamic which can impede progress on this front.

This study successfully brought together two different types of mental health treatment providers who shared the goal of supporting individuals that are suffering, but that rarely interact. The focus group brought experienced mental health workers face to face on relevant issues in mental health treatment and practice, mainly that of religion and spirituality. It provided a forum for an open dialogue on two cultural pieces which can impact a patient's self and world

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view. As these discussions presented, these themes are emerging through the patients' own disclosures, while clinical staff is left ill-advised or sufficiently trained in these dimensions of a person's life. What was also striking from this study's findings was how it presented an opportunity to observe the culture of each group (clinical and pastoral care) during the discussion. The pastoral care department participants conveyed a humility regarding discrepancies in their formal education and chaplaincy student training; the pastoral care staff noted that while they frequently interact with patients and staff on mental health inpatient units, their training on mental health could be vastly improved. In contrast, there was a profound ambivalence found in the outpatient group participants as they clung to the religious history of their hospital as ample evidence of their religious and spiritually sensitive practice with patients, without focusing much attention to their minimal exposure in formal educational settings.

Given the nature of this qualitative study for the thesis requirement, there were several limitations to its methodology. First, the sample was very small with only 10 participants. A second limitation was in regards to the racial or ethnic diversity of the sample; while two participants in the pastoral care team were of color, the outpatient group was entirely made up of Caucasian individuals. While only the pastoral care workers offered to disclose their religious affiliations, their faith denominations were primarily within the realm of Christianity. Therefore, the third limitation of this study was that recruitment process did not screen for outpatient clinicians or pastoral care staff from other faiths such as Islam or who practice within other spiritualties, such as Buddhism. A fourth limitation was my omission; I should have more directly asked participants about their own religious or spiritual identities. Due to an attempt to bolster the recruitment process and provide an open and welcoming discussion, I did not question participants' religious or spiritual backgrounds. A final limitation to this study was the

fact that with the immense amount of experience of participants in the room, there was an inevitable under representation of clinicians who have been exposed to the recent shift in social work curriculum to attend to themes of religion and spirituality.

While no definitive, universal modes of interaction in regards to religion and spirituality were drawn from this qualitative study, it did present information on directions for future dialogues and work on these themes. It appears that within this particular hospital setting there was a respect and "tolerance" of pastoral services, but not an emphasis on their use during a patient's assessment. Outpatient clinicians had many questions to share with the group, but suggested little guidance in their department on how to bolster their efforts to be more religiously or spiritually aware when meeting patients. Conversely, pastoral care staff indicated a need for more formal training and education surrounding mental health treatment and practice, even with their immersion in clinical settings.

Overall implications for future practice include the need for greater provider self-awareness, implementation of spiritual assessment across disciplines, an increased openness to the contributions of pastoral services, and greater visibility and integration of the pastoral discipline in mental health settings. In addition, the concept of *"bracketing,"* which emerged in the focus group, suggests that making value judgments can be a real barrier to an interdisciplinary dialogue on religion and spirituality. Other educational perspectives which could inform future practice is to continually affirm the dignity of each patient, by asking questions, embrace the role of student, and to take a more extensive view on what can be important in a patient's personal development and daily living. Other suggestions participants noted were increased education for patients and families regarding mental illness, particularly in

spiritual communities with limited frames of reference and the use of case examples to inform a rich curriculum on these themes of religion and spirituality.

Given that this study was conducted within a single traditional, private hospital and outpatient institution, it would be instructive to replicate this experimental design in other settings in order to determine if these findings are more universal. This would require future studies to continue exploring diversity in their design, in regards to race, gender, and religious or spiritual affiliations of their prospective participants. Another suggestion is on specific treatment interventions which would support all mental healthcare staff involved in a religious or spiritually sensitive practice with patients. If future research can identify and assess current modalities used, perhaps we will observe an increased attention on the areas of religion and spirituality in the assessment and treatment of patients.

This study served as a modest attempt to assess the current attitudes, perspectives, and treatment approaches used currently by professionals working in mental health care including outpatient clinicians and pastoral care workers. While there was a general consensus within those two groups regarding the relevancy of the themes of religion and spirituality, there is still a divergence regarding the translation of belief into practice. However, if we are to truly embody a holistic approach to mental health treatment, we must evaluate every piece of the person in context. If we see an intersection between these themes and clinical practice, we should support our clinicians and pastoral care staff as best we can to inform their effectiveness with these conversations. Formal education and training provide an excellent opportunity to bolster a provider's awareness of his or her own religious or spiritual histories, as well as continue building up a provider's exposure to these themes prior to entering the field and in their ongoing

work in clinical settings. If we continue to support the provider, we also support the therapeutic

alliance, which can make all the difference when meeting with a patient.

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Appendix A: IRB Approval Letter

Hartford HealthCare

HUMAN RESEARCH PROTECTION PROGRAM
80 SEYMOUR STREET
P.O. BOX 5037
HARTFORD, CT. 06102-5037
860/545-2893   FAX 860/545-5112

February 19, 2014

Dr. Salma Malik
Psychiatry
IOL

Institutional Review Board (IRB) - (Assurance #FWA00000601) Panel B

Project Title: The Intersection of Religion and Spirituality in Clinical Social Work Practice and Treatment

Project #:   MALI004216HU

Agenda Date: 2/18/2014

Approval Date: 2/18/2014	Type of Review: **Expedited**	Category: 7
Approval Valid Through: 2/17/2015	Form of Consent: **written**	
Status: **Approved**	Vulnerable Population **None**	

This approval includes the following materials:

1	correspondence	Agreement to Act as Principal Investigator for a Student Researcher/Outside Collaborator
2	patient information / material	Pre-session questionnaire Focus group questions Post session feedback form
3	patient information / material	Flyer
4	protocol	(version 1/20/14)
5	information sheet - consent	(version 2/4/14)
6	waiver of documentation of consent	

Informed Consent:

If your project requires the use of a written informed consent document, the version of the consent which has been approved for use by the IRB is attached. You must use this stamped form to enroll participants until the project is completed, another extension is approved, or an approved revision supersedes this version.

Progress Reports:

This project required continued review and approval by the IRB prior to the expiration date. You will be expected to submit the first Progress Report on: 12/18/2014. The project will be suspended if a "Request for Continuation (Progress Report)" Form has not been submitted prior to that expiration date. IRB suspension means that no work with human subjects may be conducted, including enrollment of new subjects, data analysis, etc. until re-approval has been granted.

The "Request for Continuation (Progress Report)" Form must include the number of subjects enrolled since the previous report or initiation of the study, as well as a copy of signature page of the informed consent for all subjects enrolled during the approval period. If applicable, a copy of the approved consent is attached. You must use the stamped form to enroll participants.
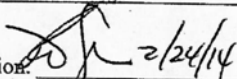
Please be aware that you will be expected to provide the composition of the patients enrolled by number of males/females and minorities (Hispanic, Black, Other). You should ensure you have procedures in place to collect and track this information.

Appendix B: Waiver of Consent/ Authorization

Human Studies Form

Waiver of Consent/Authorization
This form allows for the waiving of the written informed consent/authorization requirement or alteration of the process, such as verbal consent/authorization. It is important to receive adequate information in order to approve requests for a waiver of consent/authorization, please explain the following statement as completely as possible.

1. This research involves no more than minimal risk to participants.
There are no foreseen risks identified with participating in my proposed study. Participation is voluntary and individuals can opt out of study at any time.

2. This research could not be concluded without waiving or altering the consent/authorization process.
Due to the lack of patient data being required for my study, I am confident that verbal consent to engage in the focus groups will suffice.

3. This research requires access to the use of Protected Health Information to conduct this study.
The only PHI related aspect to the study is the voice recording of focus group sessions. However, no names will be recorded or collected from the participants.

4. This waiver or alteration will not adversely affect the rights and welfare of the subjects.
I do not anticipate the rights and welfare of my study's subjects to be adversely affected because of the lack of patient data being used.

5. This research participants will be provided with additional pertinent information after participation, when appropriate.
If any participant has a question pertaining to their engagement in study, this researcher will make herself available to answer those questions. This researcher will offer her Hartford Hospital email address to any participant who may have a question. |

IRB approval for the Waiver/Alteration of Consent/Authorization. _2/24/14_

IRB Signature and Date

Appendix C: Participant Information Sheet

Hartford HealthCare
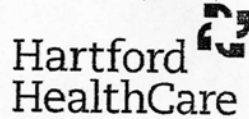
Information Sheet for Participation in Research

Principal Investigator: Dr. Salma Malik, Child/Adolescent Psychiatry
Co-Investigator: Susan Dimauro, Master's Level Intern; Smith College School for Social Work
Title of Study: <u>The Intersection of Religion and Spirituality in Clinical Social Work Practice and Treatment</u>

You are invited to participate in this study of how the themes of religion and spirituality emerge in the clinical setting and how we can assess whether our current approach truly serves the needs of the clients. I am a graduate student at Smith College School for Social Work, and I am conducting this study as part of my course work. I am interested in finding out whether or not these themes can serve as clinical tools and if so, how we can collaborate with mental health professionals to utilize these potential areas in treatment.

Your participation in this study will require completion of a pre-group session questionnaire, attendance at one focus group session on the HHC campus and a willingness to have the session voice recorded. This should take approximately one hour of your time (lunch is provided). Your participation is completely voluntary and you can choose not to participate. If you choose to participate then change your mind, you may stop participating at any time. You do not have to answer any question(s) that you do not want to answer for any reason. You will not be paid for being in this study. Your access to, and quality of healthcare will not be affected in any way.

This study does not involve any risk to you. However, the benefits of your participation may include being provided a space to reflect on these issues of religion and spirituality and on how they are being presently addressed in mental health practice. You may discover new ways to better serve your clients' needs. You may also simultaneously engage in a personal, cultural and spiritual sensitivity reflection process which could enhance your clinical skill set. Your participation will be anonymous and you will not be contacted again in the future. Your doctor and other medical providers do <u>not</u> have access to any information that you provide me.

Do you have any questions about the research study at this time?

Who you can call if you have questions about this study:

Questions about:	Contact	Phone #
the research, research-related treatments, or a research related injury	Dr. Malik	(860) 545-7087
your rights as a research participant	An IRB Representative	(860) 545-2893
the research in general	Vice President, Research	(860) 545-2893
a confidential issue that you would like to discuss with someone not associated with research	Patient Relations	(860) 545-1400

Page:	- 1 -	***IRB Use Only.*** IRB - Approved	
PI:	Salma Malik, MD		
Account #:	MALI004216HU	FEB 19 2014	
Version:	2/4/14		

Come Enjoy a Fruitful Discussion on the connection between Religion and Spirituality and mental healthcare of our patients!

Lunch is provided!

Susan Dimauro, a Master's Level Intern here at HHC, is facilitating a focus group on the connection between religion and spirituality and mental health treatment. The purpose of this group is to provide a space for mental healthcare professionals, both Adult Outpatient Clinicians and Pastoral Care Staff, to share their experiences regarding religion and spirituality as it relates to their current practice and where they observe the strengths and potential weaknesses of the current approach to these issues when meeting with patients.

This will be an inter-faith dialogue with an understanding of tolerance for all.

When: 12:00 pm – 1:00 pm

Where: TBA

While more than one focus group session will be offered to best coordinate with staff schedules, participants will only need to attend **one group over the lunch hour.

HH IRB - Approved

FEB 19 2014

Appendix E: Pre-Session Questionnaire

Hartford Hospital Research Study: The Intersection of Religion and Spirituality in Mental Health Practice and Treatment Pre-Session Questionnaire

Please identify a gender:

Department in which you work:

HH IRB - Approved

FEB 19 2014

Number of years in your chosen field:

Number of years in your current position:

Please identify your credentials and degrees held as they relate to your field:

What led to your chosen profession?

On a scale of 1-10, how confident are you in addressing these themes? If you feel unequipped, but interested in developing in this area, what do you suggest would help you?

Have these themes of religion and spirituality been addressed formally in your training? If so, briefly explain the general principles communicated in the curriculum.

Appendix F: Post-Session Feedback Form

Hartford Hospital Research Study: The Intersection of Religion and Spirituality in Mental Health Practice and Treatment Post-Session Feedback Form

Gender:

Dept:

What are your initial feelings/suggestions about how this focus group went?

HH IRB - Approved

What were some strengths of this group?

FEB 1 9 2014

What were some things you thought did not work well in today's focus group?

What are three things you learned from today's dialogue?

Overall, do you find the themes of religion and spirituality as appropriate and essential elements to explore with patients? Why or Why not?

Appendix G: Focus Group Question List

Hartford Hospital Research Study: The Intersection of Religion and Spirituality in Mental Health Practice and Treatment Focus Group Questions

How would you define religion? How would you define spirituality? Is there a difference between religion and spirituality?

How many people participate in organized religion?

How many people rate religion as important in their daily lives?

How many Social Work Graduate Schools teach courses on religion and spirituality in the United States?

What are your thoughts on inviting a chaplain or religious educator to lecture or facilitate a workshop on this topic of religion/spirituality and social work?

Have the themes of religion and spirituality emerged in sessions with patients? If so, how so and what purpose did this representation have in his or her life? If not, why do you think it never entered the room?

Do you feel these themes are relevant in the treatment of a patient? Why or why not?

Are they appropriate to explore with patients? Why or Why not?

Can religion and spirituality be a tool for patients? Why or why not?

Do you feel that these themes are adequately addressed in mental health treatment? If not, what would you change or add to the current approach?

Do you think that learning about religion and spirituality can benefit your social working learning? Why or why not?

What should be goals in teaching spirituality in social work curriculum?

Do you think that these themes should be addressed in social work courses? Why or Why not?

What does having a holistic approach to social work mean to you?

Using your own lived experience or those of past clients', can a religious or spiritual perspective foster a stronger sense of resiliency? For example, can one demonstrate stronger coping skills from their belief or value system?

What is the impact of life experiences on spiritual development?

What should be goals in teaching spirituality in social work curriculum?