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Julia E. Gallichio, M.A.
Religion, Spirituality and Clinical Practice: An Exploration of Practical Applications

ABSTRACT

The purpose of this study was to elicit clinicians' perspectives and practices with religion and spirituality in clinical practice. Recent social work researchers note the roots of social work in spirituality and believe it can reinvigorate social work practice. Four focus groups were conducted in three different geographical locations with clinicians who included social workers, psychologists, and psychiatrists. It was found that the clinicians believed that including spirituality in practice benefits the client either in secular or sectarian ways. The application of spiritual practices varied widely. The majority of participants in this study reported the use of mindfulness and meditation based clinical modalities in their practice. All emphasized the importance of the therapeutic relationship for effective healing. A minority of participants reported formal education and training on the use of religion and spirituality in clinical practice; this indicated more training and education is needed. Suggestions are made on how a broader base of clinicians can be provided with a framework and lexicon for the therapeutic process of transformation and transcendence described by focus group participants. The development of guidelines for clinical supervisors in addressing religious and spiritual issues with supervisees and using spiritually based supervision techniques are indicated.

RELIGION, SPIRITUALITY AND CLINICAL PRACTICE: AN EXPLORATION OF PRACTICAL APPLICATIONS

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

Julia E. Gallichio, M.A.

Smith College School for Social Work
Northampton, Massachusetts 01063

2009

ACKNOWLEDGEMENTS

My most sincere thanks go to the clinicians who shared their wealth of experience, their time, and their knowledge.

I would like to express gratitude to Dean Carolyn Jacobs for making this study possible, and, for her support and guidance. I would like to acknowledge and thank the School for Social Work Contemplative Clinical Social Work Practice and Research Support Fund for providing the funding for travel, rental of interview space and transcriptions for the focus groups.

My love, enormous thanks, and gratitude go to all of my friends and family for their incredible support, humor, prayers, and patience during this entire program. Especially thank you to Mom, Wendy, Mimi, Andrew, Justine, Anthony, Jackson, AY, David, Rene, Debi, Jeff and Ralph, Elaina, Else Camilla, Jen, Steve and Erlinda, the communities and monks of New Camaldoli and Incarnation, Toni, Tom and Bev, Robert, Nina, Floyd, Barbara, and Peko. A sincere thanks to Dr. Gurushanthaiah and to all of the many kind and skilled health care workers from whom I certainly benefitted.

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CHAPTER I

INTRODUCTION

There is an abundance of literature on the integration of religion, spirituality and clinical practice. There is great interest in the subject among clinical practitioners and yet it is not always clear how practitioners apply religious or spiritual principles when working with clients. A review of the literature reveals research and books, both American and international, on varying aspects of religion, spirituality and clinical practice (Canda, 2003; Canda, Nakashima & Furman, 2004; Furman, Benson & Canda, 2004; Furman, Benson, Canda & Grimwood, 2005; Northcut, 2000; Scott, 2004; Sheridan, 2004; Stewart, Koeske, & Koeske, 2006). This research explores the practical aspects of using religion and spiritual principles in clinical practice.

Previous research on spirituality and clinical practice covers broad terrain. When conducting a review of the literature the possibilities seem endless. Spirituality and clinical practice were included in such as existential psychology (Becker, 2006; Bergner, 1998; Hoffman, 2007; Keshen, 2006; Kirby, 2004; Langdridge, 2006; Yalom, 2002), transpersonal psychology (Antoniou, Blom, 2006; Hartelius, Caplan & Rardin, 2007; Moxley & Washington, 2001; Nixon, 2004; Whitehouse, 2006), children and spirituality (Diseth, 2005; Eaude, 2004; Erricker, 2007; Kvarfordt & Sheridan, 2007; McSherry & Smith, 2007; Mercer, 2006; Miller, 2006; Pridmore & Pridmore, 2004), contemplative practice, music therapy, somatic therapy (Steckler, 2006), somatic psychotherapy, dance therapy, movement therapy, meditation (Rubin, 1999; Simpson, Kaysen, Bowen,

MacPherson, Chawla, Blume, Marlatt & Larimer, 2007), alcoholism (UCA News, 2006), story telling (Trousdale, 2004), pilgrimage, art therapy (Eisdell, 2005), mindfulness (Ma, & Teasdale, 2004; Melbourne Academic Mindfulness Interest Group, 2006; Smith, 2005; Teasdale, Williams, Ridgeway, Soulsby, & Lau, 2000), and myth. Yet social work researchers noted the roots of social work in spirituality and believe it can reinvigorate social work practice (Canda, 2003; Canda, & Furman, 1999; Furman, Benson, Canda, Grimwood, 2005).

This research elicited clinicians' narratives of the process and outcomes of practices that are rooted within a spiritual paradigm. In order to elicit narratives, focus groups were used as a data collection mode. Focus groups were conducted with social workers, pastoral counselors, family therapists and psychologists. Clinicians discussed their experiences and perspectives on the relationship of spirituality, religion, and psychotherapy. In order to contextualize clinician responses, they were asked to define religion and spirituality and further queried on how these definitions influenced their clinical practice. This study elicited case examples of how practitioners determined what was important to their clients with regards to religion and spirituality and how they used, either implicitly or explicitly, religion and spirituality in their practice. Finally, clinicians were asked how religion or spirituality could negatively impact the clinical experience. It is noteworthy that all clinicians who participated in this study believe that including spirituality in practice benefits the client either in secular or sectarian ways.

This thesis was part of a larger research project conducted by Dean Carolyn Jacobs, Smith College School for Social Work. As a part of that project the thesis included focus groups in Northampton, Massachusetts; Albuquerque, New Mexico; San Francisco and Oakland, California. Relevant findings have been coded, analyzed and presented with responses in verbatim form. Finally, implications for social work training, education and practice with regards to religion and spirituality are discussed.

CHAPTER II

LITERATURE REVIEW

The literature review for this research addresses three primary areas. The first area is on clinician's definitions of religion and spirituality and how these definitions might affect practice. The second area provides an overview of therapeutic modalities that are viewed as effective with regards to religion and spirituality in clinical practice. The focus of this review is on mindfulness, meditation, existential, and transpersonal based practices. The third area is on clinicians regarding their attitudes, practices and beliefs with regard to religion and spirituality in clinical practice.

Religion and Spirituality

Among clinicians practicing within a spiritual and/or religious framework, understanding how religion and spirituality are defined contributes to a more complete conceptualization of how the definitions influence practice. Most research studying the use of religion and spirituality in clinical practice provide definitions of both terms to frame the study methodology and results. Definitions vary among researchers, similarities are also found and overlap in the definitions of the terms seems inevitable in many contexts. Religion and spirituality are interrelated although many researchers find that both terms can exist without the other.

For respondents in a study of regional similarities and differences among social workers in direct practice Furman, Benson and Canda (2004) provided definitions of religion and spirituality on the data collection instrument. For their purposes religion was

defined as "an organized structured set of beliefs and practices shared by a community related to spirituality". Spirituality was defined as "involving the search for meaning, purpose, and morally fulfilling relations with self, other people, the encompassing universe, and ultimate reality, however a person understands it." Spirituality was further explained as potentially expressed through religious forms but did not need to be limited by these religious forms. The researchers added that some of the questions on the survey "addressed spirituality in both religious and non-religious forms" indicating that some forms of religion might not include or encompass spirituality.

Furman, Benson, Canda, and Grimwood (2005) pointed out that the definition of religion could be both alternately narrow and wide. Narrowly defined, religion "identifies a person as religious if he or she belongs to a faith group, accepts the beliefs, ethics, and values and doctrines of that group, and participates in the required activities, ceremonies, and rituals of the chosen group". A more encompassing definition of religion includes an individual's socio-cultural and historical roots. Krause, Chatters, Meltzer, and Morgan (2000) note that though religion is a complex multidimensional construct many research studies measure religion inadequately due to a narrow definition, and ultimately, an inadequate understanding of the term. For example, many studies assess religion with a single question about denominational preference or frequency of church attendance. These generic questions do not address the complexity of culture, tradition or other richness in the way that religion is viewed and lived by people. To illustrate this point a quote from Bishop Ramirez describes the faith experience of

Hispanics: "spirituality touches not only the spiritual, as a mere interior and private event, but is also the one that affects their total lives … including moral and external behavior, including religious and social relationships. The social aspect brings people in touch with past spirituality of their ancestors. This, spirituality is about more than isolated or private experience – it is also a legacy." (Northcut, 2000).

The potential negative interaction of individuals with religion is also not measured in questions that only ask about denominational preference or frequency of church attendance (Krause, Chatters, Meltzer, &Morgan, 2000). Northcut (2000) addresses the potential negative effects of religion for some clients and the necessity to make a distinction between religion and spirituality. An example is provided of a homosexual client who grew up with missionary parents in a conservative religion that condemned his sexual identification. For this client separating religion from spirituality was important. According to postmodernism, definitions of religion and spirituality may change over the course of therapy. The therapeutic relationship may help develop distinct definitions of religion and spirituality that provide a new point of departure for the client.

Northcut's (2000) postmodernist perspective on the definitions of religion and spirituality postulates that we cannot separate ourselves from what we are studying. Applied to clinical work this postmodernist perspective underscores the importance of understanding and clarifying how religion and spirituality are defined because definitions ultimately influence practice. Northcut defines religion as "the external expression of

faith … comprised of beliefs, ethical codes, and worship practices". Northcut defines spirituality as "the human quest for personal meaning and mutually fulfilling relationships among people, the nonhuman environment, and for some, God". Northcut points to the importance of culture and individual experience that may not be encapsulated by these definitions that might lead to a bifurcation of external practices and internal experiences.

Webster defines religious as "relating to or manifesting faithful devotion to an acknowledged ultimate reality of deity; of, relating to, or devoted to religious beliefs or observances; scrupulously and conscientiously faithful" (Merriam-Webster, 2000; p. 985). Webster defines spirituality as a "sensitivity or attachment to religious values, the quality or state of being spiritual, of or relating to spiritualism defined as the view that spirit is a prime element of reality" (2000; p. 1130-1131). Spirituality is seen as separate from religion as the "transcendent relationship between the person and a Higher Power, a quality that goes beyond a specific religious affiliation" (Peterson and Nelson as cited by Turner, Lukoff, Barnhouse, & Lu, 1995, p. 437). In essence these definitions point out that regardless of the religion one may practice, most religions seem to have an element of spirituality as part of their structure. Whether one chooses to embrace the attached spirituality is left to the individual.

Again, it is found that researchers surmise that one can be spiritual without being religious and religious without being spiritual. Spirituality is associated with a sense or state of being in which people see themselves connected to the world in some integrated

manner while religion is associated with the following of practices and the holding of beliefs of an organized church or institution (Shafranske & Maloney, 1990). Prest and Keller's (1993) inclusive definition of spirituality holds that it is "a multifaceted relationship between human and metaphysical system" this spiritual system is constructed from within and without to "provide faith explanations of past, and present experiences, and for some, to predict the future and explain the ultimate meaning of life and existence".

The many existing definitions of spirituality point to a lack of universal consensus (Trousdale, 2004) although many similarities can be found in the definitions. Trousdale proposes, similarly to Prest and Keller (1993), that for some spirituality is primarily about a search for God and for others spirituality is constructed from within and without "both a devotional or God-directed focus, the internal aspect of spirituality, and an external aspect that relates to how one relates to the world". Spirituality can also be defined in secular terms and not necessarily related to religious impulses or experiences. Trousdale poses three questions that might help a clinician understand a patient's personal relationship to spirituality: Who am I? Is there a power beyond what I see and, if so, what is it like? What is my relationship to others and to creation? These are basically existential and relational questions that many religions seek to answer though others without a religious orientation may look for answers in alternate ways.

This secular approach to define spirituality is explored by many researchers (Lawrence-Webb & Okundaye, 2007; McSherry & Smith, 2007; Stewart &Mezzich,

2006; Trousdale, 2004; Watson, 2006). Secular definitions include values often associated with spirituality such as: wellbeing, holism, the whole person, and individual voice. Watson points out that at the UN Convention, "Spirituality … is not only to do with the "spirit" but with the physical well-being …" In working with a patient, spirituality needs to incorporate their beliefs and values as an existential response and approach to the human condition.

Lawrence-Webb and Okundaye (2007) maintain that spirituality is an "ethereal concept that appears to elude all rational understanding in discussions between and amongst people". This supposition poses a challenge to the clinician in an attempt to develop a vocabulary around spirituality that satisfies all cultural and individual needs. This might point to the importance of clarifying an individual's conceptualization of religion and spirituality as they reflect their worldview and behaviors.

Stewart and Mezzich (2006) view spirituality as a "complex construct that is most accurately defined as multidimensional, encompassing every individual's beliefs concerning reality beyond the sensory, material world." Spirituality might be seen as happiness or personality traits; however, there is much discussion around the nature of spirituality. And, it is postulated again that most conceptualizations of spirituality include religiosity as one dimension of a more global spirituality. As with other researchers, Stewart and Mezzich point to the importance of differentiating the two concepts though they can be closely related. They define spirituality with corresponding dimensions that include individual beliefs and practices that may also include religiosity.

Religiosity with corresponding practices is generally a part of spirituality and is viewed as a "social phenomenon". In conducting their research Stewart and Mezzich held that religiosity focused more on beliefs, rituals, and practices associated with social or institutional elements. Spirituality encompassed individual subjective experiences that are sometimes shared with others. Stewart and Mezzich developed a tool to conceptualize their definitions that included three dimensions: Intrinsic (i.e., individual's religious beliefs that influence life decisions); Extrinsic-Personally Oriented; and Extrinsic-Socially Oriented (i.e., beliefs that are utilized for specific goals such as personal comfort or social approval). This tool used an object relations theoretical perspective to measure an awareness of God in one's life and the quality of that relationship, therefore "Spirituality, then is conceptualized as distinct from religiosity by tapping different dimensions of relationship with the perceived Divine."

Clinical Practice

Mindfulness and Meditation

Mindfulness and meditation have been used effectively with many populations in clinical practice. Additionally, there are many empirical studies showing the effectiveness of both modalities. The modalities encompass a wide variety of techniques allowing for creativity in therapy and the ability to adjust one's approach in a way that will be most appropriate for the individual client's needs (e.g., culture, language, diagnosis, talents, interests, presenting issues). Some of the techniques preliminarily reviewed here include: storytelling, art therapy, dance/movement and body

psychotherapy, and adjunctive therapies such as EMDR, hypnotherapy, and SARI. It is important to note that though meditation and mindfulness may have origins in spiritual traditions both can be used in a secular practice. Certainly this is important for individuals who have been negatively impacted by religion or spirituality in the past or for those who have no interest in religion or spirituality.

The research reviewed was notably absent of reports of negative effects of meditation on any form of psychological distress. In fact, meditation and mindfulness based trainings have positively influenced outcomes in depression, addictions, trauma, personality disorders, anxiety and panic disorders, stress-reduction, borderline personality disorder, anxiety reduction, disordered eating, and supportive therapy in cancer (Elkman, Davidson, Ricard, Alal & Wallace, 2005; Kabat-Zinn, Massion, Kristeller, Peterson, Fletcher, Pbert, Lenderking, Santorelli, 1992; Ma, Teasdale, 2004; Melbourne Academic Mindfulness Interest Group, 2006; Simpson, Kaysen, Bowen, MacPherson, Chawla, Blume, Marlatt, Larimer; 2007; Smith, 2005; Teasdale, Williams, Ridgeway, Soulsby, Lau, 2000; UCA News, 2006). It was found that meditation might have a positive effect on individuals relating to their environment at all levels (Haimerl, Valentine, 2001).

Mindfulness encompasses a variety of techniques, all of which have a meditative component (e.g., movement, yoga, brief periods of mini-mediation, everyday mindfulness in the present moment) (Melbourne Academic Mindfulness Interest Group, 2006). Art therapy and movement therapy can also be considered approaches to the practice of mindfulness.

The successful use of most mindfulness practices, especially those with a meditative component, required commitment and thorough training on the part of the clinician and commitment and time on the part of the client (Melbourne et al; Smith, 2005; UCA News, 2006). Mindfulness based work with clients was also shown as effective with relationship enhancement (Carson, Carson, Gil, Baucom, 2004). Couples trained in mindfulness techniques reported favorable impacts on the levels of relationship satisfaction, relatedness, acceptance of one another, and relationship distress.

Many of the expressive therapies (e.g., storytelling, art, dance, movement) were useful for the difficult-to-engage client (Dent-Brown, 2004; Eisdell, 2005; Steckler, 2006). Storytelling is seen as particularly useful with borderline personality disorder when rapport was difficult to establish and patients often felt misunderstood (Dent-Brown). Eisdell's approach to art therapy primarily used the theories of Winnicott, Hobson, and Klein and placed their work within the history of art therapy, namely in the works of Freud and Jung. She used interactive art therapy with children and adults with depression, psychosomatic disorders and personality disorders as well as with those who self-harm. Use of body, movement and dance psychotherapy required rejection of the mind-body split and were useful in promoting neurobiological changes in the brain for clients who have experienced trauma (Steckler). Body psychotherapy synthesized the body and verbal therapeutic exchange. Steckler provided the theoretical roots of body and dance therapy in primarily the works of Jung, Reich, and Perls.

The use of meditation and mindfulness training were found to have other beneficial outcomes aside from treatment successes (Ma et al, 2004; Simpson et al, 2007). For example, meditation and mindfulness training have been shown to be cost effective, useful in short-term therapy, and group trainings can be conducted.

There was little information provided on the demographic or cultural background of the participants in most studies. There was also little to no mention of psychological theory in many research studies. While several articles attempted to bridge Buddhism and Western psychology, few provided examples of applicable psychological theory (Elkman et al, 2005; Rubin, 1999; Wallace, Shapiro, 2006). Researchers stated that Buddhist insights should continue to be developed and adapted by Western psychological theory, expanding the horizons of both disciplines (Wallace et al). A relationship between psychoanalysis and Buddhism was provided: both are concerned with nature and alleviating suffering, have an emotionally intimate relationship, have similar processes for alleviating suffering, and recognize that there are obstacles to alleviating suffering (Rubin). Other researchers posited that the Buddhist perspective was helpful for psychotherapy in achieving enduring happiness and eliminating afflictive emotions (Elkman, et al).

Meditation and mindfulness have affected the brain and associated neurobiological and emotional processes. A study on long-term Buddhist practitioners revealed a correlation with hours of practice and regions of the brain (Brefcynski-Lewis, Lutz, Schaefer, Levinson, Davidson, 2007). These findings suggested that meditation

strengthens the ability to inhibit cognitive and emotional mental processes such as rumination that can lead to or exacerbate stress, anxiety or depression.

Meditation has also been found to affect the normal age-related decline of cerebral gray matter volume (Pagnoni, Cekic, 2007). These findings suggested that the regular practice of meditation might have neuroprotective effects and reduce the cognitive decline of aging.

Neurobiological changes in the brain can also be affected by EMDR, hypnotherapy and SARI (Diseth, 2005). Diseth has found these therapies to be especially effective with children and adolescents who have experienced early childhood trauma.

Existential and Transpersonal Issues and Practice

The literature on transpersonal and existential therapy revealed many similarities. Transpersonal and existential therapy both focused on assisting the client in uncovering and developing meaning in their lives. One of the main differentiators of the therapies was that the transpersonal approach relied heavily on the therapeutic relationship as the pinnacle of the therapeutic process (Antoniou, Blom, 2006; Whitehouse, 2006). For example, in order to arrive at a transpersonal relationship other therapeutic relationships must first be established such as the working alliance, transference/countertransference relationship, developmentally needed or reparative relationship and person-to-person relationship. Instead of focusing on the transpersonal journey the transpersonal relationship of client-clinician was viewed as mutually beneficial. The crux of what was effective in the transpersonal relationship was the therapist's ability to use her

transpersonal self in a “common willingness to let go of all aims and assumptions” (Antoniou et al). Also, in transpersonal therapy there was an emphasis on the clinician’s spiritual life both in personal awareness and in its usefulness in practice (Antoniou et al; Cashwell, 2007; Moxley, Washington, 2001;Whitehouse).

Existential therapy considered the relationship between client and clinician as important as well but it was considered differently (Yalom, 2002). The relationship was seen as most effective when the therapist's empathy, insight, professionalism, understanding, and acceptance are employed. Existential therapy was not always viewed as spiritual or religious (Yalom).

The foundations of existential therapy were in philosophical and historical thought while the foundations of transpersonal therapy were in pioneering psychological thought (Krippner, Feinstein, 2006; Moody, 2006). The literature provided many different terms and definitions of theory and practice for both therapies, and, although the terms are different often times the meanings are quite similar.

Ken Wilber’s work on transpersonal and integral psychology indicated (Nixon, 2005; Whitehouse) that Wilber’s work has moved to no longer acknowledge the label “transpersonal psychology”. Wilbur, as one of the thought leaders in transpersonal psychology now refers to his current theoretical and clinical developments as integral psychology.

Definitions of existential psychotherapy varied often according to practitioner’s chosen philosophical and theoretical framework. However, most clinicians agreed that

existential therapy looks at a client's presenting issues through the lens of the ultimate concerns of life: meaning of life, death, isolation and freedom (Yalom, 2002). These ultimate concerns are the givens of existence with which all humans are confronted (Yalom, 1989). Existential therapy focuses on uncovering these sources of anxiety and meaninglessness in life as they are played out in everyday existence (Kirby, 2004). Culture influences how these ultimate concerns are presented in therapy, however, these concerns do not belong exclusively to one cultural group. It is important for a clinician to explore a client's cultural background to understand how these concerns are presenting for their clients in order to help them understand the meaning in their life (Keshen, 2006).

With existential therapy, there is a dearth of empirical research. Some explanations for the lack of empirical research are that quantification can be reductive to the client and the therapeutic process and that existential therapy does not lend itself easily to measurement. Much of the literature focused on philosophy with little practical information on application in a clinical setting (Becker, 2006; Bergner, 1998; Kirby, 2004; Langdridge, 2006). The opinion of some clinicians is that an existential approach is useful for short-term therapy (Van Durzen, 1997) while other clinicians believe that long-term therapy is necessary for effectiveness (Yalom, 2002).

Helping a client discover the meaning of their life is also explored in transpersonal psychology often times through myth and dream analysis (Krippner, et al 2006; Moody, 2005) which is seen as important in both approaches in the consideration of personal history and culture. Krippner et al, (2006), Moody and Pearson (2007) use

Jungian psychology as their foundational theory for transpersonal psychology. Moody and Pearson also draw on Maslow and Erikson (although Pearson does not state this specifically and focuses on Wilbur's integral theory). All three of these writers see the discovery of the meaning of one's life developmentally and provide suggestions for clinicians on how to assist the client through these stages in their journey. The specifics of their developmental models are different but all are leading towards personal transformation/transcendence. Transformation and transcendence are often defined experientially as a letting go, a dying to the old way of life and birth of the transcendent and transpersonal self.

Transpersonal therapy has been used with persons with addictive behavior, both chemical addictions and thought pattern and relationship addictions (Moxley et al, 2001; Nixon, 2005). The research makes a strong case for the effectiveness of the transpersonal approach with these populations. Aspects of transpersonal therapy that are useful with clients presenting a chemical dependency are inclusiveness and non-judgment (Moxley et al., 2001; Nixon, 2005). Both articles provide the theoretical foundations for their work and specific clinical applications (e.g., meditation, story telling, art therapy, self-observations).

Clinicians: Practice and Spirituality

This section focuses on research with clinicians, primarily clinical social workers. Aspects of practice relating to the incorporation of spirituality and religion are explored in the literature.

Furman, Benson and Canda (2004) conducted a quantitative study of social workers in the US examining regional similarities and differences among social workers in direct practice with regards to their use of spirituality and religion. Social workers tended to be homogenous in their responses on the subjects regardless of geography. Since this was one of a limited number of studies of social workers in the US on geographical significance it can be used for comparative purposes. For example, many studies focus on a particular geographic region, the results of these studies can be compared to Furman et al's research if variables studied are similar. In Dwyer's (2008) study of social workers in the Southwest United States, several themes emerged that are supported by this and other studies. First, social workers are increasingly incorporating spiritual dimensions into their clinical practice and, as has been noted in several other studies (Canda & Furman, 1999; Sheridan, 2004), there is little to no formal education and training in religion and spirituality in social work programs across the US.

Dwyer's study pointed to the need for education on the religious traditions of one's client base and also to the need for training in the clinical modalities and practical applications of a spiritually based practice. Derezotes (2003) also noted the importance of education and training from a social work perspective understanding how varying religious traditions of people of many ethnicities, races, and backgrounds is necessary for effective practice. Lawrence-Webb and Okundaye (2007) provided suggestions for social workers on how to utilize spirituality and religion with African American

caregivers. Their suggestions can assumedly be used with many populations and they include: allow for the expression of different worldviews, conduct spiritual and religious assessments utilizing spiritual genograms, allow spiritual interventions (e.g., prayer, meditation), assist in connecting caregivers with spiritual and religious communities to meet both material and spiritual needs, assess the role that spirituality and religion play in decision-making, and develop cultural sensitivity and competence with integrating spiritual and religious worldviews.

One of the most significant findings in a study among social workers was their reported lack of education and training in religion and spirituality (Kvarfordt & Sheridan, 2007). Given both the increase in the use of spiritual approaches in clinical practice and the research findings on the positive effects of spiritually based practices this finding is difficult to overlook. The research is significant on religion and spirituality functioning as effective protective factors in the lives of clients (Gall, Basque, Damasceno-Scott, & Vardy, 2007; Kvarfordt et al; Stewart & Mezzich, 2006). Stewart and Mezzich provided an example in their empirical study that found that religiosity and spirituality practiced among parents decreases neglect of their children. This was shown to be the case even with substance using parents and these results do not include whether or not religion or spirituality was incorporated in treatment. Similarly Lawrence-Webb and Okundaye (2007) found caregiver's major coping strategies were their reliance on spirituality and belief in a higher entity, these were of enormous importance to their functioning. Miller

(2006) reported that adolescents with an active spiritual life have been shown to have lower rates of morbidity with respect to mental illness and physical risk taking behavior (e.g., substance abuse, conduct disorder, weapon-carrying, poor nutrition and lack of exercise). Spiritual coping was shown to be associated with health and wellbeing and protective against adolescent depression. These results were particularly true of adolescents at risk due to poverty, psychopathology or parental psychopathology.

Furman, Benson, Canda, Grimwood (2005) conducted an international study of religion and spirituality of social workers in the UK and the US. Social workers in the US and the UK revealed that generally social workers in the US were more accepting of religion and spirituality than social workers in the UK. Historical reasons were provided as a possible explanation for this difference. For example, in the UK there have been many benefits in the secularization of service provision as it has been generally more inclusive. A large majority of the social workers in the US believed that social workers should increase their knowledge of spirituality. Lack of training in religion and spirituality was again reported as social workers in both the US and UK indicated that their training did not include course work on religion and spirituality.

The reported lack of training on religion and spirituality in social work education gives rise to ethical considerations in social work practice. Canda, Nakashima, and Furman (2004) conducted a qualitative study with social workers in the US regarding ethical concerns of religious and spiritual issues in a clinical practice setting. Although

the *NASW Code of Ethics* provides some broad guidance on a practice that is nondiscriminatory regarding diversity it lacks in specificity on religion and spirituality in clinical practice. Some areas where specificity would be useful were indicated such as healing touch, self-disclosure of the therapist, praying with clients, hidden spiritual agendas, and religious discrimination.

There was an implicit and explicit use of spirituality noted by social workers in clinical practice. Dwyer's (2008) study showed that among social workers there was a trend to use less direct interventions and, instead, an implicit approach. This same study showed an increase in the use of more direct interventions, an explicit approach, such as praying or meditating with a client. This increase in the use of both implicit and explicit approaches was usually accompanied by a fair degree of caution in practice in order to avoid coercion or proselytizing.

Related to the use of implicit and explicit approaches to spirituality was the finding that social workers were inclined to take the client's lead (Dwyer, 20008; Canda & Furman, 1999) when using spiritual language or clarifying spiritual values. A client-centered approach listens to the requests, needs, and wants for spiritual elements in therapy. Generally, social workers were trained to value client self-determination above all else, thus pointing to the imperative of letting the client set the agenda (Lawrence-Webb & Okundaye, 2007).

It was found that depending on one's personal bias or background what social workers emphasized in spiritual development was different. McSherry and Smith (2007)

applied this concept to working with children. They acknowledge that many child development theories used Western and Judeo-Christian traditions and were based on adult interpretations, and “therefore may not truly reflect the child’s perspective or be transferable or have significance for all cultural, ethnic or religious groups.” Importantly, Eaude (2004) emphasized the enormity of the role culture and society had on spirituality.

Most studies with social workers on religion and spirituality in clinical practice introduced a definition of both terms. Derezotes (2003) discussed the need to bridge this gap by drawing distinctions as a way to help clients bridge the unnecessary dualities between spirituality, religion and science. Science in this case referred to psychology as a new religious means to a "sacred marriage" of science and spirit. The dialogue among the disciplines encouraged social workers to help clients do away with unhealthy gaps in their lives. A study by Hodge and McGrew (2006) of graduate level social workers revealed that a significant minority of students believed that no or a minimal relationship existed between religion and spirituality. While the majority believed in some form of relationship between the two concepts. This research addressed the important issue of establishing a working language to discuss these concepts with clients. Interestingly, children generally do not make a distinction between religion and spirituality (Mercer, 2006). Mercer provided a complex overview of the spiritual life of children that included a significant amount of attention to the definition of spirituality and its relationship to religion. Children have a unique non-linear capacity to experience the mystical that is not supported by linear didactic and pedagogical teaching and clinical treatment

guidelines. The potential dualism inherent in differentiating spirituality and religion was not found to be entirely present for children they did not make sharp distinctions. Adults may "over-value" these distinctions in ways that were not relevant to the experiences of children. In a study among educators working with sick children, all respondents interviewed did not think that "God-talk" was necessary when working with children on spiritual development (Pridmore & Pridmore, 2004).

Scott (2004) made a significant contribution to understanding later life choices and issues of self-acceptance for adults who have been impacted by childhood spiritual experiences. Scott outlined specific guidelines for the practitioner regarding perception and self-report in helping people to make meaning of these childhood experiences including how to accept, encourage and nurture the spiritual experience that incorporated an awareness of countertransference. Marginalization and low self-esteem can result when a childhood spiritual experience was viewed as different and unacceptable, and, many aspects of adulthood can be affected. The spiritual experiences reported as significant shared many of the following attributes: a reflective process; unique awareness arising from the event; a consciousness that something out of the ordinary occurred; retain a significant role in memory; often remain unspoken; and sometimes recall of specific emotions. These experiences were significant in that they deeply affected adult lives. Exploration of these experiences will "require a shift in cultural awareness in order to come to insights about the role of these experiences" (Scott).

Addressing theory

There appeared to be a scarcity of research on psychological theory that was relevant to the research question of this study when conducting the literature search. Object relations theory has been used to develop The Spiritual Assessment Inventory (Stewart & Mezzich, 2006) by tapping different elements (i.e., awareness, disappointment, realistic acceptance, grandiosity instability) of relationship with the "perceived Divine." Developmental theories have also been used to understand a client's capabilities based on their stage of development. Additionally, stages of spiritual development were used along with the stages psychological development to compliment and enhance understanding and thus increase the effectiveness of clinical interventions (Eaude, 2004; Gidley, 2007; McSherry & Smith, 2007; Mercer, 2006; Miller, 2006). Attachment theory has been used in understanding the spiritual life of adult survivors of sexual abuse where a relationship with the divine was used when an inconsistent parental relationship was experienced during childhood (Gall, Basque, Damasceno-Scott, & Vardy, 2007). Other researchers rejected psychological theories when addressing spiritual issues as theory was often viewed as reductive to the spiritual experience (Cupit, 2007). Cupit rejected traditionally accepted theories of human development and created his own. Cupit was trying to make room in developmental theory for the unexplainable and sometimes mysterious aspects of spirit and human development. Related to the fear of reductive thinking, Erricker (2007) warned about unthinking abeyance to the

hegemony regarding issues of faith and religion. There is continued value in subjecting authority to deconstruction in determining truth with regards to faith and religion (Erricker).

Summary

There are many historical, philosophical, and theoretical roots that indicate the benefits of a clinical practice that incorporates religious, spiritual and nonreligious spiritual principles and modalities. There is also a great interest, especially in the US, among social workers in using these principles and modalities in their clinical practice.

CHAPTER III

METHODOLOGY

The purpose of this study was to elicit clinicians' perspectives and practices with spirituality in clinical practice. This research used a qualitative data collection methodology of focus groups. This qualitative method allowed for exploration of the issues in order to conduct potential future quantitative studies on the issue (Krause, Chatters, Meltzer, and Morgan, 2000). The focus group discussion guide covered the primary areas listed in the introduction, namely clinician's definitions of religion and spirituality, assessment of the importance of religion and spirituality to clients, implicit and explicit uses of religion and spirituality, and potential negative aspects of religion and spirituality in the clinical experience (Appendix B).

Demographic data was collected from the focus group participants via a questionnaire. The information collected included: number of years as a licensed practitioner; degree (e.g., MSW, MA, MFT, PhD); agency based practice or private practice; populations served; theoretical orientation; practice modalities employed; special trainings or credentials; gender identification; age; racial identification; personal spiritual or religious practice; and personal religious identification.

Sample

The participants for this research were recruited from three geographic regions: Northampton, Massachusetts; Albuquerque, New Mexico; San Francisco and Oakland,

California. The participants were recruited via email. The recruitment sample was primarily Smith College School for Social Work alumni. When necessary, additional participants were solicited from the three geographic regions using Smith College networks as well as professional networks of the researcher. No incentive was offered for participation. Participants voluntarily agreed to attend the focus groups based on the criteria listed in the recruitment email (Appendix A). Participants were not screened in advance to insure that they met recruitment criteria. Every effort was made to include a diversity of participants in the following areas: populations that they serve; gender identification; religious or spiritual practice; racial identification; and practice orientation. However, we needed to work with the applications received and in some cases participants did not meet all of the recruitment criteria. All participants spoke English as the conversation in the focus groups were conducted as such.

For each group, an attempt to recruit a minimum of ten participants was made in order for four to five participants to attend. Recruitment criteria included: clinicians (psychologists - PhD or PsyD - or master's level clinicians, social workers, pastoral counselors, family therapists) who had been licensed for at least 5 years and who were willing to discuss their perspectives on the relationship of spirituality, religion, and psychotherapy. There was no limit or specification of a particular spirituality, religion or non-spirituality of participants, as the research was not designed to evaluate any specific religion or spiritual practice.

Each focus group met one time in the summer and fall of 2008 and was led by this researcher. Each group meeting lasted approximately two (2) hours. The focus groups were held in conference rooms at Smith College (Northampton, MA); The Indian Pueblo Cultural Center (Albuquerque, NM); Fort Mason Center (San Francisco, CA); and Mills College (Oakland, CA).

Ethics and Safeguards

All quotes and vignettes used in data analysis were disguised; none were connected to any one person. The focus group sessions were recorded and transcribed, and the transcriber also signed a confidentiality pledge.

Participation in this study was voluntary and confidential, and participants were asked to make a pledge of confidentiality regarding what was said in the focus group and the identity of the group members. However, participants were informed that the researcher cannot guarantee that all participants will honor the pledge. Participants could decline to answer any questions or withdraw from the discussion at any time. Participants were made aware that the researcher would not be able to identify and extract the contributions to the process that participants engaged in prior to withdrawal. For this reason it was not possible for participants to withdraw their participation after the completion of the focus group. In any publications or presentations, the data will be presented as a whole. Participants were assured that any quotes and vignettes used for publications or presentations would be carefully disguised so that participants could not be identified. As required by Federal guidelines, all data is kept in a secure location for a

period of three years, and then they will be destroyed, unless it is still needed, in which case it will be destroyed after it is no longer needed.

If participants have any questions or concerns about this study, they will be invited to contact Dean Carolyn Jacobs or this researcher via email or phone. They were also welcomed to contact the Chair of the Smith College School for Social Work Human Subjects Review Committee.

Data Collection

The group conducted in the summer of 2007 at Smith College served as a pilot study to test recruitment strategies and to assist with discussion guide development. Based on the pilot study, the discussion guide and demographic questionnaire were adjusted to more adequately meet the needs of the research questions and purpose. Also, based on the richness of response and the enthusiasm of the participants it was also determined that a group size of four to five participants would be a minimum number necessary to conduct a sufficient focus group.

The focus groups were audio recorded and the audiotapes were transcribed for analysis. Once the transcriptions were completed they were checked for accuracy by listening to the tapes and comparing the transcriptions to the audio record of the focus group.

Generally, a thematic analysis was utilized with some attention to narrative analysis as appropriate to longer sections of participant responses. A category scheme was developed for general themes uncovered in the data. The categories helped to define

a first level of coding that was refined and reorganized as appropriate to the research questions.

The category schemes and codes were compared and patterns and connections identified. Themes and sub-themes were integrated and/or distinguished as appropriate. Once the data was reviewed in detail an analysis was applied that integrated the categories with larger sections of the transcripts in order to illustrate category meanings. Quotations were used and viewed as especially valuable for this section of the analysis.

The data from the demographic questionnaire was compiled and presented in order to contextualize participant responses. Patterns of response as they relate to the information in the demographic questionnaire were identified.

Limitations

The sample size for this research was small and limited to three geographic regions of the US. Therefore the findings from this study suggest further areas of study but are not generalizable to a larger population of clinicians. Participants were not screened for to ensure that they met recruitment criteria and in some cases participants had not been practicing for the pre-set criteria of five years. Many of the respondents were graduates of Smith College School for Social work and their responses may be skewed to the training received at this school.

Additionally, some of the respondents knew one another, knew this researcher who conducted the groups or knew the dean of Smith College School for Social Work.

This familiarity may have influenced responses as well. The dean was present at three of the four focus groups and her presence may have also influenced responses.

CHAPTER IV

FINDINGS

Participants

The demographic and background information collected from the questionnaire is aggregated across all focus groups and regional differences are highlighted where appropriate.

There were a total of 23 participants across all four groups. The groups in Western Massachusetts and New Mexico had seven participants each, in San Francisco there were four and in Oakland there were five participants.

Participants ranged in age from 38 to 73 years of age with a mean age of 54 years and a median of 52 years. There were 12 female and 11 male participants. With the exception of one Hispanic and one Asian Pacific Islander the racial identification of all other participants was Caucasian.

Participant number of years with a license ranged from 2 to 38 years. The mean number of years with a license was 18 with a median number of 17 years. There were three participants who had only had a license for two years. This did not meet the pre-determined recruitment criteria, however, they were allowed to participate in the groups. This decision was made on a case-by-case basis based on the individual circumstances of the participant and the focus group.

Participants identified their degree. However, since the Western Massachusetts group was a pilot group this information was later added to the demographic

questionnaire and, therefore, not collected from this group. In the groups in New Mexico and Northern California there were seven participants with an MSW degree, three with an MSW/PhD, two with a PhD, and two with an MD.

Participants were asked if they had an agency based practice or a private practice and to specify the percentage of time in the practice. Ten participants said that they only had a private practice. One participant said that they were engaged in private practice 50 percent of the time. Four participants said that they only had an agency-based practice while two participants engaged in an agency-based practice 75 and 85 percent of their time. Six participants had both an agency-based and private practice. Five of these participants spent 80 to 95 percent of their time in an agency-based practice with five to twenty percent of their time in private practice. There was one participant who engaged in an agency-based practice ten percent of the time and twenty percent of the time was spent in private practice.

Participants were asked to identify the primary populations served in their practice. They were asked to identify the populations by ethnicity, race, religion, age, family, individuals, and couples and any other information they felt was relevant. This was an open-ended question and responses varied in format. The majority of participants saw individuals in their practice. Several participants additionally saw families and couples. Participants identified their client populations as adolescents, children and seniors. Several participants further identified their client populations as Asian, African American, Jewish/Christian/Catholic, Latino, elderly, Native, Black, and varied. Other

populations served were identified as immigrants, poverty, middle-class, and upper middle-class. One participant chose not to respond to this question.

Participants were asked to identify their primary theoretical orientation. This was also an open-ended question and as such responses varied. A little less than half (10) of the participants indentified their primary theoretical orientation as psychodynamic while a minority (3) identified Psychoanalytic as their primary theoretical orientation. About half of the participants (11) identified more than one primary theoretical orientation. In these cases those who identified CBT as their primary theoretical orientation combined it with psychodynamic, eclectic, Gestalt and crisis intervention. One participant identified Control Mastery/Energy Psychology while another combined DBT with a psychodynamic orientation. A Jungian orientation was combined with a relational orientation by one participant and a psychodynamic orientation by another. One participant combined a Freudian theoretical orientation with a psychodynamic orientation. A Humanistic orientation was combined with a psychodynamic orientation by another participant. Other participants solely identified the following theoretical orientations: family, object relations, and solutions focused therapy. Two participants chose not to respond to this question.

A list of clinical practice modalities were identified on the questionnaire with an opportunity to include other practice modalities not listed. Participants were asked if their practice included any of these practice modalities (Figure 1). Meditation, mindfulness, journaling and contemplative were the most frequently reported clinical

modalities used in practice. The use of storytelling, meaningfulness, art, prayer, somatic/body oriented and EMDR were also reported with some frequency. Practices that participants wrote in as other were varied ranging from energy psychology to visualization.

Figure 1. Clinical Modality

Clinical Modality	n
Art	5
Contemplative	9
EMDR	4
Journaling	10
Meaningfulness	7
Meditation	12
Mindfulness	12
Prayer	5
Somatic/body-oriented Count	5
Story telling	7
Other:	
Energy Psychology	1
Guided Imagery	2
Narrative	1
Spiritual Materials	1
Viewing/Reading	1
Visualization	1
Yoga	1
Grand Count	84
None	1
No Response	1

An open-ended question asked participants to identify their personal spiritual or religious practice. Responses varied widely. Often participants identified with a specific religion and also included a mindful or meditative practice as well. Figure 2 is included to illustrate the complexity of responses to this question. Participants in Northern

California appeared to have the greatest range of practices among participants. About half of the respondents in Northern California combined a form of mindfulness or meditative based practice with a specific religious practice. Overall, specific religious affiliations included: Jewish (6), Christian, including Episcopal, Anglican, Presbyterian, Catholic, United Church of Christ (6), Buddhist, including Zen (6), and Unitarian/Universalist (3).

Figure 2. Personal Spiritual or Religious Practice

Personal spiritual or religious practice
Jewish
Buddhist
Unitarian (Universalist)
Episcopal
Christian (Presbyterian)
Zen Buddhism
Jewish, yoga, tai chi
Jewish with some Hindu oriented meditation
Jewish/Universal
Jewish/ Buddhist practices
Non-practicing secular Jewish, Buddhist mindfulness, DBT
Unitarian, meditation, mindfulness
Episcopalian with awareness of Buddhist mindfulness
Humanistic, Catholic
Evangelical Anglican Church in America
United Church of Christ. Prayer, meditation, reading
Pagan, neo-Pagan, witchcraft
12 Step Member
Vipassana
Prayer/meditation; member of United Church of Christ
Interfaith Meeting Group, yoga, mindfulness
Mindfulness

Participants were asked to list trainings, certificates and programs that they had completed in addition to their academic degree. Eighteen participants listed additional

trainings, certificates and programs, two listed none and three did not to respond to this question. Figure 3 shows the variety of additional trainings engaged in by participants.

Figure 3. Trainings, Certificates, Programs

Trainings, Certificates, Programs
Comprehensive Energy Psychology – ACEP
PhD coursework in social welfare
Religious Training
Gestalt Therapy
Jungian
Meditation; Group Facilitation
Transpersonal Psychology EMDR Psychoanalytic
Clinical member AAMFT Relationship Enhancement
Family, Solutions Focused
Ordained Anglican Priest
Post Grad Gestalt Inst of Cleveland
Post Grad Tavistock, London Many Short courses
Psychoanalytic
Pastoral Counselor
DBT (3)
MDiv, CAGS

Defining religion and spirituality

The focus groups began with a discussion of how participants defined religion and spirituality and how these definitions influenced their clinical practice. Though overlap in clinician definitions of religion and spirituality was uncovered, there were also similar patterns of distinction for almost all participants. Generally, religion and spirituality are linked closely such as one cannot exist without the other for many practitioners. However, there were also those whose definitions maintained that spirituality could exist without religion but that religion could not exist without spirituality. Religion was

generally seen as an expression of or means to spirituality. A minority of participants thought that religion could exist without spirituality.

Religion

Many participants used organization as a defining term for religion. Organization could be part of a formal religious community or of one's individual religious beliefs. As participant responses revealed:

> "I usually think of religion as sort of the institutionalized version of spirituality, … because it's usually organized around the belief system of that particular group of people."

> "It's an organized belief system that might not be connected to a traditional church. If somebody's got an organized belief system, whether or not it's connected to Christianity or any other particular system (that's religion). Some people have fairly well organized individual belief systems and I would include that as religion."

> "The word 'organized' seems to ring true for me also as opposed to – and I don't know why it's opposed to spirituality – but maybe it's 'deposed'. But, when I think of religion it's organized and structured."

Though shared beliefs were often times a part of a community organized around religion this was not always a necessity in defining religion. Community and connection were often associated with religion. As noted above, shared beliefs could be a part of a religious community and, interestingly, one community within the context of religion could include many beliefs, for example:

> "(I) tend to think of the word 'religion' as the organization, a system or structure, rather than how a person individually practices it. Maybe something that would bring groups of people together in a way that's meaningful to them; create a sense of community and connection. I go to the ____ Church and I don't necessarily believe that religion has to mean that you have to believe in the same thing. It's

> the ______Church as a religion, but it doesn't necessarily say that you have to believe this or that; you don't have to ascribe to a certain creed or doctrine. It's a way of exploring spirituality within a community context that allows for each person to develop their own expression and to find their own belief system, and it's intended specifically to promote and foster that development, that spiritual development, in a community of people that allows for various ways to develop that."

> "The word community stands out for me and within the ____faith, of which I'm a part, it's a community of diversity, within an organizational structure."

Within this context religion was defined as a means to connect with people around spiritual issues, and, individual expression and acceptance was important. Many clinicians agreed that though there may be many differences between and among members of their community it was the connection provided by religion that gave value to membership in the religious community:

> "I find it as a way to connect with people but what I believe personally is what I believe but it helps me to transcend the separation that may exist between you being so very different from me and to connect with them on a deeper level."

Another participant expressed an opposite point of view, where the organization of beliefs was primary in the definition of religion and did not need to include community or connection. This participant agreed that community might be desirable but not necessary:

> "I mean an organized system of belief about the divine is a religion in my book, but not necessarily one that involves more than one person, although often usually … it's more comfortable when you've got company."

Religious organization could take many forms, such as an organized group of people or in the form of rules and rituals that were largely associated with the definition of religion:

> "Highly structured, ritualized way of governing life and the life cycle …"

> "I think of it as an organized entity with a set of beliefs and tenants and practices that kind of guide those who come together of that religion and it guides a particular way of expressing spirituality. I think of it as a structure."

Several participants defined religion as a set of the rules that were a method to spirituality, that religion and spirituality were intricately bound such that one could not exist without the other, for example:

> "I see religion as the method, that leads to the learning . . . the rules of how it leads to the education, kind of like the religion leads to the greater spirituality. So I see religion as the path – maybe the hardening the binding – the putting into rules a way of life to get to the greater spirituality. But the spirituality is a bigger piece that's maybe harder to explain and maybe the religion explains it and there are different ways to get to the spiritual."

For other participants, the term religion and the concept of religion could, and often did exist without a relationship to spirituality:

> "I think about what it means to do something religiously … you know, if I ride my bike religiously it means I do it regularly and I'm committed to doing it. So, I think that's a piece of what a religion is. It's something that's organized … but it doesn't necessarily have to be connected with spirituality."

The introduction of rules and rituals as a part of religion led to a discussion of the actual roots of the word. The roots of religion as understood by many participants contributed to definitions that included community and connection, 'binding' people together, for example:

> "My understanding of the root of religion is actually 'to bind'. "

> "I heard that the root of religio actually means to bind together, so I think of it now as a set of spiritual principles binding them together into a social institution."

Religion when defined as a means to bind people together, often times through shared principles and beliefs, provided clinicians with a framework that could contribute to their understanding of a patient's relationships or world view:

> "The concept to bind and at times in my work I think about religion; their (patient's) religion, their connection to things like an extension of their family. So the relationship with religion or whatever that is; God, the universe, is sort of an extension of their family."

> "I perceive it as a group that has a set of beliefs and rules that are valued and binds them together. But I think in that it is effecting their perception, their orientation – and when I think about my clients – I think about how it is orienting them and their perception of the world, community – their relationship with others including God."

Defining religion led participants to a discussion of the stereotypes that were associated with one's identity with an organized religion. Clinician's discussed issues associated with self-disclosure. The one of the groups voiced the most concern with self-disclosure and the potential of being misunderstood due to preconceptions of their religious community or culture. For example:

> "I have trouble with the religious ideas, the negative aspects, as a Roman Catholic, I very rarely let people know that I'm Roman Catholic especially in the spiritual realm because there is so much baggage with it. Yet, I'm deeply identified personally. But I just find that it gets in the way."

> "In the hospital that I work in to say or even admit that you're religious … I always get credit that you even admit to the claim, like brave because I just think that's a negative."

> "I don't go to staff functions on Friday nights. Why? Because that's the Jewish Sabbath and here it's blocked out – I cut a limit. It's like I have this thing like I'm going to be home with my family and that's it and I've said that to people and it's risky in a lot of ways."

Spirituality

After discussing the definition of religion, clinicians were asked how they defined spirituality. Many participants provided definitions of spirituality in relationship to religion, both in juxtaposition to or in contrast with it. For many clinicians, a definition of spirituality was difficult to provide, in part because spirituality was very important in their lives and there was a fear of being misunderstood. Many clinicians also shared that spirituality was "beyond words" and, therefore, difficult to discuss due to the nature of the concept. Participants provided case examples illustrating how their clinical work has influenced their understanding of spirituality. The quote below illustrated the complex and beautiful relationship between religion and spirituality as understood by one clinician through work with a dying patient:

> "I work in a hospice talking to people about what their religion is and what their spirituality is (and they) can be two wildly different things. And, particularly in end of life work, I actually find a lot of people are questioning their religion more deeply than their spirituality a great deal, so there's kind of a dialogue between the two. . . I'm thinking of a woman who had been raised in the Catholic Church and toward the end of her life a lot of the ritual started to lose meaning for her and what she did to continue a connection, how she expressed a continuing connection with God was to sit in her garden. That's what she wanted to do. She didn't want the priest to visit, she didn't want communion; she didn't want a lot of things that had identified her religiously throughout her life. But she did feel and she expressed an ever-growing connection to God."

Many participants used the word connection to define spirituality but connection seemed to have a somewhat different context than when it was used to define religion. Connection now referred to a universal connection with nature and God. Connection could be expressed very individually and, paradoxically, be an expression of Oneness with the Universe.

> "Well, it's paradoxical isn't it? You're talking about the inter-related web, so it's relationship, how we relate to one another. So that even though we aren't using the word 'community,' it's still has to do with relationships."

> "There's some other paradoxes … it seems like reflection or 'turning inward' and things like that … but it can both be looking deeply inside or looking way out to the universe and, you know, larger systems, and also relationships between parts of the self. But there are several paradoxes mixed up with all that."

> "Spirituality is something that is more than just the physical world and it's bigger. I'm not sure it's understandable. I think that religion tries to understand. . . It's (spirituality) just the unknown. It's connection to something greater, and, that something is the mystery. Maybe religion tries to interpret what that mystery is. I'm not one that is going to, but it's a mystery. It's bigger. It's something that is not the physical."

These seemingly complex concepts used to define spirituality actually assisted in simplifying a clinician's understanding of a patient's process:

> "When I think of spirituality, (what) do we all universally share in common as human beings? So that when you are sitting with a client there may be many things that you feel are distinct or separate but there are some ultimate things that we share as being human or being part of the Universe. And, I think people arrive at their own personal belief systems and spirituality. Yet, there is the universality of being that lies beneath all of it, that we all can relate to."

When providing definitions of spirituality, clinicians very often used terms and concepts to compare it to religion. There seemed to be a grappling for specific words for

a definition, instead ideas, usually based on clinician experiences, both personal and professional were used to convey meaning:

> "The psychological and spiritual work together. And, if I am working towards understanding, and, I'm at a place that feels dark; I find myself thinking, 'now we're in the realm of mystery'. It's a little more chaotic, it's less structured. (I begin to think) what type of resources, what type of experiences does the client bring (to therapy) in a more spiritual realm? We just kind of have to sit with (the experience) until it starts to form. In terms of my own practice and my own life, I think that is something, that over the years, that I have come to incorporate - making space for those pieces that feel like mystery and confusion."

Most participants were unable to provide a definition that was unrelated to their personal experiences with spirituality. For many, their experience with spirituality was ultimately secular in nature and the terms they used to define it were devoid of sectarian jargon:

> "When I think of spirituality, I think of basic principles of living that enable me to touch the deeper parts of my self, and ultimately experience those transcendent experiences that bring meaning and quality to my life. I wrote a book once and in that book I developed what I believe are four basic principles of life that, to me, are spiritual principles that I have incorporated into my psychotherapy practice. They have to do with: keeping agreements … creating … self-inquiry."

When spirituality was defined in comparison to religion, participants were attempting to put some parameters around a concept that seemed unwieldy and formless. When providing support for a patient around religion, the treatment plan was fairly straightforward and usually included concrete suggestions about connecting to a faith community. However, providing spiritual support for a patient required more individualized approach:

> "If we're talking about religion, we're often talking about an organization that can provide some support… In our line of work we're identifying who's out there, what's out there to support you (the patient). And, so the religious piece is really, really important at the external level. At an internal level we're talking about the spiritual piece and that's where we get into: how does it help you cope? How can we help support that while you're here? Is it a conversation with me, one of our chaplains, someone else, do you do it by yourself? I realize that there are two very different things we are getting out of that conversation …"

The parameters used to define spirituality included the internal and more personal element inherent in the concept. This was somewhat in juxtaposition as well as in comparison to the communal element of religion:

> "… spirituality is a more personal way of being aware of something bigger or just some sense of awareness . . . that brings you to a deeper level."

> "… spirituality as something that is really within a person …"

Participants grappled somewhat more with a definition of spirituality than they did with religion. Spirituality was sometimes defined as beyond words, amorphous and a mystery:

> "I think it has this amorphous feeling, what is spirituality really? Well, it's not religion. I don't personally have a full answer, it has this undefined feeling, it's not religion."

> "Spirituality tends to be my individual expression of my connection with the greater powers in the universe, the healing powers, whether that is expressed through a religious group or community, or individually focused."

In the Southwest, where the presence of Mexican, Hispanic and Native American cultures were acutely felt spirituality was related to diversity, both personal and cultural diversity:

> "It feels more individual to me and less structured, and I guess very diverse."

> “It’s a sense of having an understanding within yourself of how you relate to your environment and to other people. A couple of us were at ___ Pueblo for a presentation on Native American issues and one of the panelists brought up their sense of how they defined their religion or their spirituality, and they were saying that it’s one of the Pueblos that hasn’t been influenced so much by the Catholic Church and so they define themselves as “we are the ____ People” you know, and “that’s how *we* (emphasis) see our spirituality,” and then it’s connected also to, you know, just a cultural release, the way they practice, not only their spirituality or religion, but how they practice raising their children or keeping their language. It also sort of ties in to some of my own background - that is Hispanic - where besides being connected to the Catholic Church - because I was raised Catholic; still Catholic – there was a sense of spirituality that came from my great grandmother who was a *Curandera* and there was a lot of beliefs beyond just what you would call traditional religion and the way she practiced. She was a healer and very well respected community people; so that whole sense of community came in to play in that small northern New Mexico village where I was born, and where she was a *Curandera*, so there is that cultural connection also."

Another clinician expressed similar sentiments, although they were not necessarily associated with a particular culture or religion:

> "I don’t perceive myself as religious but I do perceive myself as spiritual and that’s what I want to access. I think it really guides my beliefs, my values, how I live my life. But I think it is also universal. My spirituality is really almost how I connect with everything, with living beings, with the plants, with air. It’s just how everything is. And is how I am with everything. So that’s for me is what spirituality is about."

Determining what is important to clients

Religious and Spiritual Assessment

Clinician religious and spiritual assessment practices varied widely and were influenced by a clinician's comfort level, the practice setting, and the patient's presenting issues. Many participants, and this was particularly prevalent among the clinicians in one

group, did not include religion or spirituality on their initial assessment form. For those who did include assessment, it was found to be extremely useful. The clinicians in this study generally felt a high level of comfort in discussing religion and spirituality with their patients. Many of the participants were supervisors and had experienced resistance from their staff when they had encouraged them to inquire about a patient's religion or spiritual life:

> "It's been very interesting as a teacher, as a supervisor (I've) consulted with lots of social workers and it's very difficult for social workers to ask those questions, even in a very general assessment. Do you practice a particular religion? Do you have a spiritual practice? People still ask me, "Why do we need to ask that? That's hard for me. I don't want to ask that. I feel like it's intrusive." I still get that and that's so amazing to me."

Even though the clinicians reported a high level of comfort discussing religious and spiritual issues with patients, when queried about their assessment process some realized that they had left it off of their intake form:

> "I made up this psychosocial assessment form for my interns, it's like eleven pages. Then I made it much shorter for myself and I left off the spiritual question, I just realized as we were talking about this … it's interesting that I left it off."

A clinician's professional training as well as their personal religious or spiritual tradition influenced their comfort level as well as their inquiry into a patient's religious or spiritual life:

> "I went to Smith under Dean _____ and we learned to do bio-psycho-social-spiritual assessments."

> "Another huge part of it is what religious or spiritual tradition the clinician is coming from and what is their relationship to it? I would say the clinicians that have a spiritual tradition that is not particularly conflictual (sic) will have a

greater comfort level and are more likely to see it as an appropriate avenue of exploration with families."

Practice Setting

Practice setting had a major influence on how the assessment process was conducted and what was asked. However, even in settings where a spiritual care department was available clinicians may not be comfortable with it on their list of duties, for example:

> "With the social workers I supervise, I think there are those who are more comfortable than others. Working in a hospice, where there is a spiritual care component, there is this idea among some of our staff that that's spiritual care department; that doesn't have anything to do with social work."

Clinicians working in private practice reported greater freedom in their assessment and therapeutic process:

> "I don't really have this part of the assessment process, I suppose in part because of the type of work I do which is long term. So, for me, it's more being interested and open to talking about it when it emerges."

Working in a sectarian setting, a spiritual assessment was often a given in the clinical intake. For example:

> "I do a lot of pastoral care and often this (religion) emerges right away."

There were clinicians that did include it in their intake form but allowed for further exploration to be driven by the client:

> "I ask on a piece of paper about their spiritual practices or beliefs, but I don't necessarily explore it unless the client mentions it directly."

Presenting Issues

A patient's presenting issues could be a powerful driver in a clinician's decision to attend to religious or spiritual issues. The participants mentioned grief, loss, forgiveness, trauma, spiritual problems, and anger as issues that indicated a need for a religious or spiritual assessment and exploration with a patient:

> "One of the areas that I specialize in is grief and loss. If someone is dealing with some grief issues, somewhere along the way I will ask them, “What kinds of dreams are you having?” or “What kind of connections have you had with the deceased, since then?” There are some real sacred moments that occur at that point, sometimes where they say, “Well, I’ve seen the person.” Or “I’ve had this dream.” And, it’s an opportunity to look at whether that’s a healing experience for them. It’s very special times."

> "I find that couples go through a grieving process, the loss of the romance or the connection that they once knew. And, now they’ve gotten themselves involved with lots or responsibility, things around children and so forth, and they lost that contact with each other. So our struggle is how do we re-connect them to the deeper parts of their relationship that they once knew … it’s a spiritual process that we go through with them."

For those who regularly include religion or spirituality in their assessments, their discussion of it conveyed an energy and excitement with an element of discovery. These clinicians felt that they could tap into an immediate source of strength when religion or spirituality were a regular part of a patient's life:

> "I do it every time … it’s embedded in every assessment. … many of them in the community who are very, very related to their churches … and church is very much an extension of who they are … it provides them a tremendous amount of support. And they are very happy to talk about that connection with their church."

Patient Perceptions

Patient perceptions of social workers and the clinical setting influenced a clinician's decisions about when to attend to religious or spiritual issues. There were many reports of patient's who did not think that they could discuss religion or spirituality during their clinical time. Some clinicians thought that including religion and spirituality helped to address the non-sectarian view that most patients seemed to have of social workers and the clinical setting.

> "Many people who come in have certain preconceptions or assumptions about what is within the domain of psychotherapy and what is out of bounds. And, if the question isn't asked about religion or spirituality, many people are going to assume that it's out of bounds. By simply naming it and asking about it, at the beginning, it really opens it up to people. So people know they can talk about that here and I think the way that the therapist asks questions or shows an openness to it, is going to communicate a lot about whether this is territory we can go to or isn't it."

> "People in my community think that psychotherapy is a totally secular endeavor and that there is some mystique going on that isn't looking at the larger philosophical, existential, health issues."

> "When I ask, "Well, would you like to see one of our chaplains for a conversation?" they are very happy to have people come by. They probably do some practice with them that they wouldn't necessarily think a social worker would do."

> "She was shocked, she said, "Nobody has ever asked me that question before." And she was shocked because she felt like it was important in the mental health setting. She was just overjoyed that somebody actually brought up that issue. SO since then I have always asked, I was a clinic director so it made it onto the intake – it was accepted by the clinicians as important part and, if you left it off, you were leaving out an important part of their life. So in my private practice I continue with that. I have a very depressed young man right now, who says "There can't be a God if I'm feeling the way I'm feeling." So you get it either way whether it is an important part to their lives or if it isn't. But I definitely think

> it has to be or you are leaving out a part of their life and I think that's been a part that's been absent in psychotherapy for years."

By asking about religion or spirituality on the intake, clinicians were perceived as creating a safe space for the patient to discuss these issues. The patient could choose to ignore it or elaborate as appropriate to their needs.

> "I ask straight out, the first day, really simply: What's your religious and spiritual background? Just one more thing I'm asking and no matter how they answer, I'm saying this is something that we can discuss, that can be in this room."

Interestingly, a minority of clinicians who did include religion and spirituality on their assessments, admitted that they lacked a clear understanding of how the information might be applied in a clinical setting:

> "From my perspective we do a good assessment. We ask about religion and spirituality … and I don't think we've really thought … I haven't thought too much about why am I asking about both other than to be respectful of the fact that some people identify what they do as being related to religion and others related to spirituality."

Another clinician included it on their intake as a way to evaluate a parent's relationship with the divine and how this might be influencing the parent-child relationship:

> "My intake process is usually with a parent and child and I ask about religion and spiritual practice. Watching the relationship between the child's thoughts about the question and the parent's response tells me a lot about their relationship, their attachment, separation/individuation with adolescents ... It tells me a lot about the parents' separation/individuation – their relationship with religion, with God, with the universe. I think that's information that is so valuable to me."

Another clinician used religious and spiritual inquiry in her private practice to observe developmentally where a patient might be:

> "I can listen to how they pray, an adult, a parent especially. It's always a short cut to the object relations just listening and deciding how I'm going to work with them. I can't do that in the hospital."

This clinician viewed religion as a potential protective factor and, therefore, important to include on the assessment:

> "Just recently I was working with an adolescent who is coming out and mom is very, very Christian. I thought about the information that I got in the intake and I thought this is going to be OK. They are going to survive this because for them it (religion) was a support."

The use of religion and spirituality in practice

This section of inquiry resulted in rich and varied discussions among clinicians. Regional differences were not overly prevalent other than those previously noted. Several themes emerged and discussion centered on how these themes influenced clinical practice. The theme of the importance of the therapeutic relationship as a key to healing was emphasized repeatedly. A patient's grappling with existential issues were identified as critical times that might be effectively dealt with through the use of a spiritual intervention. The implicit or explicit use of spiritual interventions often depended on patient readiness and clinician comfort level and experience. Clinicians often reported the use of mindfulness solutions in practice. Participants reported that the clinical setting also influenced whether or not religion or spirituality were introduced either explicitly or implicitly in practice.

Therapeutic Relationship

The therapeutic relationship was pointed to over and over as one of the most important aspects of healing. Variables that influenced the therapeutic relationship included the clinician's spirituality and their ability to recognize a moment of spiritual healing either through the self-disclosure of their patient or through a recognition of the spirit moving through them as a therapist. Clinicians related many stories where the therapeutic relationship was vital in helping them to understand the developmental needs of the patient. Clinicians cited examples of the patient using the therapeutic relationship from an object relations theoretical point of view and for patients recovering from trauma when transference was an extremely effective tool.

> "I had a patient once who was very suicidal and the forgiveness came late in the therapy. We had to first go through a long period of letting her learn to trust me. The issue of forgiving her mother came up, and she says, "I can't forgive her because I can never forget." And, so just distinguishing the fact that in order to forgive you don't have to forget anything that existed … she suddenly found her mother to be the mother she always wanted. It all had to do with some kind of education about what is forgiveness and what does it entail and what does it not require. Which I think gets back to spiritual issues and beliefs."

> "When I tell clients that I've been thinking about what we talked about last time, and I've been really contemplating about it, and I tell them what I've been thinking, they're often astonished. Because, first of all I care enough to think about them between sessions and I was anticipating their visit. That is so meaningful to them, that there is this connection, relationship (and) that I really care about them enough to think about them between sessions and to mention to them what I was thinking about. Sometimes what I say is irrelevant."

Once the therapeutic relationship had been developed psycho-education could occur. In the example, above as well as many others, educating patients about spiritual

issues in order to help them understand their experiences was an effective therapeutic modality. For many patients providing secular contexts of their experiences helped to catalyze the healing process. In the case below, the use of guided imagery within the context of a healing therapeutic relationship was shared:

> "A woman I've been working with for a long time has plenty of physiological, diagnosable things such as fibromyalgia and bipolar disorder. And, she tends to be in relationship with other people where she's demanding … With her specifically I encourage exercise. I have her do guided imagery to help do some self-soothing… I can see how her having a regular relationship with me, where she feels safe, is kind of undoing some of the dysfunctional relationship she had with her mother where she had a lot of abuse as a child. Learning how to have a relationship with a woman where she is cared for consistently and accepted is healing a lot of the old stuff from her childhood."

In their description of the therapeutic relationship, the concept of connection occurred. This was interesting to note as the definitions for both religion and spirituality included the concept of connection.

> "The assumption that you have to forget just in order to forgive certainly does make you feel very vulnerable. You can remember so that you make sure that it never happens again, and it allows you to re-connect and trust again."

Participants shared examples of cases that made a deep impression on them. The therapeutic relationship was also a time of discovery for them as clinicians. Many of the examples shared an observation of how the spiritual and religious learning of the clinician was closely linked to the healing of patients:

> "I deal a lot with another form of grief and loss. I work in special education settings, so we have parents, grandparents who are raising severely multiple disabled children. Last week I had an interview with a grandmother who is raising a little boy who is pretty disabled. It was the first time I met this grandmother and I asked her – which I often do with parents/grandparents, "How

> do you do it with everything have you have to go through?" The first thing she said was, "Well, I pray." She identified herself as a Jehovah's Witness. We started talking about what are some of her other internal strengths? And she said, "There's a sort of a spirit I have that allows me to be patient with this little boy, even though we only have limited resources." To me, being able to interview and talk with grandparents and parents of these really fragile multi-disabled kids is very spiritual because I learn a lot about how they cope, how they deal with some of these tremendous issues. And to learn from them what their internal strengths are which are often connected to maybe a formal religion."

In the therapeutic relationship trust was a important to patient progress and in the example above the patient clearly trusted the clinician enough to open up the possibilities of her understanding of her experience. The connection of clinician and patient was used as a way to promote spiritual healing. The effective therapeutic relationship contributes to safe space for the patient to talk about their religious or spiritual experiences:

> "I find that some clients are afraid to talk about some of their spiritual experiences, because they're afraid that I'm going to say they're crazy. Some are confident enough that I'm not going to say that they're crazy by the time that they actually tell me about their spiritual experiences, or confident enough that they don't really care if I say their crazy or not. Usually the relationship is established."

Clinician Spirituality

Many participants reported how the development of their personal spiritual life influenced their practice as a clinician as well as how their work as a clinician influenced the development of their spiritual life. Most times this influence was viewed positively, however, some cautions were provided about keeping their responsibility to their client as the primary goal. Below a clinician shared her experience as a supervisor and the

challenges that she and her supervisee faced when a pregnant adolescent patient was considering abortion:

> "I said, "You need to go home and take care of yourself." She was so distraught. Can you imagine if you're anti-abortion and you're sitting in an abortion clinic? What an awful experience. It was a really interesting thing looking at someone's values that are faith based values and how they can get very messy and how as a supervisor, your first responsibility is to the client."

And another shared this experience:

> "One of the social workers that I supervise is regularly doing Bible study with a client. And we have to have a lot of interesting conversations about what are you trying to do with your client while you're doing this Bible study? What's the purpose of it for her and what is being accomplished? There's always a question about at what point am I doing something that just makes me feel more comfortable in a challenging position? It comes back to basic clinical principles of boundaries and the purpose of the work. How is it helping my client?"

Several participants shared moving stories about their personal spiritual journey and the influence this has had on their identity as a social worker:

> "When I started being a social worker I was not a very spiritual person, I was sort of anti-spirituality. I became somewhat observantly Jewish. But I think that really changed the way I looked at clients and their spirituality because of my spiritual journey. How would I have responded to that person who wanted me to pray for them if I was like prayer eck? That's a terrible thing. That was probably my attitude back then and now I have a very different response and feeling about prayer. How does where we sit affect what our clients struggle with?"

And, another participant shared what he saw as a somewhat parallel process, how practicing social work has led to his deeper exploration of his spiritual life:

> "I remember being in school and being somewhat spiritual, but not being as connected to it. Definitely having a practice of social work has really deepened that for me. It allowed me to join a church for the first time in my life, which I thought I would never, ever do. "

Through their personal spiritual and/or religious journey, many participants reported an increased comfort level working both implicitly and explicitly with their patients on spiritual issues. For example:

> "I think my own practice has helped me be less afraid of it. And, to be open to it and to allow myself to be moved by it."

> "I was thinking about this question of who is comfortable, what makes someone comfortable as a clinician discussing these issues? I think of my professional work as a spiritual practice, it's a part of how I approach each day and it's present to me each day. Of course it comes up in questioning and in conversations with clients - what meanings religion and spirituality have for them."

Clinicians shared experiences of when they felt a profound influence of their spiritual life and its pervasiveness in practice:

> "I can't think of a time where it doesn't (inform my work). I think it's helped the listening process for me, that I/Thou encounter, dialogue … I experience a dimension of holiness in the work I do. That to be truly seen and understood is an experience of the divine. To be able to hear and understand to some degree is also an experience of the divine. There's something of two subjectivities being in relation to each other in that kind of way, in that kind of intimacy that is really a holy moment."

> "My clinical practice is suffused with my spirituality. I remember very much my first internship when I was first sitting down doing psychotherapy with people, thinking, "I have no idea how anyone does this work without something spiritual or a meditation or a prayer practice because everything I know about how to sit here and how to hold the kind of attention I need to hold I've learned from that practice."

> "I also think there's a process issue that spirituality has in my work. There's something about the I/Thou relationship … a critical piece of what happens in an authentic encounter between people in doing clinical work and that is deeply spiritually informed. So there could be ways that one relates to a dream that a patient brings or an experience that a patient describes where there is an interest, a curiosity, an openness in hearing the person's experience in a way that allows it to resonate on all these different levels, including a deeply spiritually

> transformational one. As a clinician if you're hearing it that way within your own subjective experience then the person's who's expressing it feels something different, more accepted maybe like it's okay to have that kind of experience. It's a validation of it; it's a welcoming."

And, this pervasiveness was manifest for some clinicians in very practical ways in their sessions with patients:

> "I rely on my spiritual practice around work (when) there are moments with a client where I feel so off kilter that I have a system. There's a whole self talk, a faith because we'll work it out … (I tell myself) you don't have to figure it all out now, you need to breathe, ground yourself, feel mother earth holding you and father sky containing and supporting you. I can do it pretty quickly in a session and get myself to that place of feeling very grounded and in my center because it's a practice that I have throughout the day. There are times when there's a reenactment going on where I need to be so available to know what's happening that when things are flying around the room I have to have a practice. And, I consider that part of my spiritual practice."

This clinician provided a case example of when his spiritual practice sustained him through a difficult clinical issue:

> "A client who had ALS and was no longer able to move much … in sitting with him he had a great deal of fear of dying. What emerged was that his fear of dying was founded in a belief that he was going to go to hell and what came out of that was him talking about having, 20-30 years before, sexually abused younger children. He was found out and there was some sort of trial. This was a family secret. He wanted to write letters to family members, some of whom were connected to people he had abused. And, he couldn't write, so he asked me to take dictation on his letters, and that was certainly a moment … all my work with him was filled with times when I thought, "It's a good thing that I some ability to sit here because this is overwhelming."

For some clinicians, their spiritual awareness gave way to pervasiveness of action and attitude with their patients:

> "What I'm aware of is that there aren't moments of consciously thinking, "This is my spiritual practice at play," or, "We're talking about spirituality or religion at this moment." But rather that it is infused in the work."

This clinician provided an example with a supervisee, of when the attitude of being fully present was the modus operandi:

> "I was thinking about one of my staff members who called me weeping this week and said, "I need to come over." I said, "Come on over." She came in and she sat down in tears to tell me that she just found out that her dad had an inoperable brain tumor and was going to die and she needed to go home. I had tears in my eyes and I thought, "God, this is just amazing, this is quite a painful moment for her." She apologized that I had tears in my eyes, and I said, "You certainly don't need to apologize for that." I was aware in the moment that just listening is how we practice, but if we really let ourselves be fully present as human beings in the practice …"

He also provided the need for professional boundaries to be effective as a supervisor or a clinician:

> "You know some folks might say that there's an element of disclosure, there's that whole other conversation. But, I don't agree. I really think that it is just about being fully present and still boundaried (sic). If you're sharing, if you're out of control, clearly then you're boundaries are shot, but I mean that I think that being human is so essential to everything that we're talking about."

Mindfulness

Explicit use of religion or spirituality was usually seen in the employment of mindfulness and meditation as many clinicians reported the use of mindfulness techniques in their practice. Though most all clinicians believed that mindfulness techniques, including meditation, had their roots in spiritual traditions these techniques could be introduced to patients in secular terms. This was viewed as beneficial for patients who were not necessarily religiously or spiritually oriented and also for those

who may have been negatively impacted by religion at some point in their life. First and foremost, clinicians reported that these techniques were effective with patients.

> "One of the things that happens most frequently in the work that I do is the work with mindfulness which is not God-focused, it's not let's pray, it's more meditative. It's more of a let's take a moment to just kind of to be here, to focus on our breathing, and to focus on kind of what's in the moment here from a sensory standpoint as a way of calming or centering. I think of that as part of the spiritual practice that I certainly bring in the hospital work on a regular basis including with my staff. It's not just the clinical work with patients, but clinical work in supervision and consultation."

> "My spiritual practice is Buddhism. There are a lot of things that I have used that don't have to be labeled spirituality; mindfulness kinds of things. An example is a middle-aged man who was coming to see me around some work related issues, high anxiety and stress. As we talked about ways he had worked successfully with anxiety in the past, he told me about a terrible surgery he had some years ago. He was terrified of this life-or-death kind of surgery. He had no religious affiliation, but he had read a lot about Ghandi, and he had picked out a prayer or mantra of Gandhi's and he learned to say that over and over again as he prepared for surgery, it was stilling and calming to his mind and it made such an incredible impression on him. So we began to work with ways that he could find his own mantra. It was coming from my own spiritual tradition; we never labeled it. He chose his own words to use in a repetitious, mindful and meditative way. I saw a strength of his that connected for me."

This was a strength-based use of spirituality, coming from the client and recognized by the clinician due to her own spiritual growth.

> "A lot of people would call me to go to the ICU and do relaxation exercises with folks and we would always begin by talking about spiritual practices or religion and is there something that you've ever used. Is there a part of your practice historically that's ever been helpful for you in coming to a quiet place, relaxing? Just starting from there whether they do or don't have it and using that or starting it fresh with relaxation exercises, breathing exercises if they're able to breathe on their own kind of individualizing an approach, but very focused."

In discussions of the use of mindfulness and meditation, clinicians questioned whether some of the practices were spiritual. Though it was often seen as an advantage that mindfulness and meditation could be seen as secular modalities, clinicians did sometimes struggle with vocabulary.

> "What's the definition? Is it spiritual? I do something called 'energy psychology' and it really helps for people to be present and in their body when we're doing that work, so sometimes before we start I'll say, "Okay wait, before we start, take a breath." It's a little bit more like a mindfulness: feel your body on the couch, feel your hand on your thigh, get present, okay, now we're all in the room."

> "I don't have somatic training, but I think that some of that is more in the somatic world. So is it spiritual? I don't know, but when I'm doing the work and I'm watching the shifts (for example) I remember once saying, "This is a divine moment." I think somebody was letting go of some horrendous abuse and I was watching their (sic) body change and I thought, "Oh wow, to be able to witness that and facilitate that type of healing felt like such a gift to me."

> "Do I call it spiritual? Sometimes it feels like whatever that spiritual feeling is …"

Unless a patient or clinician was comfortable with religious or spiritual methods, there was a tendency to avoid overt use of either framework. Sometimes eliminating the use of religious or spiritual jargon from mindfulness or meditation techniques assisted with accessibility to a healing modality for those who may not consider themselves to be spiritual or religious. Generally, clinicians carefully considered how they discussed spiritual and religious issues. Both in their role as a clinician and supervisor, the question of how to talk about spirituality arose:

> "With some students and new social workers I've taught and supervised the issue of what is spirituality comes up (for example) the discomfort of assessing for spirituality, talking about it, what does it means. I've had patients say the same

thing, “Well what do you mean?” So what I’ve always said and I kind of believe this is: it’s whatever nurtures your spirit. And so it’s a way to open up the discussion to dance, song, writing, and whatever it is you do that takes care of you, that makes you feel good. I think that’s made it easier here for some folks."

"We sometimes talk about it in terms of what brings beauty into your life or what brings joy or meaning to your life."

"This week a guy was talking about going on a backpack trip, he was in a snow storm and the morning after the storm, he talked about hiking up to this ridge and seeing these peaks that were covered in snow and the sunlight on them and the blue sky above them, it was his experience of an encounter with the divine, and he was deeply moved by that … and I was very moved by hearing about it. It just sounded like one of those transformative moments for him that he’ll never forget."

Familiarity with the patient's faith

Clinician familiarity with the patient's faith was viewed as useful. This familiarity allowed a clinician to identify where a patient's interpretation of their faith may be causing a problem in their life. It also allowed for the clinician to identify opportunities for therapeutic insight usually taking a strength-based approach with the client. Participants approached the interpretation or therapeutic use of a patient's faith with caution and respect. The example below illustrates one way that a clinician worked with a patient in this way:

"For me I’m Jewish, I feel very spiritual so it depends on the client. I have a client who goes to a fundamentalist Christian church and he beats himself up horribly. I don’t think it’s improper for me to say as we are trying to get on the psychological level, that part of him, that internalized parent that is beating him self up. So I said, "I thought Jesus was about forgiveness …" To allow him to start having compassion and love for himself. I think it fits together and that’s appropriate. From the psychological level you’re talking about having some compassion for himself and to bring in Jesus, which is how he identifies with

> compassion and forgiveness, I think that's the art of therapy and that's a useful tool. And that is his path of how he finds his spirituality in his life."

This clinician's familiarity with a patient's faith helped her to identify a moment of insight and meaning:

> "I think about another patient … a woman I've been seeing multiple times a week for about a year and a half now. Her initial dream was a very interesting one that involved an encounter with a huge religious icon and she was kind of face-to-face with this larger than life icon, this Christ figure. She was so deeply moved by this. We have many times referenced back to that dream. She grew up Catholic so this was a family that was quite involved in the church so it's a very powerful image for her and it was for me too as I got to know more about it. I didn't grow up Catholic, but I was certainly familiar with Catholicism, but I didn't grow up moved by those images in the way that somebody is who grows up with that as part of a weekly and daily ritual the symbols are really imbued with all meaning and power."

Use of Prayer

Direct use of prayer with a patient was approached with caution. Again, setting was important in determining appropriateness of such an explicit use of religion and spirituality. A hospice or a pastoral counseling center were settings where prayer could be a regular part of the therapeutic process. Regardless of setting, almost all clinicians reported that they would take the patient's lead with regard to prayer. Either the patient would ask for the therapist to pray with them or for them or the clinician might offer prayer and respect the patient's decision. Clinicians reported that their personal spiritual life greatly assisted in both praying and their comfort level with a patient's prayers. Below are quotes that sensitively illustrate a clinician's ability to use prayer on the patient's behalf:

> "We were colleagues both working on the palliative care team, there was a woman who was in the hospital on dialysis and struggling with the decision to stop dialysis and die. Twice a week we would go in and we would hold hands while the other social worker, who was Catholic, would pray Catholic prayers with this patient who was also Catholic. It was very powerful. I'm not Catholic, I didn't know the prayers, but it felt very right and (I) felt very privileged, it's a real privilege to be there with these folks at these moments. I think that was the most overt religious spiritual stuff that I've been involved with."

> "I've had many, many patients ask me to pray with them, comes up all the time. I have never said no. I will pray with them and I let them take the lead. Frequently, they're praying silently and I will do a practice that is meaningful to me (as a) Buddhist silently. I've never had anyone ask me what it is I'm doing with them when they ask me to pray with them. Also, when I'm with a patient who is no longer verbal and I'm just going to sit with them, what I'm doing with myself while sitting with them is generally some form of spiritual practice for myself, some form of meditation."

Clinical Setting

As noted earlier, the discussion of religious and spiritual assessment and use in therapy resulted in consideration of clinical setting. Further discussion revealed more influences of the clinical setting. Participants reported needing to be cognizant of where they were practicing and based on setting the expectations of colleagues, supervisees and patients also needed to be considered.

Clinicians in one group reported with the most frequency the current need to consider setting when approaching religious or spiritual issues in their practice. Several clinicians reported an attitude of some colleagues that was less accepting of a bridging of psychology, behavioral health and spirituality. Clinicians commented on their fears of being caught in the middle, between client needs and the rules of the clinical setting.

Overt discussion or practice of a religious or spiritual nature with patients might result in job loss or loss of one's professional reputation, for example:

> "I feel a dichotomy, I've been told because of my reputation in the community, if I am caught praying or talking about it too much, my job in the hospital is on the line. It's got to be on the intake. I can't do anything more with it – like in terms of support if I pursue it as a strength for the family, there are consequences."

> "My perception is that there is fair level of coldness about it or a bifurcation to frame it in the best possible way –that this isn't appropriate – you want to go into your spirituality, go talk to your clergy person. We are here to do the behavioral health, talking about behavioral health. We are not talking about spirituality – it is not in the boundary. That I think is the stance where I work."

Although not as pervasive, this same comment was echoed in the Southwest:

> "Well, most of my career, except for some private practice, has been within settings where one really couldn't talk about religion or bring it up. It's a touchy subject."

> "Everybody at the _____ Counseling Center was really quite squeamish about getting into religious things. A lot of people would automatically refer to one of the pastoral counselors if something religious came up. I was one of the ones who kind of crossed that line and moved back and forth."

Clinicians discussed a bias that existed in many settings of which mental health and religious or spiritual needs should be addressed separately. Although many clinicians felt that this bias was shifting it was reported to be firmly in place in some regions, particularly in one group, and in some settings, particularly hospitals. Clinicians discussed the history of the field of psychology as a contributing factor to this bias:

> "Historically, Freud going this way, Jung going this way. "This is science and we are going to stick with the ego and what we know". "

> "It's a science. We are working in a world of behavior health science. Evidence based practice. It's (spirituality) irrelevant. And it shouldn't be."

This bias was viewed as having shifted over the years:

> "I was given the privilege of bringing a pastoral care program into a psychiatric hospital. There were all of these psychiatrists who were so fearful and threatened by these people of cloth coming into their units where they felt they had enough to deal with … It took years of work to educate people (staff) as to what this was about. Over a course of ten years, we had two conferences and the first was amazing. We had people of the cloth and the psychiatrists and they were sitting there trying to find a common language. They just couldn't speak to each other. Five years later they came together again, different people of the cloth and different psychiatrists but they were speaking the same language trying to find solutions to common problems. Which came right after the DSM inclusion of that spiritual diagnosis in their manual."

> Setting also influenced the expectations of the patient, as one clinician shared:

> "When I worked at Catholic Social Services clients would come in with the underlying assumption that because it was Catholic, they were waiting for me to make a judgment. One young man announced that he was gay and he really wanted me to give a judgment about whether I thought, as a Catholic, and he was a Catholic man, that he was morally right or wasn't. And then, I'd get other clients who said, "Oh, you must be a religious person." Or "You must be a Catholic because this is Catholic Social Services." So, it was a built-in issue that had to be dealt with right away. I basically would say, "You know, yes, I am a Catholic, but this is not specifically having to do with a religious connection or the Catholic Church. This is a counseling place where you can come and work on issues." Some people, I felt, had an underlying motive: "Well, you need to tell me or guide me about this and tell me this is wrong or this is not wrong."

In public practice, the expectation was of religious or spiritual neutrality in clinical practice. One participant shared an experience with a supervisee:

> "I supervised a woman who was Christian and very anti-abortion and she was seeing a 13 year old who got pregnant. She came in and said, "Well I told her that I didn't think she should have the abortion." In public practice you can't put your religious values on clients. If you worked in a Christian counseling center that's what people are coming for, that's part of the practice. But in public practice you can't do that."

Setting influenced the clinician in many ways. For this clinician, his own spiritual journey was profoundly effected in unexpectedly by practicing in a clinic that did end of life work:

> "It was so clear to me, being a gay man in the 80's, surrounded by HIV and then launching into my career in HIV. It put me face to face with what's real, I don't think there's anything that does that like end of life work. I was able to do a lot of my own reflection on those Mormon groups; those Congregational groups that I come from and what does that mean and why don't I connect with that? And, why do I make fun of Jesus? What's going on with me?"

Culture

Clinicians discussed the relevance of culture in many patients' religious and spiritual lives. This awareness appeared especially prevalent in the Southwest (as noted earlier) while in one group there was some awareness but little actual experience of the influence of culture, especially indigenous practices. Many of the clinicians indicated that they were not necessarily addressing a patient's culture with regards to their religious or spiritual life. Some responses below indicated awareness but little in-depth knowledge:

> "I am aware of a lot of people who have done the whole sweat lodge thing and try to incorporate Native American practices."

> "Wickin, Druids you know and all that."

> "A lot of Latin American Catholicism, Roman Catholicism is influenced by Mayan and so a lot of times the indigenous practice come through a larger religion."

> "There is something in Puerto Rico I've forgot the name of it."

> "Yes, Santoria, that's it."

Though there was a lack of knowledge about indigenous practices, the social work value on the importance of learning from the client was clearly present. Clinicians exhibited curiosity and respect for their patient's beliefs and cultures:

> "The Wickens, you know pagan, some of my families are presenting (as Wickens) but to listen to how they experience it, what it is, how they make meaning. I think it is so helpful to me (to listen) in a non-judgmental ways."

> "I feel ashamed that I can't remember the word, but I do have some clients that bring that it up. So we explore how it is impacting, how they're functioning and how they are using it as a means of coping with some of their challenges."

When clinicians treated patients who had cultural or religious backgrounds different from their own, they sensed that even though the patient could be hesitant for many reasons (i.e., trust, fear of being misunderstood) the patient did want to talk about it. The quotes below illustrate a clinician's skill in respecting the patient and taking a strength-based approach:

> "They are anxious to talk about it."

> "It's interesting because sometimes they will bring it up with hesitation, like they are really concerned I'm going to make a judgment about it. So that's when I am very respectful and careful because I don't want them to misperceive me. I'm very open to discussing it and how it impacts them … as one more resource that they are using to handle life, one more strength."

> "At the medical school I often would see people who weren't responding as the doctors hoped they would, and so they'd get referred to psychiatry. I'll never forget one young woman who was Navajo, who had dreadful headaches and she had been through every kind of neurological evaluation anyone could think of and she still had terrible, terrible headaches and was mad that she was sent to see me. At some point, I said, "What would your grandmother have done about this?" which turned out to be a very, very useful question, especially with people who come from cultural traditions that are different than mine. And she said, "Oh well, she would have had us sing …"

How Religion and Spirituality Negatively Impact the Clinical Experience

Clinicians were asked how religion or spirituality might negatively influence the clinical experience. There were three main areas reported. First, a patient may have been negatively impacted through a past experience, usually religious, and might carry it as a scar throughout her life. An example of this might be a patient who rejected all things religious or spiritual due to sexual molestation by a priest. A second negative influence might have manifested through a particularly punitive view of God communicated through one's religion or one's interpretation of spiritual or religious doctrine. Finally, in integrating spiritual or religious practices in therapy there was the potential for clinician proselytizing or judging a patient based on one's own beliefs. For example:

> "I think if we try to impose any of our beliefs on a client or patient, that's a stumbling block."

> "I know the challenge for me, growing up in a very traditional Catholic family and still practicing as a Catholic, is to not let that interfere with the work I do. (To not) make judgments and moral values."

> "The biggest obstacle (for me) is value judgments, something I have to be aware of and not act on it."

One clinician shared his experience with couples counseling. He was challenged to meet the patients where they were at and not impose his values onto their situation:

> "I'm thinking of particular couple I'm working with where they've got all kinds of issues in their relationship and the one that they keep coming back to, that brought them in, is how they create a budget together. And the husband says, "We've got to work on this. This is the only way things go. We can't do anything else but this." I'm being challenged to approach this work in a very different way than I usually do. And the spiritual beliefs or the concepts that I

> usually use aren't going to work right now. I've got to somehow approach this in a different way. I'm not sure how I'm going to do this yet, but … in some ways I'm going along with him, and … we'll get to the deeper issues later if we can get something accomplished here."

Some clinicians felt challenged when they did not agree with their patient's religious views. For this clinician, the challenge did not feel as if it was met effectively:

> "With Evangelical Christians sometimes who are sure of a very literal understanding of what's in the Bible. I'm thinking about a couple and they had that kind of religious background. I never resolved how to deal with it other than to be quiet and listen to it. But it just was in the room and I just listened. But it was a real feeling of discomfort on my part because it was so literal. I wasn't uncomfortable with their Christianity; I was uncomfortable with a fanaticism, a kind of a rigid belief. That's really different from the way I think about things. I didn't challenge it in a way or ask what if you thought about it this way? Or could you imagine it being more compassionate? I just listened."

Another clinician would sometimes handle a similar obstacle by saying, "Let me refer to somebody who does (or is more familiar with)." Several clinicians reported that they would respectfully challenge what appeared to be beliefs that were contributing to the detriment of their patient. The challenge might be in the form of introducing alternate possibilities to the patient:

> "I have a client who is an alienated Catholic and felt very guilty about not liking the priest in her particular home church within a particular town and I said to her "Do you have choices?" And she said, "Well we should go." And, I said, "I know but where does it say that you have to? And, are there other Catholic churches? And do you know other priests? And, who do you gravitate to?" Kind of using the Jewish model like 'rabbi so and so'. And, guess what she did it! And, it was great. She said, "I asked father so and so if I could go to mass in his church and he said sure come on." And she was so grateful to me because it made all the difference in the world. Just to feel like she had a spiritual home again."

> "In the end I think it was a useful conversation, I wasn't saying, "Well, why is God running your life?" I was saying, "Well, could you think of God in a different way?"

Clinicians discussed when it was not appropriate to attend to religion or spirituality in a therapeutic setting. The primary indicator for clinicians was the patient's needs, interests, background and presenting issues, for example:

> "(It's not appropriate) when the client has made it absolutely clear. For example, a victim of sexual abuse by a priest and they were angry at the church. I'm not going to go there. I'm just going to listen to what happened and tread very carefully."

In addition to letting the patient take the lead, clinicians also considered the importance of distinguishing religion from spirituality when determining appropriate therapeutic modality:

> "I wonder if there are places where we absolutely would not attend to religion until we were directed to do so. But I don't think that means that we wouldn't be attending to spirituality. Again it gets back to the important question of how we define one versus the other."

Attending to spirit or religion could be a very simple and yet liberating process:

> "It is attending when my client says, "there must not be a God to make me feel like this." That's attending – that he could say that in the session. I'm not going to go into yes or no. When he talks, he talks. That's attending – I think. It's not saying that this isn't an issue we can't talk about."

Very few clinicians reported fostering relationships with churches, religious groups or other spiritually based community groups to use as a referral source in their practice. Clinicians reported that they did not have the time to familiarize themselves with many community resources. They did try to be aware of what was available in the

community. The referrals that clinicians did report occurred often in response to client's presenting as negatively impacted by religion. Often a clinician's response to a patient's difficulties with their religion was to attempt to introduce other avenues for spiritual and religious exploration. Sometimes this meant opening up the possibilities of breaking out of the rules of the religion in which they grew up. This process was paralleled with the rules of family conditioning and associated theoretically with object relations and attachment.

> "If I know of a meditation group or a yoga class or a group that sits and discusses (I will encourage them to attend). I have a client that wants to go back to church – has never been in a church that was welcoming to them and so we did some work around just asking questions and some staff took her to different churches so she could figure out what felt good to her and what felt right."

> "For me, a specific priest, rabbi that I know or pastor that has a human service background or something like that and (I know that) they are not going to be judgmental and be able to deal with issues such as sexual abuse by a priest or something that could help that person, I do keep a list in my head of who might match well."

CHAPTER V

DISCUSSION

One of the more striking findings of this research is the variability with which many clinicians apply spiritual principles into their practice. Not surprisingly, very few participants had received training in the use of religion and spirituality in clinical practice. This does not imply that clinicians are not effective in their applications of spirituality in therapy. As was seen, there was an element of mystery present that is intertwined in their work, and often, beyond words. Here, we see evidence that healing is as much an art as a science.

An interesting implication is derived from the definitions of religion and spirituality. Most of the participants had some difficulty defining spirituality and needed to refer to religion in order to ground their definitions. Respect and attention need to be given to the element of the unspoken, beyond words that are inherent in spirituality (Northcut, 2000). At the same time a spiritual process religiously adhered to would seem to be implicated for many clinicians (Trousdale, 2004). There was a minority of clinicians that did adhere regularly to a spiritual process. These clinicians expressed confidence in their approach and easily provided case examples.

In the discussions of religion and spirituality, there was a minority of respondents who related either concept to culture. The literature repeatedly points to the importance of culture in religious and spiritual expression in a clinical setting (Furman, Benson, Canda, & Grimwood, 2005; Keshen, 2006; Krause, Chatters, Meltzer & Morgan, 2000;

Northcut, 2000) in order to address the complexity of tradition in the way that religion is lived by people. This indicates a need for further education and training on cultural expressions of religion and spirituality.

With the above exception, generally, the definitions of religion and spirituality participants provided echoed much of what was found by other researchers. This included the association of religion with structure, community, rules, rituals, as a path to spirituality, and, the association of spirituality with meaning, connection, universal, and beyond words (Furman, Benson & Canda 2004; Furman, Benson, Canda, & Grimwood, 2005; Northcut, 2000). Participants provided many different definitions, especially for spirituality (Stewart & Mezzich, 2006; Trousdale, 2004). Also, clinicians echoed previous research that found religion can exist without spirituality and spirituality can exist without religion (Prest & Keller, 1993; Shafranske & Maloney, 1990).

Participants operationalized the definition of spirituality in case examples creating a safe space for the patient to experience mystery and healing. Further research and exploration might follow some of the specific questions outlined by Trousdale (2004) in order to facilitate a patient's use and understanding of spirituality in their own healing. Those questions might include: Who am I? Is there a power beyond what I see and, if so, what is it like? What is my relationship to others? The spiritual assessment tool developed by Stewart and Mezzich (2006) might assist clinicians in understanding their patient's relationship to spirituality. Further research on how to conduct a spiritual assessment is indicated.

An interesting example was provided of a Native American Pueblo and the view of spirituality they hold that it is woven throughout every aspect of life on the pueblo. Most participants would agree that they held a similar view of spirituality yet did not seem to have the systematic vocabulary to articulately describe their approach (Eaude, 2004). Many participants were aware of the spiritual presence in their life and yet not quite able to fully harness this power. There was a lack of certainty for many about how to apply religious and spiritual principles in their practice, although there was absolute certainty in its effectiveness and presence. This indicates a need for more education and training in the practical application of religious and spiritual principles in clinical practice.

The majority of participants in this study reported the use of mindfulness and meditation based clinical modalities in their practice. The reported effectiveness of these practices reflects outcomes in the large body of research on mindfulness and meditation in clinical practice (Elkman, Davidson, Ricard, Alal & Wallace, 2005; Kabat-Zinn, Massion, Kristeller, Peterson, Fletcher, Pbert, Lenderking, Santorelli, 1992; Ma, Teasdale, 2004; Melbourne Academic Mindfulness Interest Group, 2006; Simpson, Kaysen, Bowen, MacPherson, Chawla, Blume, Marlatt, Larimer; 2007; Smith, 2005; Teasdale, Williams, Ridgeway, Soulsby, Lau, 2000; UCA News, 2006). Clinicians in the current study reported the significant influence of their personal spiritual development on their clinical practice. Further research might quantify the clinician commitment and training to their own use of mindfulness and meditative practices and the specific uses of

these practices with clients (Melbourne Academic Mindfulness Interest Group, 2006; Smith, 2005; UCA News, 2006).

All participants emphasized the importance of the therapeutic relationship for effective healing. What was interesting was that this emphasis occurred within the context of the use of religion and spirituality in their practice. These results indicated the significance of transpersonal therapy that both focuses on the relationship as well as the importance of the clinician's spiritual life (Antoniou, Blom, 2006; Cashwell, 2007; Moxley, Washington, 2001; Whitehouse, 2006). Further research is suggested on the specific modalities used in a transpersonal approach, such as dream analysis, art therapy, and self-observation. The inclusion of aspects of transpersonal therapy in education and training may provide a broader base of clinicians with a framework and lexicon for the therapeutic process of transformation and transcendence (Krippner, & Feinstein, 2006; Moody, 2006).

Trends for the implicit and explicit use of spirituality found in previous research were generally confirmed in this research. For example, the use of prayer in session is generally driven by the requests and needs of the patient (Canda, Nakashima & Furman, 2004); there appears to be more use of an implicit approach to the use of spiritual interventions (Dwyer, 2008); an inclination to take the patient's lead (Canda & Furman, 1999; Lawrence-Webb & Okundaye, 2007); and a consciousness that something out of the ordinary has occurred (Scott, 2004).

A minority of participants in this study reported formal education and training on the use of religion and spirituality in clinical practice. This has been found as well by other researchers (Kvarfordt & Sheridan, 2007). There continues to be a need to develop more thorough ethical guidelines on how to have a spiritually based practice and the influence of setting (Canda, Nakashima & Furman, 2004). Interestingly, several of the suggested guidelines were being addressed by many of the clinicians in this study, such as self-disclosure, praying, hidden spiritual agendas, and religious bias. Guidelines for clinical supervisors in addressing religious and spiritual issues with supervisees and using spiritually based supervision techniques might also be helpful.

References

Al-Krenawi, A. (1999). An overview of rituals in Western therapies and intervention: Argument for their use in cross-cultural therapy. *International Journal for the Advancement of Counseling*, 21(1), 3-17.

Antoniou, A. S., & Blom, T. G. (2006). The five therapeutic relationships. *Clinical Case Studies, 5*(5), 437-451.

Becker, D. (2006). Therapy for the Middle-Aged: The Relevance of Existential Issues. *American Journal of Psychotherapy*, 60(1), 87-99.

Bergner, R. M. (1998). Therapeutic Approaches to Problems of Meaninglessness. *American Journal of Psychotherapy*, 52(1), 72-87.

Brefczynski-Lewis, J. A., Lutz, A., Schaefer, H. S., Levinson, D. B., Davidson, R. J. (2007). Neural correlates of attentional expertise in long-term meditation practitioners. *Proceedings of the National Academy of Sciences of the United States of America*, 104 (27), 11483-11488.

Brenner, M.J. & Homonoff, E. (2004). Zen and clinical social work: A spiritual approach to practice. *Families in Society: The Journal of Contemporary Social Services*, 85 (2), 261-269.

Canda, E. R. (2003). Heed your calling and follow it far: Suggestions for authors who write about spirituality or other innovations for social work. *Families in Society,* 84(1), 80-85.

Canda, E.R. & Furman, L.D. (1999). Spiritual diversity in social work practice. New York: The Free Press.

Canda, E. R., Nakashima, M., & Furman, L. D. (2004). Ethical considerations about spirituality in social work: Insights from a national qualitative survey. *Families in Society,* 85(1), 27-35.

Carson, J.W., Carson. K.M., Gil, K.M., & Baucom. D.H. (2004) Mindfulness-based relationship enhancement. *Behavior Therapy*, 35, 471-494.

Cashwell, C. S., Bentley, D. P., & Bigbee, A. (2007). Spirituality and counselor wellness. *Journal of Humanistic Counseling, Education & Development, 46*(1), 66-81.

Cupit, C. G. (2007). The marriage of science and spirit: Dynamic systems theory and the development of spirituality. *International Journal of Children's Spirituality,* 12(2), 105-116.

Dent-Brown, K. (2004). Developing a rating scale for projected stories. *Psychology and Psychotherapy: Theory, Research and Practice*, 77, 325-333.

Diseth, T. H. (Aug 2005). Trauma-related dissociative (conversion) disorders in children and adolescents – an overview of assessment tools and treatment principles. *Nordic Journal of Psychiatry*, 59(4), 278-292.

Dwyer, M. M. (2008). Religion, spirituality, and social work : a quantitative study on the behaviors of social workers in conducting individual therapy. (Master's of social work thesis. Smith College School for Social Work).

Eaude, T. (2004). Do young boys and girls have distinct and different approaches and needs in relation to spiritual development? *International Journal of Children's Spirituality*, 9(1), 0-66.

Eisdell, N. (2005). A Conversational Model of art therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 78, 1-19.

Elkman, P., Davidson, R.J., Ricard, M., &Wallace, B. (2005). Buddhist and psychological perspectives on emotions and well-being. *Current Directions on Psychological Science,* 14(2), 59-63.

Erricker, C. (2007). Children's spirituality and postmodern faith. *International Journal of Children's Spirituality, 12*(1), 51-60.

Furman, L. D., Benson, P. W., & Canda, E. R. (2004). Religion, spirituality, and geographic region in the USA: An examination of regional similarities and differences among social workers in direct practice. *Social Work & Christianity, 31*(3), 267-294.

Furman, L. D., Benson, P., Canda, E., & Grimwood, C. (2005). A comparative international analysis of religion and spirituality in social work: A survey of UK and US social workers. *Social Work Education, 24*(8), 813-839.

Gall, T. L., Basque, V., Damasceno-Scott, M., & Vardy, G. (2007). Spirituality and the current adjustment of adult survivors of childhood sexual abuse. *Journal for the Scientific Study of Religion*, 46(1), 101-117.

Gidley, J. M. (2007). Educational imperatives of the evolution of consciousness: The integral visions of Rudolf Steiner and Ken Wilber. *International Journal of Children's Spirituality, 12*(2), 117-135.

Haimerl, C.J. & Valentine, E.R. (2001). The effects of contemplative practice on intrapersonal, interpersonal, and transpersonal dimensions of the self-concept. *The Journal of Transpersonal Psychology*, 33(1), p. 37-51.

Hartelius, G., Caplan, M., & Rardin, M. A. (2007). Transpersonal psychology: Defining the past, divining the future. *Humanistic Psychologist, 35*(2), 135-160.

Hodge, D.R. & McGraw, D.D. (2006). Spirituality, religion, and the interrelationship: A nationally representative study. *Journal of Social Work Education*, 42(3), 637-654.

Hoffman, L. (2007). Paradoxes of Time in Existential Therapy: Can a Time-Limited Existential Approach Work? Review of Short-Term Existential Intervention in Clinical Practice. *PsycCRITIQUES*, 52(36).

Krause, N., Lindam, C., Meltzer, T. (2000). Negative interaction in the church: insights from focus groups with older adults. *Review of Religious Research*, 41(4), 510-533.

Kvarfordt, C. L., & Sheridan, M. J. (2007). The role of religion and spirituality in working with children and adolescents: Results of a national survey. *Journal of Religion & Spirituality in Social Work, 26*(3), 1-23.

Jacobs, C. (1997). Essay: On spirituality and social work practice. *Smith College Studies in Social Work, 67*(2), 171-175.

Jacobs, C. (2004). Review of spirituality and the black helping tradition in social work. *Psychiatric Services, 55*(6), 726-727.

Jacobs, C. (2007). Transformation and kaleidoscope memories. *Smith College Studies in Social Work, 76*(4), 113-123.

Keshen, A. (2006). A New Look at Existential Psychotherapy. *American Journal of Psychotherapy*, 60(3), 285-298.

Kirby, S. (2004). Dimensions and Meanings of Anxiety. *Existential Analysis*, 15(1), 73-86.

Krause, N., Chatters, L. M., Meltzer, T., & Morgan, D. L. (2000). Using focus groups to explore the nature of prayer in late life. *Journal of Aging Studies, 14*(2), 191

Krippner, S., & Feinstein, D. (2006). Psychotherapy in a mythic key: The Legacy of Carl Gustav Jung. *ReVision, 28*(4), 2-16.

Langdridge, D. (2006). Solution Focused Therapy. A Way Forward for Brief Existential Therapy? *Existential Analysis*, 17(2) Pg. 359-370.

Lawrence-Webb, C., & Okundaye, J.N. (2007). Kinship and spirituality: Utilizing strengths of caregivers. *Journal of Health & Social Policy*, 22(3), 101-119.

Ma, S. H. & Teasdale, J.D. (2004). Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. *Journal of Consulting and Clinical Psychology*, 72(1), 31-40.

McSherry, W. & Smith, J. (2007). How do children express their spiritual needs? *Paediatric nursing, 19*(3), 17-20.

Melbourne Academic Mindfulness Interest Group. (2006). Mindfulness-based psychotherapies: a review of conceptual foundations, empirical evidence and practical considerations. *Australian and New Zealand Journal of Psychiatry*, 40, 285-294.

Mercer, J. A. (2006). Children as mystics, activists, sages, and holy fools: Understanding the spirituality of children and its significance for clinical work. *Pastoral Psychology, 54*(5), 497-515.

Merriam Webster's Collegiate Dictionary, 10th E. (2000). Merriam-Webster, Inc., Springfield, MA.

Miller, L. 2006). Spirituality, health and medical care of children and adolescents. *Southern Medical Journal*, 99(10), 1164-1165.

Moody, H. R. (2005). Dreams for the second half of life. *Journal of Gerontological Social Work, 45*(3), 271-292.

Moxley, D. P. & Washington, O. G. M. (2001). Strengths-based recovery practice in chemical dependency: A transpersonal perspective. *Families in Society, 82*(3), 251-262.

Nixon, G. (2005). Beyond "dry drunkenness": Facilitating second stage recovery using Wilber's "spectrum of consciousness" developmental model. *Journal of Social Work Practice in the Addictions, 5*(3), 55-71.

Northcut, T. B. (2000). Constructing a place for religion and spirituality in psychodynamic practice. *Clinical Social Work Journal*. 28(2)155-170.

Pagnoni, G., Cekic, M. (2007). Age effects in gray matter volume and attention *Neurobiology of Aging*, 28(10),1623-1627.

Pearson, W. (2007). Integral counseling and a three-factor model of defenses. *Counseling and Values, 51*(3), 209-220.

Prest, L.A. & Keller, J.F. (1993). Spirituality and family therapy: Spiritual beliefs, myths, and metaphors. *Journal of Marital and Family Therapy*, 19(2), 137-148.

Pridmore, P., & Pridmore, J. (2004). Promoting the spiritual development of sick children. *International Journal of Children's Spirituality, 9*(1), 0-38.

Rubin, J.B. (1999). Close encounters of a new kind: Toward an integration of psychoanalysis and Buddhism. *The American Journal of Psychoanalysis*, 59(1), 5-24.

Scott, D. G. (2004). Retrospective spiritual narratives: Exploring recalled childhood and adolescent spiritual experiences. *International Journal of Children's Spirituality, 9*(1), 0-79.

Shafranske, E.P. & Malony, H.N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy*, 27 (1), 72-78.

Sheridan, M.J. (2004). Predicting the use of spiritually-derived interventions in social work practice: A survey of practitioners. *Journal of Religion and Spirituality in Social Work*, 23(4), 5-25.

Simpson, T. L., Kaysen, D., Bowen, S., MacPherson, L. M., Chawla, N., Blume, A., Marlatt, G. A., & Larimer, M. (2007). PTSD symptoms, substance use, and vipasana meditation among incarcerated individuals. *Journal of Traumatic Stress*, 20(3), 239-249.

Smith, J. (2005). Mindfulness-Based Stress Reduction as supportive therapy in cancer: systematic review. *Journal of Advanced Nursing*, 52(3), 315-327.

Steckler, L.H. (2006). Somatic soulmates. *Body, Movement and Dance in Psychotherapy*, 1(1), 29-42.

Stewart, C., Koeske, G.F., & Koeske, R.D. (2006). Personal religiosity and spirituality associated with social work practitioners'' use of religious-based intervention practices. *Journal of Religion and Spirituality in Social Work*, 25(1), 69-85.

Stewart, C. & Mezzich, A. C. (2006). The effects of spirituality and religiosity on child neglect in substance use disorder families. *Journal of Family Social Work, 10*(2), 35-57.

Tart, C. (2006). Current status of transpersonal psychology. *Journal of Consciousness Studies, 13*(4), 83-87.

Teasdale, J.D., Williams, J. M. G., Ridgeway, V.A., Soulsby, J.M., & Lau, M.A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting & Clinical Psychology*, 68(4), 615-623.

Trousdale, A. (2004). Black and white fire: the interplay of stories, imagination and children's spirituality. *International Journal of Children's Spirituality*, 9(2), 177-186.

Turner, R.P., Lukoff, D., Barnhouse, R.T., & Lu, F.G. (1995). Religious or spiritual problem a culturally sensitive diagnostic category in the DSM-IV, *The Journal of Nervous and Mental Disease*, 183, 435-443.

UCA News. (2006). Therapy for alcoholics uses meditation. *National Catholic Reporter*, 12, 5-6.

Wallace, B.A. & Shapiro, S.L. (2006). Mental balance and well-being. *American Psychologist*, 61(7), 690-701.

Watson, J. (2006). Every Child Matters and children's spiritual rights: does the new holistic approach to children's care address children's spiritual well-being? *International Journal of Children's Spirituality*, 11(2), 251-264.

Whitehouse, T. (2006). Transpersonal connection within psychotherapy. *Counselling Psychology Review, 21*(4), 4-17.

Yalom, I. (1989). Love's Exexcutioner & Other Tales of Psychotherapy. HarperCollins.

Yalom, I. (2002). The Gift of Therapy. HarperCollins.

Yalom, I. (2002). Religion and Psychiatry. *American Journal of Psychotherapy*, 56, (3), 301-316.

Zabat-Zinn, J.K, Massion, A.O., Kristeller, J., Peterson, L.G., Fletcher, K.E., Pbert, L., Lenderking, W.R., & Santorelli, S.F. (1992). Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. *American Journal of Psychiatry*, 149 (7), 936-943.

Appendix A

Email Recruitment Letter

Can spirituality and religion have a place in the clinical relationship?

We are looking for clinicians (psychologists - Ph.D. or Psy.D. - or master's level clinicians, social workers, pastoral counselors, family therapists) who have been licensed for at least 5 years who would be willing to discuss their perspectives on the relationship of spirituality, religion, and psychotherapy.

If you are willing to be in a focus group that will meet in the ____ **area on Saturday, _____, 2008** for one time and last for approximately two (2) hours on this topic, please email Julia Gallichio at jgallich@email.smith.edu.

If you know of colleagues who meet the criteria and

would be interested in participating in a focus group, please have them email Julia.

Your participation would be greatly appreciated and contribute to the continuing work done to strengthen spiritual or religious psychotherapy research and practice.

If you would like further information about this study, please contact:

Carolyn Jacobs, M.S.W., Ph.D.
Dean and Elizabeth Martin Treuhaft Professor
Smith College School for Social Work
Northampton, Massachusetts
sswdean@email.smith.edu

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Smith College School for Social Work
Office of Advancement & Alumni Affairs
Lilly Hall
Northampton, MA 01063
Telephone: 413/585-4290 or 413/585-7964
Fax: 413/585-7990
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Appendix B

Focus Group Discussion Guide

Spirituality and Clinical Social Work Practice

Introduction and Ground Rules (5 minutes)

Good afternoon and welcome to our discussion group. My name is________, and I work with Smith College School for Social Work, as a research assistant. The key reason why Smith College School for Social wanted to have this discussion session was to explore how religion and spirituality are viewed and incorporated, or not incorporated, in clinical practice. The School is very interested in your honest feedback. The School will use the information in a larger study on religions and spirituality in psychotherapy and will be compiled to help formulate more precise questions for future clinicians to consider on this topic.

Today's session will be an open discussion. Since we are a small group, we want you to feel comfortable and to really contribute to the discussion. Your ideas and comments are very important to us. My role will be to listen and guide us through the topics of discussion. We have a lot of material to cover. At times I may need to move us on even if a topic may inspire a great deal of interest. It is not that what you are saying isn't important but that we need to try to cover all of the topics in my outline.

Please speak clearly and one at a time so I can capture your comments and suggestions. It is ok to agree or disagree with each other. In fact, if I am doing my job right many different points of view may arise. All comments are welcome.

We are audio taping the session for report writing purposes. Your comments and identity will remain confidential. All remarks will be reported in aggregate without direct association to anyone.

Please feel free to use the restrooms and help yourselves to refreshments during the group. Any questions before we begin?

Participant Introductions (10-15 min)

Please introduce yourself by your first name only. Let us know how long you have been in practice and briefly tell us whom the primary population is that you serve. And, tell the group where you came from today.

(OVERALL – LISTENING FOR THEMES AROUND GUILT, SHAME, FORGIVENESS)

Defining Religion and Spirituality

Religion and spirituality can mean different things to different clinicians. Beginning with religion, how do you define religion? What is religion?

> Probe:
> How is religion different for you in your professional life and your personal life?

Now, how do you define spirituality? What is spirituality?

> Probe:
> What is the difference between spiritual needs and religious needs?

Would you give an example of how your definition/relationship with religion plays out in clinical practice? Think of a specific case from your practice to share with us. (May have them write it down and then share it.)

Would you give an example of how your definition/relationship with spirituality plays out in clinical practice? Again, think of a specific case from your practice to share with us. (May have them write it down and then share it.)

Would you give an example of how your personal religious or spiritual identity plays out in clinical practice? Again, think of a specific case from your practice to share with us. (May have them write it down and then share it.)

Intake and Assessment

Please describe your intake and assessment process with regards to spiritual and religious assessment.

> Probes:
> How do you determine that this was important to a client?
> Examples.
> Tools used?

Explicit and Implicit Use of Religion

Describe how your use of **religion** in practice is used explicitly. Probes: How does the client influence this process? How does the agency influence this process? How does your own religious practice influence this process? Please give an example from a specific case.

Describe how your use of **religion** in practice is used implicitly. Probes: How does the client influence this process? How does the agency influence this process? How does your own religious practice influence this process? Please give an example from a specific case.

Describe how your use of **spirituality** in practice is used explicitly. Probes: How does the client influence this process? How does the agency influence this process? How does your own religious practice influence this process? Please give an example from a specific case.

Describe how your use of **spirituality** in practice is used implicitly. Probes: How does the client influence this process? How does the agency influence this process? How does your own religious practice influence this process? Please give an example from a specific case.

Potential probes for this section:

Do you use ritual, prayer, meditation?

With which clients do you engage in a practice or ritual?

How do you know when it is appropriate?

How do you adjust for different populations? (e.g., age, race culture income, education, spiritual orientation/experience, couples, families)

Potential Negative Impacts

If a client seems negatively impacted by religion or spirituality, how do you work with this?

How can religion or spirituality be a hindrance in your work?

Probe:
What is the potential harm of integrating spiritual or religious practices?

How can the therapeutic relationship be affected negatively (e.g., transference, countertransference)?

Does the risk outweigh the harm?

Is there a spiritual bias in the field?

Recap of practices and discussion of personal practices (15 minutes)

What will the future bring in terms of religion and spirituality in clinical practice? What do you think will be in the best interest of the client?

Is there anything else anyone would like to add that we haven't covered?

Thank you for your input!

Appendix C

Informed Consent Form

Dear colleague,

Please allow me to introduce myself. I am Dr. Carolyn Jacobs, Dean and Elizabeth Marting Treuhaft Professor at the Smith College School for Social Work in Northampton, Massachusetts. I am engaged in a research project involving the role of religion and spirituality and its place in the clinical relationship. I am looking for licensed clinicians who have been practicing for period of at least five (5) years who would be willing to discuss their perspectives on the relationship of spirituality, religion, and psychotherapy. If you fall into this category and are interested, I am asking you to participate in a useful focus group to explore with other clinicians the relationship between religion, spirituality, and psychotherapy. Demographic information will be collected: gender, race/cultural background, age, education, spiritual/religious orientation and number of years in the field. My hope, in collecting the data, is to gather relevant variables and clarify questions for how clinicians can proceed in dialoguing about clinical integration, which is the use of spirituality or religion in psychotherapy. I am curious to hear an honest reflection of how you see religious or spiritual issues in the therapy room with clients.

The benefits of your participation include exploring your beliefs on religion and spirituality, and how you think about and behave towards clients' possible religious and spiritual issues. The results may contribute to the growing knowledge about the role of religion and spirituality in clinical practice and may be submitted for publication or presentation.

If you are a clinician (psychologist - Ph.D. or Psy.D. - or master's level clinician, social worker, pastoral counselor, family therapist) and have been licensed for at least five (5) years, can speak English, you can be a participant. The focus group will meet one time in the fall of 2008 or spring 2009 and will be lead by myself and/or my research principal assistant. I anticipate that the meeting time will take approximately two (2) hours. The focus group will be held at a university or agency meeting room, or focus group facility. There may be some parts of the final project that include quotes and statistics based on the findings from the interviews. All quotes and vignettes will be disguised. These will not be connected to any one person and no personal information will be given out in any publications or during presentations. Any data that is kept on a computer will have a disguised label and be password protected. The focus group session will be recorded and transcribed, and the transcriber will sign a confidentiality pledge. Please note that there is no compensation for participating. We will have refreshments during the focus group.

Participation in this study is voluntary and confidential, and participants will be asked to make a pledge of confidentiality regarding what is said in the focus group and the identity of the group members, however, the researcher can not guarantee that all participants will honor the pledge. You may decline to answer any questions or withdraw from the discussion at any time. Please be aware that the researcher will not be able to identify and extract the contributions to the process that participants have engaged in prior to withdrawal. For this reason it is not possible for participants to withdraw their participation after the completion of the focus group. In any publications or presentations, the data will be presented as a whole. Please be assured that any quotes and vignettes used for publications or presentations will be carefully disguised so that participants can not be identified. As required by Federal guidelines, all data will be kept in a secure location for a period of three years, and then they will be destroyed, unless it is still needed, in which case it will be destroyed after it is no longer needed.

If you have any questions or concerns about this study, you are welcome and encouraged to contact me, Dean Carolyn Jacobs, via email at sswdean@email.smith.edu , or by calling 413-585-7977. You are also welcome to contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

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

Signature *Date*

Appendix D

Demographic Questionnaire

1. *Number of years as a licensed practitioner: __________*

2. *Your Degree:*
   MSW MFT MA Ph.D. Other, specify: _____

3. *Agency based practice or private practice? (Percentage of time?)*

____

4. *Primary populations served (please identify by ethnicity, race, religion, age, family, individuals, couples, etc.):*

____

5. *Your primary theoretical orientation: __________________________________*

6. *Does your practice include any of the following? (Please check all that apply)*

- *Contemplative* ☐
- *Meditation* ☐
- *Mindfulness* ☐
- *Prayer* ☐
- *Meaningfulness* ☐
- *Story telling* ☐
- *Journaling* ☐
- *Art* ☐
- *Dance* ☐
- *Somatic/body-oriented work* ☐
- *EMDR* ☐
- *Other: ___________*

7. *Have you completed other training, certificates, programs, etc. in addition to your degree? Please list:*

____

8. *Your gender identification:*
   Female *Male* *Transgender* *Other identification:*

9. *Your Age:* ________

10. *Your racial identification:* ___________________

11. *Your personal spiritual or religious practice:*

____

12. *If you affiliate with a specific religion(s), please list here:*

____