

**UT-NASW
FRONT PORCH CE MODULE
REGISTRATION FORM**

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

EMAIL: _____

REFERRING CHAPTER (if any): _____

DATE COURSE COMPLETED: _____

NASW MEMBERSHIP NUMBER (if applicable): _____

**Mail completed quizzes and payment to:
UT-NASW
U of U College of Social Work #229
395 S. 1500 E.
Salt Lake City, UT 84112**

Instructions for Continuing Education

The Front Porch CE Module is a way for social workers and other licensees to gain continuing education in the convenience of your home and your personal time.

To take advantage of the continuing education, follow these steps:

- Read the nine essays contained in this booklet. Read each one of them twice. The first time you read them, read with the perspective of your experience and beliefs about your own spirituality. Then, the second time you read the essays, view them with the lens of your professional self and your service to clients.
- Complete the quiz using the answer sheet to record your answers. You must have 15 out of 18 questions correct to receive the verification for **4.0** CEU's. No retakes are accepted.
- Send the answer sheet and registration form to the chapter office. Staff will send you a CE verification within 5 business days.
- Include a check in the amount of \$48 members/\$60 non-members to **NASW**.

Each essay is used by the permission of the author(s) of the essay. All materials are copyrighted. None of the material can be reproduced in any manner without permission. For permission to copy any of the materials, make a written request to: Emily Bleyl, executive director, UT-NASW, U of U, College of Social Work #229, 395 S. 1500 E., SLC, UT 84112.

This Front Porch CE Module was funded by a grant from the Kansas United Methodist Health Ministry Fund and produced by the Kansas Chapter, National Association of Social Workers

“The views contained in this collection of essays are the views of the author(s) and do not necessarily reflect the views of the Kansas Chapter, National Association of Social Workers or the United Methodist Health Ministry Fund.”

NASW
Front Porch CE Module

Spirituality and Its Role In Mental Health

List of Essays

1. Starting Points For Spiritually Sensitive Mental Health Practice and Assessment

Edward R. Canda, Ph.D

2. Working With Spiritual Concerns In Mental Health Practice

Gene Deegan, Psy.D and Monika Eichler, LMSW

3. Spirituality In The Clinical Setting

Virginia McDonough, LCSW

4. A Joyous Collaboration? Social Worker and Clergy Working Together

Marion Bilich, MSW, Ph.D, Susan Bonfiglio, MSW

5. Using Christianity For Healing: One Woman's Journey

Connie Morris

6. Indigenous Practice Wisdom

Venida S. Chenault, MSW

7. Working with Gay, Lesbian, Bisexual, and Transgender Clients

Kathy Knobloch, MSW

8. Biophilia and Deep Affiliation With Nature: Implications For Social Work

Fred H. Besthorn, M.Div., MSW, Ph.D

9. Christianity and Mental Health: The Parish Nurse's Role In Holistic Health

JoVeta Wescott, RN, MSHA

Starting Points for Spiritually Sensitive Mental Health Practice and Assessment

Edward R. Canda, Ph.D

Introduction

The word psychotherapy literally means “healing for the soul.” The Greek root of “psycho” refers to breath, spirit, soul, and mind. Many languages note this connection between mind, breath, and spirit. Mental health is not just the absence of symptoms that relate back to mental disorders and maladies as listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). It is a dynamic condition of well being and well doing characterized by a sense of centeredness, clarity of perception and thinking, personal integrity, and relational responsibility. From a social work perspective, mental health practice should address the whole person in the context of his or her relationships and environmental setting. From the perspective of spiritually sensitive social work, mental health practice makes explicit this mind/spirit connection by honoring the whole person in environment with special attention to the way people work out a sense of meaning, purpose, and morally fulfilling relationships with oneself, other people, the world, and the ultimate ground of being, however one may understand it (for example, in theistic, atheistic, agnostic, animistic or other ways). In general, spiritually sensitive social work practice is not about imposing or restricting any particular religious beliefs or practices. However, it is about honoring the diverse religious and nonreligious ways that people find meaning, resilience, strength, resources, and creative transformation, even in times of joy and despair, crisis and stability, illness and ease.

In social work and related health and mental health professions, the past sixteen years has witnessed an incredible shift from major neglect of spirituality to a tremendous amount of research, educational and practice innovations, and publication on this subject (e.g. Canda, et al., 1999). In these fields, it is becoming common to define spirituality as having to do with people’s search for a sense of meaning, purpose, morality, and responsible relationship in the context of their understanding of ultimate reality or the divine (Canda and Smith, 2001). Religion refers to institutional patterns of beliefs, values, and behaviors concerned with spirituality and shared by a group with traditions developed over time (Canda and Furman, 1999). Thus, spirituality may be expressed through religion, but it need not be.

Spirituality as a resource for people with mental distress and illness

In the United States, most people profess some type of religious belief and affiliation and consider them to be important for their daily life and well being. Everyone is working out a spiritual path, whether or not one uses words such as spirituality, religion, and faith. Especially for people who face crisis, distress, serious illness, and disability, issues of spirituality often come to the forefront. Although people may experience harmful effects from unsupportive or damaging behaviors in religious and nonreligious spiritual groups and beliefs, there are a tremendous amount of spiritual resources to support mental health and resilience. Given the prevalence of religious and nonreligious spiritual perspectives, the universal human quest for meaning, and the opportunities for strength and resilience in spirituality, it is crucial for mental health practitioners to attend to spirituality.

There are now hundreds of quantitative and qualitative empirical studies about links between religion, spirituality, and health. For example, quantitative (statistical) studies have shown that religious commitment and participation are commonly associated with positive results such as:

lessening the likelihood of suicide and suicidal impulses; enhancing self-esteem; lessening the likelihood of illicit drug use; lessening the likelihood of alcohol abuse; lessening the likelihood of juvenile delinquency; increasing the likelihood of marital satisfaction and stability; lessening the likelihood and severity of depression; and decreasing the severity of psychological distress (Larson & Larson, 1994). In interviews with 40 adults who had severe mental illness, Sullivan (1992), learned that some people associated positive effects with social support experienced in religious communities; a sense of meaning and self-understanding, including dealing with a mental illness, gained from religious beliefs and spiritual perspective; positive feelings in response to prayer and worship; a sense of support and love from God or a Higher Spiritual Power; and spiritual perspective on ways to cope with and transcend a mental disability. These studies reinforce the importance of building on the strengths of people's inner spiritual practices (such as meditation, prayer, inspirational reading, and dream reflection) and resources (such as sense of loving relationship with the divine, personal wisdom, and spiritual experiences) as well as their outer spiritual support systems, such as religious communities, culturally based wisdom traditions, religious leaders and traditional healers, spiritual mentors, and wise relatives and friends.

Assessment of spiritual resources in a mental health context

In order to tap spiritual resources, helpers first need to know what they are for the mental health service consumer. One simple way to begin is to ask the person during initial assessment whether spirituality, religion, or faith are important to her or him in any way; and if so, would the person like to include them in the helping process. Then the consumer can describe what they mean to him or her and give examples. This can easily be done in the context of a strengths assessment by including spirituality as one domain of life to consider. Any such question should be open-ended and should allow the person to indicate whether spirituality is relevant, what words are appropriate to describe this aspect of life, and what ways, if any, spirituality should be addressed. In keeping with the NASW Code of Ethics and the principle of client self-determination, no particular ideological or religious agenda should be imposed or insinuated. On the other hand, social workers and other mental health professionals should not restrict or denigrate any particular religious or non-religious spiritual perspectives of clients.

Sometimes mental health professionals are reluctant to address religious and spiritual issues because they are worried about exacerbating delusions or hallucinations with religious content. This raises another more complex assessment issue: How to distinguish between psychopathology and spiritual experiences that may appear strange or problematic? Transpersonal theory in psychology and social work provides some helpful distinctions (Canda and Smith, 2001; Nelson, 1994). Assessment can explore distinctions between common qualities of some mental disorders and spiritual experiences and crises that are sometimes mistaken for psychopathology, such as: symptoms generated by organic disease (e.g. a brain lesion) versus absence of organic pathology; chronic long term debilitation versus short term incapacitation; subjective sense of meaningless chaos versus meaningful life disruption and transformation; disability versus intensified ability; incoherent speech versus poetry, metaphor and paradox; religious delusions versus spiritual inspirations; ego inflation versus ego transcendence and genuine humility; involuntary dissociation versus spiritual trance; hallucinations versus mystical visions and insights. This is complicated because spiritual crises and experiences can intersect with mental illness symptoms, and, in a more human way of putting it, people with serious mental distress and mental illness (and all of us are some point) may find some of the strongest insights, strategies, and environmental supports for dealing with the challenges through spiritual experiences and support groups. Further, some people endure periods of intense spiritual suffering and mental distress as part of the spiritual journey.

The DSM-IV-TR offers some cautions and help in this regard. DSM-IV introduced a V-Code, V62.89 Religious or Spiritual Problem, to be used when religious or spiritual issues are the focus of clinical attention but are not part of a mental disorder and may or may not be related to one (p. 741). Several sections of the DSM-IV-TR include cautions to complete diagnosis in the context of the person's larger life context, culture, and religion, so that inappropriate ethnocentric or religiously biased judgments are not made. Further, Appendix B (Criteria Sets and Axes Provided for Further Study) includes Dissociative Trance Disorder and Appendix I (Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes) includes guidelines for cross-cultural assessment, with many examples of religiously related types of distress or mental disorder. In general, the authors of successive editions of the DSM have been moving toward approaches to assessment that are more contextual, culturally aware, religiously informed, and based on international research.

Conclusion

There is a danger of drifting into a technocratic, expert-driven approach to studying, evaluating, and 'doing to' the client, while consider implications of diagnosis and assessment. That is far from what spiritually sensitive practice is about. Canda and Furman (1999) provided a comprehensive framework for spiritually sensitive social work practice. It can be summarized by going back to the link between spirit, mind, and breath mentioned in the beginning of this essay. Mental health practice should literally be a conspiracy between client and worker. The roots of the word conspiracy mean "to breathe together" or "to be together in spirit." The helping process is most powerful and satisfying when worker and client join in rapport and empathy, breathe together, get centered together, and work creatively together to enlist the highest, deepest, and widest resources for resilience and recovery. When we engage these resources, we can enjoy well being and health in a profound way even while we respond to the challenges of mental distress, illness, and disability.

References

- American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders, fourth edition, text revision. Washington, DC: American Psychiatric Association.
- Canda, E. R. & Furman, L. D. (1999). Spiritual diversity in social work practice: The heart of helping. New York: Free Press.
- Canda, E. R., Nakashima, M, Burgess, V. & Russel, R. (1999). Spiritual diversity and social work: A comprehensive bibliography with annotations. Alexandria, VA: Council on Social Work Education.
- Canda, E. R. & Smith, E. (Eds.) (2001). Transpersonal perspectives on spirituality in social work. Hazelton, PA: Haworth Press.
- Larson, D. B. & Larson, S. S. (1994). The forgotten factor in physical and mental health: What does the research show? An independent study seminar. MD: National Institute for Healthcare Research.

Nelson, J. E. (1994). Healing the split: Integrating spirit into our understanding of the mentally ill. Albany, NY: State University of New York Press.

Sullivan, W. P. (1992). Spirituality as a social support for individuals with severe mental illness. Spirituality and Social Work Journal, 3,1, pp. 7-13.

Further Resources

The Society for Spirituality and Social Work was founded at the University of Kansas in 1990. It is an international organization dedicated to an inclusive and respectful approach to spirituality in social work. Contact: Professor Robin Russel, Director, c/o email sssw@unomaha.edu or phone 607-777-2420.

The University of Kansas School of Social Welfare has several faculty, doctoral students and staff engaged in teaching and research on spirituality, mental health, and social work. Contact: Professor Edward Canda, Chair of the Ph.D. Program, c/o edc@ku.edu or phone 785-864-4720.

Pathways to Promise: Interfaith Ministries and Prolonged Mental Illness is an organization that promotes understanding, information, and cooperation among religious denominations regarding people with mental illness. It can be contacted at 5400 Arsenal Street, St. Louis, MO 63139.

Ed Canda, Ph.D, is a professor at the University of Kansas, School of Social Welfare. He researches, teaches, and writes on issues of spirituality. He is a founding member of the Society for Spirituality and Social Work. He can be reached at edc@ku.edu or 785.864.4720.

Working with Spiritual Concerns in Mental Health Practice

Gene Deegan, Psy.D and Monika Eichler, LMSW

When working with spiritual concerns in mental health practice, several questions seem to arise. One is "Why is it important?" Another is "Can I, as a professional, explore this dimension?" Finally, the question of "how" arises. In other words, "How does one approach this sensitive and often controversial area with clients?"

First we'll address the question of "Why is it important to address spiritual concerns?" At the National Mental Health Consumer's Self-Help Clearinghouse Summit in 1999, attendees were asked to reflect on the important aspects of recovery. They were asked, "What are the top priorities for supports necessary to the recovery process?" as well as "What are the values that are most important to recovery?" "Relationship with God" and "spirituality" were common answers to these questions. In our own research, 85% of those surveyed (professionals and consumers) believe that spirituality should be explored in the context of recovery. Similarly, 91% of those responding to an NASW survey by Canda and Furman (1999) said they have dealt with "nonsectarian spirituality in their practice."

In *Mental Health: A Report of the Surgeon General* (2001), David Satcher, M.D., Ph.D., highlights the importance of spiritual beliefs, practices and communities as mental health resources for members of minority groups and cultures. Such citizens are often reluctant to seek out help from the mental health establishment. They frequently use their indigenous spiritual resources as a natural alternative.

Since the 1980's, research has demonstrated a clear connection between spirituality and positive health outcomes, including less depression, less pain, greater health-related knowledge, and behaviors that enhance recovery from illness (Levin, 2001). In 1997, the Journal of American Medical Association published a special volume on spirituality, religion and medicine in which they urged physicians and medical educators to "become more aware of the importance of spirituality in patients' lives" (Levin, Larson, Puchalski, 1997). As a leader in defining standards of medical practice, the American Medical Association's acknowledgment of this importance marks a new era that encourages the exploration of the spiritual dimension in health care.

Now we'll address the question, "Can I, as a professional, legally and ethically respond to clients' spiritual concerns?" The First Amendment of the U.S. constitution guarantees freedom of religious expression. Interpreting this "religious freedom clause," recent Supreme Court rulings have required public agencies to provide reasonable accommodations to facilitate disabled clients' spiritual expression and development (McNeely, 1995). However, the "separation clause" of the First Amendment of the US Constitution prohibits: 1) promoting one religion or faith group over any other; 2) promoting a religiously based life over a secularly based life; and, 3) promoting a secularly based life over a religiously based life. Mental health professionals can respond to their clients' spiritual concerns. However, they must respect clients' own spiritual and religious inclinations, and not impose other spiritual beliefs, practices or values on them.

Finally, we'll address the question of "how" to approach spiritual concerns. As with all concerns, one should approach these with respect, tolerance and validation. Ethical standards from professional associations further guide our practice in approaching spirituality. According to the Code of Ethics for the National Association of Social Workers, for example, "Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests."

Using the resources described above, we have developed a few basic guidelines for our own practice. These include:

- DO: 1) Do facilitate the exploration of spiritual concerns, but only if our client's seek that exploration.
2) Do accommodate clients' access to spiritual resources in the community when needed.
3) Do refer to appropriate resources, especially when we don't feel qualified in a particular area.
4) Do follow our client's lead.
- DON'T: 1) Don't pressure consumers to explore spiritual concerns when they don't want to.
2) Don't judge the merits of clients' spiritual or religious beliefs.
3) Don't proselytize.
4) Don't encourage clients to follow our spiritual beliefs or practices.

The role of the mental health professional is to facilitate consumers' access to a spiritual life and spiritual resources, if these are sought, without imposing any specific spiritual beliefs or practices on them.

References

Canda, E.R. & Furman, L.D. (1999) *Spiritual Diversity in Social Work Practice: The Art of Helping*. New York: Free Press

Department of Health and Human Services (2001). *Mental health: Culture, race and ethnicity: A supplement to mental health: A report of the surgeon general*. Washington, DC: Author

Levin, J.S. (2001) *God, Faith, and Health: Exploring the Spirituality-Healing Connection*. US: John Wiley & Sons.

Levin, J.S., Larson, D.B., Puchalski, C.M. (1997) *Religion and Spirituality in Medicine: Research and Education*. JAMA, 278, 792-793.

McNeely, R. (1995). *The secularizing of the faith: Recent supreme court decisions regarding religion*. *Premise*, 2 (6), 8-15.

National Association of Social Workers. (1996). *The NASW Code of Ethics*. Washington, DC: Author.

Gene Deegan, Psy.D., program manager for consumer led research and training, at the University of Kansas, School of Social Welfare, Office of Mental Health Training and Research.

Monika Eichler, LMSW, is a research assistant at the University of Kansas, School of Social Welfare, Office of Mental Health Training and Research. Lawrence, KS 66044-3184.

To contact authors via email: gdeegan@ku.edu; monikae@ku.edu.

Spirituality In The Clinical Setting
Virginia McDonough, LCSW

Most of us have not been trained to consider spirituality in our overall assessment of our clients. This is changing. Since 1996, the NASW Code of Ethics has included the assessment of our client's spiritual life as one of several aspects of the client's overall psychosocial history. This may seem an intimidating mandate. But let us not confuse spirituality with religion. Religion can be thought of as the bridge to spirituality. Joseph Campbell suggests that today we are seeking new myths by which to give meaning and purpose to our lives. Whether through a formal structure such as religion or an informal process, the spiritual quest deepens our experience as humans and provides a web of connection to the community, the earth, each other, and ourselves.

By suggesting that we, as social workers, assess the spiritual dimensions of our client's lives, the NASW Code of Ethics is acknowledging the impact that the spiritual life has on the individual, couple, family and group. The spiritual aspect can have the same if not more influence on our clients as their physical, mental, and emotional life.

What does this look like in practice? Reviewing a national managed care company's Out-Patient Treatment Report from, sixty five symptoms are listed. Fully nineteen of the symptoms listed can be seen as spiritual issues. These include: excessive guilt, destructiveness, suicidal or homicidal ideation, hopelessness, etc. Although not labeled under the heading of "spiritual issues," we can agree that at the core, these issues are spiritual. So how do we approach this issue with our clients? We begin with where the client is at!

First, we allow the client to show us their personal spiritual domain—is this a resource of strength and courage to them or is it a source of guilt and frustration? By listening carefully, we can help the client shift to a more compassionate and accepting view of themselves.

Second, clients are not generally interested in our (social worker's) spiritual life other than to be reassured that we have one. Just as we do not try to influence cultural or physical aspects of our client's experience, we do not try to influence our clients regarding their spiritual experience. We can and should trust our clients to know what is right for them. We help our clients move to wholeness and wellness within their own frame of reference. Our task is to empower our clients to ask questions, feel their feelings, and explore options available to them and make appropriate choices. Those options might include prayer, meditation, intuition, ritual, ceremony, or service.

Third, we cannot expect to take clients where we have never gone. Our responsibility is to broaden ourselves to be ready to work in this area with comfort. This may mean that we are reading, working in a peer group, doing spiritually based retreats, or meditating and experiencing the seekers path. Clients will resonate with a clinician who is familiar on a personal level and at ease discussing the deeper meaning of life.

Fourth, the client has the answer—simply respect that and a great deal of work is already completed. Many clients are looking for the permission to question their experiences and feelings. "Is this okay? Do I have the right to question what I was taught or what I believed all my life?" Our role is to validate the right of our client to have their own thoughts, feelings, and experiences regarding spirituality. We know that the client is finding the right answer when we see the esteem level rise, the ability to affirm themselves is present, and the client moves from guilt and shame towards compassion for themselves and others. This is a process which, at its best, takes a lifetime for all of us.

Sources

Larry Dorsey, Healing Words

Stephen Levine, A Gradual Awakening

Lewis Mehl-Madrona, Coyote Medicine

Thomas Moore, Care of the Soul and Soul Mates

Virginia McDonough, LCSW, is in private practice in Illinois. She speaks nationally on spirituality and social work. She co-leads a Vision Retreat in Canada for social workers.

A Joyous Collaboration? Social Workers and Clergy Working Together

Marion Bilich, MSW, Ph.D and Susan Bonfiglio, MSW

Before you read any further, grab a piece of paper and make three columns. Write down the following three words: "Religion," "Spirituality," and "Clergy." Now, for each word, list everything that comes into to your mind--everything you associate with each word. Do not censor yourself. When you are done put this list aside.

What if we gave a party and nobody came? That is what happened in a mid-western town a few years ago, when a group of social workers and psychologists invited the clergy from the community to a get-together--a meeting aimed at giving mental health professionals and clergy an opportunity to learn more about each other. Only *one* member of the clergy showed up, *and he only came there to complain about secular psychotherapy!*

The rift between mental health professionals and clergy continues, but it is not only clergy who are wary. While social workers have become more aware of the valuable role spirituality and religion can play in the lives of their clients, few of us have reached out to the clergy in our efforts to bring a spiritual dimension into their work. Collaboration with clergy is a largely untapped resource, one that can enrich our work with a variety of clients--survivors of severe childhood abuse, people facing chronic and severe mental or physical illness, the dying.

Benefits of Social Worker/Clergy Collaboration

The benefits of social worker/clergy collaboration are many, among them,

1. *Consultation can bring a much-needed spiritual or religious dimension into therapy* - Our clients hunger for spiritual direction, yet few social workers have had the training (or until recently, the encouragement) to bring religious and spiritual issues into psychotherapy.

Sometimes, clergy can educate us about our clients' religious belief systems. Other times, we may turn to clergy to provide the spiritual direction missing from the psychotherapy sessions.

2. *Collaboration with clergy can broaden the client's social support network* - Social isolation is a serious problem for many clients, especially those with severe mental or physical disorders. The inclusion of clergy and other resources from within the client's religious community helps broaden the available support networks.
3. *Collaboration with clergy minimizes some problems associated by managed care* - Often managed care insurance programs offer inadequate psychological services for people with chronic mental and physical disorders. These individuals often require long-term therapy, well beyond the twenty or thirty sessions allotted to them each year. Collaboration alleviates the social worker's burden of providing *all* the care for the client.

Types of Collaboration

Social workers and clergy can work together in a variety of ways.

1. *Minister as Consultant* - When working with a deeply religious client whose faith system is unfamiliar to the social worker, consultation with clergy can be invaluable. This can be done on the telephone and with minimal time constraints.
2. *Social Workers as Consultants* - Clergy generally have little time or training to minister to the mental health needs of their parishioners. Ongoing contact with a social worker can provide the minister with much-needed information and suggestions on how to best serve the mental health needs of the congregation. Again, phone contact is often all that is needed.
3. *Limited Collaboration* - In such cases, the client sees the social worker for therapy, and the clergy member for spiritual or religious guidance, and both clergy and social worker maintain regular contact. This type of collaboration requires a greater degree of mutual involvement by the social worker and clergy.

4. *Full Collaboration* - This type of collaboration is most appropriate for clients with serious, chronic mental and physical illnesses--people whose lives have been so damaged that they require the resources of a wider community to heal. For the religiously oriented client this may involve utilizing their religious community. In this type of collaboration, social worker and clergy member are copartners. They not only meet regularly, but also meet with the client. Therapy sessions can sometimes include the clergy member. A full collaboration takes much time and energy, and unless both parties are willing and capable of making the commitment, other forms of collaboration should be considered.

Overcoming Roadblocks to Collaboration

1. *Preconceived Notions* - One of the first roadblocks with which we must deal is our own preconceived notions about religion, spirituality, and clergy. Take out the list you put aside earlier. Some of the words on your list may point to potential problems in your interactions with religious professionals. What does your list tell you about your own prejudices and judgments that will impact on your work with clergy? For instance, if the word "rigid" appears on your list in association with the word "clergy," this may suggest past experiences with clergy which must be worked through so that you can work together successfully in the present.
2. *Turf Issues* - Territorial and power issues endanger any effort at interdisciplinary collaboration. The collaboration must be an equal partnership with each professional having his or her own area of expertise and specialization. Equally important in minimizing potential problems is that each recognizes the *limitations* of his or her expertise. Early on, ground rules should be established about how turf issues will be handled as they arise.
3. *Ethical Issues* - Informed written consent is essential. The client must be made aware of any potential problems that could arise out of involving clergy in the therapy. It is essential to discuss issues of confidentiality with your client and with the religious professional.

The most important guideline we can offer is to *always put the needs of the client above all else*. No matter what the obstacle--be it a turf issue, a different value structure, a difference of opinion--all issues can be resolved as long as both clergy member and social worker keep this principle as their guide.

Interdisciplinary collaboration can be fraught with difficulties, but the benefits far outweigh the problems. We can learn so much from each other--and in turn add so much to the lives of our clients--through collaboration with clergy. With persistence and some reaching out, we really could look forward to an era of joyous collaboration.

The authors can be reached at sharedgrace@yahoo.com

Marion Bilich, M.S.W., Ph.D. is a psychologist in private practice in Hewlett, NY. She is the author of Weight Loss From the Inside Out: Help for the Compulsive Eater (Wellness Institute, 2000) and co-author of Shared Grace: Therapists and Clergy Working Together (Haworth, 2000).

Susan Bonfiglio, M.S.W. is a social worker in Woodmere, New York. She directs a psychiatric rehabilitation program, and is a co-author of Shared Grace: Therapists and Clergy Working Together (Haworth, 2000).

Using Christianity For Healing: One Woman's Journey

Connie Morris

I was reared in the Appalachian Mountains by abusive and violent parents. After their divorce I was subjected to an incestuous stepfather, which led to years of misery throughout my teenage and young adult life. Drugs, alcohol, various unhealthy behaviors, my own failed marriage, and two toddler girls preceded my appointment with spirituality and mental health. God's mercy was rich as I searched for a healthy, happy life. The following are excerpts from my autobiography "*From the Darkness*" released in Spring 2002 by Huntington House Publishers.

...The baby was due the end of January...they discovered the baby's heart was getting weak from the hard, yet unsuccessful labor. It was New Year's Eve; and Harvey had party plans that he wasn't going to have interrupted, no matter what... I had a device strapped around my belly that monitored the baby's heartbeat and the labor pains concurrently. We were both growing weaker and facing death...The baby's little heart finally gave up and stopped, announcing she had done enough and wanted to quit. I had felt the same way so many times in my life; but I was sure, since I had, she could also find the strength to live. I felt my own life slipping away as well; with mixed emotions I whispered in God's ear and asked Him to please help us survive.

...We cooked on an open fire or ate mostly cold foods. Jessica was growing out of baby food, and many times she ate canned green beans or carrots straight from the can. We sometimes showered in the rain or carried water from the pond, also on our property, for sponge baths. Harvey...hung a garden hose over the rail of the truck and water dumped out in one weak stream. We had a large, barrel-shaped cooler that we filled with water and placed Jessica inside for her bath. She loved it; I suppose she didn't know there was any other way to bathe...

...when it got late and she got sleepy, Harvey took off his black, leather, biker jacket and found a safe corner to hide it. He instructed Jessica to "guard" his most favored possession from being stolen, by lying on the jacket, and sleeping there until he came back for it. It was a routine they established and followed night after night. In her little heart, I think she knew Daddy would come back for his black, leather jacket, even if he forgot *her*.

...Incredibly I became pregnant again. ...Perhaps one child was sporting to Harvey...but he didn't cope well with the prospects of another baby. I was also in crisis... I honestly wasn't sure I had the strength or love to stretch far enough to cover this little baby.

...The fighting was getting dangerous. Harvey even chased me with an ax and swung at my advanced pregnant belly. Only my quick feet kept the baby and me alive. He was beating me worse everyday, using his fist and punching me in the belly. Unable to work, I stayed home with Jessica while each evening he prepared to go out and find a party. Many times he started a fight before he left and told me he would be back to kill me, often describing how he would do it and how much he was going to enjoy it...

...The congregation had been dismissed and people were filing out the door. I was collecting my child and our belongings (Harvey almost never went to church) when my Aunt Kay stopped to give me a hug. It made me cry. "You need to pray," she said sweetly. I nodded my head, chuckled, and said "Yea, I *sure* do." I didn't mean I *wanted* to pray, just that I was fully aware that my life was in shambles...my little girl and soon-to-arrive child deserved more than they were getting... things were downright terrible and I had no hope...but I *still* didn't *want* to pray! Aunt Kay motioned for some others to join her, "Connie wants to pray," she told them.

Everybody got so excited, I hated to let them down; so up to the altar they led me. Aunt Madge took charge of babysitting Jessica. Helen Patton took the right side; Aunt Kay, the left. Uncle Harold sat on the front pew smiling and hiding an occasional tear. I already had on my coat when I was pulled to the front. They didn't dare distract me by trying to remove it, so I knelt at the altar with it on. I knew how it was done and might have gotten through the scene without anything *really* happening, if only the Holy Spirit had stayed out of it. But He didn't (Thanks, Lord). Several others were gathered around and praying loudly for the forgiveness of my sins and courage to live for Christ. I listened to them more than I prayed for myself. I cried a lot just because I needed a good cry, not necessarily because I was sorry for my sins. They prayed for a long time, perhaps an hour; and then each one started giving me advice on how to be a Christian, and to not expect too much out of myself at first. "It's a growing process," they said. "Just trust the Lord; take it one step at a time; forgive yourself..." Sweat and tears were running down the side of my face; Helen Patterson laughed and squeezed me as she said with a country accent, "You've been diggin', Honey; you've been diggin'."

Then somewhere in all of that, it seemed the Holy Spirit whispered softly, simply, and only one time...something to the effect of, "How about it? Do you want to live for Me?" I sat back and pondered the thought. I didn't think I could really do it; I refused to be an unscrupulous hypocrite. It took mighty guts, like doing something heroic, to say, "Yes," in my heart. So after the praying was done, as we sat on the closest pew to relax and rejoice, I made the decision to live for the Lord Jesus Christ, the Son of God, the One who died a horrible death on the cross at Calvary for my sins. I didn't cry, laugh, or make any outward sign of my conversion. It was simply a decision, a stamp of ownership proudly and decisively pounded with one astonishing move of the hand of God. I knew it wouldn't be easy (it wasn't), and I might make a lot of mistakes (I *did*); it might even cost my life (it would, so to speak). My innate, stubborn disposition would not make it happen; but the love, forgiveness, and protection of God... would.

...We still didn't have running water in our home. Harvey had found a cheap water tank and cobbled it to run cold water into the bathroom and kitchen sink. We had a *real* toilet, which had to be flushed with a bucket of water (usually once every few days), that ran into a hole dug just behind the building...

...The incision on my stomach was nearly eight inches long and required special care, just as Lacy's little body did. It was typically hot and muggy; the flies swarmed freely through our opened doors. When the baby slept, I placed a fan directly in front of her and draped an old sheer curtain over her to keep the flies off. God protected us from infections and sickness that easily could have originated in such foul conditions...

...Revival broke out in our church... I wasn't really expecting it and (ashamedly) sure wasn't praying for it, but God gave it anyway. People reserved by nature were confessing sins and dancing with their whole heart to music that gave Jesus honor... People were slain in the Spirit from front to back and in between. At first I was too cold to reach out for the blanket. It was easier to remain snuggled up in my safe, protective world in which I had enveloped myself for thirty-four years. I was sitting in my pew, feeling lifeless and unmoved, as I watched miracles take place around me. The speaker, Mike Taylor, asked everyone to come to the front, take a piece of paper from the basket he provided, and write what we wanted most from God. I went forward like all good little Christians should, took the paper and pencil, and knelt on the floor with the others.

I considered what to write. I thought I should ask for my children to be mighty Christians, or for a wonderful marriage (now remarried)...I was trying to keep it down to something manageable by God. Out of the blue, I thought of writing, "I wish I had never been abused and raped." Time ran out, so I jotted down exactly that, tossed it back with scoff into the basket, and returned to my seat. A few moments later, while the worship team led us in songs of adoration, the Spirit of the Lord said to me, "I want you to thank me that you were abused." Had He been a human, I might have slapped Him! How dare He make such a request! ...But I knew the moment was mine to grab, if only I had the guts. Where I could hide from view, I went to the end of my pew and knelt in the narrow walkway next to the wall. At the time I didn't understand God's request. I told Him I would receive His healing, but could it please be private. I didn't want to hop, holler and hoot, or foam at the mouth like a demon-delivered deviant. That seemed to turn off the flow of the Lord, so I got up and went to the back of the church to wait for my family. They were all kneeling at the altar, taking care of their own business with the Lord. The exit to the sanctuary was in the back, with an overflow section positioned close by. I sat in the front pew of the added wing with my Bible and purse in tow, ready to make a quick get-away. Reflecting upon this reminds me how Satan slowly undermines our footing so we're unaware of an imminent, disastrous fall; I teetered on that tragic edge. I'm ashamed I allowed myself to entertain such a cold attitude. Two ladies started walking toward me, each coming from opposite directions.

I knew I was had! They sat on each side of me and started praying for me. Before long the Lord permeated my hardness.

...I doubled over in my seat, holding my stomach from gut-wrenching rips. I wailed like an angry toddler, not caring how I looked or how loud I carried on. The Lord pulled away heartache after heartache till I finally screamed in agony. That brought others to the scene; I prayed my children weren't watching, but if they were would God please help them understand.

...People were praying feverishly and making me wonder if I could take any more "healing." I thought about saying, "That's all folks. I've gone as far as I care to go. Stop praying now. I can't endure any more." But I yearned to be free of the cloud that loomed over me all my life. I was afraid if I pushed God away this time, He may never make the same offer again; so I continued with the process...it wasn't near being over. I leaned over the lap of a lady next to me; then I felt as though I might vomit. I *did* pull back at that moment and asked God to please not list regurgitation as a requirement in this course. With no waste can in sight, I thought of the nice, red carpet and decided to lie down on the floor. The nausea passed; but in rushed mighty, boisterous waves of cleansing. It started at my feet and moved up my perspiring body to the top of my head in vibrations that came again and again. Every speck of my body took turns tensing and releasing in sweet shivers. As my legs quit trembling and the river flowed against gravity up my body, my back arched and breathing ceased...I remembered the beatings, burnings, vile touches and words...my teeth even chattered as the river flowed through my mouth, cleansing my own fowl utterances. Then a few seconds of rest before it came again, beginning with my toes... the ones my mother used to kiss... then up and out. I visualized a maze so intricate that no mastermind could conquer it, yet here was the Holy Spirit weaving in and out with superior intelligence, knowing exactly what turn to take, erasing hidden secrets, and illuminating dark corners before exiting... then swiftly returning to another concealed passageway.

I'm guessing I was on the floor several hours. I could have stopped it at any time; I wasn't in a trance or outside of my body. I was fully aware of my actions, yet totally uninvolved in causing them. I made myself allow God complete control...well, that's not exactly true...I *could have* flopped like a fish there on the floor; I worked hard at holding my bones together as they rattled. Ezekiel 37:1-14 captures the idea better than I, "...can these (dry) bones live?...Oh Sovereign Lord, you alone know." In that passage, with a rattling sound, the Lord pieced together dry bones and recreated a breathing being...as He did in me...

It has become crystal clear to me that an alarming number of people are crippled by a life similar to that from which I was delivered. My life's passion is to reach out with hope to those whose hearts and lives have been brutally broken. That is why I tell my story with such candor...that is why I must.

*Connie Morris, now happily married to Kelly Morris, a rancher and plumber, resides in western Kansas on their 500 acre ranch. Her two daughters are now ages 20 and 17; both are living for Christ and are solid, happy young women. Connie is a first grade classroom teacher in a rural Great Plains. She may be reached at 785-332-2424 or at cmorris@nwkansas.com for more information, to schedule a public appearance, or to purchase a copy of "**From the Darkness.**"*

Indigenous Practice Wisdom

Venida S. Chenault, MSW

Discussions about the role of spirituality in the lives of people often evoke passionate discourse as diverse cultures and religious doctrines simultaneously intersect and diverge along a continuum of beliefs and practices. Recognition, tolerance, and respect for differences in the multiple ways individuals, groups, and cultures express spirituality, as well as the central role of spirituality in the lives of many individuals, families, and communities is critical. This essay will examine spirituality from the standpoint of “a” First Nations woman. It is not intended to represent a universal perspective of all Indigenous People, but instead may be useful in generating insight and discussion about the role of spirituality in social work practice.

The term spirituality is interpreted in many ways and it is important to understand spirituality from the perspective of the person being worked with. Spirituality refers to my connectedness with an essence of sacred and universal power that is not easily compartmentalized. As such, it affects my relationship with all that emanates from this power that I call Creator and is a way of life. This connectedness is not limited to people but to all that has been created, including the Earth, stars, the moon, the sun, the plants, the waters, and animals.

The cultures of First Nations People are rich with spiritual traditions although we may or may not be associated with formal institutions, such as churches, or meet on days set aside for religious activities within a mainstream society. My expressions of spirituality may be carried out at any time or place, individually or through community gatherings, lasting from hours to days. The long history of religious oppression and more recently New Age appropriation of Indigenous spirituality has produced a guardedness that may be difficult or impossible to overcome with some First Nations People. This context needs to be considered and respected when difficulties arise related to spiritual assessment.

The empowerment of Indigenous People can take place in many ways, including honoring the right to determine when and if it is appropriate to discuss matters of spirituality. Assessment that includes questions related to religion might be expanded with First Nations People to include items that ask, “are traditional Indigenous or Native American spiritual practices a part of your religious beliefs?” If an individual responds affirmatively, one might follow up with a question such as, “are there specific practices that I need to be sensitive to while you are here.”

The setting and nature of the work to be done should also be considered. In some situations, issues of spirituality are paramount while they may not be as critical in others. For example, it is not uncommon when an individual is seriously ill or near death to have many visitors from one’s community come and offer support to the person and their family. Such support can include prayers, singing of chants or songs for the person, placement of spiritual objects near the person or placing or burning small amount of cedar, sage or sweet grass in the room of the person.

In some cases, this will need to be negotiated with the family, particularly if it creates problems, i.e., smoke alarms sounding, but the emphasis should be on trying to accommodate that which is doable. Early assessment will reduce unnecessary problems and stresses associated with such crisis.

Spiritual voyeurism, described here as an inappropriate demand to know details of spiritual practices or ceremonies that are not relevant to the overall needs of the client should be avoided. If an individual indicates they do follow traditional practices or identifies a religion you are not familiar with, this information in itself, along with the suggested follow-up questions should be adequate. Prying into details that may have culturally imposed restrictions may undermine the relationship being established and may be considered as disrespectful behavior. Understand that when Indigenous People come together for ceremonies, we pray, just as others do when they attend church or enter mosques or synagogues.

While there are many established Indigenous religions, many will be unfamiliar to those outside tribal communities and most will not be included on lists of religious preferences. If the intake records are marked with other for religious preferences, a quick assessment as discussed earlier may be useful. In some settings, it may be useful to inquire whether there are helpers or other people in the community who also treat the kind of problem the person is experiencing. Referral to these individuals may be useful if the treatment available in your agency doesn't produce the desired results and they may also serve as a culturally appropriate support network after the individual has completed your requirements. I have referred Hmong individuals back to Hmong spiritual practitioners when individuals have described imbalance in their lives, as well as First Nations people back to traditional medicine people as legitimate alternatives.

Venida Chenault is a professor at Haskell Indian Nations University in Lawrence, Kansas.

Working with Gay, Lesbian, Bisexual, and Transgender Clients
Kathy Knobloch, MSW

“Trying to be what others want us to be is a form of slow torture and certain spiritual death” (Anne Wilson Schaef)

Most of us question who we are, why we are here, and what is our purpose in life. These are spiritual questions. These are timeless questions, with ever-changing answers. The spiritual is not static; it is a process. The questions are not answered by others, but through a very personal journey of discovery.

My personal journey included the dominant and popular societal belief that heterosexism is superior and acceptable. Rather than facing exorcism, I shifted into automatic pilot, dating boys, marrying a man, and having children. The road on the journey came to a crossroads when I found my marriage was shambles and my alcohol consumption a problem. For the first time in many years, I came face to face with myself and all the questions I had chosen to ignore to follow the easier, softer way.

Seven years later, here I am, a recovering alcoholic and a lesbian in a committed relationship with another woman. I asked the questions and wrestled with the answers. It was a pain-filled process, questioning religious beliefs, family beliefs, and societal beliefs; moving from the embracing arms of society to the fringes, from the acceptable to the questionable.

My journey is not unique in the gay, lesbian, bisexual, and transgender community. Many have been married, their stories more painful than mine. The friend whose two children were taken away in a custody battle, the friend whose children have disowned her, or my partner whose mother is convinced she will burn in hell. Many stories which portray pain, loss, and grief.

My personal journey is intertwined with my professional one, starting an agency working specifically with gay, lesbian, bisexual, and transgender (GLBT) clients. Especially for those first coming out, many of the questions are about religious beliefs. Father Leo Booth (1991) defines religion as a belief system organized around a prophet, teacher, or set of human precepts. A group shared system of thought and action that offers the individual a frame of orientation and an object of devotion. If the religious denomination you were raised in condemns homosexuality, the “frame of orientation” becomes an obstacle, the “object of devotion” your judge and juror. The “group shared system” now rejects you, and may even persecute you. Where you were once accepted, you are now an exile.

The Handbook of Nursing Diagnosis defines spiritual distress as “the state in which an individual or group experiences or is at risk of experiencing a disturbance in the belief or value system that provides strength, hope and meaning” (Carpenito, 1993, p. 301). For many GLBT people, their religious faith and the community of the church did provide strength, hope, and meaning. When abandoned by their faith community, the process of finding new avenues and new communities to provide these needs may be long and arduous. The very values underlying these precepts also come into question.

A young gay client is trying to re-define his values since coming out. His parents and his church reject and condemn his homosexuality. Not only does he question the beliefs of his faith, but also asks, “what are family values?” He no longer experiences the parental love, acceptance, and support he grew up with. Another issue he faces is that of his own bigotry and prejudice, for he describes himself as having been “just like his parents.” So, another task is also to forgive himself for the way he treated homosexuals in the past. He is on a quest, looking into other religious denominations and faith communities, discovering what his personal belief system consists of, and what a relationship with God really means to him as a young gay man.

When losing one's religious faith and support, the questions get very personal and the spiritual questions arise. There are varying definitions of spirituality, but all seem to include a relationship to ourselves, others, and the Divine. Shafranske & Gorsuch (1984), describe spirituality as the courage to look within and to trust. What is seen and trusted appears to a deeper sense of belonging, of wholeness, of connectedness, and of openness to the infinite. For GLBT people, the nature of the abuse by religious institutions leads them directly to the path of spirituality. Re-defining God or a Higher Power is a high priority. Finding a supportive community, usually consisting of other gay people, provides the sense of belonging and connectedness, which may have been severed by families, churches, and society. Families of origin may have rejected the GLBT person, so some may have families of choice, rather than "blood."

Society defines homosexuality as "abnormal" because of the attraction to members of the same gender. This may cause a serious rift between one's sexuality and spirituality. Sex is a curse, rather than a blessing. This becomes a process of integrating one's sexuality with spirituality, as sexuality is something within, which is expressed as part of the self. Not accepting our sexual energy causes a rift between the physical and the spiritual, and a lack of intimate connectedness with a special other. When society's view of morality does not accept same-gender sexual attraction as a viable expression of love, GLBT people are not validated at one of the deepest levels of intimacy possible.

Spiritual well-being is defined as a secure set of meta-empirical and natural beliefs and values giving rise to an inner hopefulness about the ultimate meaning and purpose in life, providing a deep peace that is a source of joy in living as well as courage to confront suffering, and an active connection with others and the universe (Kelly, 1995). The active oppression, discrimination, and even hatred of GLBT people constricts and represses their physical and spiritual well-being. As social workers working with GLBT people, walking the spiritual journey with our clients is inevitable.

References

Booth, L. (1991). *When God becomes a drug: Breaking the chains of religious addiction and abuse*. New York: G.P. Putnam's Sons.

Carpenito, L.J. (1993). *Handbook for nursing diagnosis*. Philadelphia: J.B. Lippincott.

Elkins, D.N., Hedstron, L.J., Hughes, L.L., Leaf, J.A., & Saunders, C. (1988) Toward a humanistic-phenomenological spirituality. *Journal of Humanistic Psychology*, 28, 5-18.

Kelly, E.W. (1995). *Spirituality and religion in counseling and psychotherapy: Diversity in theory and practice*. Alexandria, VA: America Counseling Association.

Kathy Knobloch is the director of a community based program serving gay and lesbian persons in South Dakota.

Biophilia and Deep Affiliation With Nature: Implications For Social Work

Fred H. Besthorn, M.Div., MSW, Ph.D

People of diverse backgrounds have long held that natural settings are good for the mind, body, and spirit. Around the world, untold numbers of people gaze out a window at a scene of trees and grasses or tend a small garden and feed a deep sense of satisfaction.

At any given moment, a child or elder picks up a cherished pet and feels less alone and more loved. In 1984, evolutionary biologist and then Harvard professor, E.O. Wilson, concluded after a generation of research that these phenomena and countless others like them furnish compelling evidence of what he called the Biophilia Hypothesis. Wilson and other biophilia theorists since have asserted that human beings not only derive specific aesthetic benefits from interacting with nature, but that human species has an instinctive, genetically-determined need to *deeply affiliate* with natural settings and lifeforms. Wilson (1993) contends that the desire to affiliate with other sentient, non-human organisms and ecosystems and the response people have to them is innately biological and intensely emotional. The human response to these affiliations have complex benefits which not only enhance our psychic and physical well-being, but are critical to our evolutionary survival as a species.

The conceptual essence of biophilia is that human beings have a need—a biological imperative—to connect with nature in order to maximize our potential and lead productive, fulfilling lives. According to Robert Ulrich (1993), biophilia researcher, humanity's eons old *affiliation* with nature conferred advantages in humanity's effort to survive throughout history and that people continue to need and value nature precisely because of the genetically encoded *adaptive benefits* it has offered us physically, emotionally, and intellectually (Kellert, 1997).

For social work, the story of nature has been quite different. Social work has always had an ambivalent understanding of its relationship to the natural world. The profession has consistently claimed for itself and ecological awareness. Our person/environment, ecological, and ecosystems models of practice have centered the profession's attention on the link between the individual and their unique surroundings (Besthorn, 1997). Indeed, few social workers would allege their professional orientation is not guided by some form of environmental or ecological consciousness. Yet, social work's conventional environmental models, with few exceptions, have shown an almost complete disregard for integrating a comprehensive understanding of the connection between person and the natural environment and the way we derive individual and collective meaning from this association (Besthorn, 2000).

Biophilia offers social work a fundamentally different view of the person/environment construct and argues for the primary shift in the way the profession views its relationship with the natural world. There is little dispute that experiencing nature and finding intense connections with animals enriches people's lives in ways never before understood. Nature, in all its forms, is a critical ingredient for healthy development and realization of full human potential. It is certainly essential for our survival. Our biophilia propensities represent a vast accumulation of resources critical to the way social work understands and responds to the physical, psychological, social, and spiritual development and well-being of the clients it serves.

Biophilia is compatible with the core values and concerns of social work. Like social work, biophilia theory recognizes the intrinsic worth and dignity of all human beings inasmuch a biophilia respects the significance and integrity of all beings. Biophilia acknowledges the complex interrelatedness of life. This means that all living organisms, not just a select few, have inherent value.

Biophilia has great potential for social work practice settings as well. natural settings can assist in reducing levels of stress, promote healing, and aid in problem solving. Social workers can begin to employ natural elements in interventive settings. The design and siting of buildings and practice spaces is an essential place to begin. Observations from windows can include natural views, gardens, or nicely landscaped areas.

The social work profession has as one of its missions, the enhancement of human well-being. Nature, mediated through our biophilic attachments, offers an essential vehicle for human identity formation and a tool for healing, both individually and collectively. However, increasing sprawl and consumerism have diminished vast areas of natural habitat and caused immense declines in biological diversity. The question now facing us is, do the prospects of these habitat and species' extinctions pose a serious threat to the welfare of humanity? More specifically, can we and the people we serve, experience full lives with material, emotional, and spiritual significance if the natural environment is substantially diminished and degraded? Biophilia would suggest the answer is an unequivocal, "no."

Resources

Besthorn, F. H. (1997). Reconceptualizing Social Work's Person-in-environment Perspective: Explorations in Radical Environmental Thought. *Dissertation Abstracts International*, 58(10A), 4067.

Besthorn, F. H. (2000). Toward a Deep-Ecological Social Work: Its Environmental, Spiritual, and Political Dimensions. *The Spirituality and Social Work Forum*, 7(2), 2-7. Brookfield, VT: Ashgate Publishing.

Kellert, S. R. (1997). *Kinship to Mastery: Biophilia In Human Evolution and Development*. Washington D.C.: Island Press.

Ulrich, R. S. (1993). Biophilia, Biophobia, and Natural Landscapes. *The Biophilia Hypothesis*. Washington D.C.: Island Press

Wilson, E. O. (1993). Biophilia and the Conservation Ethic. *The Biophilia Hypothesis*. Washington D.C.: Island Press

Fred H. Besthorn, Ph.D, is Assistant Professor of Social Work at Washburn University, Topeka, Kansas. Dr. Besthorn is a founder of the Global Alliance For A Deep Ecological Social Work (GADESW). He writes and speaks on the subject of person/environment practice. He can be reached through the website, www.washburn.edu/ecosocialwork.

Christianity and Mental Health: The Parish Nurses Role in Holistic Health

JoVeta Wescott, RN, MSHA

The role of the parish nurse is to offer health promotion and prevention in a holistic way (body, mind, and spirit), oftentimes helping others through the healing process. In this context this issue becomes more manageable.

Mental health can be viewed as a negative or a positive. Negatively many think of diagnosed mental illnesses (clinical depression, paranoid, bipolar, schizophrenia, etc.) In our society, including the Christian community, there continues to exist a stigma about mental illness. Can you have a mental illness if you are Christian? Do Christians get a diagnosis of cancer? Absolutely. We, as Christians, are not exempt from the disease/illness process. However, the way we handle it may, or may not, be different.

If we, as Christians, can look at the issue as one part of the healthcare picture, would our response be positive and, then, could we affect how others view mental “health?” If we truly believe that God loves us can we be the “skin on” God that makes that love become alive and real? Can we be part of the process of helping someone become “healed” --- whole-- even if the person has an illness? Parish nurses believe that physically sick, dying persons can be healed even though life on this earth will end for them. Do we need to examine our beliefs about mental health and illness to see if our beliefs reflect the light of God’s love and truly the healing (versus curing) of a person?

We view darkness as negative, light as positive. Oftentimes, mental illness is spoken of as a darkness. Christianity and light are synonymous. For many people the world is a dark and lonely place. The Christian light is one that shines from within and warms the heart and illuminates the dark recesses of the mind, body, and spirit. It is a gift we can give to others. There is a story about a young girl who purchased a Christmas decoration. It was an 18 inch plastic star that was strung with small white and gold Christmas lights. She hung it in her living room window. She noted how beautiful it was when she viewed it from the outside of her 5th story government housing project home. The light shone brightly whether anyone saw it or regardless of how cold it was. What if we could share the gift of love that God gave to us through his son Jesus so that everyone would know and believe that their light was shining and bright whether it was being admired or ignored? Isn’t it indeed the shining light itself that is important?

What if we left our lights plugged into Jesus all the time? Wouldn’t it continue to shine brightly? As humans we get so hung up on whether we “feel” something or not as the test of whether it is “real” or not.

My belief is that the shining of the light is important, whether or not I feel I am making a difference in someone else’s life. Someone may be stumbling in discouragement, sadness, or fear and in need of the light that we can give. Whatever light you offer may be a beacon Of hope and encouragement in someone's darkness. And if you feel that your light is no more than a candle in a forest, remember this -- there isn't enough darkness in the entire world to put out the light of one small candle.

As a parish nurse the resurrection experience of death to life seems to present itself as a way of walking the path to “good” mental health. Because of the resurrection of Jesus I can offer hope to believers and non-believers. Because of the resurrection I know about sin and forgiveness. Sin cripples the Christ in me and in others. It takes away my opportunity to see Jesus in the face of my brothers and sisters.

A grateful heart is required of the Christian. Being able to forgive to the point of gratitude is not magical but it can bring healing. Forgiveness to the point of gratitude is, for the Christian, a way of allowing God to heal in the way He wants to and in His time frame. God does not promise to take away disease/illness from us but He does promise to walk with us on the journey. Forgiveness can be the tool that heals the mind and spirit, oftentimes leading to a physical healing as well.

The parish nurse role includes being a counselor, an educator, or a referral agent. In these roles, s/he may provide the listening ear and heart. She may do a depression screening and make a mental health referral or she may give an educational workshop on how to eliminate bad stress and maintain a healthy mental attitude.

As a parish nurse I must be willing to go deep inside to find the answers to life. I cannot share with you what I am afraid to tell myself. I have to surround myself with good people so I learn how to trust others and God. I have to be willing to share what is in my heart. I have to allow myself to become who I really am. When I allow myself to start this journey then I am able to reach out to others. By walking the road and meeting the wounded I then give them permission to look inside themselves and discover the real person that exists. Because we live in a relationship oriented world we need each other to be mentally, physically, and spiritually healthy. All it takes is a moment to reflect on a time in life when loneliness, depression or perhaps homesickness prevailed and the value of relationship becomes valid and important. We know in grief work that once a person reconnects with someone the work of grief becomes manageable and the light at the end of the tunnel can be seen by the naked eye. Relationships are healing as they offer what might be while fostering wellness.

To go within one has to develop a keen sense of humor. According to research, laughing may be one of the healthiest things that can be done to maintain or restore holistic health. As early as the 1970s Norman Cousins found while writing *Anatomy of an Illness* that ten minutes of belly laughter relieved pain for up to two hours. Laughter has the effect of sweeping out the cob webs of our mind, lightning the weight in our hearts and erasing pain in our bodies. My recent experience with an illness reinforced the importance of laughter therapy as part of the healing process. Laughter and relationships embraced my soul as I physically, mentally, and spiritually healed.

Christianity calls us to a life of acceptance – acceptance of people where they are, acceptance of who they want to become. Acceptance can be powerful, joyful and freeing, leading one to a healing experience and a truly healthy body, mind, and spirit. Jesus continually spoke about acceptance and loving one another under all conditions. He literally resurrected people from life to death. Our call is the same and our actions as Christians are the evidence of the fact that Jesus Christ does indeed still live among us. The role of the parish nurse is to respond to that call in her faith community and in her world. The call is to let the light shine -- to bring healing -- to bring the living Jesus into our world.

JoVeta Wescott, RN, MSHA
Manager, Parish Nursing Services
Via Christi Regional Medical Center
1148 S. Hillside, Ste. 11
Wichita, KS 67211
316-689-5152
FAX 316-691-6716

e-mail: Jo_Veta_Wescott@via-christi.org

Front Porch CE: Spirituality and Its Role in Mental Health

Continuing Education Quiz

- 1) In social work and mental health professional literature, the concept of spirituality is most closely related to:
 - a. sense of meaning.
 - b. understanding of ultimate reality or the divine.
 - c. participation in community rituals.
 - d. both a and b

- 2) Empirical research about the mental health effects of religious commitment and participation show that they are often associated with:
 - a. lessening the likelihood of drug and alcohol abuse
 - b. increasing the severity of mental distress
 - c. social isolation
 - d. increasing severity of depression

- 3) According to guidelines in DSM-IV-TR, assessment of a mental health consumer's spiritual experience should take into account:
 - a. the person's religious beliefs.
 - b. cultural variations in the way mental health and illness are shaped.
 - c. possible interrelation with mental disorders.
 - d. all of the above

- 4) The United States Constitution:
 - a. does not address responding to spiritual concerns for people with disabilities.
 - b. says you can discuss spiritual matters as long as you share the same spiritual beliefs as your client.
 - c. requires public agencies to provide reasonable accommodations facilitating disabled clients spiritual expression and development.
 - d. promotes secularism over spirituality in public agencies.

- 5) In addressing spiritual concerns in a mental health setting:
 - a. it is suggested to refer clients to appropriate resources, especially when you do not feel qualified in a particular area.
 - b. do not encourage clients to follow your spiritual beliefs or practices.
 - c. do not pressure consumers to explore spiritual concerns.
 - d. all of the above

- 6) The clinician should:
 - a. expect to instruct the client on spiritual issues.
 - b. not be responsible for having some experience with spirituality.
 - c. validate the right of clients to question their spiritual experience.
 - d. none of the above

- 7) The spiritual quest deepens:
 - a. the clinician's understanding of the client
 - b. the client's experience as a human.
 - c. the connection to the community, the earth, each other, and ourselves.
 - d. all of the above.

- 8) In overcoming roadblocks to social worker/clergy collaboration, the social workers should always:
 - a. consult with an attorney.
 - b. put the needs of the client first.
 - c. take charge.
 - d. yield to the values and beliefs of the clergy.

- 9) You are working with a religiously committed Catholic woman and you would like to consult with her priest. The first thing you need to do is:
 - a. Call the priest and see if he is interested in working with you.
 - b. Ask the priest to attend a session.
 - c. Speak to your client and obtain an informed consent.
 - d. Get a colleague's opinion.

- 10) Who was Aunt Kay?
 - a. A nickname for moonshine.
 - b. The mother.
 - c. An abusive and cruel person.
 - d. The person who initiated the first spiritual change.

- 11) Sensitivity to the diversity of Indigenous spiritual practices can be improved by:
 - a. Determining the extent to which protocol within agencies confine definitions of appropriate or legitimate religious or spiritual practices.
 - b. Acknowledging and respecting differences in spiritual practices.
 - c. Providing clients the space to determine what is shared in terms of spirituality.
 - d. All of the above.

- 12) Which of the following best reflects an indigenous interpretation of spirituality?
 - a. Practices and ceremonies carried out by First Nations religions.
 - b. Singing chants and songs when a person is seriously ill or near death.
 - c. The extent to which a person is filled with universal love.
 - d. A relationship with creation.

- 13) According to Knobloch, spirituality consists of:
- A set of human precepts.
 - A group experience.
 - Looking within.
 - A frame of orientation.
- 14) Spiritual distress can be defined as:
- Not believing in God.
 - A disturbance in one's values or belief system.
 - Changing from one religious denomination to another.
 - Being abandoned by one's family of origin.
- 15) When companioning someone on the journey, it is important to:
- Look within oneself.
 - Share with others.
 - Have a sense of humor.
 - All of the above.
- 16) Healing:
- is an act of doing something for another.
 - means to "become whole."
 - combats illness.
 - ignores grief.
- 17) The Biophilia Hypothesis suggest that humankind's connection with the natural environment is:
- instinctive and a genetically predisposed biological imperative.
 - loosely associated with our genetic inheritance.
 - based in aesthetic preferences.
 - does not matter to the course of human inter-relationships.
- 18) A common value the Biophilia theory shares with the practice of social work is the concept of:
- discrimination.
 - intrinsic worth and dignity.
 - economic justice.
 - competence.

Front Porch CE Module
Spirituality and Its Role In Mental Health

QUIZ ANSWER SHEET

- | | | | | | | | | | |
|----|---|---|---|---|-----|---|---|---|---|
| 1. | a | b | c | d | 10. | a | b | c | d |
| 2. | a | b | c | d | 11. | a | b | c | d |
| 3. | a | b | c | d | 12. | a | b | c | d |
| 4. | a | b | c | d | 13. | a | b | c | d |
| 5. | a | b | c | d | 14. | a | b | c | d |
| 6. | a | b | c | d | 15. | a | b | c | d |
| 7. | a | b | c | d | 16. | a | b | c | d |
| 8. | a | b | c | d | 17. | a | b | c | d |
| 9. | a | b | c | d | 18. | a | b | c | d |