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Including Spirituality in Assessment and Intervention

Introduction

This paper is written for those who are involved in clinical or pastoral work with individuals in crisis. The concept of spirituality is highlighted in pastoral work, but may not be clearly delineated or defined for specific use in crisis situations. For those trained in counseling, there may be barriers to using spiritual practices in assessment or intervention. The paper provides some simple tools to introduce the ideas of spirituality into crisis work and give examples of how spiritual practices may be used in a professional helping relationship.

Theory and Conceptual Framework

Engaging people in crisis is at the heart of work in the professions of social work, clinical counseling, home care and pastoral counseling. Those trained in these professions expect to meet people and their immediate family members in times of crisis. Crisis in human life can take many forms and can be associated with both positive and negative events. Crisis theory provides a framework to explain how people respond to crisis and how best to develop interventions to support positive coping. The initial goals of crisis intervention are to provide stability against further loss. Most professionals use a brief intervention therapy and move forward with steps to encourage long term growth as a re-

sult of the crisis (James 2008). Crisis situations cause stress and require coping resources, both internal and external. The theories of Hans Selye are the starting point to understanding the concepts of stress, adaptation and coping. Selye (1950; 1956; 1978) wrote that people experience stress when the demands of the environment exceed personal resources. Stress may be both positive, such as the birth of a child or a promotion to a new job, or stress can be negative, such as illness or loss of a job. Stress can be personal, as those mentioned above, or stress can be community-based, such as natural disasters or war. Using stress theory to conceptualize a problem involves several steps: (1) the person experiences a stress reaction/ a distress; (2) personal resources are either available and adequate or the resources are not available or adequate; (3A) the resources address the overload of the stress by either reducing the burdens of the overload or increasing the coping abilities of the individual; (3B) the resources do not address the overload and the stress continues; (4) the person experiences more stress (the situation worsens) or the person experiences some relief (the situation stays the same or improves). Personal resources typically are defined as psychological resources, social resources and/or environmental resources. Several theorists, including Pearlin & Schooler (1978) and Lazarus & Folkman (1984) have taken Selye's original ideas about stress and refined them so the theory can be used to explain as well as to predict outcomes of stressful situations. Resources to address stressful situations and to reduce feelings of stress have been further categorized into positive coping strategies that reduce stress and negative coping strategies that are ineffective in reducing stress. Talking openly with family or friends, personal reflection, exercise, re-framing the problem and taking action are some commonly used positive coping strategies. Denying the problem, drinking alcohol, taking drugs, minimizing or maximizing the problem and keeping worries to oneself are seen as negative and less productive strategies. These negative coping strategies can lead to social isolation and separation from others, which further weakens one's ability to engage in successful coping in the face of a crisis.

Kenneth Pargament's work on the use of religion to cope with stressful situations advanced the discussion of the use of religious practices as coping mechanisms (1997). Perhaps the most common times people seek the comforts of spirituality are those linked with death, grief and bereavement. Religious practices associated with death and dying are familiar and people are accustomed to seeking spiritual care when they experience a death of family or friend (Stoebe 2004). However, people seek help for a number of other problems and concerns and spirituality may be a useful tool in engaging a range of populations who are experiencing physical, social or mental health problems. Nairn & Merluzzi (2003) have illustrated the use of spirituality to boost coping among people with cancer; chronic pain sufferers also benefited from

using spirituality practices (Dunn & Horgas 2004). Mohr and his colleagues described the use of spirituality and religious coping for people with psychiatric problems (2007). Sagaser and colleagues discuss the use of spiritual explorations in prenatal genetic counseling work (2016). Hodge, Salas-Wright and Wolosin surveyed older hospitalized people and found the practice of addressing spiritual needs was linked to higher levels of overall satisfaction with care (2016). The devastation of Hurricane Katrina led to the exploration of religious coping and spirituality in the face of a natural disaster (Henderson 2010). Albert Ellis, who developed rational emotive behavior therapy (REBT) and spent many years in opposition to religiosity, reviewed the overlap of principles REBT with some religious perspectives. He cited the ideas of unconditional self-acceptance, high frustration tolerance, and unconditional acceptance of others as shared between REBT and "god-oriented philosophies" (Ellis 2000, p. 32). If we are to understand spirituality and religious coping as a tool for engaging and helping people in crisis, we have to understand more about the ways in which spirituality and the coping process might influence each other.

Spirituality and Coping

Humans are social and spiritual creatures, so it is not surprising that there are many definitions of spirituality and the ways that humans make meaning of their lives. Viktor Frankl's 1988 views on spirituality highlight the search humans undertake to find and adhere to meaning, purpose and commitments outside of the self. Spirituality usually means to seek and to engage in an experience with the transcendent. Frankl's ideas set forth two interrelated ways people seek to make meaning in their lives. Individuals create their own meaning for their lives, that is, a personal meaning that can be derived from any number of activities and beliefs. Individuals can also understand the meaning in their lives as a separate reality that exists independently, a universal meaning of life. These two ways of understanding the meaning of human life, deeply personal and universal, are not necessarily an either-or proposition. For many people, these two ways of making meaning in life are related, intertwined and equally important. For example, a person might find personal meaning in tending a community garden and providing fresh produce for neighbors and others. This same person may also find meaning in the association with the forces of creation, nature and the universe and being part of a greater tide of spirituality or religious beliefs.

At this point it is important to talk briefly about the differences between spirituality and religion. The two are related and spiritual people are often also

religious, but spirituality can and does exist without religious affiliation or religious practices. Religion can be seen as the institutional representation of the ways humans experience the divine whereas spirituality is more the unique ways the individual experiences the divine or the transcendent. As helping practitioners, we must be able to make the distinction between spirituality and religious affiliation or lack of religious affiliation.

One's meaning of life and definition of spirituality can be seen to influence one's coping resources. Spirituality and the tie to a universal meaning of life can reduce feelings of isolation that so often accompany times of crisis, illness, separation and bereavement. Physiological mechanisms of a relaxation response through prayer, meditation and reflection can lesson feelings of anxiety and depression. The communal aspects of spiritual and/or religious groups can enhance healthy lifestyle choices and provide positive social and instrumental supports including physical and financial helps. Spirituality and religious practices, seen through the stress-adaptation-coping theory lens, can offer the practitioner the following benefits: to connect with clients in a time of disconnection or crisis; to activate a deeply personal process for internal change; to support internal changes through social engagement; and, perhaps, to foster a reconnection with prior spiritual practices and communities.

Spirituality Assessments

In the United States, where there is a plurality of religious affiliation and range of spiritual beliefs, work has been ongoing in the assessment of the dimensions of spirituality that benefit and should be included in assessment. Koenig and Pritchett (1988) have developed six elements of spirituality that are recommended as part of any assessment of spirituality in a professional helping relationship. Their recommendation is that any assessment of spirituality include questions about the following dimensions: (1) beliefs, meanings and the individual's process for seeking purpose; (2) vocations, consequences and how the person understands obligations and what happens when obligations are not met; (3) experience, emotion and the affective tome of spiritual life; (4) rituals, practices and how the person enacts key believes; (5) participation and engagement in a religious and/or spiritual community; and (6) locus of authority and how the person understands what guides his or her personal beliefs. These dimensions can be used to determine the breadth of standardized assessment tools or could be used to develop a spirituality assessment questionnaire for a specific setting.

There are a number of tools from which to choose to assess spirituality. However, most clinicians do not include more than one or two question about

religious affiliation as part of an initial intake interview. If we accept that spirituality can be an asset to coping, stress reduction and potential growth, why would this topic be absent from the assessment process? In the United States, only hospitals and hospice organizations are required to include an in-depth assessment of spirituality in recognition of the end-of-life care provided. Other secular or government sponsored agencies do not require such assessment questions, even though there is evidence that use of spiritual practices can assist in health and recovery for a variety of problems. Some possible explanations for this omission could be the helping professionals do not have the time or the experience to inquire about the client's spirituality. If one is not sure how to use the information, what is the merit of asking about it? Others barriers may include an attitude that it isn't part of the job to ask about spiritual practices. If a practitioner feels uncomfortable in his or her own experiences with religion and does not see the differences between religious and spiritual practices, it is unlikely he or she will include these questions. Some practitioners may feel concerned that asking about spiritual beliefs and practices will foster an expectation of engaging in a practice with a client and crossing a professional boundary. In the United States, given the religious plurality, there is an understandable lack of knowledge about all of the religious and spiritual practices found in various populations. Lack of knowledge and fear of offending may create a barrier to assessment. In Poland, however, the majority of the population is Roman Catholic, so there may well be an assumption that all hold similar beliefs and no need to ask about the use of spirituality or religious practices. Might there be a concern among clients to disclose that his or her spiritual beliefs may not be in line with the official beliefs of the church? Could the assumption that all are part of the church create a barrier to assessment of spirituality in Poland?

Despite the many types of barriers to assessment that might exist, there are some simple steps to raise awareness of spiritual assessment options and to increase professional skills. Self-reflection on one's own definition and use of spirituality is an excellent starting point. Professionals might ask themselves the following questions: What are your own feelings about the meaning of your life and how do you use spirituality and/or religious practices to cope with stress? Do you feel tension in asking others about their use of spirituality and/or religious practices? Talking about your responses to these reflective questions in supervision or with a peer discussion group would further one's exploration about the use of spirituality in life and in professional practice. A library search of some simple screening tools that will be briefly described later in this paper could give rise to some individual practice and role play sessions to familiarize yourself with specific questions, potential barriers and areas of discomfort about spirituality.

In their review of the spiritual assessment in health care practice, Saguil and Phelps (2012) provide an overview of several methods of assessment processes to improve the health care providers' understanding of the clients/patient's use of spirituality and to consider the use of spirituality and religious practice as a coping mechanism and as an intervention. These tools could be used by any helping professional, including pastoral counselors. Perhaps the most straightforward and least complicated is the two step "Open Invite" method that presents the topic for conversation and invites the individual to talk about his or spiritual needs. Saguil and Phelps present sample questions such as:" Do you have a spiritual or faith preference?" "What helps you through hard times?" "Are there resources in your faith community that you would like for me to help mobilize on your behalf?" (Saguil & Phelps 2012, p. 549). These questions are not systematic, but they do provide a way to begin the conversation about spirituality and to communicate you are willing and able to talk to clients about this aspect of their lives. A more structured set of questions is presented in the FICA spiritual history tool developed by The George Washington Institute for Spirituality and Health and described in the Saguil and Phelps article (Saguil & Phelps 2012, p. 548). This tool includes four categories of questions: faith and belief; importance of these beliefs; community participation and how to address these issues in the care plan. These questions, as in the Open Invite approach, are straightforward and set the stage, if desired, for a more in-depth discussion about the role of spirituality and religious practices in coping and care. A similar, yet more detailed set of questions developed by Anandarajah and Hight (2001) and cited by Saguil and Phelps (p. 548) is the HOPE. HOPE is a mnemonic devise for the categories of questions. H questions ask about sources of hope. O questions focus on organized religion. P stands for questions on personal spirituality and practices. E refers to questions about effects on medical care, and if appropriate, end-of-life care. E questions also touch on any aspect of the current problem/crisis that affects one's ability to do the things that usually help spiritually – assessing the barriers the client may experience in using spirituality to cope. Any or all of these three assessment approaches could be adapted for any type of crisis care or any type of organization sponsoring the care.

The gold standard in the measurement of religious coping is Pargament et al.'s Religious Coping Questionnaire (2000). Pargament and his colleagues conceptualized religious coping as both positive and negative, in line with stress adaptation and coping theorists. Positive religious coping engages God and the religious communities to deal with distressing and overwhelming situations. Negative religious coping is defined as dissatisfaction with God, coping without God, questioning God and dissatisfaction with a religious community. The theory posits that positive religious coping is associated with more posi-

tive outcomes associated with physical and mental health problems. Pargament et al.'s tool has demonstrated psychometric properties, has been normed on several different populations. It has been translated into languages other than English, including Polish. The Polish version is focused upon adolescents and provides an interesting view into the ways in which Polish youth may use religious coping, which is not unlike other samples of youth, in most respects (Talik 2013). The drawback to this tool is that it is longer and requires some knowledge to administer and interpret it. It is best used as a research tool rather than a clinical tool, but offers insight into ways young Polish people use religious coping; this knowledge could benefit professionals in a clinical setting.

Examples of Spiritual and Religious Practices as Interventions

The use of spirituality in assessment affirms that we are focused on the person and not the disease or problem: a person is more than the list of his or her symptoms and diagnoses (Sussman et al. (2013). Using the information from the spirituality assessment as an intervention tool focuses our work on building connections with our clients and helping them to construct or re-construct meaning in their lives during a time of crisis. Interventions to strengthen social supports can focus on attachments with religious or spiritual communities or to rebuild ties that might have weakened. Providing help to increase personal attachments and connections can decrease anxiety and increase positive coping skills. Centering prayer, chanting, guided imagery, and mindfulness meditation practices have been associated with mood regulation and stress relief. Optimism for the future, regardless of prognosis, can be reinforced as a spirituality practice. Gratitude interventions such as keeping a gratitude journal or recognizing the good in a situation can enhance optimism and acceptance. Of course, one of the most well-known use of spirituality as in intervention is the role of the "higher power" in the Twelve Steps of Alcoholics Anonymous (AA). The higher power can be conceptualized any way in which the person sees his or her higher power – "God or a Higher Power of your understanding" is the phrase used. The recognition that the idea of spirituality is individual and can be separate from religious affiliation is consistent with the views of this paper. While AA originated among Christian believers, there are various adaptations of the Twelve Steps for those who follow other religious traditions, such as books describing the Twelve Steps for Judaism (Copans, Olitzky & Grunberg 2009).

The transcendent in all humans, one's spirituality, is an avenue for growth and strength despite crisis situations. Many of our clients struggle with very difficult issues including depressions, guilt, shame and the aftermath of trau-

ma. For people who have not experienced the positive coping aspects of spirituality or religious practices, there is a special challenge. All helping professionals must be able to hear and accept those for whom religious experiences or affiliations have been judgmental, hurtful or stigmatizing. The assessment process must be open to these aspects of experience in order to re-focus on some of the possible positive aspects of spirituality as an intervention and not to level blame for lack of belief or participation in religious community or practice.

Conclusion

There are many definitions and interpretations of spirituality and many ways to describe and to discuss elements of religious coping. The differences in definition may be of interest, but the practitioner must be focused on his or her abilities to introduce the topic, to lead the conversation to explore the dimensions of spirituality with the clients and then to use the information to develop or to restore an effective use of spirituality and religious coping to aid the client in the resolution of the crisis. Too often we allow barriers to dissuade us from asking these important questions and to skip the topic as not part of our responsibilities. To do so, is to ignore the possibilities for change that may be available to our clients to ease their distress and to build their connections with others. The growing body of scholarship regarding the association of spiritual assessments and positive outcomes of crisis and stressful situations is compelling evidence that helping professions can no long afford to ignore spiritual assessment in their work.

WYKORZYSTANIE DUCHOWOŚCI W DIAGNOZIE I INTERWENCJACH

STRESZCZENIE

Artykuł ten adresowany jest do osób zaangażowanych w pracę kliniczną albo duszpasterską z jednostkami doświadczającymi kryzysu. Autorka analizuje zastaną literaturę dotyczącą wykorzystania duchowości w diagnozie i interwencjach po to, by przedstawić proste narzędzia pozwalające na uwzględnienie duchowości w pracy z osobami w kryzysie. Przedstawia przegląd aspektów duchowości i religijności, które mogą być wykorzystane w radzeniu sobie ze stresem i sytuacjami kryzysowymi.

Podaje także przykłady sposobów włączenia praktyk duchowych do relacji między zawodowym pomagaczem a klientem. Oprócz korzyści, wskazuje także na trudności w uwzględnianiu duchowości w pracy klinicznej oraz ryzyko związane z tym procesem.

Słowa kluczowe: religijność i radzenie sobie ze stresem; duchowość i zdrowie psychiczne; poradnictwo duszpasterskie

SUMMARY

This paper is intended for those who are involved in clinical and pastoral work with individuals in crisis. It overviews existing scholarship on using spirituality in assessment and interventions in order to provide some simple tools to introduce spirituality into crisis work. It presents the dimensions of spirituality and religiosity that can be beneficial in coping with crisis and stress. It also gives examples of how spiritual practices may be used in a professional helping relationship. Alongside with opportunities, barriers to including spirituality in clinical work, as well as the risks involved in this process, are also discussed.

Keywords: Religious Coping; Spirituality and Mental Health; Pastoral Counseling

REFERENCES

Anandarajah G., Hight E. (2001), *Spirituality and medical practice*, "American Family Physician", 63 (1), p. 87.

Copans S., Olitzky K., Grunberg M. (2009), *The Twelve Jewish Steps to Recovery.* (Second Edition) www.Abebooks.com.

Dunn K.S., Horgas A.L. (2004), *Religious and nonreligious coping in older adults experiencing chronic pain*, "Pain Management Nursing" 5(1), p. 19-28.

Ellis A. (2000), *Can Rational Emotive Behavior Therapy (REBT) be effectively used with people who have devout beliefs in God and religion?*, "Professional Psychology: Research and Practice", 31 (1), p. 29-32.

FICA Spiritual History Tool. The George Washington Institute for Spirituality and Health, https://smhs.gwu.edu/gwish/clinical/fica/spiritual-history-tool

Henderson L. (2010), *Religious coping and subjective well-being: African Americans' experiences of surviving hurricane Katrina*, "Dissertation Abstracts International" 70(10B), p. 6552.

Hodge D., Salas-Wright C., Wolosin R. (2016), *Addressing spiritual needs and overall satisfaction with service provision among older hospitalized inpatients*, "Journal of Applied Gerontology" 35 (4), p. 374-400.

James R. (2008), *Crisis Intervention Strategies*, (6th ed.) Belmont [USA, California].

Koenig H., Pritchett J. (1998), *Religion and Psychotherapy*, in: *Handbook of religion and mental health*, Ed. H.G. Koenig, Academic Press, p. 323-336.

Mohr S., Gillieron C., Borras L. (2007), *The assessment of spirituality and religiousness in schizophrenia*, "Journal of Nervous and Mental Disease" 195(3), p. 247-253.

Nairn R.C., Merluzzi T.V. (2003), *The role of religious coping in adjustment to cancer*, "Psycho--Oncology" 12 (5), p. 428-441.
Pargament K. (2001), *The psychology of religion and coping*, New York.
Pargament K.I., Koenig H.G., Perez L.M. (2000), *The many methods of religious coping: Development and initial validation of the RCOPE*, "Journal of Clinical Psychology" 56 (4), p. 519-544.
Sagaser K., Hashmi S., Carter R., Lemons J., Mendez-Figueroa H., Nassef S., Peery B., Singletary C. (2016), *Spiritual exploration in the prenatal genetic counseling session*, "Journal of Genetic Counseling" 25, p. 923-935.
Saguil A., Phelps K. (2012), *The Spiritual Assessment*. Downloaded from the "American Family Physician", www.aafp.org/aft May 1, 2017.
Selye H. (1950), *Stress*, Montreal.
Selye H. (1956), *The stress of life*, New York–London.
Selye H. (1978), *The stress of life*, revised edition, New York.
Stobe M. (2004), *Religion in coping with bereavement: Confidence of convictions or scientific scrutiny?*, "International Journal for the Psychology of Religion" 14(1), p. 14-23.
Sussman S., Milam J., Arpawong T., Tsai J., Black D., Wills T.A., (2013), *Spirituality in addictions treatment: Wisdom to know… what it is,* "Substance Use & Misuse" 48 (12), p. 1203-1217.
Talik W. (2013), *The Adolescents Religious Coping Questionnaire. Translation and Cultural Adaptation of Pargament's RCOPE Scale for Polish Adolescents*, "Journal of Religion and Health" 52, p. 143-158.

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