Relational Social Work Practice with Evangelical Christian Clients

David P. Cecil and Kenneth M. Stoltzfus

Introduction

Practice with Evangelical Christians requires an authentic relationship and a close examination of the diversity and relational aspects within this group. Relational theory, as an approach to relational social work, provides valuable methods for working with this group for all practitioners, regardless of their own religious affiliations. This chapter begins with an overview of the defining beliefs and practices of Evangelical Christianity and a discussion of the types of presenting problems and clinical issues that are common among Evangelical Christian clients. The discussion addresses relational clinical principles in work with Evangelical Christians from the perspectives of the relational clinician as a non-Evangelical Christian and as an Evangelical Christian. A case study of Kelly, a 29-year-old Caucasian woman who grew up in a nondenominational Christian Church, demonstrates the use of the clinical relationship in addressing issues between the social worker and client, the client and her family, and, for the purpose of this case, the client and God. The client's presenting problems and treatment are analyzed in light of attunement that contains authenticity and not knowing, mutuality and the co-construction of meaning and treatment goals, and the balance of reflective exploration with affirmation of strengths. The chapter includes recommendations for direct relational social work practice with Evangelical Christian clients, as well as discussion questions.

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Overview of Evangelical Beliefs

Evangelical Christians currently make up about a third of the population across the United States (Bader et al. 2006). Inevitably all relational clinicians will encounter Evangelical clients and need to attain a basic understanding of the religious beliefs and cultural attributes of this group. Despite shared characteristics, a specific definition of "Evangelical Christian" is difficult given multiple dimensions of diversity within this group. The term *evangelical* derives from the Greek word *evangelion* and literally means "good news." Evangelical Christians are one of many subgroups within the larger Christian community that, Evangelical or not, believe that God came to earth in the form of Jesus Christ, lived a perfect life, was wrongfully executed by crucifixion, and was resurrected through the power of God. These beliefs are based in Bible passages such as John 3:16 and Philippians 2:5–8 (New International Version [NIV]). The nearly universal belief among Christians, including Evangelical Christians, is the "good news" that Jesus' life, death, and resurrection allow humans to be reconciled with God and to escape from the burden of their sins (Romans 5:10, New International Version). In addition to sharing these beliefs with the larger Christian faith community, Evangelical Christians emphasize a number of unique convictions.

Bebbington (1989) suggests that Evangelical faith can be defined by the presence of four core beliefs: *activism, Biblicism, conversionism,* and *crucicentrism*. *Activism* is activity focused on telling the story and promulgating the Christian faith. Evangelical Christians place a high value on "witnessing" or "testifying" to their faith in hopes of converting others. Although such activity may seem presumptuous or judgmental to others, Evangelical Christians view such "evangelism" as the sharing of their most prized possession, the "good news" of their faith. *Biblicism* reflects regard for the Bible as the divinely inspired, irrefutable word of God. While there is debate within the Evangelical community regarding how properly to utilize and understand the Bible, most groups agree that the Bible should be considered a guide for life and religious practices. Some groups require a literal adherence to all aspects of the Bible, while others tolerate a considerable amount of nuance and ambiguity in terms of Biblical interpretation (Olsen 2004).

Conversionism refers to the importance that Evangelical groups ascribe to having a conversion experience (Bebbington 1989). Christians may refer to such a conversion experience as being "born again" or "saved." *Crucicentrism* refers to the centrality of the crucifixion of Jesus of Nazareth to Evangelical Christian theology. Again, there are varying views among Evangelical Christians regarding the crucifixion, but in general there is common agreement that Jesus' crucifixion frees humans from the bondage of sin and restores a relationship to God (Eddy and Beilby 2006). Some scholars utilize additional elements to define Evangelical Christian belief. McGrath (1995) emphasizes "controlling convictions," including "[t]he majesty of Jesus Christ," "[t]he lordship of the Holy Spirit," and "[t]he importance of the Christian community" (pp. 55–56). Olsen (2008) adds assent to traditional Christian doctrine (i.e., the nearly universal beliefs of the larger Christian community).

Intra-group Diversity

Relational clinicians' effectiveness relies upon a deep and nuanced understanding of diversity, including relational dynamics, within all groups. There are specific diversities among Evangelical Christians (Olsen 2004). For example, Evangelicals differ widely in terms of sacraments, such as baptism and communion, and eschatology, or beliefs about the end of time/history (Olsen 2004). There also is political diversity. Chaves (2011) reports that while a majority and dramatically increasing percentage of Evangelical Christians are politically conservative, there remains a noteworthy "Christian left." The intentionally multiracial *Sojourners* community makes the case that Christians should promote social justice and environmental care (Swartz 2012). The political views of Evangelical Christians may be complicated by a sense that faith transcends party affiliation and eschews voting or other political activity. Alternatively, they may be extremely conservative on some social issues (such as abortion), while liberal or progressive on other issues (such as health-care reform). It cannot be assumed, therefore, that Evangelical Christians are homogenous. Nonetheless, they do share the primacy of faith as a determinant of their thinking and behavior.

Constructivist Relational Practice with a Positivist Client

For the relational clinician, the essential understanding is the individual's submission to a religious doctrine that prescribes beliefs, secure attachment through membership, and the path to ultimate salvation. This positivism is at odds with the constructivism of relational theory. The fusion of self and religious convictions, even if those convictions are explicated differently in subgroups, establishes the Evangelical Christian client as a particular challenge to cultural competence in relational social work. Not as definitely self-identified as a marginalized United States population as Orthodox Jews or Muslims, for instance, Evangelical Christians may find reflection on their religious beliefs less evident as aspects of clinical treatment. While no social worker would consider reflection on any religious beliefs in the sense of questioning them, the exploratory nature of relational practice requires special attunement with clients for whom exploration itself is religiously threatening.

How can the clinician establish accepted empathy, authenticity, mutual goal setting, co-construction of meaning, and the like to become interpersonally valuable to her client when a lack of confirmation of the client's religious convictions places her among the unsaved? How can the clinician work with the entanglement of religious beliefs and personal problems (illustrated in the case study) while supporting convictions that are irreducible? This dilemma is a striking example of relational social work with diverse populations altogether: shared and unshared realities must meet in an interpersonal relationship. With religious diversities and especially a religious

belief system striving for conversion of the nonbeliever, the shared and unshared aspects take on implications that call for exceptional empathic attunement, and willingness to not know and be educated, at every step. Personal conflicts and suffering are universal; the relational model reaches for the healing power of interpersonal connection (Baker Miller 2012; Bromberg 1998; Greenberg and Mitchell 1983) without falling into ideational power struggles? Evangelical clients' struggles with their personal conflicts and doubts can be understood by the relational clinician as part of their pursuit of greater connection, with their faith or with the relational social work process. In the article "Jesus and Object-Use: A Winnicottian Account of the Resurrection Myth," Hopkins (1989) states that "believers can acknowledge their own destructiveness while at the same time enabling them to live life more fully in 'a world of objects…a world of shared reality.' The sacrament of the Eucharist is seen as partly reenacting this process" (p. 93).

Clinical Issues in the Relational Social Work Process with Evangelicals

Evangelicals seek relational social work services for essentially the same reasons as others, but there also are a number of presenting problems that are unique to Evangelicals and may manifest in unique ways. After describing the unique formulations of the problem definition, the remainder of the chapter will utilize a relational theory perspective to suggest ways that relational clinicians can address these presenting problems in their work with Evangelical Christian clients.

Unique Presenting Problems

Religiously based denial and resistance. Evangelical faith can sometimes serve to undergird relationally challenging defenses of denial and resistance among Evangelical clients. This is especially true when the client, or the clinician, does not connect her/his faith to the treatment process. In such cases, individual clients may believe they are immune to certain types of problems because of their faith or they may resist involvement with a relational clinician if that worker is not coming from an overtly Biblical perspective. For the clinician, recognition of denial and resistance stemming from religious conviction can expand the perspective on transference and countertransference. The relational practitioner perceives the parameters of establishing a mutually determined and strength-enhancing course of treatment requiring a "space" where their goals can be sufficiently aligned to have a dialogue. This requires the clinician to search for, and inquire about, a form of interpersonal joining that may take the clinician far into not knowing.

Stoltzfus (2006) reported working with an Evangelical client who, while on parole and court-mandated to attend substance abuse counseling, informed his therapist that he had injected heroin but that due to the power of God, the drug no longer had any effect on him. The client believed his faith eliminated the impact of his continued chemical dependency, and therefore, there was no sense that the relational clinician could offer help. Using the Bible, the relational clinician should explore the consistencies of pursuing faith in God with the truth-seeking process of psychotherapy (i.e., 2 Timothy 3:16; 2 Peter 1:21, NIV). For the less Biblically informed clinician, the process might be how to affirm the client's comfort in his interpretation of truth yet authentically question how the clinician should make sense of it in the face of legal processes that require other truths. Pointing to this disjuncture can open the dialogue to personal consequences and feelings they engender. The relational principle of mutual definition of the problem thereby shifts the focus from substance abuse per se to his life situation, about which the relational clinician is concerned.

Decision paralysis. Many Evangelical faith communities believe that God has a preordained plan for the lives of individuals, and instruct their members to attempt to discern God's will for their lives, especially prior to making major life decisions. For some individuals, such injunctions may be extremely troubling, as they may not have a sense of God's will. Such individuals may find themselves "paralyzed" and unable to make decisions, due to their fear that they may be acting outside the will of God. The relational clinician should work to ensure that relational exploration is seen as an acceptable aid to the discovery of a sense of God's will. The collaborative goal is the client's resolution of conflict. The clinician cannot resolve this by authority about God's will but can collaborate with the client in her search clarity. The relational clinician's role in this search is to broaden the parameters, including intrapsychic as well as interpersonal experiences that have added to paralysis.

Duality. Psychodynamic and relational perspectives provide a way to understand and address how Evangelicals sometimes embrace a dualistic view of human life and functioning that places a unique filter on the issues that relational clinicians deal with on a daily basis (Aron 1996; Freud 1977; Narramore 1994). Within the Evangelical view, spiritual needs are prioritized as eternal concerns, but temporal concerns (such as health, relationships, and mental health) are de-emphasized because such concerns belong only to the present, earthly life. Such belief systems can lead to the neglect of medical care, nutrition, mental health, and personal relationships, to the detriment of the overall functioning of the individual. Evangelical clients may also believe that their faith should lead to mental and physical health. This belief that requires careful navigation by the relational clinician so as to avoid conflict and support a process of mutual searching for health through inquiry about understanding health deficits of the moment and affirming the collaborative search as religiously congruent. In other words, the relational practice emphasis on process does not have to run aground about content; the healing impact of interpersonal joining and authentic acceptance of unique individual versions of a solution reduces duality as a state.

It could also be asserted that Evangelicals may feel safer keeping their problems between them and God rather than exposing themselves to the vulnerability of an open relationship with another person. It is therefore a complex process to determine when there are psychodynamic issues such as unconscious use of defense mechanisms that prevent the client from addressing disturbances (Freud 1977). For example, resistance in the form of denial, repression, and projection leads to decisional paralysis and neglect of physical health for all clients. Practice based in relational theory is a powerful way to address these issues (Aron 1996). Given the confluence of religious and psychodynamic processes, the informed relational clinician is mindfully open to the specific practice processes accessible to this population. The remainder of this chapter will utilize relational theory to suggest ways in which relational clinicians can be of assistance to Evangelical Christian clients.

The Relational Clinician-Client Relationship

Of the many factors that may affect the social worker-client relationship during the course of clinical work with Evangelical Christians, some issues are more likely to arise when non-Evangelical social workers provide services to Evangelical clients. A different set of issues is likely to occur when Evangelical social workers practice with Evangelical clients. These differences are illuminated as the relational clinician learns to apply relational solutions to Evangelical Christian client issues. A core concept from relational theory that applies overall comes from Winnicott's (1971) explanation of the necessity of the object (the mother/the clinician) to withstand destructiveness in order to become "useful." By "useful," Winnicott means trustworthy and of value. The Evangelical client's resistance to and even repudiation of clinical intervention can be seen, in this light, as necessary to this nonreligious process of engagement becoming useful.

Non-Evangelical relational clinician-Evangelical client. Research suggests that social workers are least likely to self-identify as Christian than the general United States population and most likely to self-identify as atheist or agnostic (Canda and Furman 1999). Jewish, Muslim, Hindu, and other faith traditions also populate the relational social work profession. This means there is a high potential for Evangelical clients to be treated by relational clinicians who are unfamiliar with, and perhaps inwardly skeptical of, their belief systems. Even if the relational clinician and client share other aspects of cultural backgrounds (e.g., racial, ethnic, geographic, and socioeconomic identities), Evangelical clients may distrust the secular social work profession and any intervention that is not based in their own belief system. Some conservative Evangelical groups are opposed to any counseling or therapy that is not based solely and explicitly on the Bible (Johnson 2010). Other groups may prefer to utilize "Christian counseling" conducted by individuals who are trained both in pastoral ministry and psychotherapeutic techniques, rather than secular social work services. At the same time, circumstances may necessitate service despite

religious beliefs. The relational clinician therefore must be prepared to work effectively with all clients, including those who are resistant based on distrust due to religious difference.

Political views also are likely to differ between the relational clinician and Evangelical client (Rosenwald and Hyde 2006), as relational clinicians are more likely to be politically liberal or progressive and Evangelical Christians are more likely to be politically conservative (Chaves 2011). The *Code of Ethics of the National Association of Social Workers* (National Association of Social Workers 1999) states that social workers should always be respectful of differing cultural and political views. Rosenwald and Hyde (2006) reported positive findings about social workers' ability to be respectful of differing views. Respect, however, is a term that may or may not accompany interpersonal distance, which is contrary to the relational practice stance. The relational clinician must be aware of these potential issues in the transference and countertransference but even more must invoke her "belief" in the apolitical and a-religious clinical process as a professional obligation and a professional solution.

For example, errors of assumption are a consistent subject for the practitioner to bear in mind, irrespective of identified sameness and differences with the client. The relational clinician is attuned to errors she may make by empathic assessment of the interpersonal process. This assessment is continuous, applying not only to problem definition but to how practice is unfolding. The authenticity principle allows the relational clinician to inquire about or observe, at any time, a disjuncture between herself and her client. The openness of her intent to cocreate meaning, not impose or falsely agree, may be slow to penetrate suspicion and may not always succeed. The relational stance is inherently respectful but also inquiring; patience for the invitation to inquire is maintained by sincere interest and willingness to not know or even to understand rejection as a statement of the client's need for self-preservation.

Despite the likelihood of divergent religious and political views, it is possible for non-Evangelical relational clinicians to work effectively with Evangelical Christian clients. The relational clinician must be able to empathically understand and explore belief systems that may be radically different from their own. Exploration may easily become challenging if the relational clinician encounters an ideology that she finds to be offensive or incomprehensible according to her own views. Evangelical clients may educate the relational clinician as no other diverse group can about the suspension of an a priori perspective on problem definitions, their components, and the order and timing of relational outreach to establish interpersonal connection. An emphasis on collaborating with the client in defining the presenting problem and developing the treatment plan, utilizing the relational principle of co-constructivism, will allow the relational clinician to enter the world of the client and to partner with him in problem resolution.

Evangelical relational clinician-Evangelical client. Relational clinicians who identify as Evangelical Christians may face a different set of issues when attempting to establish a therapeutic relationship with an Evangelical Christian client. Narramore (1994) describes a dilemma for Christian therapists wherein Evangelical

therapists may have difficulty confronting manifestations of Evangelical faith that appear to have been unhealthily distorted or utilized as a means of resistance. For example, a client who is abused by a spouse may believe God is testing her and it is therefore God's will that she stay in the marriage. The dilemma occurs when Evangelical therapists must confront such possible distortions of faith with their clients, which can lead clients to question the faith and therefore the utility of the relational clinician. The relational theory principle of authenticity guides the clinician to present her hypotheses of a different interpretation of events as hers alone, not as official judgment. Her hypotheses are provisional, seeking confirmation, and, if rejected, seeking deeper clarification of her misunderstanding. This demonstration of nondefensive pursuit of collaborative structuring of viewpoint as well as intervention is in itself a relational therapy action: it clarifies the absence of an agenda of control or professional dominance.

The relational clinician may also struggle with feelings of guilt if her comments lead the client to confusion or questioning of faith. Building on the prior example of the abused spouse, the client begins to look at the relational clinician as a worldly tempter or, conversely, becomes distressed at the prospect of misinterpreting God's will. Such an encounter is potentially troubling to both parties and may interfere with the functioning of the therapeutic relationship. However, relational approaches to relational social work allow both the relational clinician and the client to explore their concerns via authentic, open dialogue. The construction of a safe, supportive relationship requires the occurrence and the survival of conflict (Winnicott 1971). The work of the relational practitioner, then, is to encourage exploration and non-hierarchical definitions of truth as a basis in all practice and a basis particularly useful in the complex intersection of religion and interpersonal and intrapsychic work.

Toward Mutuality

Tosone (2004) suggests that mutuality is a defining characteristic of relational social work. Building on the work of Aron (1996), Tosone further states that mutuality "implies that both parties are impacted by their interaction, but not necessarily in an equal or symmetrical way. Instead, mutuality reflects that the participants have been open to and touched by the authenticity and genuineness of another" (p. 484). Relational techniques such as active listening, open-ended questioning, and allowing the client to be the "expert" on his situation are concrete ways of promoting mutuality when working with Evangelical Christians.

Striving for an authentic, genuine, and mutual relationship, the relational clinician may begin to bridge the gap created by divergent religious and philosophical worldviews. Mutuality should be viewed as a respectful understanding and appreciation for the client's views and is especially important if the client's Evangelical faith is undergirding unhealthy emotional, relational, or behavioral patterns. In such cases, the therapeutic relationship must be strong enough to allow the relational

practitioner to help the client confront unhealthy distortions of faith without losing the trust of the client. Such trust will be heightened if the relational clinician expresses an appreciative understanding of the client's faith while also exploring distortions that prevent growth. It is especially important for the skeptical clinician not to imply the client's faith is simplistic or anachronistic. This judgmental position violates the constructivist principles of relational therapy.

In order to work toward mutuality in therapeutic relationships with Evangelical Christian clients, it is important for relational clinicians not only to show respect for the belief systems of their clients but also to seek to understand how these beliefs influence the client's cognition, relationships, and behavior. Delving into the client's understanding of the four key Evangelical beliefs (activism, Biblicism, conversionism, and crucicentrism) may be helpful for clinicians who are attempting to understand the belief systems of their Evangelical clients. For example, asking about a client's view of the Bible or understanding of the crucifixion will show some familiarity with Evangelical faith and also convey a desire to better understand the client's situation. The relational clinician can also explore how these beliefs inform the client's issues.

Postmodernism and social constructionism. Relational clinicians who have been trained in postmodern social work practice models (such as constructivism) may struggle with the rigidity of Evangelical faith, which posits a connection to, and limited understanding of, absolute truth as divinely revealed. In fact, the postmodern impulse to deconstruct traditional narratives and critique traditional forms of authority may lead relational clinicians to instinctively feel critical of people who subscribe to traditional beliefs. In light of the apparent conflict between postmodernity and religious faith, it is important to remember that postmodern perspectives allow for multiple sources of authority and validate multiple perspectives simultaneously. In their openness to multiple, overlapping constructions of reality, postmodern social work practice models "leave room" for the belief systems of the client, even if these are significantly different from those of the clinician herself.

Postmodern perspectives have begun to influence Evangelical theology more recently, which may be helpful in clinical practice with Evangelical clients. One such development is the impact of narrative theology, which emphasizes the importance of understanding the Biblical narrative as a unified story, rather than focusing on rigid interpretation of short scriptural passages as rules for belief and behavior (Frei 1974). Another development is the emergent church, which seeks to understand the Christian faith story by incorporating many overlapping and contrasting understandings of Christian doctrine (McLaren 2004). The incursion of a more constructivist perspective may be helpful in working with some Evangelical Christians, especially those for whom extremely rigid understandings of faith have become problematic. For example, some Evangelical women have been reluctant to leave abusive spouses because of a rigid interpretation of Biblical injunctions against divorce. In such cases, a relational clinician can seek authorization to explore the underlying themes of the Biblical narrative, which are usually summarized in terms of God's love for humanity and God's desire for reconciliation and peace among the

created order. Cocreation of meaning as a relational principle does not mean finding agreement; it means illuminating more aspects of a belief through dialogue to look at other options which were not "on the table" when the focus was on developing rules based on a few select Biblical passages.

Case Analysis and Discussion: Kelly

Kelly is a 29-year-old Caucasian woman who grew up the daughter of a minister at a nondenominational Evangelical Christian Church. (Such churches tend to interpret the Bible literally and believe it should be the ultimate authority for religious life and practice.) Kelly continues as a member of this church to present day. She states emphatically that her relationship with God is "everything" to her. Kelly demonstrates how Evangelical Christian clients will often present with the same types of issues we see in our non-Evangelical clients. Her case further illustrates that Evangelical Christianity, along with other religious belief systems, is not inherently exclusive from the kinds of thinking that inform psychotherapeutic practices of many schools such as relational theory. Though they will not be the focus of this analysis, approaches that bridge a perceived divide between the psychotherapeutic process and issues of faith, including Carl Jung's work on the collective unconscious and spirituality (Jung 1961) and the 12-step program as suggested by Alcoholics Anonymous (Alcoholics Anonymous 2001), draw widely on spirituality along with psychotherapeutic processes.

Kelly works as a bank teller, has four children, and is in her second marriage. Her reason for seeking treatment is that she is "completely overwhelmed and ashamed and cannot believe what I am doing to my husband and I just want to run away from it all." Kelly's church and family held strong beliefs regarding the sinfulness of extramarital sex. She became pregnant prior to each of her marriages, and marriage in both cases legitimized her behavior. She states she was a "model Christian" through high school but went through a "rebellious phase" when she went to college. She states, "I love the Lord, but when I got to college I fell in with some girls who were smoking pot and having sex. I was like their mom for a while until I was like, hey, I can have some fun, too!"

Kelly became pregnant the next semester, had a very hard time staying away from marijuana even during her pregnancy, dropped out of college, and married the father of her child. Divorced at 23, Kelly started seeing Eddie and was soon pregnant again. They married and had two more children shortly thereafter. She states that Eddie is a much better person than her first husband, but she is not sure she loves him: "There is just not much that is exciting and we do not have much to talk about." Kelly is anxious, depressed, and restless. The most current and acute issue is anxiety bordering on panic-type symptoms related to recent intimate contact with another man while at a conference for work. Here is part of that interview:

SW: So tell me about your current anxieties and what has you so overwhelmed?
Kelly: Well, you know I am an idiot. I have everything to live for, but I have days that I just can't stand it.
SW: What is it you cannot stand?
Kelly: Just the pressure, the life, you know, of being a mommy and a wife. It is so not me! And now I've really gone and messed up. I've had an inappropriate relationship with another man. We crossed some lines.
SW: You feel you are living the wrong kind of life and that now you have done something inappropriate?
Kelly: No! I am right where God wants me! It's me; it's not my life. I am just such a fool.
SW: You feel foolish.
Kelly: I am foolish.
SW: You are saying that you cannot stand the pressure of your life but that you feel God wants you right here. Is that right?
Kelly: Yeah, it's spiritual warfare. Satan is attacking me everywhere right now.

Kelly is struggling with ambivalence, feeling torn between being a good Christian and having natural desires for independence and excitement. The psychodynamic assessment suggests Kelly did not resolve adolescent conflicts related to identity and intimacy (Erikson and Erikson 1997), but Kelly's view is that sinfulness leads her into temptation. Since the relational clinician must establish mutual conceptualization, she must be oriented by the religious explanation and strive for co-construction of a more complex interplay of Kelly's individuality with her Evangelical convictions. Authenticity is demonstrated by not knowing and inquiry about how Kelly reconciles, or doesn't, these two states of self. The "not-me" restless sinner is dissociated from the "me" compliant believer, and the clinician's collaborative goal setting needs to demonstrate the value of bringing these states into communication. In the following section, the relational clinician draws on his relationship with Kelly to begin to challenge some potentially distorted aspects of her beliefs:

SW: Kelly, can you help me more clearly understand some of your concerns? I get the impression that you feel your relationship with God has not been strong enough, that you have not believed enough in God or you have not been good enough to receive God's blessings. And the choices you have made and regret are because of this?
Kelly: Well, that could be part of what is going on.
SW: Yes. But on the other hand you say that it will be God who delivers you from these problems.
Kelly: Yes! Without God, none of this is possible.
SW: Right, you count on God to provide you with what you need to get through this.
Kelly: Yeah, I really believe he would be able to give me what I need, if I could only really lean on him.

SW: I think I understand. You feel that you have just not been able to trust God enough.
Kelly: You don't think I am a freak and a failure?
SW: Absolutely not! On the contrary, you seem very bright and gifted.
Kelly: Well, that's nice to hear.
SW: But you are very disturbed with where you are now and you wish it could have been different.
Kelly: No kidding. If I had it all to do over again.
SW: Yes, what would that look like?
Kelly: Well, I would not have fallen into Satan's traps; that's for sure!
SW: So you would not want to have any of the experiences you had. They were all Satan's traps.
Kelly: Well, I mean. Here's the thing. I was looking forward to college. I wanted to get away. I needed to get away. My brother and sisters could just hang in there at home and church; they never seemed to want more or anything different. It wasn't that I could not stand my family or being a Christian. I was just ready to see some new things and let my hair down and relax some.

This was a critical moment to engage with Kelly: she apparently had not been able to tell this part of her story before. The relational clinician amplifies this authentic disclosure to begin the co-construction of a space where her ambivalence is acknowledged but remains within the religiously informed narrative of her identification.

SW: Ok, so part of your plan was to get away from home and try some things you could not do at home. To go where there was not so much pressure?
Kelly: Well, I don't just mean go off and smoke pot and have sex. But to be somewhere it would not matter so much if I did these things. At least I would have the choice. At least I wouldn't feel I was letting everyone down; it would be a normal thing to do in that situation.
SW: Sure, it was important for you to test the boundaries a bit, to make some decisions for yourself.
Kelly: Absolutely! I actually like that part of me. But here I am now.
SW: But here you are now.
Kelly: Yeah, things didn't go as planned. I was immediately punished.
SW: But I can see this great part of you that wants to get out and explore and try new things. That really is a part of your personality that you love and want to embrace. But you feel that you were punished the moment you tried anything different.
Kelly: Well, I don't really believe in a God who punishes me. But I guess I feel he did let me fall down right away. And disappointing my family was incredible punishment!
SW: Yes, these would be very disturbing and painful things, I imagine. You feel that you have been a disappointment. But you also feel that God and your family have let you down in some ways.
Kelly: Yes, that's it.

The relational clinician affirms the disparate parts of the client. Empathic inquiry creates an interpersonal space where conflicting self-aspects can converge. The relationship thereby becomes the active therapeutic action.

Kelly: Well, I must say that I am confused about why things had to go so wrong and I cannot say I have not questioned my faith…. Every second of every day (smiling).
SW: So ultimately, you feel as though you have let down many people and also feel that God, even though he loves you, has taken a pretty harsh position with you?
Kelly: Yeah, and I cannot do anything about that. I cannot recreate history.
SW: I suppose not. You speak of your love and trust of God but you also seem confused and even a bit hurt by what you see Him doing in your life.
Kelly: I would never question God's will, but yes, I am definitely confused.
SW: You would never question God's will, but if you thought of God like another person, what would you say?
Kelly: Gosh, I don't know. Kind of like, hey, where ya been? Was I really so bad? Sorry I disappointed you.
SW: In a way you wonder where He's been, but you are also sorry for things you've done.
Kelly: (tearful) It has been so hard. I am so tired. I think I have been more unfair with myself than He has.
SW: In what way?
Kelly: I guess I can't really expect God to go easy on me when I can't stop punishing myself.

Kelly had high hopes for herself and feels strongly that the way she values her faith should have kept her from making mistakes. The relational clinician may wonder if Kelly blocks her own path to resolution because her behavior is outside the bounds of her perception of acceptable behavior, but she focuses on God and her family expressing disappointment. Inquiry that accepts the content of her religious beliefs but addresses the affect state of confusion for an empathically attuned exploration process can reduce resistance to her own reflections as worthy content. Kelly wonders if she is also punishing herself. Posing this as an interesting question and inquiring about its foundation, the clinician opens the door to exploration about issues with the family, from which she learned how her religious beliefs should be expressed.

SW: So Kelly, can you tell me more about your relationships in your family?
Kelly: Well, my family is everything to me, but they are very disappointed I am sure. Now there is all of this weird tension. I don't know if it is them or me, but I know that I made things difficult.
SW: You love them deeply but are pretty sure they are not happy with you?
Kelly: Well, it's not that they are unhappy. They are always there for me, but there is a strange competition in my family, I mean with my brother and sisters.

SW: You feel they are there for you, but that you are in competition at the same time. So they are support and competition?
Kelly: Yes, you could say it that way. I never thought of it that way, but it's true.
SW: And what about your parents?
Kelly: Well, I know I am a huge disappointment to them! You should have heard some of the fights that my Mom and I had. But my Dad is like my siblings; he is there for me, but I sense he is none too happy with my choices.
SW: But wait a minute; here you are, living back in your hometown, going to church, married with children. Did these things not satisfy them? Was there pressure even before you and Eddie started having problems with your marriage?
Kelly: Oh yeah. The pressure is always there. It's hard to describe. And it's not just pressure from my family. Really, they are okay. But everything changes at church. My Dad is the pastor; I know he has a reputation to uphold. I just feel that I bring shame on them, that everyone sees me that way.
SW: Wow, that would be a lot of pressure indeed! You are simultaneously involved and helping in the church but also feeling that you are a source of… what? Embarrassment, shame?
Kelly: I don't know how embarrassed I am. I mean, if these people are going to judge me… believe me, I could tell some stories on them, too! But I love my church and I know they love me. But I could tell some stories.

Several important things are occurring at this juncture in the relational social work process. First, Kelly recognizes troubling themes of disappointment and competition. Second, she acknowledges that these are her perceptions. By following, rather than presenting, this line of thought, the relational clinician invites self-reflection. Finally, Kelly begins to normalize her behavior by acknowledging how common it is for her fellow church members to fall short of the high ideals of their faith. All of these indicate levels of socially constructed beliefs, which are explored in the following dialogue.

Kelly: Well, I am clearly the black sheep of the family.
SW: I am curious to know how someone becomes a black sheep; this has something to do with disappointment?
Kelly: Yeah, you just repeat mistakes and get down and after a while, people just expect you to fail.
SW: Is this you or your family that expects you to fail?
Kelly: In a way it's a self-fulfilling prophecy, I guess.
SW: And what of marriage?
Kelly: Oh, the Bible is very clear about marriage. One man, one woman, forever, that's the way it is meant to be.
SW: And most Christians get this right? They pick out a life partner, get married, and that is the end of the story?
Kelly: I highly doubt that. But I knew better than to make the mistake I did.
SW: Oh, so you say the Bible is clear, but you are confused?
Kelly: Huh, well, yes. Clearly I have been confused. I mean, I knew better, didn't I?

SW: Okay, I see. You have a clear definition and you have clearly not lived up to that definition.
Kelly: Right, I am way off of the path.
SW: You are off the path because of your recent behavior (intimate contact with another man)?
Kelly: I've been off track from the beginning! I haven't done any of this right. I keep getting it backwards.
SW: You got off track years ago and it has never been right since?
Kelly: Right, you make one bad choice and it is like you are stuck in those decisions forever!
SW: Okay, so this is something that you have to get right from the beginning or else it can never be right?
Kelly: Wait, what?
SW: I thought I understood you to say that since you did not do marriage correctly from the beginning, you could basically never get it right; somehow it was doomed from the start. Was I wrong about that?
Kelly: Well, no. Did I say that?
SW: I do not mean to put words in your mouth.
Kelly: No, I think that is exactly what I was saying. I cannot get right because it was never right to begin with.
SW: Well, is there anything in the teaching of the Bible about situations like that? Or does the Bible basically tell you to get it right from the beginning or else you will never have it right.
Kelly: I can't believe I am saying this. Of course not. The Bible is filled with stories of people who never got anything right and God's grace and power helped them transcend their problems. (Pause, smiling) But I doubt their dads were pastors!

This passage illustrates the presentation to the client of the clinician's understanding of what is being said. The dialogue extends the tolerance for ambivalence by keeping conflicting beliefs in view. For example, the clinician emphasizes relational issues alongside religious ones and self-criticism alongside the redemptive aspects of Christian faith. Inquiry about Biblical understandings can reveal multiple dimensions that build a more complex picture within which complex self-states can be contained. In this case, Kelly references Biblical passages on marriage (1 Colossians 7:2, NIV) and adultery (Ephesians 5:3, NIV) that mandate levels of morality and purity, but she does not refer to passages on grace and forgiveness (Roman 3:23–24, NIV). It is psychodynamically tempting to point out the convergence of her struggles against excessive expectations from father/pastor, but the more relationally attuned path is to keep the resolution focused on her individual religious beliefs and their flexibility compared to her own rigidity. The following discussion occurs after some time, during which social worker and client have concurred on the treatment goal of Kelly solving her confusion, rather than Kelly becoming a better Christian.

SW: So Kelly, you identified real differences between your definition of marriage and morality and what you have actually done in your life. You attribute this to the fact that you are human and prone to making mistakes. You view this as part of your sinful nature?

Kelly: Yes, I am so short-sighted as a human being and cannot see the forest through the trees.

SW: So where do you go from here?

Kelly: I can see how a lot of my pain comes from my own definitions. I am sure there is some truth to God's disapproval and my family's disappointment. But honestly, I have just not been able to let God or my family in. Maybe this was my pride, but I did not want all of my defects to be on display. I just could not stand that.

SW: Sure, nobody wants to feel like they have disappointed everyone. But what is it that makes it so difficult to open yourself to God's or your family's understanding?

Kelly: Like I said, I guess it is my pride. But I think it is also that my definitions of a Christian life were just much more simple and constricting and it is time to open my mind to a broader and more accurate viewpoint. But I think it is also that I have not seen much value in forgiveness when it doesn't change my circumstances.

SW: You felt that if you are going to be forced to live with your mistakes, what good is forgiveness, from God, your family, or you?

Kelly: Yeah, nothing can give me a fresh start. But now I see how that puts me in an impossible situation. No wonder I am such a mess!

SW: You are seeing how you subconsciously developed expectations that could never be met. And how will these definitions change moving forward?

Kelly: Well, I have to realize first and foremost that I have all of the love and support I will ever need. I also need a constant reminder that I am just like anyone else. I get to make mistakes, too. And all of this new understanding is consistent with what I have learned in church. I just never realized how much I would need love and understanding or how hard it would be to accept that.

This case illustrates the utility of a relational approach to relational social work practice with Evangelical Christian clients: Kelly and her clinician established an exploratory dialogue marked by trust and mutuality. The relational clinician uses Kelly's spiritual and ontological frameworks without pathologizing her belief systems. Kelly begins to assert that her original views of herself and behavior require modification, but not the impossible rejection of her Evangelical values. She seems interested in developing new constructions that will accommodate imperfection and an ability to allow others to love and support her in spite of her mistakes. She also seems to recognize there may even be things to value about her experiences in terms of deepening her self-worth and her sense of faith.

Practice recommendations that emerge from this illustration include the development of the authentic and genuine relationship, an intentional openness to client's beliefs, utilization of established literature on the integration of faith and practice, and a continued effort to help the client to see the consistencies between therapeutic

help and their faith (Freedberg 2008). In Kelly's case, we see the social worker and client stumble a few times in developing shared understanding. This vital part of relationship building fosters growth that encompasses ruptures.

If the relational clinician in fact does not share the religious beliefs of the client, she can validate, by an open and inquisitive demeanor, how Kelly can help her better understand; removing the pressure to get it right the first time, as the case demonstrated, empowers the client's sense of personal authority and valuable resources. Diversity does pose risks of transference and countertransference oversimplification. Although the relational clinician may not oppose, disrespect, or discriminate against the client, differences can subtly influence interactions with clients. The relational model of relational social work practice is steeped in empathic attunement, not only to the client but also to the nuances of interpersonal alignment in the treatment process.

Important developments are bringing the secular psychotherapeutic domain together with faith-related issues. The North American Association of Christians in Social Work (NACSW 2011) is working to equip Christians in social work to ethically integrate their faith and practice and may be helpful by providing written material and/or individual consultation related to understanding and treating Evangelical Christian clients. Also, Evangelical colleges and universities are increasingly adding academic programs in social work, counseling, and psychology and are accredited by secular agencies, such as the Council on Social Work Education. Such developments speak to a healthy discourse on blending social work and faith-related issues. They also encourage the relational clinician to place herself in the process of inquiry, mutuality, cocreation of understanding, and professional enhancement as a parallel to treatment goals.

Conclusion

This chapter illustrates important ground in considering how to practice with Evangelical Christian clients from a relational theoretical perspective. Definitions and meanings of terms like *evangelical* were explored with discussion of how meaning has evolved in our culture. Bebbington (1989) provided a framework for a deeper understanding of the client's Evangelical background. Clinical issues, including problem presentation and relationship building, were also explored. Next, a case analysis based on Kelly demonstrated how a relational clinician could apply relational theory, emphasizing relatedness, strengths perspective, and social construction of meaning. Focusing on relational aspects and social constructions of meaning, the relational clinician built on the client's understanding rather than tearing it down and starting over. Kelly described both a sense of great love and commitment to God as well as feelings of restriction and harsh judgment. Before seeking help, Kelly was unaware of these beliefs, yet they caused significant emotional disturbance. These discussions and analyses yielded recommendations for the relational clinician to foster an authentic relationship, learn from the client, bridge the gap between social work practice and Evangelical beliefs, and carefully explore her own beliefs in order to manage countertransference.

Study Questions

1. Give a brief overview of the definition of "Evangelical Christian." What are some of the variations that make defining this term complex?
2. How do the areas of diversity within the Evangelical group impact practice?
3. Give a specific example of how a relational clinician would avoid assumptions about religious beliefs regarding a problem area introduced by the client.
4. What are the strengths you can identify in the Evangelical Christian group? (What are the strengths you can identify within the Evangelical Christian group? How would a relational clinician emphasize and utilize those strengths to inform their practice?
5. Give an example of a constructed view that Evangelical Christians might have. What are some of the challenges a relational clinician may have when it comes to understanding and working with a client with this view?
6. How might social and political differences influence the relationship between the social worker and the client? Focus specifically on the differences in values that are tied to these ideas.

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