Relational Social Work and Religious Diversity

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Introduction

The Council on Social Work Education states:

> Given the pervasiveness of religion and spirituality throughout people's lives and cultures, social workers need to understand religion and spirituality to develop a holistic view of the person in environment and to support the professional mission of promoting satisfaction of basic needs, well-being, and justice for all individuals and communities around the world. … Social workers are expected to work ethically and effectively with religion and spirituality as relevant to clients and their communities and to refrain from negative discrimination based on religious or nonreligious beliefs. (www.CSWE.org 2012)

This declaration emerged in 2011 from the CSWE Religion and Spirituality Work Group, on which I served as a member. Its purpose is "to promote social workers' knowledge, values, and skills for ethical and effective practice that takes into account the diverse expressions of religion and spirituality among clients and their communities" (www.CSWE.org 2012). This position statement makes clear the centrality of religious and spiritual considerations in clinical social work practice.

Relational theory's emphasis on discovering and articulating meanings in the immediate clinical process embraces exploration of the religious and spiritual dimensions of what Greenberg and Mitchell (1983) delineated as key intrapsychic structures: self, the other/object, and the unconscious template of self with others. Religion has both conscious and unconscious impact on how these self-structures are defined and enacted. It does not exist in a separate realm from other components

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of interpersonal experience and functioning that make up the content of clinical social work practice. Being mindful in assessment, treatment planning, and transference and countertransference to religious and spiritual content is essential not only with clients for whom religion and spirituality, or their rejection, are important self-dimensions but also for clinicians' self-awareness of their own religious and spiritual orientations. Cornett (1998) reminds us, "One of the most helpful things that therapy can do with regard to spirituality is not to change the client's view but to amplify it or bring it to sharper focus so that the client may scrutinize it more carefully and decide whether it truly fits the individual circumstance of life and current self-understanding." (p. 41)

Religion and Spirituality in Relational Clinical Social Work Practice

Establishing the kind of engagement and attunement with clients that will facilitate Cornett's goals requires the relational clinician to adopt a posture of letting the client be the teacher about what it means for him or her to be religious or spiritual. The relational principle of mutuality does not require agreement; confirmation that the client's perspective is understood respectfully by the clinician is co-constructed in the "space between" (Bromberg 1998) upon which all interpersonal engagement rests. The client as a teacher is an invaluable role for establishing engagement and identifying core issues that are not to be confused with conflict-free beliefs. For instance, following Cornett's (1998) description of social work and religion, a relational clinician may work with a client struggling with birth control, a concern which is at odds with the doctrine of her religion. The depth of such a struggle cannot be reduced by reducing the role of her religious convictions, but rather by empathizing with her dilemmas and doubts, helping her articulate and be heard about her various thoughts and feelings, including the reality context impinging upon her, and other relational strategies of joining and supporting her as a whole person in a real as well as emotional situation of distress. Religious beliefs and practices can clarify clients' needs and the resources that they rely upon, which emphasizes the relational emphasis on interpersonal and cultural context. The client as a teacher captures the shift from the classic paradigm of treatment by expert clinician to the co-constructed relationship that defines the relational social work perspective. Having content knowledge about the particular history, values and beliefs, and practices of a religion is important, but far more helpful for the relational clinician is to understand the religious client and not just the facts about that client's religion.

We may question whether some of the tenets of a religion as understood by our clients are hurtful or helpful to them, oppressive, or providing a sense of freedom. People who identify themselves as oppressed may interpret their experience of oppression through their religious faith. For instance, many African Americans support a meaning of Christianity that is radically different from the

wider Anglo-American Christian community and reflects a religious response to the history of enslavement as a race. Discerning and appreciating such specific distinctions in religious interpretation in the individual client facilitates the professional social work relationship. Self-identification as part of a recognized religious group, be it Islam or Judaism or Buddhism or any other, does not in itself illuminate the intrapsychic meanings and functions of that identification and therefore its role in assessment and intervention. The relational social worker applies the principles of authenticity about what is not yet known and mutuality in developing understanding to deconstruct her own countertransference and explore religious content as she would other aspects of identification like race, gender, sexual orientation, and the like. The central concept is that religion is not extraneous to in-depth assessment, empathic exploration, and inclusion of religious beliefs and memberships as important aspects of client in context.

The Relational Clinician and Religious/Spiritual Content

Apprehension about the relationship between clinical social work and religion is to be appreciated for its value in illuminating the role of this dimension of cultural diversity. Awareness of skepticism or overcompensation to conceal skepticism alerts the relational clinician to engage all the more acutely with the meanings of the client's communications. The same can be said of unexamined assumptions of knowledge based on shared religious affiliation. Both poles represent the relational theory's principle of examining countertransference as the window on the clinician's potential for misapprehension, and thereby redirecting her to empathic listening. It also calls the question of why religious countertransference or transference or religion altogether is so often placed in a special and hands-off category of social work practice.

Some social workers may feel that religion is outside of their professional expertise, and therefore their clients with religious concerns should consult with someone from their own religious tradition. Others worry that the values, principles, and mission of social work as a profession could be compromised and supplanted by religious ideology and evangelical zeal. The perspective long held among some social work educators, implicitly if not consciously, is that the confessional and subjective nature of religious belief does not lend itself to scientific scrutiny, inquiry, and the search for truth. As discussed in chapter "Orientation to and Validation of Relational Diversity Practice", elevation of scientific data as the path to truth not only contradicts the entire interpersonal discovery enterprise but also leaves unanswered the application of such caution when it comes to religion. It reifies a faith/clinical dichotomy. Relational theory allows us to reevaluate this essentially prejudicial and exclusionary position: no meaningful client communication or conviction is extraneous to an attuned clinical social work relationship.

Gender, class, and ethnicity are more present in social work literature as aspects of clients' identity and social context that influence how client and clinician

interpret experiences. The relational emphasis on interpersonal attunement has been identified as an important antidote to marginalization in life, and in clinical practice, for many populations (Altman 2010; Berzoff 2011). Our understanding of people and their cultures is incomplete without knowing something about what they consider ultimate in their lives, and religious/spiritual dimensions are not exceptions. An additional feature of religion and spirituality is the understanding that its significance and role may change over time. Relational social workers, along with their clients, live with and negotiate many conflicting, competing, and contradictory values and beliefs in their effort to keep their lives flowing and meaningful. Accounting for the role religion values play in this process adds depth to our knowledge base about diversity and practice as social workers.

Apparent Versus Inherent Tensions Between Religion and Clinical Social Work

Social work supports a client's right to self-determination even when the client's choice may not appear congruent with the clinical social work treatment process. Some religious approaches, for example, direct or proscribe of how the client should handle their problems or concerns. Prayer, for example, rather than self-reflection, may seem to abrogate the clinical function in dealing with a distressing conflict. For the relational practitioner, this tension opens, rather than closes, doors to mutual exploration of how a religiously defined pattern of functioning plays a role in either supporting or obstructing the client's presenting problems. Addressing that mutual exclusivity is not the only question that can set a clinical social work treatment on a course of combined cultural/religious attunement and intrapsychic exploration. The exploration makes conscious but does not judge the impact of religious conviction and fully acknowledges its contributions alongside any discovery of restriction or difficulty it presents in seeking a solution that is self-coherent.

Some clinical social work educators, regardless of their own beliefs, wish to avoid the appearance of promoting religion in any form in their teaching of practices. Concerns about how religious ideologies and practices can be interpreted or used destructively are legitimate, but the answer is not avoidance. For example, the conception of God as the source of behavior and the explanation of feelings is a positivist, cause-and-effect way of thinking that forecloses qualitative inquiry. A more qualitative, constructivist perspective is curious not so much about a specific religion's tenets, but about how those tenets determine ethical discernment, value clarification, approach to conflicts, and pursuit of a meaningful life, which for many define their spiritual quest. For the educator and student, liberation from preconception or avoidance allows authentic interest about how the client makes decisions and assesses outcomes. Psychodynamic thinking is not itself another religion. It is applied in relational practice as a method of becoming attuned to multiple sources of authority and sustaining interpersonal connections.

Relational Appreciation of Religion and Spirituality in Individual Functioning

Relational clinicians are cognizant of how some people more than others seem more aware of living with conflict, ambiguities, and contradictions regarding what they value, believe, and the choices they make. The values people derive from religion give texture to their identity and self-esteem. These values contribute to their sense of cultural continuity and serve as a defense against what they perceive and experience as oppressive. There are those who seem more confident about their convictions than others**.** The religiosity of a client may be well integrated into their self-understanding, and some dimensions of that religiosity may pose difficulty for the clinician/client relationship regardless of the clinician's own personal or professional view of religion. Relational clinicians are encouraged to show, in a nonjudgmental and authentically inquiring way, interest in the person's religious orientation to life. This approach is one whereby the practitioner asks questions that encourage the client to reflect upon how he or she chooses to live their life and what the sources are that sustain and gives them hope and meaning for living. For example, Smith, in his *The Relational Self: Ethics and Therapy from a Black Church Perspective* (1982), emphasized the importance of helping members of this community see the relationship between personal and social transformation and how this dynamic shapes the way people relate to one another, themselves, and God. Personal identities and ways of relating to one another are socially constructed, and Smith's work explicates the constructed causes and effects of the particular interpretations of religion in a historically oppressed population.

This role of religious beliefs in constructing personal identity and relationship to self, others, society, and God by exploring religious identity is mediated by the context, culture, ethnicity, gender, and sexual orientation of the believer. Relational theories share in common a basic interest in understanding all the factors that influence the development of the sense of self and the capacity to act upon the world and reflect upon how the world impacts us. Not all clients who are religious and who seek the assistance of a clinical practitioner will present that their faith is a problem or concern for them. This does not mean that they are denying that religion might be a part of their clinical needs and desires. Rather, their religious position, whatever it may be, is not apparent, or safe, for them to introduce in the social work process. The relational clinician is alert to what is missing as well as what is presented, especially in the assessment phase of practice. Therefore, omission of something as central to self as religion, including repudiation of religion if that is the case, forecloses a dimension of interpersonal sharing. Maintaining authentic curiosity and not knowing empowers the relational social worker to inquire about religion, along with other ordinary inquiries about a person's central life constructs. Asking, rather than waiting or suggesting, reflects the relational principle of building interpersonal connection itself as a central factor in healing: it establishes the clinical connection as one where no topic is off limits.

Clinical Social Work and Pastoral Counseling

Dittes (1990) offers what I think is an elegant description of pastoral counseling:

> Pastoral counseling aspires to enable people to take their place as responsible citizens of God's world, as agents of God's redemptive hope for that world. But it does not assign them to this mission or instruct them in how to carry it out. It is more effective because it is indirect Pastoral counseling exercises the discipline to be disinterested in the dismaying facts of life just because it takes them so seriously, seriously enough to mobilize people's best resources for contending with them. Pastoral counseling exercises the discipline to disregard the facts of the counselee recounts because it so profoundly regards what transcends these facts; namely, the meaning that they convey to the counselee. The postures of hope or despair, attack or submission, trust or fear, isolation or participation-these makes the difference in how the person lives life. To reclaim commitment and clarity, to beget faith, hope, and love, to find life affirmed-this is the conversation of soul that sometimes happens in pastoral counseling. (p. 61)

In this description of pastoral counseling, Dittes avoids being religiously dogmatic – a position that would not be so liberally stated by more conservative religious counselors. Indeed, many people have an image of religious and pastoral counseling as ideologically narrow, wanting to control and manipulate how people think and live. Other views border on stereotyping all religion as an "opiate of the masses" (Marx 1843). Helping a person to have a relationship with God is not a goal of social work. To the extent such intent is part of the social worker's private motives, corrective supervision is indicated. Relational theory guides the clinician emphatically not to impose upon his or her client, but rather to practice clinical social work in a way that is directed to the client's needs and goals for a meaningful and helpful outcome.

Definition of Terms

Religion is a complex enterprise (Gunn 2003) which one can make an industry. Moving away from organized religion to its key and universal components suggests the common definition as being that which binds or connects us to God (and God, of course, being multiply conceptualized). Definitions of religion are always contextual and provisional as Canda and Furman (1999) observe: "*Our definitions are affected by our life situation, sociocultural conditioning, and self-understanding. Since these change overtime, our personal definitions of spirituality and religion may change as well"* (p. 74). Dow (2007) describes religion by using three categories: (a) cognizer of unobservable agents, (b) sacred category classifier, and (c) motivator of public sacrifice (p. 8). Burton's (1992) description of the interrelationship of spirituality and religion is helpful:

1. Spirituality is grounded in the midst of history where messy life events are being experienced and interpreted.
2. Human beings (a) seek interpersonal connection and (b) at the same time seek safety in/from connection.

3. Spirituality is experienced and expressed in the context of physical structure, social class, ethnicity, gender, age, and sexual orientation.
4. Religion [is] secondary to religion…religion is an organized expression of spirituality, and therefore is more specific and defined in its structure (pp. 14–15).

Canda and Furman (1999) offer five common attributes of the concept of spirituality:

1. An essential or holistic quality of a person that is considered inherently valuable or sacred and irreducible.
2. An aspect of a person or group dealing with a search for meaning, moral frameworks, and relationships with others, including ultimate reality.
3. Particular experience of a transpersonal nature.
4. A developmental process of moving toward a sense of wholeness in oneself and others.
5. Participation in spiritual support groups that may or may not be formally religious (pp. 44–45).

Sheridan (1994) gives this simple definition of religion: "religion refers to a set of belief, practices, and traditions experienced within a specific social institution over time." Every definition or description of religion and spirituality goes wanting. A person is religious, for the purpose of our discussion, when he or she believes in a deity and that belief is informed by a system of beliefs in and adherence to doctrines or dogmas. This is often accompanied by their involvement with rituals and living according to a code of ethics and conduct, all of which influences the believers' view of reality, conceptions of the truth, perspectives on life and its meaning, human nature, and the cosmos. The meaning of these beliefs and actions are filtered through the cultural context and gender of the believer and may include ancestral and other cultural traditions. Matters of religious beliefs shape the believer's way of life and personal and communal identity and influence their actions.

Intrapsychic Functions of Religion and Spirituality: Multicultural Implications

Religious beliefs, values, and practices are among the many characteristics of a client who comes to the social worker seeking assistance. What the client attributes to these aspects of himself is a subject of the discerning work of the helping relationship. A client's religion, spiritual practices, gender, ethnicity, and sexual orientation are not neutral value expressions of a client's being. Any expression of who we are reflects the interplay of the multiple factors that constitute our identity. Religious beliefs, practices, and values are three of the many powerful mediators of the meaning we derive from our interaction with other people and the larger society.

In many places around the world today, the religious beliefs of people cannot be separated from their cultural or national identities (Canda et al. 1999). Old and new immigrant communities in America also reflect this character. Motivated by the

growth of these communities and religious convictions, people representing religious institutions and faith based organizations provide significant social support services to many in need living in these communities.

Many ethnic communities such as African American, Hispanic, Native American, Jewish, Middle Eastern, and Asian have strong historical religious traditions and values. The presence of such religious diversity in American society means that we must rethink the value we once placed on the dualistic thinking inherited from the ancient Greeks, that is, mind vs. body, scientific knowledge vs. knowledge from experience, truth vs. falsehood, and feelings vs. reasoning. There is the tendency in Western culture to separate the religious and spiritual aspects of our clients from their other personal attributes. When separated, thus, we run the risk of losing a part of who we are as whole persons. Our understanding of people and their cultures is incomplete without knowing something about what they consider ultimate in their lives.

Our values influence our behavior and the choices we make. Some people derive their values from their religious beliefs. In the effort to keep the dance of their lives going and meaningful, most people live with conflict and negotiate many values that compete with one another. Embedded in their struggle is the challenge that cultural and religious pluralism brings to the values that shape their self-understanding. People who seek the help of a relational clinician may in some way be experiencing a challenge to some of their assumptions about life and the values by which they have made decisions. Their religious worldview may give us additional clues about who they are, their culture, and the nature of their problems.

A Brief Example of Religiously Informed Clinical Practice

Early in my career as a relational clinician and a pastor, a congregation member called to make an appointment. I knew Mrs. Jones from her participation in many of the church's programs. The salient facts of her story she shared with me when we met were that Mrs. Jones is a very nurturing person who is always willing to extend a helping hand to anyone in need. She and her husband were taking care of their teenage niece who had become pregnant, and she found herself feeling a great deal of stress. She also said that she was having difficulty sleeping, was feeling anxious about leaving her home, and had begun to recall a rape experience as a young woman that had caused problems in her relationship with her husband in earlier years. She said what she wanted from me was to pray with her regarding her life situation. She did not link her current distress to caretaking her niece: to her it was inexplicable.

Part of my task when I met with Mrs. Jones was to assess the nature of the issues she was presenting and see how I could be of help. As pastoral counseling, there were areas of convergence with and divergence from essential clinical social work. Engagement by attuned listening and creation of a spirit of exploration by not knowing and striving for mutuality were all relevant skills reflecting relational social work. At the same time, Mrs. Jones was requesting a mode of treatment, prayer, and an implied core problem conceptualization based on her religion. She was unaware

of some, not all, of the many emotional, ethical, legal, spiritual, and practical aspects of the experiences about which she was concerned. As the chapters that follow on religious diversity indicate, working within but not being clinically constrained by the client's religious expectations is a challenge in social work and also in pastoral counseling where the counselor is clinically trained. The task is to find a way of introducing dynamics that are active in the client's problem in a way that is congruent with religious convictions. An aspect of pastoral counseling that can broaden clinical social work with diverse populations is this kind of self-relocation to speak from within a client's world view in ways that nonetheless bring necessary awareness to psychodynamic and contextual issues that are converging in their need for help. Listening to Mrs. Jones and asking for clarification gave us both a way to explore how she understood God, her situational reality and her inner world, herself, and her spiritual values. The process and content of our conversations made visible and collaborative a framework to address her feelings and to promote her resilience and capacity to make choices. Our meetings provided the interpersonal recognition and containment that Baker (2012) sites as therapeutic in itself. In addition, recognizing overtly the impact of her choices on herself and her family helped reduce her symptoms: they become understandable as reflecting the complexity of what initially seemed a simple, religiously dictated caretaking obligation. Wise's (1983) description of the pastoral helping process captures the interplay of religion and relational social work:

> Real change comes slowly and with effort at working on those parts of ourselves that are causing us pain. God has placed the potentiality for change within us but we have to accept our responsibility in bringing it about. … Our past cannot be changed. What can be changed, or rather what we can change, is the character of our inner responses, our feelings and attitudes and patterns of relationship. (p. 191)

Religion and Spirituality in the Secular Clinical Social Work Setting

Clients seem far less confused or concerned about religion than do some social workers and social work educators. Opening the religious door in relational practice often reveals that some form of prayer, meditation, traditional healing, or animistic practice is widely prevalent. When this is the case, the relational clinician begins to uncover the character of what Smith (1982), writing of religion in Black churches, terms *relatingness*, meaning "a way of speaking of the indwelling presence of others in our own concrete reality and of our presence in theirs. Relationality also implies that we can respond not only to the intention and actions of others, but to our own sense of self as well" (p. 51). Smith (1982) adds "Humans need to engage the perspectives of others, especially the oppressed from other cultures and ethnic backgrounds, so that their own understanding of their society and their position in it can evolve beyond where it is presently constituted" (p. 52). These statements, addressed in a designated religious framework, echo the relational theory principle of the

social constructions of reality. Religious constructions constitute one way clients filter the meaning of their experiences. Taking this perspective into account, Smith (1982) argues that the "dialogue of therapy" is a form of intervening "into an oppressive situation which seeks to do several things:

1. Bracket the unquestioned and taken-for-granted world of experience and clarify the individual's, the family's, or the group's context.
2. Enable the person or family to reflect upon and reconstruct past events in ways that bring the meaning of the past into working relationship with the present and future. In addition, therapy can help the individual, family or group do something constructive about conditions that oppress them, and thereby they can become agents in the liberation and healing of others.
3. Heighten a person's sense of self as a member of a community (and the community's consciousness of the importance of each member) where perspectives are available for the person's and the community's enlargement, enrichment, and critical reflection.
4. Chart alternative possibilities.
5. Enlarge and free the person's or family's capacity for creative change and meaningful participation in a larger community context in light of a new image and new whole" (p. 111).

These therapeutic actions set goals for clients to assume personal responsibility for their own emotional well-being and not continue their victimization. In the process of our fostering this development, the relational clinician considers the religion of the client as mediating risk, resistance and resilience factors.

Wimberly (2000) offers the concept of "relational refugees," who are "persons not grounded in nurturing and liberating relationships. They are detached and without significant connections with others who promote self-development. They lack a warm relational environment in which to define and nurture their self-identity. As a consequence, they withdraw into destructive relationships that exacerbate rather than alleviate their predicament" (p. 20). While not identifying his ideas as based in relational theory, Wimberly describes the role of the relational clinician as employing skills to assist relational refugees in finding a home in their current context. "Through empathetic listening the mentor provides a safe place for the refugee to risk attempting human connection which is basic if she or he is to come to feel at home in the world. The mentor invites the learner to imitate the mentor's positive attitude and way of being present. This communicates welcoming hospitality. When he or she accepts the mentor's hospitality, the learner is no longer homeless" (Wimberly 2000, p. 35).

Conclusion

I maintain that human actions are more reflective of what we value than what it is we think or believe. Our experiences, gender, sexual orientation, ethnicity, and religious beliefs are all filters through which these values are formed and help form

our sense of self and how we relate to others and the world. A relational theory considers the diverse ways that constitute our own being and ways of relating to others and the world, as well as the diversity that is within and among religions. The convergence of relational theory and religious diversity is openness to the content of religious beliefs and values, their context, and how they are processed that leads the believer to feelings and actions in the world. Judgment of religious devotion as fanaticism without understanding the dynamic process of religious conviction and commitment in the life of the believer deprives the social worker of necessary clinical criteria of what we understand as healthy and unhealthy ways of being religious.

Western attitudes toward religion, and particularly its Christian varieties, are often dismissed as offering people a trip to some kind of Garden of Eden or a place free of evil, pain, and death. To the contrary, the relational clinician is attuned to how religious beliefs and practices are not fantastical coping mechanisms but ways people can look realistically at evil, suffering, and death. In Elie Wiesel's novel, *The Fifth Son* (1998), a young son asks his father: "'Since we are Jews, how come we are not dead?' 'Because,' said his father, 'something in us is stronger than the enemy and tries to be stronger than Death itself'" (p. 224). Religious beliefs help to awaken in some people a meaning to their life and guide them in the choices they make. Relational clinicians contribute to this process by helping people realize the choices they have to live responsibly with the consequences of their actions and in a manner that helps them and our society to flourish.

Study Questions

1. Explain how "relationality," described as part of pastoral counseling, reflects the relational theory approach to clinical social work.
2. Discuss how religious beliefs include, rather than substitute for, personal responsibility. Give an example of how a relational clinician can emphasize this concept to develop the therapeutic relationship.
3. Describe how a client's skepticism in the practitioner can be helpful to a relational clinician and illustrate an example from your own practice.
4. Explain why particular attention to religion may be needed when working with ethnic minorities and/or immigrant populations. How might "relatingness" be used in this situation to help to strengthen the connection between the social worker and the client?
5. What initial challenges may a relational clinician face when exploring religion with a client, and what relational steps can be taken to dispel the tension?
6. Write a paragraph about how your perspective on religion as part of the clinical social work process has been affected by this chapter.

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