Exploring Spirituality in Systemic Supervision

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Frame (2003) suggests that spirituality “includes one’s values, beliefs, mission, awareness, subjectivity, experience, sense of purpose and direction, a kind of striving toward something greater than oneself. It may or may not include a deity” (p. 3). The integration of spirituality in therapy is rooted in a holistic perspective of human beings—a biopsychosocial and spiritual viewpoint. It recognizes that there is a complex relationship between mind, body, and spirit when it comes to physical, mental, and relational health (e.g., Koenig, King, & Carson, 2012). For spiritual people, spirituality impacts cognitive, emotional, behavioral, and relational functioning. Openness to the inclusion of spirituality in therapy also recognizes that over 90% of Americans consistently identify themselves as religious and/or spiritual (Walsh, 2009).

Although training in the integration of spirituality, including attention to religion has been recommended for two decades, research has found that this training often does not occur in systemic educational programs (e.g., Prest, Russel, & D’Souza, 1999) though there are indications that this may be changing (Grams, Carlson, & McGeorge, 2007). As a result, the systemic supervisor can play a key role in training therapists to work with spirituality. (See Chapter 17 for how incorporating spirituality is consistent with contextually informed best practices for supervision.) The author has supervised couple and family therapists and interns in the integration of spirituality for 30 years predominantly at the Samaritan Counseling Center (SCC). SCC is part of a nationwide network of counseling
centers where licensed therapists are skilled in the integration of spirituality when clients desire its inclusion in therapy. While interns at SCC from systemic (and other) degree programs express a strong interest in spirituality, they rarely begin the internship prepared to integrate spirituality effectively in therapy.

In one clinical study that I was involved in, approximately two-thirds of systemic therapists trained as marriage and family therapists reported a willingness to include spirituality in therapy (Carlson, Fitzpatrick, Hecker, & Killmer, 2002). When compared to previous studies of clinicians, this percentage was a significant increase in openness to the inclusion of spirituality in therapy. It is interesting to note, however, that 95% of the therapists identified themselves as a spiritual person and believed that there is a strong positive relationship between spirituality and mental health. Yet, nearly 30% of the therapists with a very high regard in the efficacy of spirituality chose not to include it in therapy. Furthermore, affirmation of specific spiritual or religious interventions only ranged from 17% to 48% of the therapists. A close study of their responses found that most respondents were uncertain about rather than rejecting these interventions. This suggests that many therapists are unsure about how to address spirituality in therapy, which underscores the importance of discussing spirituality in supervision.

The Importance of Attending to Religious Beliefs

Using Frame’s definition of spirituality, *religion* could be understood as an organized, traditional, and often communal pathway for spirituality. The clinical community has struggled to agree on the definitions of religion and spirituality often eschewing the term “religion” in favor of spirituality. There are times, however, when it is important to recognize that these can be distinct concepts especially in locales, such as the United States, in which religion has played a significant role historically. For example, approximately 78% of Americans have identified themselves as “religious” or “religious and spiritual,” whereas 19% describe themselves as “spiritual only” (Zinnbauer et al., 1997). While the “spiritual-only” group seems to be growing, the majority of individuals still describe themselves as religious. Furthermore, the religious individual often identifies strongly with a specific religious tradition and/or community (e.g., Judaism, Islam, LDS, and Christian) that include unique beliefs, sacred practices, and history.

It is critical, then, that the therapist and supervisor are open to the use of specifically religious language in spiritual interactions with some clients. In addition, much of the research on the efficacy of religion and spirituality on physical, psychological or relational health, such as coping with distress, actually measures the role of religion for participants. This research may or may not extrapolate accurately to people who identify as “spiritual only.” Hopefully, future research will deepen our knowledge of the impact of spirituality on health for “spiritual-only” individuals.
The Self of the Therapist and Supervisor

A high level of differentiation in the area of spirituality enhances the ability of the therapist to address it effectively with clients. Clinicians who are emotionally reactive to and/or emotional cut-off from spirituality are particularly vulnerable to harmful interactions, particularly with devout clients. Even when a therapist makes the decision not to include spirituality in therapy, it still is important to be aware of and respectful toward the spiritual perspectives of clients. This heightened sensitivity can prevent harmful behaviors such as ignoring, minimizing, belittling, or undermining spiritual/religious views.

Similarly, spiritual differentiation is equally important for the supervisor to work effectively with supervisees in the integration of spirituality in therapy. If self-of-the therapist is central to the supervisor’s model of supervision then supervision can facilitate the spiritual differentiation of the supervisee.

Supervisory tools for increasing differentiation of the supervisee

There are three supervisory tools that I have found especially helpful. First, a spiritual genogram (Frame, 2000) may be employed with supervisees. This multigenerational view of spirituality in one’s family of origin often reveals important patterns, such as its importance for the family, religious cutoffs, family conflict with spirituality (e.g., marrying a partner of a different religious background), and/or spiritual issues. Second, a spiritual life map (Hodge, 2003) can enhance the supervisee’s understanding of his/her spiritual history. In a spiritual life map, individuals draw a winding line representing their life journey demarking key spiritual events over the course of their life.

Third, for the past two decades, the SCC has used a spiritual autobiography to facilitate the process of differentiation. Periodically, supervisees reflect on a set of questions that trace the role of spirituality in their life and in their family of origin from childhood to the present time. The use of spiritual autobiography is based on the hypothesis that clarity about and comfort with one’s spiritual position and history can increase comfort with addressing spirituality with clients in therapy and supervisees in supervision. The following is an illustration of the spiritual autobiography process:

The supervisee was provided with the first set of questions with the intention of processing her responses the following week. Upon glancing at the question, “What is your earliest spiritual memory?” the supervisee spontaneously shared that following her first communion and first confession at 8 years of age, she told her parents that she was never going to their Catholic church again. The family accepted her decision and subsequently joined a Pentecostal church where she was still actively involved as a young adult. In the intervening week, I wondered if this experience might impair her ability to work with Catholic clients. Prior to discussing this set of questions, a case was presented in group supervision where a Catholic couple believed that confession played a key role in their
recovery from an affair. When the supervisee came to supervision, she reported that her internal reaction to the couple’s use of confession was that “this was a waste of time.” Furthermore, she concluded that this was a judgmental reaction that could impair, at times, her ability to work with clients. As a result, she determined that increasing openness to diverse S/R clients was an important growing edge. Over the next two years, the supervisee was effective in working with diverse spiritual clients.

An outside group consisting of local therapists and a professor conducted a program review of the supervision of spirituality at the SCC. Supervisees consistently reported that the spiritual autobiography process increased their comfort with and confidence in working with the spirituality of clients. A surprising outcome was that many supervisees reported that supervisory interactions modeled how spirituality can be discussed with clients in therapy.

Since a rigorous lifelong process of education, experience, reflection, and supervision is needed for effective therapy, it follows that a parallel spiritual process with the same level of effort and commitment is needed for spiritual competence or in-depth work. The ability to integrate spirituality in therapy and supervision may be limited by the level of spiritual depth of the therapist and supervisor.

Recommendations for supervisor differentiation

Educationally, it is important for the supervisor to keep abreast of the ongoing research on the relationship of S/R to individual mental health as well as couple and family relationships. In addition, it is beneficial for the spiritually sensitive supervisor to have an understanding of spiritual and/or religious characteristics, similar to understanding other cultural contexts such as those associated with ethnicity. Several resources in these areas are listed in the section prior to the references for use by supervisors and supervisees.

Spirituality in Case Supervision

The inclusion of spirituality in supervision is rooted in the commitment of the supervisor to examine the spiritual dimension of the cases presented by supervisees. This commitment means that the supervisor routinely inquires about the role of S/R in the cases presented by supervisees. When spirituality plays a vital role for clients, attention to this spirituality becomes part of supervising the case. The spiritually sensitive supervisor also can facilitate the development of specific skills in the integration of S/R for supervisees.

Spiritual assessment

The therapist can gather information to make a spiritual assessment in a variety of ways, including a spiritual section on intake forms, direct or indirect questions,
spiritual genogram or life map, and other formal instruments. This assessment may seek to determine the clients’ S/R in these areas:

- Framework and worldview
- History and background
- Concerns and/or issues
- Practices and/or support network
- Current level of involvement with S/R

With this information, the therapist can formulate a systemic hypothesis of the role of spirituality in the life, relationships, and presenting problem of the clients.

Conducting a spiritual assessment also communicates clearly to clients that the therapist is open to the inclusion of S/R in their therapy. Many therapists are open to spirituality if the client brings up the topic (Carlson et al., 2002). This passive stance may be a disservice to clients with strong spiritual beliefs, who often interpret the silence of the therapist as disinterest in or a taboo against addressing these concerns. The initial spiritual assessment also affords clients the opportunity to communicate that they do not wish to include spirituality in therapy. Similarly, the initiative of the supervisor conveys his/her openness to addressing S/R in supervision.

Spiritual case conceptualization

Spiritual case conceptualization seeks to understand the relationship of the spirituality of clients to the presenting problem. Spirituality can be a valuable resource for coping, engendering hope, or making important changes. Other times, it may play a homeostatic role helping to maintain the presenting problem. For other clients, the current distress may create a spiritual crisis, such as a loss of faith or a sense of spiritual failure. Finally, some clients may experience spirituality as harmful in some manner.

This process also strives to integrate the spirituality of clients with a clinical systemic hypothesis that makes sense of the clients’ presenting problem. In this regard, it can be effective to begin with the clinical assessment of a case followed by an exploration of how the clients’ spiritual framework relates to this assessment. For example:

“Peg” was a 50 year-old married woman with a strong evangelical Christian faith. She presented for therapy with a high level of stress rooted in the challenge of caring for her elderly parents. The health of her parents was declining and it was very difficult to continue to maintain them in their home. The parents resisted a move to a safer environment. Furthermore, her parents demanded daily visits and expected her to be “on call” for non-emergency tasks, such as shopping. This significantly impacted the relationships with her husband and children. Recently, Peg had given up her favorite activity – church choir – to be readily available to her parents.
Peg clearly had a strong sense of moral responsibility to care for her parents. Her religious framework provided strong support for this moral responsibility. However, a high level of stress was created by the increasing needs and high or unreasonable expectations of her parents. These expectations raised questions of relational justice. A key clinical goal for the case was the establishment of clear boundaries that could reduce stress by setting limits on the high expectations while providing quality care for her parents. Like many devout religious people, however, Peg was uncomfortable with boundaries, perceiving them as uncaring and selfish from her spiritual viewpoint. Furthermore, the lack of boundaries was equated with being sacrificial—a key component of her faith. Thus, her religious perspective played a homeostatic role helping to maintain her stress.

Treatment planning

The spiritual case conceptualization leads to inclusion of S/R in the treatment planning for clients. In the example just described, it was identified that Peg’s religious framework played a homeostatic role that maintained the high stress level by supporting her inability to set appropriate boundaries. Thus, the treatment strategy for meeting the goal of establishing effective boundaries would include addressing the religious framework that maintains the current lack of boundaries.

Spiritual intervention

The therapist then employs spiritual interventions to implement the treatment plan. One type of intervention is to engage in spiritual dialogues with clients, which are honest, respectful, and differentiated conversations rooted in a trusting relationship. These are in-depth conversations where clients and therapists grapple with serious spiritual concerns such as meaning in life, moral responsibility, and/or ultimate values. Client and therapist seek to understand the implications of a client’s religious/spiritual perspective for their current distress. Spiritual dialogues (i) engage spiritual perspectives that may aid or hinder the process of healing, (ii) identify and address key spiritual concerns, (iii) discern religious/spiritual guidance, and/or (iv) wrestle with how to respond to these religious/spiritual insights (Killmer, 2006a).

Another type of intervention is the use of spiritual practices in conjunction with therapy to activate spiritual resources that can facilitate change. A spiritual practice is an individual or community activity that taps spiritual or religious resources and/or nurtures spiritual growth. Examples of spiritual practices include meditation, prayer, mindfulness, journaling, and sacred texts or spiritual readings. These practices can be useful in conjunction with therapy for several reasons. First, they can tap internal spiritual resources and religious coping mechanisms that produce intangible healthy qualities including inner peace, courage, meaning, or hope. Second, spiritual practices may create or activate a spiritual support network that provides support, encouragement, guidance, or assistance for the client. This network is understood as religious/spiritual relationships such as a faith
community, spiritual friends, guides, or small groups, and/or a relationship with God. Finally, these practices can be therapeutic interventions serving to block the escalation of emotions or impacting cognitive distortions. In sum, spiritual resources can contribute significantly to the process of change within therapy and may become a powerful context for sustaining or increasing this growth after therapy (Killmer, 2006b).

The therapist also can apply clinical interventions to the spiritual dimension of a case. For example, classic cognitive interventions may be employed to address problematic spiritual conceptions. Or, the widely known “empty chair” technique might be used to express strong spiritual emotions, such as the pain and anger of trying to come to a spiritual understanding of the loss of a child. Setting boundaries, de-triangulating, re-authoring one’s spiritual narrative, or increasing differentiation are typical systemic interventions that can be effectively adapted to spiritual issues.

In the therapy with Peg, spiritual dialogues supported her moral responsibility to care for her parents while helping her to differentiate the application of appropriate boundaries from the religious beliefs that these boundaries represented selfishness, a lack of caring and/or being sacrificial. The dialogues were augmented when she read a recommended book on boundaries that fit her religious framework. The shift in her religious perspective on boundaries was vital to progress in therapy. Finally, Peg set one boundary by returning to the choir, which provided her with spiritual support and inspiration.

Summary

In sum, the systemic supervisor can play a vital role in training therapists to integrate spirituality in therapy. This role can include helping the supervisee to differentiate spiritually. Supervision can provide the discipline of insuring that the spiritual dimension is examined during case presentations. Finally, the supervisor can facilitate the growth of the spiritual clinical skills of assessment, case conceptualization, treatment planning, and intervention.

Additional Resources


This resource addresses the use of specifically spiritual interventions, such as yoga and prayer.

Aten, J. D., O’Grady, K. A., & Worthington, E. L. (Eds.). (2012). *The psychology of religion and spirituality for clinicians: Using research in your practice*. New York: Routledge. Each chapter summarizes the research on spirituality and an aspect of psychology, such as personality, and illustrates how the practitioner can use this research through case examples.


Paloutzian, R., & Park, C. (Eds.). (2013). *Handbook of the psychology of religion and spirituality* (2nd ed.). New York: Guilford Press. This also is an excellent summary of religion and spirituality research.


Pargament, K. (1997). *The psychology of religion and coping: Theory, research, practice*. New York: Guilford Press. Pargament’s research identified specific religious coping mechanisms that facilitate positive coping or hinder coping. The practitioner can integrate positive mechanisms in therapy.


References


