IN THIS ISSUE

1 Spirituality Integrated Psychotherapy

5 Should Psychologists Self-Disclose Their Religious Affiliation or Beliefs to Their Patients?

6 Does Religion Protect Against Suicide?

10 Calendar

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Spirituality Integrated Psychotherapy

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Consider this clinical situation:

A psychologist was treating a man who was depressed following the death of his adult daughter. He was slowly coming out of his depression and had found the support of fellow congregants at his local church to be very helpful. The patient asked his psychologist if he could recite his prayer from his church that he had found especially helpful.

Now, consider this other situation:

A psychologist was treating a woman who was in a troubled marriage. Her husband was verbally abusive and overly disciplines their children. The school had filed a child abuse report on the family, but the physical discipline did not reach the threshold necessary for child abuse to be founded. She was miserable but said that she would not divorce her husband because "my religion is opposed to divorce."

Most psychologists would conclude that discussions of religion/spirituality would be appropriate in both situations, because the patients brought in religion/spirituality as it relates to their presenting problems.

Religion/spirituality is important in psychotherapy in several ways. First, it often establishes values and norms that people strive to follow. Although beliefs and behavior are multidetermined, religious/spiritual beliefs often strongly influence a person's behavior, self-concept, and world view.

Religion/spirituality can often facilitate patient recovery by offering solace, a new perspective on life stressors or events, or by mobilizing social and emotional supports, although sometimes religious beliefs or practice can harm patient well-being. Psychologists can help patients by mobilizing the strengths and resources that religion/spirituality has to offer and help patients to identify and correct harmful aspects of religion/spirituality, if any. However, the process of identifying and correcting harmful aspects of a patient's religion/spirituality can be quite challenging as harm can be subjective in nature. For example, fasting as part of a spiritual discipline is associated with a number of traditional religions (e.g., Buddhism, Christianity, Hinduism, Islam, Judaism), but might be harmful for a patient with an eating disorder.

Finally, religion may influence how patients respond to their psychologists. For example, some conservative religions are skeptical of psychologists. The most skeptical would probably never enter the offices of psychologists as they perceive that secular psychologists will use mind control, brainwashing, or other techniques to undermine their faith. Somewhat less skeptical individuals may be concerned that a secular psychologist would question and pathologize their faith's beliefs and practices. Those less skeptical may enter psychotherapy but may be sensitive to anything that they perceive to be critical of their faith tradition. A psychologist may better help their patients if they can identify the influence of the patient's faith on how they interpret their psychologist's behavior.

Is Religious Competence a Part of Cultural Competence?

If psychologists are going to be culturally competent (and they should be), then it would seem necessary to consider the religious dimensions of

Continued on page 2

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Continued from page 1

their patients' culture. Culture is defined as a set of behaviors, attitudes, or values that is shared by an identifiable group of people. To the extent that religion involves a system that creates or transmits beliefs, traditions, and social norms, it is an aspect of culture.

General Principle E of the APA Ethics Code states that

> Psychologists are aware of and respect cultural, individual and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups (APA Ethics Code, 2017).

Religion is a unique contributor to culture, but it also overlaps with other dimensions of culture such as ethnicity. For example, Orthodox Christians are traditionally of Greek or Russian descent; Roman Catholics are traditionally of Irish, Italian, French, German, Spanish, or Portuguese descent; and traditionally most Protestant groups are of European/American or African/American descent; Hindus are mostly from South Asia; and Muslims are mostly from North Africa or the Middle East (although Black Muslims are African/American). Taoist and Buddhist are mostly from East Asia, and Bahai's mostly from Iran or the Middle East.

However, the relationships between ethnicity and religion can be more complex. For example, many persons from India are not Hindus, but Sikhs, Zoroastrians, Moslem, or Christian. Some Latinx have religious practices and beliefs influenced by African-based traditions, such as Santeria (Regla de Ocha) or Spiritualism (Espiritismo) and others are evangelical Protestants.[1] Many Asian-Americans are conservative Christians and many European/Americans now identify themselves as Buddhists.

Regardless of the religion, there is diversity within diversity. A broad label, such as being Christian or Jewish, only reveals so much about a person. Psychologists should avoid assuming too much based only on a general descriptor of one's religion. For example, world-wide most Seventh Day Adventists believe that men are Biblically sanctioned to be the leaders of the church and that women should hold secondary roles. However, California Adventists "believe in the full equality of women, [and] favor the ordination of women to the gospel ministry" (Rayburn, 2014, p. 217). Some Quakers are evangelical Christians; others are non-theistic. Within the Confucian tradition, some view filial piety as requiring children to obey their parents or other authorities (authoritarian piety) while others emphasize reciprocal obligations (reciprocal piety; Chan & Chen, 2007).

Psychologists, Religion/Spirituality, and Psychotherapy

As a discipline, psychology has had a long and complicated relationship with religion. Some psychologist and psychotherapists, such as Sigmund Freud, Albert Ellis,[2] and John Watson, were openly hostile toward religion. Others, such as Abraham Maslow or William James respectfully integrated religion into their study of psychology. Today, interest in religion and psychology has resurged as evidenced by the development of several journals specifically devoted to religion and psychology, the vibrance of APA's Division 36 (Society for the Psychology of Religion and Spirituality), and the development of a cadre of scholars and practitioners passionately devoted to integrating psychology with religion and spirituality.

Some religious traditions or denominations welcome the contributions of psychologists and the field of pastoral counseling borrows highly from psychological knowledge and practices. Other religious traditions are openly hostile toward psychologists and caution their members to avoid psychological services.

Shafranske and Cummings (2013) found that 80% of Americans in a national survey reported that religion was very or fairly important to them, compared to 52% of clinical or counseling psychologists (although 74 % of those psychologists reported that spirituality was very or fairly important to them). Some have interpreted this as a major belief gap between psychologists and the patients they treat. However, this gap should not be overstated. Although psychologists are less religious than Americans in general, they are more likely religious than not. Psychology is a diverse field made up of many persons with highly diverse religious and spiritual backgrounds. Just as we should not over generalize about religions, we should not overgeneralize about psychologists either.

How to Competently Integrate Spirituality and Psychotherapy?

Vieten, Scammel, Pilato, Ammondson, Pargament, and Lakoff (2013) identified 16 required attitudes, knowledge statements, and skills (see Table One) that psychologists should demonstrate in order to competently integrate religion or spirituality into psychotherapy. For example, one of the attitudes was that "psychologists view spirituality and religion as important aspects of human diversity, along with factors such as race, ethnicity, sexual orientation, socioeconomic status, disability, gender, and age" (p. 135); one of the knowledge statements was that "psychologists know that many diverse forms of spiritualty and/or religion exist, and explore spiritual and/or religious beliefs, communities, and practices that are important to their clients" (p. 135); and one of the skills was "psychologists help clients explore and access their spiritual and/or religious strengths and resources" (p. 135).

1. According to Baez and Hernandez (2001), Latinx Catholics have varying attitudes toward Santeria and Spiritualism. Some consider them blasphemies and will avoid them entirely. Others may occasionally participate in a ritual or consult a Santeria/Espiritismo practitioner; and some may participate equally in Christian and Santeria/Spiritualist rituals.
2. Despite his controversial public statements, Ellis often dealt with religious patients with empathy, sensitivity, and kindness (Johnson, 2016).

Table One:
Vieten et al.'s 16 Attitudes, Knowledge Statements, and Skills (paraphrased)

Attitudes and Beliefs

- Empathize, respect and appreciate patients from different spiritual, religious, or non-religious backgrounds;
- View spirituality and religion as important aspects of diversity, along with race, ethnicity, sexual orientation, socioeconomic status, disability, gender, age, et al.;
- Reflect on how their own religious or spiritual background can influence their clinical practice

Knowledge

- Know that spirituality and/or religion can have many forms and are willing to explore those forms with their patients;
- Understand the relationship and overlap between religion and spirituality;
- Understand that clients may have religious experiences that are hard to distinguish from psychopathology;
- Recognize that beliefs, practices, and experiences change over the lifespan;
- Know about spiritual and/or religious resources and practices that can help in recovery;
- Identify potentially harmful spiritual or religious experiences, practices, and beliefs;
- Identify legal and ethical issues related to spirituality and/or religion that may arise in treatment

Skills

- Conduct empathic and effective psychotherapy with patients from diverse spiritual and/or religious backgrounds;
- Routinely inquire about their patient's spiritual and/or religious background and experiences;
- Help patients to explore their spiritual and/or religious strengths and resources;
- Identify and address spiritual and/or religious problems in clinical practice;
- Keep abreast of research in the area of spirituality and religion; and
- Know the limits of their competence

Understanding the ethical issues in integrating religion and spirituality into psychotherapy was another standard and it needs to be expanded upon. Competent psychotherapists understand their roles and do not use a religious-based intervention to prioritize a specific religious worldview at the expense of the patient's treatment goals or the treatment relationship. Nor do they confuse the role of being a psychologist with that of a religious/spiritual counselor. That is, the goal of the psychologist is to treat mental distress. Faith issues are discussed primarily as they related to the mental distress of the patient.

Competent psychotherapists also respect their patient's wishes concerning the integration of spirituality or religion into treatment. Psychologists should only integrate spirituality or religion into psychotherapy if their patients want to (Hathaway, 2011). And, because many patients experience spiritual struggles (Pargament, 2007), psychologists should be ready to assess and process those struggles without judging or trying to solve the problem for the patient.

Some of the religiously or spiritually oriented interventions include, but are not limited to, referencing Scripture, incorporating religious imagery into relaxation exercises, encouraging forgiveness (including self-forgiveness), teaching spiritual or religious concepts, encouraging altruism or service to others, or clarifying values or spiritual goals. Sometimes these involve integrating or phrasing traditional psychotherapeutic concepts into religious language. Psychologists should not, however, use religious approaches or techniques in place of other interventions that have demonstrated efficacy in treating a specific disorder (Hathaway, 2011). And, psychologists should not engage in religious/spiritual practices in psychotherapy that are inconsistent with their own faith tradition. Consider the first vignette. If the prayer the patient asked the psychologist to recite is meaningful for the patient and not overtly harmful, but incongruent with the psychologist's worldview, rather than reciting the prayer with the patient, the psychologist could encourage the patient to continue using effective religious/spiritual practices outside of the therapy sessions (Pargament, 2007).

How to Think About Religious Beliefs

Beliefs are important, but religion is much more than a set of beliefs. Instead it is the totality of traditions, rituals, interpersonal relationships, and identifications with a group.[3] Sometimes when asking about their religious beliefs, patients will respond with "I was always taught that. . .,"

Continued on page 4

3. From the standpoint of cognitive psychology, concepts have more meaning if they are embedded in related concepts. As this applies to religion, religious concepts for many individuals have great meaning because they are often embedded in concepts related to family ties, emotional bonds, ethnic identity, and other affect-stimulating contexts.

SPIRITUALITY INTEGRATED PSYCHOTHERAPY

Continued from page 3

suggesting that the relationship that they had with their parents or early teachers represents extraordinary authority that needs to be respected.

Nonetheless, beliefs can often be important in determining a patient's behavior or interpretations of life events. But beliefs are more than just declaratory sentences. Beliefs have other dimensions that change with time and circumstances. Here are some ideas about beliefs:

- Very often psychologists need to show ***cultural humility***—a willingness to admit ignorance and ask guidance from the patient on what their beliefs or practices mean.
- It can often help to ask about the relational or affective dimensions of those beliefs. How does this belief make you feel? How does this belief get you closer to your life goals? What do others close to you believe?
- Beliefs often fulfill a social function. It can be worthwhile to ask patients if others in their faith community have the same beliefs or how others feel about a belief, or what would be the consequences if the patient expressed a different belief.
- Religious denominations may have much more wiggle room than what may appear on the outside. From the outside a denomination may seem like it has a solid lockstep set of doctrines. On the inside it is often more nuanced.
- The strength of beliefs may fluctuate depending on circumstances. In some contexts, a religious individual may feel guilt or shame and downplay the role of self-forgiveness. In other contexts, the same individual may give self-forgiveness a higher priority.
- Beliefs may develop idiosyncratically and have internal inconsistencies. Psychologists can help people identify and think through the contradictions in their beliefs if they are related to the patient's presenting problems.

Some mistakenly believe that psychologists are ethically forbidden from challenging any cultural practice or religious statement of a patient. After all, they could argue, isn't a psychologist showing disrespect for the patients' right to make decisions about their lives if they criticize patients' religious beliefs or practices? On the other hand, one could just as easily argue that psychologists would be failing to promote patients' well-being if they did not address beliefs that are causing great emotional harm. On the surface, it appears that respecting patients' autonomy to believe what they want could conflict with the ethical imperative to act in the patients' best interests (beneficence).

Johnson (2016) questions whether the conflict between respecting the patients' beliefs and promoting their well-being must be so stark. Harmful beliefs can be examined, but "confrontation does not imply 'going against' a client but 'going with' the client to critically and empirically explore how specific beliefs—religious or nonreligious—create, exacerbate or maintain clinical distress" (Johnson, 2016, p. 12). Patients will become defensive if they perceive that their beliefs are being attacked. They will become more open in response to nonjudgmental and compassionate requests for self-exploration.

These "confrontations" can be empathic and supportive. They can start with simple questions, such as asking a religious person suffering from great guilt, "What does the Bible say about forgiveness?" The goal is to help patients explore their beliefs. Explorations of this nature are more effective if psychologists strive to understand their patients carefully and empathize with their suffering. The probes or exploration-encouraging questions will be more effective if psychologists have listened carefully to their patients and tried to understand their beliefs and conflicts accurately. It may be indicated to borrow a page from Motivational Interviewing and only offer one's opinion after patients have had a chance to fully explain their beliefs and the patient asks for feedback or if the psychologists ask the patients for permission to give their opinions (Rollnick & Miller, 2013).

Consider the patient from one of the opening vignettes who stated that divorce was against her religion. Instead of taking that statement at face value, the psychologist can ask her to explore that idea more deeply. "Tell me more about this belief." "What does your religion say about family life and marriage?" "Has anyone in your church gotten a divorce?" "How do other people in your church feel about divorce?" "How does this belief make you feel?" "Do you wish your denomination had another doctrine?" "How would it impact relationships with others if you believed something different about divorce?" "What would be the consequences to you if you believed something different?", and so on.

It is possible that this patient is engaging in ***deferred religious coping or spiritual by-pass*** (using a religious or spiritual position to avoid discussing personal issues; Magyar-Russell & Griffith, 2016). If so, patients will be better able to think through these issues if they are working with a supportive psychologist who makes honest discussions of sensitive issues less frightening. However, it is also possible that this patient is experiencing a spiritual struggle in which consideration of her religious values might be critical in helping her to explore her thoughts, feelings, and choices within and beyond her current worldview (Pargament, 2007).

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Should Psychologists Self-Disclose Their Religious Affiliation or Beliefs to Their Patients?

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Consider these scenarios:

A psychologist received a call from a prospective patient who asked a serious of questions that suggested that she and the psychologist would be a good fit. Then she asked the psychologist, "Are you a Christian?"

When attempting to schedule an initial session a patient inquires if the psychologist is available on Friday evening, unaware that the psychologist observes Shabbat.

In choosing a psychologist and in order to foster self-determination, patients have the right to know a reasonable amount of information about that psychologist. A patient might choose a psychologist because of gender, ethnicity, theoretical orientation, or any number of other attributes. For example, a patient pursuing substance abuse treatment might believe (possibly incorrectly) that the only psychologist who can assist him or her is one who has also been in recovery. Likewise, patients have the right to choose a psychologist either similar or dissimilar to them in terms of religion and spirituality identification (Pargament, 2007). These initial questions from a potential new patient need not distress the psychologist. Instead, for a psychologist who is open to having religion and spirituality as part of the therapeutic process, inquiry from the patient opens the door to further discussion of spiritual integration.

In other cases, the request to learn about the religion of the psychologist comes after psychotherapy has already started. Patients already in treatment may have disclosed some information about their religious background or may feel a desire to do so and then ask, "What church do you go to?" or some similar question.

How should the psychologist respond? For some psychologists the answer may be obvious, especially if they used a specific religious or spiritual term in their public announcements. In some parts of the United States, it is common for psychologists to identify their specific place of worship in the public advertisements. In other situations, patients may infer (sometimes incorrectly) the religion of their psychologists from surnames that are commonly associated with being Jewish, Italian Catholic, Scandinavian Protestant, etc.

The religious identity of other psychologists may be less obvious, and patients may not be able to discern the religion of their psychotherapists without asking them. The general rule is that psychologists should self-disclose selectively if the disclosure promotes the well-being of their patients (Hill, Knox, & Pinto-Coelho, 2018; Pargament, 2007). The research on the benefit of self-disclosing one's religion to patients is inconclusive. The only available data came from two analogue studies which found mixed results in the benefits of disclosing one's religious affiliation (Danzer, 2018).

The question then, is whether disclosing one's religious affiliation furthers the goals of psychotherapy. We have known psychologists who have responded differently to these questions. Some psychologists may refuse to respond and instead focus on the apparent reason for the question, noting that they show respect for the religion of their patients and will incorporate religious perspectives into psychotherapy if their patients so choose. Such a response promises respect for the patient's religious perspective and a willingness to incorporate their worldviews into psychotherapy. Other psychologists may disclose their religious affiliation. Nonetheless, a word of caution is in order. Although such a limited disclosure of one's religious self-identification is probably harmless and potentially helpful, psychologists should avoid going down a slippery slope of increasingly more detailed self-disclosures. Although disclosing one's religious affiliation or self-identification may satisfy some patients, it may not satisfy others. Some patients may continue to ask more questions such as whether the psychologist was "born again," "believed in salvation by grace," or believed in "the physical resurrection of the body?"

Some patients (and some psychologists) over value the importance of having similar religious backgrounds. The outcome research here is complex. Patient preference makes a difference in outcome, at least in terms of types of treatment (Swift, Callahan, Cooper, & Parkin, 2018). So, it is likely that some patients may enter treatment with a fixed attitude that only someone of a certain religion can help them. Their preconception closes the door to accepting help from anyone else. But, on the whole, matching psychologists and patients according to religion has not yielded any improvement in outcome (Cummings et al., 2014). There may be methodological issues that mask a true relationship

Continued on page 9

1. Samuel Knapp wishes to thank Dr. John Lemoncelli for mentoring me in the area of religion, psychology, and ethics.

Does Religion Protect Against Suicide?

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Emile Durkheim, a pioneer of modern sociology, concluded that Roman Catholics in Europe had a lower rate of suicide than Protestants, because they were better able to create a supportive social environment (1897/1967). Since his seminal work a hundred years ago, much more research has been conducted on the relationship between religion and suicide. The conclusions from subsequent studies were usually consistent with Durkheim's claim that religion can reduce a person's risk of suicide.

Nonetheless, the religion/suicide relationship is complex. Some studies found no relationship between religion and suicide, and a few studies found that religion increases the risk of suicide. The inconsistencies in findings may be due to differences in the samples studied or the way that researchers defined religion (Gearing & Alonzo, 2018).

Using General Social Survey data, Kleiman and Liu (2018) found that religious affiliation alone was unrelated to suicide, but attendance at religious activities (for data sets after 2010) was related to a lower risk of suicide. It could be that participation in religious activities may protect against suicide because it is an involvement with a group that may provide instrumental support (e.g., financial assistance when needed) or emotional support (e.g., caring persons willing to listen to one's troubles). Also, the religion may teach *life protecting* beliefs (e.g., beliefs that suicide is sinful and prohibited) or *life promoting* (beliefs that they have an affirmative obligation to flourish and promote the flourishing of others; Knapp, 2019). Furthermore, religions often discourage the misuse of alcohol or other drugs.

A shortcoming of these studies is that almost all are correlational. However, longitudinal studies reviewed by VanderWeele (2017) found the same trend that religious participation is positively related to emotional well-being.

The religion/suicide link appears to vary by gender and age. Religious participation better protects women than men and older adults more than younger adults (Gearing & Alonzo, 2018). The age/religion/suicide relationship is hard to evaluate, however, because some older adults with severe disabilities are at a higher risk for suicide and may be unable to participate in religious activities.

The specific religion of the individual appears to be a factor as well. For example, the reported rate of suicide among Muslims is very low, although there are reasons to believe that suicide, which carries a very high social stigma in Muslim societies, may be under reported. In those Muslim societies where women experience substantial discrimination, suicidal behaviors were noticeably higher among women than men (Gearing & Alonzo, 2018).

What are the practical implications for psychologists? When interviewing suicidal patients, psychologists can ask their patients about the extent to which they would like to have religion or spirituality incorporated into their treatment.[1] Many patients find religion a source of comfort, strength, and support that can be mobilized to reduce their risk of suicide. However, psychologists should not assume that religion is always a protective factor. Religion has been linked to poorer mental health among those with spiritual struggles, among unwed mothers who are religious, and among those who have had negative interactions with their congregations (VanderWeele, 2017). Evaluating professionals need to be sensitive to an individual's unique life narrative and beliefs, the nature of their participation in religion, and its meaning for them (Lawrence et al., 2016).

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1. Religion and spirituality overlap as concepts. Religion generally refers to institutional practices and rituals; whereas spirituality refers to a sense of transcendence or a commitment to something greater than oneself. One should not draw too great a distinction between the two, however, as most religious persons expresses their spirituality through religious practices and rituals. Nonetheless, many patients will respond positively to inquiries about their spirituality but decline to identify themselves as religious.

PPA AND THE COMMITTEE ON MULTICULTURALISM ARE PROUD TO PRESENT:
FOOD FOR THOUGHT

PPA's Committee on Multiculturalism (COM) has created a custom cookbook featuring favorite family recipes from our members. These cookbooks are sure to be a treasured keepsake for all. Proceeds will be used to fund the Multicultural Student Award. Recipes from all cultures and ethnic backgrounds are included, and most also include a brief story about the heritage of the recipe.

Cookbooks are available for purchase for $20. Cookbooks may be purchased by mailing a check, **made out to PPF**, to the PPA office at 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112 with 'cookbook' included in the memo line or online by clicking on this banner and entering 'cookbook' in the reference line.

What is the Meaning of Life?

A Review of *Meaning in Life: A Therapist's Guide* by Clara Hill

Samuel Knapp, Ed.D., ABPP
Director of Professional Affairs

Sometimes questions about the meaning of life are related to the primary issues facing patients. At other times they are lurking in the background. Dr. Hill reviews the meaning of life issues that may arise in psychotherapy and how to address them.

Not everyone agrees on what is meant by the question, "What is the meaning of life" (or sometimes phrased as the "meaning in life"). Hill's review identified 13 different descriptions on the meaning of life (although there was much overlap and some of the differences appeared to be primarily semantic) and found three common elements: (a) *coherence or comprehensibility* (What is your framework for understanding the world? Is it God or science or both or something else? Where do we fit in the world?)[1]; (b) *purpose or goals* (What should drive our behavior? Where should we invest our time and energy?); or (c) *significance* (Do our lives make a difference?). In addition, she added two more dimensions that she deemed important: a felt sense of meaning, and reflectiveness about meaning. Therefore, according to Hill, meaning in life "involves a felt or intuitive sense of meaning, a sense that one matters and is significant, a sense that one has purpose and goals and is engaged in life, a sense of coherence or comprehensibility, and a sense of enjoyment on reflecting about meaning" (2018, p. 37).

Dr. Hill is not the first psychotherapist to address meaning of life issues. Viktor Frankl, author of *Man's Search for Meaning,* focused on existential concerns in his logotherapy. In addition, meanings of life are addressed in Irving Yalom's existential therapy and in Acceptance and Commitment Therapy (ACT). Dr Hill draws from each of these perspectives in developing her strategies for working with meaning of life psychotherapy.

According to Hill's research, a minority of patients (perhaps 12% or so) have meaning of life issues explicitly or implicitly related to their presenting problems. Often interpersonal conflicts, career decisions, or life transitions prompt these questions. Other patients will have meaning of life issues arise during discussions of other life problems. Meaning of life discussions are not appropriate for all patients. Some patients simply do not have an interest in such topics, and other patients may try to use detached philosophical debates to avoid talking about more clinically relevant but emotionally laden concerns.

Meaning of life work involves three steps: exploration, insight, and action. Effective psychotherapists addressing meaning of life issues tend to use insight-oriented interventions to help patients better understand themselves. They were empathic and supportive when patients struggled with their decisions and encouraged patients to take specific steps to improve their lives. Psychotherapists of any orientation can incorporate meaning of life issues into their work and can use a variety of techniques to help patients to think through these issues and to make useful changes in their lives.

As psychotherapists, we tend to do better at helping others when we seek to understand ourselves, our experiences, and our life histories. An attitude of humility helps a lot. As Hill notes, "by experiencing the depths and ambiguities of self-examination, therapists are more likely to be humble and compassionate and thus able to help and encourage clients in navigating their journey toward self-awareness" (p. 76). Along that vein, the chapter entitled "Finding meaning in life: A self-help guide," was especially interesting to me. It contains many questions designed to encourage self-exploration and insight and includes action steps that could be of value to anyone interested in better understanding themselves.

The book contains case examples of meaning of life work, a chapter on ethical and multicultural issues, a review of the research on meaning of life work, and a final chapter on future directions in meaning of life work.

Dr. Hill is a professor of psychology at the University of Maryland and a prominent researcher in psychotherapy outcomes.

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1. This has important implications for some patients. They may believe that the world is always unfair and that they will be cheated by others at every opportunity. Others believe that God is out to punish them for some sin they committed earlier in their lives. On the other hand, others believe that God is looking out for them and has a plan with their best intentions in mind, etc.

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PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Essential Skills for Therapists Interested in Working with Couples and Families

Amelia Herbst, MS; Deangie Davis, M.Ed; Liora Schneider, MA, MS;
Scott Browning, PhD, ABPP
Chestnut Hill College

The skills taught in most counseling programs examine the techniques of psychotherapy provided to an individual. While coursework on systems treatment is common, it is still limited. Many people work with couples and families and yet may have limited education on the specifics of these clinical challenges. If one is choosing to work with couples and families, it is that person's responsibility to have proper training and supervision with systems. The skills established in individual treatment alone, are not sufficient to be competent with systems. The following short article examines some essential skills needed to do responsible work with cases involving more than one person. Readers can find more information on both the underpinnings of systems thought, and specific interventions, in the readings in the reference section.

1. **Assessment of the family structure:** Evaluate in the first session the hierarchies, subsystems and boundaries as they exist in the family. A good way of assessing the couple or family is through a genogram. A genogram is a three generational, visual family map that allows the therapist to collect factual and relational data. The genogram can also be used as a visual reference to help the therapist orient treatment especially if clear familial patterns are present.
2. **Determine who needs to be in the therapy room:** Not everyone needs to be involved in family therapy but sometimes there are people that are obviously missing from the room. Talk with the family to see who they believe are important members to be involved in the work. Even though getting an idea of who should be in the room is important at the start of treatment, does not mean that others cannot be invited in when they are needed.
3. **Confidentiality and secret keeping:** How are you going to handle secrets when working with the family? Does everyone have the right to their own secrets? Or are secrets in family therapy harmful to the progress of treatment? Every couple and family therapist have her or his own views on handling information given to them in secrecy. The consent form adopted should explain how secrets will be handled in treatment.
4. **Joining:** Being able to develop the therapeutic relationship is important in any type of therapy. When working with families, the therapist needs to balance relationships with all members of the family. There are times that the therapist will be more aligned with a certain member of the family depending on the work that is being done. However, it is pertinent that the therapist continues to maintain relationships with all of the family and to shift focus to another member when appropriate.
5. **Identified client versus the problem in the family:** With most of our cases, especially families with children, we are presented with an identified client. It is important to remember that the work is focused on the whole family. At times, it can be easy to be lulled into focusing on one particular member without bringing the attention onto other members of the family.
6. **Focus on strengths:** Compliment the family's efforts on attending therapy and engaging in a process of change. Encourage each family member to acknowledge their achievements and to express them openly with each other. (You can practice with them in session and they can keep doing that at home.)
7. **Keep what is functioning:** Do not get rid of the interactions and behaviors that are functioning. Assess with the family what is working for them and what is not and focus on both. Sometimes when taking away maladaptive behaviors at the beginning, the couple or family becomes unstable without the proper coping mechanisms or alternative behavior in place.
8. **Collaborative therapy:** Engage the family in therapy, they will be more powerful if they can contribute to therapy instead of just following directives. With couples, make sure that you create a space that allows them to be vulnerable with each other so they can feel connected. This also allows them to work in collaboration with each other as well as with the therapist.
9. **Support systems:** Utilize as many supporting systems as they need in the therapeutic process (extended family, school, church, community centers, etc.). Sometimes we forget that families need resources and support outside of the therapy room. Paying attention to the benefits of their other systems can help their progress in treatment.
10. **Creating Change:** For individual treatment, change is usually a shift in one's own behavior. For system's work, change involves an interactional adjustment. For this to occur, usually one's perception of the other's actions or intension needs to be considered from an alternative perspective. It is for this reason that the process of reframing, or assisting one to see the dilemma of their current patterns, is often part of clinical change when working with couples or families.

While keeping the aforementioned skills in mind, it is also imperative to think of the implications of the current sociopolitical cultural climate. We are called to be multiculturally sensitive and humble at all times, especially in family work. Be aware of the differences in systemic oppression that each person in the family faces. In complex and diverse families, the therapist is urged to evaluate how the members of marginalized identities may be affected. In addition to race and culture, be mindful of possible immigration and acculturation concerns. When working with all clients, be mindful if the family is from a collectivistic or individualistic background.

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SHOULD PSYCHOLOGISTS SELF-DISCLOSE THEIR RELIGIOUS AFFLIATION OR BELIEFS TO THEIR PATIENTS?

Continued from page 5

between matching patient and psychologists on religion, but so far, the data does not support the benefit of such matchings.

Furthermore, even if patients and psychologists do match on religion, there is a danger that the psychologist may assume that they understand the patient's perspective without listening carefully to what the patient actually said. Some patients may be unclear or unsure of their own religious beliefs and seek affirmation from the psychologist. Although it may offer comfort to agree with a patient, psychologists who do so risk misusing their position of power. Other patients may ask questions such as "What would you do?", "Have you struggled with this kind of situation?" Although the amount and type of self-disclosure should focus on enhancing the therapeutic alliance rather than on the psychologist as a figure of authority, the psychologist might also consider his or her own authenticity in the interaction. Pargament (2007) cited several reasons why a modest amount of self-disclosure from the psychologist can facilitate therapeutic progress, including sharing a sense of understanding existential aspects of life while respecting the patient's autonomy regarding values and decision making.

Consider this example,

> One psychologist received a referral from a local priest to conduct psychotherapy with a woman whom he described as "a very devoted member of our church." Although the psychologist was very good at establishing rapport with patients quickly, he was unable to do so with this patient and puzzled as to why this was occurring.
>
> Then, during the next session he said, "I want to apologize to you. I do not think I have been listening as carefully as I should have been. I am going to try to do better."
>
> While he was reflecting on the apparent impasse in treatment, he realized that the woman was not a devoted member of the church but had many issues and conflicts with her faith. But the mere statement of the priest that she was a devoted member of the church caused him to misunderstand and distort her comments.

In summary, a psychologist may, but should not feel compelled to, self-disclose their religious affiliation if they believe that it will further the goals of treatment. However, the self-disclosure should be limited, and psychologists should avoid going down a seemingly endless cascade of patient requests and psychologist disclosure. Although sharing a religious background or perspective may help many patients, it also involves risks if it causes the psychologists to assume too much about their patients and fail to listen carefully to their unique life experiences and belief formation.

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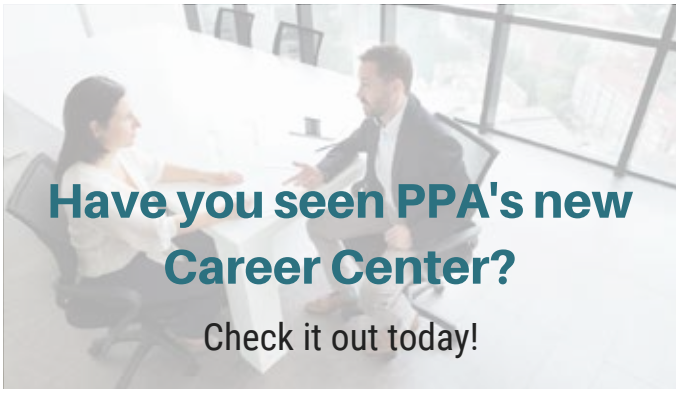

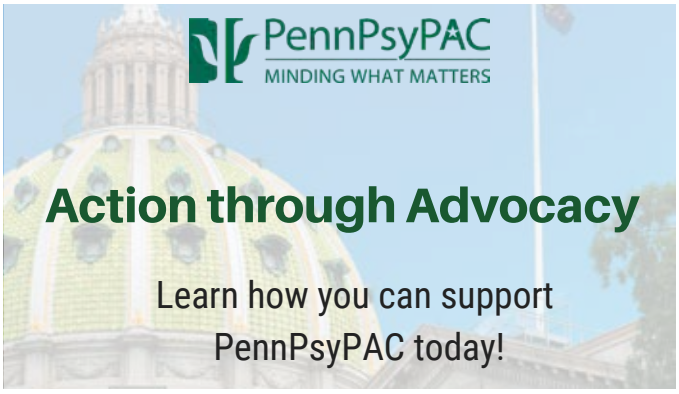

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