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Elizabeth Anne Levy
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ABSTRACT

This study was designed to examine whether clinicians who identified themselves as maintaining a religious or spiritual practice as part of self-care routines found these practices helpful in continuing to practice effectively. To collect information regarding this question, eleven clinicians doing direct service work were interviewed; each clinician was asked the same set of questions. The study was qualitative in nature.

Each clinician had a unique way of expressing, carrying out, and maintaining his or her religious and/or spiritual practices. As a whole, however, the eleven stories created a surprisingly cohesive narrative. All eleven clinicians reported maintaining religious and/or spiritual practices as part of their self-care helped them continue to do difficult work, avoiding burnout, compassion fatigue and vicarious traumatization.

ROLLING SMOOTHLY ALONG

The Stories of Eleven Clinicians' Spiritual self-care
as a vital aspect in avoiding burnout, compassion
fatigue and vicarious traumatization

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2010

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This study is dedicated to Holly McCormick, for showing me just what is possible when we live in a place of spirit and sending on my own spiritual journey. I would also like to thank my family and friends who have been so patient with me throughout the process of bringing this study to fruition. I would like to acknowledge Professor Andrew Jilani for making research inspiring. I would like to thank Michael Murphy for his dedicated advising and editing throughout this process and Kelly Coffey for helping me find the energy to keep going. And I would especially like to thank the eleven amazing women and men who took time out of their lives to take part in this project. I cannot thank you by name, but this work is essentially yours, and I cannot thank you enough. To Chris, thanks for everything.

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CHAPTER 1

INTRODUCTION

The work of a clinician can be painful and even dangerous to the health of practitioners. The ways in which clinicians continue to do this highly rewarding, but often-difficult work was the general focus of this study. My conjecture was that the time during which clinicians were able to be most present and focused led to greater efficacy of treatment. It therefore seemed that if this was true, the ways in which clinicians cared for their own physical and psychological health was vital to the practice of social work. More specifically, the research herein focused on the topic of spiritual practices amongst clinicians and their use as a self-care tool in combating compassion fatigue and burnout.

When I set out to examine the ways in which self-care and religious and/or spiritual practices might be linked, I had one main question: Do clinicians who maintain a religious or spiritual practice as part of self-care routines in fact find it helpful in continuing to practice effectively? As I began to explore the literature, I found that I could not find much that had been written specifically on the topic.

I then began to look more deeply into the literature that existed on clinician self-care. I came across terms such as vicarious traumatization, burnout, and compassion fatigue as common themes. I began to develop a beginning understanding of how and why these things could potentially have a major impact on those in direct service clinical work. I quickly discovered that self-care is a broad and multi-layered topic. I therefore narrowed my focus to the spiritual and religious side of things. Since the

birth of Psychotherapy, there has been something of a separation between the "science" of clinical work, and the more airy, amorphous world of religion and spiritual practices.

In recent years, there has been a resurgence in the interest of the spiritual lives of clients, and how clinicians worked with them in that area to help give them greater strength and stability. I had difficulty, however, finding specific, qualitative work on how clinicians' own sense of spirituality and religion helped to give them strength and stability. I found that many noted and long-term researchers had explored this topic, as is shown below in the Literature Review, but what I found missing were stories. Stories, what happened in people's lives, the things that brought them into the offices of clinicians' around the world, and the power and strength that they possessed, were few and far between. I wanted to hear, from the people in the field, engaged with clients, how they continued to do work that produced effects such as "vicarious trauma". I began with an exploration of the literature presented in Chapter 2

CHAPTER 2

LITERATURE REVIEW

Clinician self-care is a topic often mentioned in classrooms as new clinicians learn about how to begin the process of holding the pain and suffering of others. Laurie Anne Pearlman (1995), a pioneer in the field of looking at the effects of working with traumatized clients, wrote “Those who voluntarily engage empathically with survivors to help them resolve the aftermath of psychological trauma open themselves to a deep personal transformation” (p. 51). This learning and depth and growth are incredible reasons to engage in this work, to choose to become a clinician and continue to do the work. I was not sure, however, that this by itself was enough. Clinician burnout and vicarious traumatization are topics that have been of increasing concern to researchers in recent history. Though there were a number of articles written about the meanings and concepts of burnout or compassion fatigue (Horner, 1992; Munroe, et. al., 1995) and vicarious traumatization (Aravay, 2001; Buchanan, et. al., 2006; Figley, 1995; McCann & Pearlman, 1990; Harrison & Westwood, 2009; Pearlman, 1995; Pearlmann & Saakvitne, 1995; Yassen, 1995), I chose the following definitions for use in this study. Maslach (1982) defined of burnout, “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment” (p. 260). Compassion fatigue was defined as “emotional exhaustion from working with traumatized clients” (Adams,et.. al., 2006). Vicarious traumatization was defined as “a process of change

resulting from empathic engagement with trauma survivors” (McCann & Pearlman, 1990). These types of changes, suggested McCann & Pearlman (1990) could be devastating to a clinician and their ability to do the important work they set out to accomplish.

The darker side of the transformation includes changes in the self that parallel those experienced by the survivors themselves...[vicarious traumatization] is neither a reflection of inadequacy on the part of the therapist nor of toxicity or badness on the part of the client. It is best conceptualized as a sort of occupational hazard...p.52

Categories of self-care ranged from vacations and physical relaxation, physical activity, working on projects important to the clinician, seeking the support of others, and the focus of this project, spiritual practices. These were broadly defined (Britt, 2003; Kaye & Fortune, 2001; Pearlman, 1995; Schure, Christopher & Christopher, 2008) and part of the scope of this study was to examine the ways in which individual clinicians defined these practices for themselves.

Shure, Christopher & Christopher (2008) conducted a 4-year qualitative study "examining the influence of teaching hatha yoga, meditation, and qigong." Thirty-three (27 female and 6 male) 1st and 2nd-year graduate students in mental health counseling, school counseling, and marriage and family counseling participated in the study. Participants were all enrolled in an elective "15-week, 3-credit mindfulness-based stress reduction course". Students spent time in class practicing different types of mindfulness, such as yoga, breathing techniques and qigong, and were also required to practice "for at least 45 minutes, four times a week". Readings were also a part of course work. Data were collected through a final journal assignment in which the students were required to

answer questions regarding "(a) physical changes, (b) emotional changes, (c) attitudinal or mental changes, (d) spiritual awareness, and (e) interpersonal changes. (p. 49).

Answers were transcribed by the authors and analyzed using NVivo (Software in Qualitative Research NVivo Version 1.2) qualitative data analysis software. According to the authors, participants "reported positive physical, emotional, mental, spiritual, and interpersonal changes and substantial effects on their counseling skills and therapeutic relationships. Most students reported intentions of integrating mindfulness practices into their future profession" (p. 1).

Past research also suggests that there would be a positive correlation between clinicians' own religious or spiritual practices and their ability to continue working with clients. The NASW Code of Ethics (2008) stated, "The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people..." (p. 1). There were several key factors to consider in the development of this research project.

The first concept relevant to this topic is the prevalence and types of religious and spiritual beliefs held by the general population in the United States. Research indicates that a vast majority of Americans have a belief in G-d or a higher power (Miller & Thoresen, 2003; Plante, 2008). Furman, Benson, & Canda (2004) found evidence that there are regional difference in the ways people in the U.S. conceptualize and practice forms of religion and spirituality. There are also many ways in which "religion" and "spirituality" are defined. Hodge and Boddie (2007) conducted a qualitative study examining the ways in which social workers define these terms. Their finding suggested that

faith tradition, orthodoxy, and spiritual motivation were all unrelated to how respondents defined spirituality, with one relatively minor exception. Higher levels of spiritual motivation were associated with a greater likelihood of defining spirituality in terms of Belief in/experience of G-d. pgs. 64-65

One of the major biases shown in past literature was the historical separation of spirituality/religion from psychotherapy as a profession (Aten & Leach, eds. 2009; Sperry, eds., 2004). However, according to a recent study by Plante (2008), “It appears that professional psychology has rediscovered spirituality and religion with renewed interest in integrating this aspect of life into psychotherapy...” (p. 429). Furman, Benson, & Canda (2004) offered specific definitions of “religion” and “spirituality”, which seemed to contradict these findings presented by Hodge and Boddie. They defined spirituality as “involving searching for meaning, purpose, and morally fulfilling relation with self, other people, the encompassing universe, and ultimate reality, however a person understands it”, whereas religion was defined as “an organized structured set of beliefs and practices shared by a community related to spirituality” (p. 274). They also included the caveat that “Spirituality can be expressed through religious forms, but is not limited to them” (Canda, 1990a; Canda, 1990).” (p.274). Lee & Barrett (2007) defined spirituality as

one’s real and irreducible inner, sacred experience that invites increased consciousness and responsibility for oneself and others (Hodge, 2005b). It can exist within and/or outside of a traditional religious structure and may include diverse values and belief systems (Canda & Furman, 1999). Religion...is commonly defined as belief concerning the supernatural, sacred, or divine, and the moral codes, practices, and institutions associated with such belief (Paragant, 1997). p. 3

For the purposes of this study, the definitions offered by Griffin & Griffin (2002) served as the working definitions from which exploration began. Hodge and Boddie (2007)

explored how the individual participants defined these terms within the contexts of their lives. According to Griffin & Griffin (2002), "*Spirituality* is a commitment to choose, as the primary context for understanding and acting, one's relatedness with all that is" (p. 15).

Religion represents a cultural codification of important spiritual metaphors, narratives, beliefs, rituals, social practices, and forms of community among particular people that provides methods for attaining spirituality, most often expressed in terms of a relationship with the G-d of that religion. p. 17

The recent interest in religion and spirituality across the country was the subject of several studies over the past ten years as well. With the above definitions in mind, it seemed important to note that it appeared from the consistency of research (Plante, 2008; Miller & Thoresen, 2003), the idea of spirituality was important to the general population across regions of the country (Gallup & Lindsay, 1999). It was a topic that is rich and textured, and the studies did not generally examine these issues from a personal perspective but attempted to look at a broader, more scientific picture.

Miller and Thoresen (2003) reported on a way to study spirituality scientifically. They asserted that "although it is seldom covered in the training of social, behavioral, and health scientists or practitioners, a very large body of scientific research on spiritual/religious processes already exists..." (p. 2). They went on to say, however, that "some understandable confusion exists about how best to study spiritual/religious factors and how to interpret the results of empirical studies in this area (Oman & Thoresen, 2002)," but also that "there is, however, little scientific basis for assuming that spirituality cannot be studied (Easterbrook, 1997)..." (p. 2). They also wrote

A second possible reason for asserting that spirituality should not be studied is essentially the materialist argument in reverse: that is, science, by definition, is

incapable of studying spirituality (e.g., Thomson, 1996). According to this view, the methods of science offer inept or inappropriate ways of trying to understand spirituality, regardless of its relevance to health and patient care. If one believes spiritual tenets to be fundamentally subjective and ineffable, then it follows that spirituality will elude methods that rely on direct observation and replication. There is integrity to this perspective, but again, it is a philosophical position and is not scientifically based."

Another important concept examined in undertaking this research was the potential health benefits of spiritual and religious beliefs. Researchers such as Miller and Thoresen (2003) and Brenner (1997) conducted studies that showed a clear correlation between individual's physical and mental health and their engagement in a spiritual or religious practice. Miller and Thorsen (2003) also wrote

The concept of health itself has emerged in recent decades as something far more than just disease-free biological functioning. Health is powerfully influenced by cultural, social, and philosophical factors, including the existence of meaning and purpose in life and the quality of intimate personal relationships (Ornish, 1999; Ryff & Singer, 1998). Such considerations have persuaded us that further investigation of spiritual/religious factors and health is both clearly warranted and clinically relevant. Many scientists nevertheless remain uninterested or uninformed about the existing literature linking spiritual/religious factors to health. p. 2

There has, however, been a focus amongst researchers in the past on the ways in which clinicians learn to and practically address the spiritual needs of their clients (e.g. Brenner & Homonoff, 2004; Gilligan & Furness, 2005; Sermabeikian, 1994) and the clinicians' direct incorporation of spirituality into practice with clients, (Aten & Leach, 2009; Lee & Barrett, 2007; Sperry & Shafranske, 2004). It appears that there has been little done on the ways in which the spiritual beliefs of clinicians impact their work with clients. However, according to Frazier & Hansen (2009), "the greater [the clinician's] own religious self-identification and number of relevant continuing education hours, the more frequently they reported engaging in these [religious/spiritual] psychotherapy

behaviors” (p. 84), which included items such as “actively communicate respect for clients’ religious/spiritual beliefs” and “strive to repair religious/spiritual based mistakes in treatment” (p. 83). Sori, Blank, & Helmeke (2006) suggested that “to be able to utilize [the] resource [of the relationship between spiritual health and mental health] in clients, therapists need to tend to their own spiritual needs as well” (p. 3). They examined what they called “spiritual self-care activities”, which they divided into the categories “meditation, prayer, conducting a personal moral inventory, attachment to God and spiritual coping styles, religious coping activities, nature, movement and the arts, spiritual self-care through care for others, and spending time with others and play” (pgs. 7-8). Cornett (1998) talked about “spiritual health values” and stated, “spirituality is really no different from any other area in terms of a therapist’s health values” (p. 123).

The present study examines whether or not individual clinicians feel that is true for them, and perhaps expand the notion of “spiritual practice” as it explores clinicians’ individual understanding of this term. Given the research on the positive effects of spiritual/religious practice on health and well-being and the research on how spiritual/religious practice informs work with clients, it has been surprising to find little research on the ways in which clinicians may or may not use their personal sense of religion or spirituality to combat compassion fatigue or burnout.

One major issue is the lack of consideration of diversity within the literature examined. Most studies reviewed were conducted with primarily White subjects when it was specifically discussed, such as in the study by Shure, Christopher & Christopher (2008) in which of their participants "30 were White, 2 were Japanese, and 1 was Native American" or Lee and Barrett (2007), while other studies did not mention the racial or

socioeconomic background at all. (Miller & Thoresen, 2003). There has also been an assumption in much of the literature examined that spirituality is directly related to the dominant Christian culture in the modern United States. More research of the available literature is needed to try to address this current limitation in the literature.

Only one study (Meidros, M. E., & Prochaska, J. O., 1988) focused on these issues as a major theme. This study was most closely related in methodology and subject matter to my own research question. Interviewing social workers (n=30) in the greater Boston area, demographic information such as "age, race, sexual orientation, marital status, education, religious affiliation" (p. 8) was collected, and each participant was asked "to define spirituality in their own words". The researchers examined how participants used this concept of spirituality within their clinical practice. They did not explore the impact of spirituality, however, on the clinicians' personal self-care.

Based on the analysis thus far of relevant research, I have found that the current methodology of studies conducted about clinicians' own spiritual beliefs have used mainly quantitative survey methodology to gather the data. Even Meidros & Prochaska (1988) took the qualitative data they had gathered and analyzed in terms of charts, graphs and numbers. There was also a lack of examination of the nuances of the interplay between the clinicians' personal practices and their ability to continue doing a very difficult job. The studies on burnout, compassion fatigue or vicarious traumatization (Adams, et. al., 2006; Aravay, 2001; Buchanan, Anderson, Uhlemann & Horowitz, 2006; Figley, 1995; Harrison & Westwood, 2009; Sprang, Clark, & Whitt-Woosley, 2007; Horner, 1992; McCann & Pearlman, 1990; McLaughlin, 1978; Munroe, et. al., 1995, Pearlman, 1995; Pearlmann & Saakvitne, 1995; Yassen, 1995) provided numerical data,

but did not give the reader any access to the personal stories behind these numbers. I was interested less in the anecdotal and numerical evidence of the methods clinicians employ to combat compassion fatigue and burnout and much more so in the stories of the individuals working on the front lines with clients everyday. It was these stories, and the ways clinicians have persevered, that was the focus of this study.

This research examined what impact clinicians' felt maintaining an individual spiritual or religious practice as a self-care tool had on their ability to continue working in a profession with potentially high rates of compassion fatigue or burnout. While the terms "religion" and "spirituality" have broad and varying definitions, this research worked from definitions proposed by James L. and Melissa Elliott Griffith (2002), but, like Meidros & Prochaska (1988), also explored how the individual participants defined these terms within the contexts of their lives. This study was qualitative in nature. The current literature on this subject had been mainly quantitative in nature (Aten & Leach, 2009; Lee & Barrett, 2007; Miller & Thoresen, 2003; Plante, 2008; Shafranske & Sperry, 2004; Sperry, eds., 2004). This research is focused particularly on exploring clinicians' stories in a way that built upon current research and expanded the scope of discussion about spirituality and psychology. I felt this was best accomplished through individual interviews with clinicians.

CHAPTER 3
METHODOLOGY

Research Design

This project examined the ways in which clinicians used their personal religious or spiritual practices to help them continue to work in a stressful profession. Given the evidence discussed in the literature review above, I believed at the start of the project that there would be a positive relationship between clinicians' own religious or spiritual practices and their ability to continue working with clients. The research examined clinicians' individual spiritual or religious practices as a tool to combat compassion fatigue or burnout. Specifically, I explored the question: How do clinicians who maintain a regular spiritual or religious practice feel it allows them to avoid burnout or compassion fatigue? In order to fully explore this question, the study was qualitative in nature. The current literature on this subject had been mainly quantitative in nature, and though there had been a breadth of information gathered about spirituality and clinical work, there had been a lack of in-depth analysis of clinicians' own practices in this area. I was interested in exploring clinicians' stories in a way that built upon current research and expanded the scope of discussion about spirituality and psychology. I felt this could best be accomplished through individual interviews with clinicians.

In practice, interviews lasted between 30 and 60 minutes. In-person interviews took place at a location that offered privacy and was mutually agreed upon by each participant and me. In hopes of making participation in the study as convenient as

possible, the meeting places were determined on a case-by-case basis. Phone interviews were also scheduled at the participant's convenience.

Participants were asked to answer questions regarding their routine of self-care and how religious or spiritual practices played a role in this part of their lives. I then asked the participants to reflect on ways in which they felt these practices had made a difference in their perceived ability to continue working with clients. As this was a qualitative study, the interviews were semi-structured following an Interview Guide (See Appendix A) with room for exploration as the interview process unfolded. After the interview took place, participants were thanked for their time.

Sample

The sample size for this study was relatively small, with 11 participants completing interviews. In order for participants to be eligible for participation in this research, they had to be clinicians working actively in direct service positions with clients and consider religion or spirituality a part of his or her self-care routine. "Clinician" was defined as an individual who has received at least a Masters' level degree in Psychology, Social Work, or Counseling. "Direct service" was defined as individual, family, or group work with clients of any age group. Clinicians were required to have at least five years of direct service work with clients in order to be eligible. Participants also needed to live in the Northeastern United States or be available by telephone to complete interviews. Age, gender identity, race, religion, socio-economic status and types of clientele served were not considered as criteria for participation in the study. Clinicians were either in private

practice or employed through an agency, as indicated by participation requirements. For clinicians who worked within agencies, the interviews were conducted outside of the purview of their agencies and the clinician's individual experience were the focus of the research.

Participants were all English-speaking. In addition, the study excluded Psychiatrists and lay-counselors from participation. I limited the population to those with Masters' level training. This was an attempt to keep the sample within a population with similar training backgrounds. Additionally, participants had access to either regular telephone and email access in order to participate in the recruitment and interview process.

Data Collection Methods

Participation in this project involved taking part in a one-on-one interview with me. The 11 individual interviews lasted between 30-60 minutes and were recorded either in person or over the phone using the Macintosh program GarageBand on a computer as sound files. Participants are identified in this study only by pseudonym. Demographic data, aside from age and gender identification, was not connected with specific participants. Data will be kept secure for at least three years, as required by federal regulation, and I will either destroy them at that time or, if I continue to need them, keep them secure until no longer needed, at which time they will be destroyed.

I began recruitment by speaking with clinicians and others who might know interested participants. A one-page informational flyer (See Appendix B) was sent to

contacts to pass on to those they felt might be interested. This flyer provided basic information about the project and the requirements for participation, as well as my contact information.

I found that through this snowballing technique interested participants did in fact both contact me for participation and pass on the information to others with whom they were acquainted. Potential participants then contacted me by telephone or email. Once a potential participant and I were in contact, I discussed the generally eligibility requirements with the participant to make sure they fit the criteria for participation. If the potential participant was eligible, I then sent a copy of the Informed Consent Letter (See Appendix C). Each potential participant was asked to review the form and after reviewing the Informed Consent Letter I arranged to gather a signed copy from each participant. Once both the participant and I were clear on my receiving a signed Informed Consent form, an interview was scheduled. There may have been minimal stress created within the process for several of the participants who gave in-depth answers to questions, but generally the study was low risk. Because of the participants' status as mental health professionals and the minimal risk of the study in general, it was not necessary for me to provide resources for potential supports to the participants.

Data Analysis

After interviews were complete, I transcribed relevant portions of the interviews. The information gathered through these interviews provided information about how the maintenance by clinicians of a regular spiritual practice as part of a self-care routine

helped them to combat burnout or compassion fatigue. It also provided insight into how uniquely each defined religious or spiritual practices for themselves. In addition, it highlighted the import that having these practices has well-being in everyday life. They found this true across many more material dimensions of their sense of physical and psychological health, as well as the ways affect the their sense of their work with clients.

Transcripts from each client were broken down into 8 discrete categories related to the exploration implied within the research question; these sections were "(a) enjoyable aspects of direct work with clients, (b) challenging aspects of direct work with clients, (c) interviewees' definitions of their own religious or spiritual practices, (d) past religious or spiritual practices, (e) current religious practices, (f) other forms of self-care, (g) reasons it could be difficult to maintain self-care (more specifically related to religious or spiritually related self-care), and (h) why interviewees found their spiritual or religious practices helpful in continuing to do their work with clients. Transcription of relevant sections and content allowed me to explore the research question and provide an in-depth exploration of personal and subjective experiences that could be accurately reported through content analysis.

Demographic information such as age, gender identification, years of practice, types of clientele, region, race, and whether or not he or she has a specific religious background and/or is currently involved with any religious group was not specifically considered in this study. Where available, it is used factually and solely as a lens through which qualitative data is examined. The inclusion of this information is a way to present

and discuss the variety of participants' identities. It is also used in the discussion section to analyze potential biases of the study.

A sample size of 10-12 participants was approved early in the data collection process. The information provided in the interviews has been rich and in-depth, and the participants have provided a diverse set in terms of years of work, client populations served and definitions of their personal religious or spiritual practices. Ultimately, 11 clinicians (n=11) participated in this study.

CHAPTER 4

FINDINGS

The stories of 11 clinicians and their spiritual self-care

The major findings of this project strongly supported the theory I posited; clinicians who defined themselves as maintaining a religious or spiritual practice as a regular part of their self-care routine were able to use it to prevent burnout or vicarious traumatization. In fact, several participants used those exact terms in the course of the interviews. The group of participants ranged from their 30s to their late 60s, and covered a broad spectrum of religious and/or spiritual practices. One of the most striking things I found in talking to these clinicians from different regions of the country, with different ages, life experiences and belief systems were the ways in which maintaining a religious or spiritual practice created effects for each that were quite similar. The choice of language, the sense of purpose as people, and their identity as clinicians all seemed connected across the spectrum. That being said, each participant had a unique story and voice, and a large portion of this section will therefore be in the participants' own words, as they are the experts in their own stories.

The Clinicians

There were four participants with very clear definitions of their religious and spiritual practices and were strongly affiliated with organized religious traditions. First there was Clarence, a Caucasian man, who lived and worked in a large city in the Central Midwest. He was in his 30s, and had come to counseling from a pastoral perspective. He

had both his MDiv. and MA in counseling. He was currently a doctoral candidate in Psychology at a large university. He had a very clear sense of his religious and spiritual practices as being part of the Reform Christian tradition and was affiliated with the Presbyterian Church. Ruth, was an LCSW also in a Midwestern city. She was in her 50s, and was very strongly identified with her Jewish identity and practices. She was a Para-Rabbinic Fellow, and a leader in both her synagogue and in the larger Jewish community of her city. She reported that the community mental health crisis center where she worked was an agency she "started from scratch".

The third, Anna-Marie, defined herself as Muslim. She had been practicing since 2001 and at the time of the study was working for large human service agency in a Northern state. In the past she had been a program supervisor and clinician for large DBT program, and started a behavioral health department at another agency. At the time of the study she was Program Director for an AHRMS (Agency Human Resources Management System) department at a community mental health agency, and did individual therapy as well as staff training. Her clinical work included a "specialty in PTSD and personality disorders".

Last in this group was Erin. In her 40s and from the Northern part of the United States, she was a Psychologist and had been working for 7 years as clinician. She was involved in intensive case management "in a team environment at community mental health agency serving severely and persistently mentally ill". She was strongly affiliated with the Catholic Church. She said she drifted from her Catholic upbringing early in college, but during the interview said "It's a part of my anchor in my weeks is making sure I get over to Mass on Sundays".

There was also a group of participants who identified with an organized religion, but who also defined their practice as strongly supplemented by spiritual or religious traditions from other faith groups. Catherine, also from the central Midwest had been in practice for 34 years. She reported that she had worked in private practice since 1981 and did individual counseling with a specialty in treating clients with histories of trauma. She was trained in EMDR, and had found this a method she used frequently in her practice. When asked to define her religious or spiritual practices she reported, "those are kind of different for me actually". She reported a long-time affiliation with a Christian church and considered this the "religious" part of her practice. For her, spirituality was rooted in different practices, such as Reiki and her connection with the 12-step movement, as well as other practices that have grown from that connection.

Zoe, an African-American woman in her 30s, had been practicing since 2005. Post-certification, she reported working for one year in a hospital setting. Since that time she had been working at a non-profit agency serving severely and persistently mentally ill clientele. She was involved in several traditions, one strongly tied to an organized Christian church and the other an exploration of Buddhist practices. She said, "I call it... pseudo-Christian pseudo-Buddhist, which would be about 50% Christian and about 50% studying Buddhist principles. I suppose that they would be more like American Buddhist principles."

The youngest participant, Anna, also fit into this category. She was in her 30s and lived and worked in a small city in the Western part of New England. She was employed at a large, mostly government-funded program. She worked primarily with children and youth at one of the agency's many smaller programs. She had her LICSW degree, and had

been in practice for five years. Like the majority of the participants, she was Caucasian, and defined her overarching practices as grounded in Buddhism, with some New Age aspects, such as "spirit guides...and groundings in other religious or shamanic" practices.

One of the more amorphous "definitions" came from Max, a Caucasian man in his 40s from Northern New England. He had 6 years in practice as clinician, working part-time in a private practice with individual adults, couples and occasionally teenagers, and part-time as a school counselor. His individual practice had a very defined and spiritual bent, which he described as "psychosynthesis". He also counted this amongst his personal practices. This was in addition to a myriad of other practices in which Max found meaning, ranging from an identification with Judaism as his religious background, to Tai Chi practices and a journaling routine.

There were then a number of participants who had a consistent way of defining their religious or spiritual practices, though they did not solely affiliate with a specific organized religion. Another clinician with many years of experience had also been practicing as a psychotherapist for 34 years. Charlotte, a Caucasian woman in her 70s, maintained a small private practice with "adult survivors of childhood sexual abuse", including a number of clients with Dissociative Identity Disorder diagnoses. She also lived and worked in a large Midwestern city. She has had a highly varied career. After receiving her MA in Counseling, she worked for 6 months at juvenile court. After that she held a number of positions, such as Director of group home for adolescent girls and senior clinician at a community mental health center for 5 years during which she received an MSW in order to enter private practice. She had moved recently from another Midwestern city to be near family. She reported that she is "near retirement" but that she

had "been saying that for years". Her practice had been grounded mainly in following individual teachers, such as Eckhart Tolle, over the years.

Helen, also a Caucasian woman, had her LICSW degree and was in her 60s. She lived and worked in New England at the same clinic as Anna. She had been in practice for 30 years, almost all of which had been with this community mental health agency. She reported she worked mainly with latency age children and adolescents, as well as doing occasional family work and work with individual adults. Her spiritual practices, she reported, are contained within A course in miracles, "published and disseminated since 1975 by the Foundation for Inner Peace" (<http://www.acim.org/>). She said it used Christian language with sort of a Buddhist philosophy, and she had been using it on and off for a number of years.

Steffany had been a clinician "on and off" for 12 years. A Caucasian woman in her 40s, she was working in clinic setting. The agency was in Northern New England, and was a mostly publicly funded community mental health clinic where she worked as a fee for service psychotherapist. She said her practice consisted of a lot of work "with people with addictions, mostly those who are newly clean or sober". She also worked with women around relationship issues, a lot of whom "have experienced battering". The population she served is generally low socio-economic status (SES), she says. She had also worked with a few children, where the work had turned into family cases. She reported that she meditates using some Eastern traditions, but the main form of spiritual practice in her life was a meditation from Jungian theory, active imagination. Steffany defined the practice as follows:

What the process is...I have a pad of paper and I start to write down the things that are the things that I find are worrying me and I just get them all out; I just clear them out of my brain by getting them on the paper. And then I, this may sound odd, but I come into contact with a presence, a person you might say just came to me as a caretaking presence ...and basically what I think it is is sort of a form of re-parenting and working with and doing sort of inner-child work...

Her practice took specific forms and had been developing over the course of several years.

As this study shows, though these 11 men and women see their religion and/or spiritual practices very much personally, there are clear themes related to self-care and their continuing ability to work as psychotherapists in very difficult and demanding field.

Why they enjoyed their work

The 11 men and women I interviewed had all been working for at least 5 years, and most for many more. None had any difficulty answering the question, "What do you find enjoyable about your work?" For Anna, "witnessing growth in people" made her work feel important. She had a calm and even demeanor, and spoke clearly. She talked about how "it can often be really inspiring to just sort of hear people's stories and sort of see them integrate those stories into wisdom you know their own kind of wisdom" and "witnessing in kids their resilience and courage amidst...difficult circumstances".

For Clarence, this seemed to be an exciting subject to ponder. The space for new experiences and stories was also evident in his reasons for enjoying his work. He said he

enjoy[s] trying to create safe context in relationship where people can go deeper into their experience, maybe places where...they've shielded from themselves from their partner being able to help them kind of facilitate their own emotional experience and maybe go to places where they haven't experienced fully before and make sense out of that be able to communicate more clearly their sense of needs and desires from their partner...

For Max, his sense of why he liked his work is not at all amorphous, but clear and assured. "Providing a place where people can come and work on issues related to sort of their own personal self and growth" was something he enjoyed about his private practice work as well. It was clear that these clinicians recognized the strength in having someone present to witness strength and hold one up in hard times were major factors in why they enjoyed their work.

For other clinicians, the enjoyment of their work was more concrete and specifically altruistic in nature. These clinicians talked about themselves as an integral part of the process as individuals in the room. Helen found the work "interesting...I'd have to say it's intellectually stimulating," she told me with a smile, going on to say, "I like people so I enjoy the interactions". The other thing she enjoyed "is being helpful from time to time of course, filling a function that clients appreciate or find useful...". Anna-Marie put it simply: "I enjoy helping people and seeing them make some significant changes in their lives". Zoe put it similarly, saying, "I would say...the work I do is actually making a difference in people's lives and it really matters to people in society as a whole". She also talked about feeling good about the work she did on a personal as well as simply altruistic level. She said, "I like to think I'm pretty good at it". Her confidence in her own work only made her internal religious and spiritual conflicts seem more complex, as will be discussed later. For Catherine, her work was "a gift".

I have always loved [she told me with a smile in her voice,] hearing people's stories and their experiences and the stuff that makes them tick and I find that that's one of the gifts of being a therapist is that you can help people understand that a little better too and so they get to have a better understanding of their past history and how that effected them and what they're doing what they're feeling...

She went on to say she also found that this "learning aspect of it is very important" but that she "also like[s] the part where you actually have solutions and you can do things that can actually make a difference and help".

For Steffany becoming a clinician was a calling; in a similar way Clarence reported a calling toward becoming a pastor as well as a clinician. Steffany reported "I didn't decide to professionally become a clinician until I was 30...I sort of had an epiphany when I was thirty...that this is what I needed to be doing and that I wanted to be a healer". Charlotte also echoed this theme of being a healer. She said, "I really appreciate the healing that happens when people come together and when there's a spaciousness that allows what wants to come forward". In addition she, like many of the others, spoke in terms of growth and journey. "I really enjoy," she told me "...walking with or being with people as they find out they can listen to themselves and change ...". She also talked about her own learning as part of what makes difficult work enjoyable over the long term, stating she also had "gratitude for the people who reflected back to me that I had strengths that I didn't know about".

For some clinicians, it was as much the environment in which they worked with clients that made the work most enjoyable. For Erin, it is the community involvement she most enjoys. She said "I like being out in the community...and I like seeing a client in the community". She told me about how there "can often be a very different presentation [than in an office setting]...so I like being out there I feel like a lot of dynamics are just more real...". She also enjoyed that at this point in her career her position meant that "there is a lot of independence..." and room to rely on her own "clinical judgment". Similarly for Ruth, there was the pride in the fact that she worked with her clients in an

agency she "started from scratch" in order to meet clients' needs in an area where she saw a need.

As unique as each of these participants are, there were striking similarities in the reasons they found their clinical work enjoyable. Ideas of growth and change and forward motion, of witnessing and holding ran through most of the participants ideas about what makes their clinical work rewarding. The generosity of spirit of these clinicians and their sense of hope for their clients was inspiring.

What makes clinical work challenging

One of the major reasons behind this study was to examine whether these clinicians felt that their religious or spiritual self-care helped them continue to do work that can often be difficult. The self-care certainly did not eliminate difficulty for any of the clinicians. It seemed that challenges changed over time, but that there were also themes to be found in what caused the burnout and vicarious traumatization that had been studied in the past. Part of what seemed to make this work so hard is that often the things that make it enjoyable and worthwhile are intrinsically tied to those that can make it seem impossible some days.

For all 11 clinicians, there was a clear sense of challenges that existed at a professional level, but also at times at a deeper, more personal level. And, of course the day-to-day challenge of paperwork. "The paperwork," Helen said, "is the first thing that comes to mind, which is a big part of client work at a community mental health center so that's the biggest thing that comes to mind for the most part..." The aggravation of paperwork was certainly echoed by other clinicians as well. What Helen went on to say, though, was that in addition to the volume of paper that comes across her desk, she

"hate[d] putting down on paper...it's like quantifying...it's like trying to make a three-dimensional real person appear on paper" which lead them to appear "to be just a fragment or a portion of themselves". Other more structural issues of day-to-day work, such as "just the sheer length of the day that can be stressful..." (Max) or the fact "of isolation ...seeing clients one on one...in a clinic where everyone else is doing so...there's very little feeling of teamwork and there's very little professional interaction at all and so it gets lonely..." (Steffany).

Another issue raised by a number of clinicians was expressed well by Anna, who talked about clients wanting to be "fixed" and how "often people will, especially with kids, come to therapy wanting things to be fixed; you know, behavior changed or erased or... personalities completely restructured..." She was able to see that this could be difficult for both client and therapist when "the projection is that the therapist will do that" and that when this did not happen "it can be difficult...frustrating for clients in that way" that she is, she said with a laugh, not generally able to "perform those hopes". Anna-Marie talked about how this same phenomenon could be difficult for clinicians in supervisory or training positions as well. "Training the staff not to feel like they need to fix it all the time...is stressful". "Sometimes," she sighed, "as I watch my staff struggle and struggle... I feel helpless in some ways, in that sometimes there just isn't a thing you can do about a situation".

The more serious side of this sense of "letting clients down" was, as Clarence put the sense of weight. "I think just as much as I like to be a catalyst and see people make connections that they've lost or that are...just hanging by a thread". He said he often felt

"this sense of the weightiness of having enough skill and competence to help them through those points where they continually get stuck". Even more difficult, he said, is

if I get stuck with them and if I get to the edge with of what seems to be my capability the sense of that can be personally very difficult for me, feeling ... the shame of that or the hurt of that or the letting them down...

He and Anna were not alone at all in this sense of personal shame or failure when unable to meet clients' needs, though they were two of the clinician's newest to this work.

But for Clarence there was an added complication in his dual role as pastor and clinician. A unique challenge amongst these participants, Clarence struggled with

The ethical issues around counseling especially in the church environment that can be the stressor of trying to have people understand what my particular role is...I think there's multiple boundaries in a church setting where I have to constantly be aware of and wrestle with some of those issues as well...

In these dual roles, he talked with a real sense of the weightiness in his voice of how he went to church on Sunday as a pastor and he could "see congregants' marriages and families fall apart but I know them on a deeper level and I can see the wreckage..."

Seeing that, he said, "can weigh on me often more than the emotions of therapy" because with those boundaries he was "able to engage my clients but I don't let it ruin the rest of my life". It's these areas of confluence that added a different challenge for Clarence than for the rest of the clinicians in this group.

An area where he was far from alone in this group, however, was the need to have a strong sense of self to do the work required of them. Charlotte put it succinctly. "I think, she said, "if I find it difficult I'm more apt to ask myself inside what's going on with me than thinking it's the client doing something". Erin and Zoe also named some of the very concrete issues that can be a part of working as a clinician. Erin talked about the

great difficulty that can come "when the clients are very ill they're very ill and... for some the behaviors can be potentially life-threatening." That being said, sometimes clinicians do lose clients to death. Zoe added that "especially because this population tends to have poor health" in addition to the dangerous behaviors,

there's...a significant number of deaths that have happened. After each death you have to...wonder did I try to do this, did I try to do that? You to try and get where it comes from.

There are never simple answers to questions like that, or simple solutions to the heaviness these clinicians can leave the office with at the end of a day. Catherine really conveyed the extreme challenges that clinicians could face.

I think when you are carrying that many sad stories all the time you have to figure that that does take a toll on you...I happen to have a specialty in trauma so a lot of that information is a lot more stressful than just the run-of-the-mill stuff so that's kind of hard...I mean obviously it's hard for the clients but there's some secondary traumatization that happens for the therapist I think. Which is why I ... started to find ways to take better care of myself...to deal with the toxic stuff that was the residue of my work.

This led to the question regarding *how* these clinicians have found ways to care for themselves. There are, as quantitative research had shown, myriad ways to do so, and most clinicians found that using various methods in combination worked best. These 11 clinicians had identified spirituality and/or religion specifically as a major part in their self-care, each in unique ways, but often with similar results.

Religious and/or spiritual definitions: further exploration

As I introduced each clinician, I shared a distilled sense of their religious or spiritual identification. Each of these identifications had a depth that I could not capture in a short introduction. Here, I share, as much as possible, each clinician's definition of

what their practices meant to them. The text below is their words, simply linked together by me.

Anna defined her religion and spirituality as very much linked. "I would say", she said, "that... most of my religious practice training has been grounded in Buddhism...and that I do have some sort of more New Age-y parts of it that aren't Buddhist in nature...When I say New Age I mean I believe in the whole notion of spirit guides, which has sort of a which has its own groundings in other...religious or shamanic practices but I don't know where I would point to other than just saying New Age...". She also added "another addition is being outside...being just another element of communing with the Earth..."

She practiced what she defined as "a less structured form of Theravada Buddhism and said it was "mainly about just being with...what's arising...You're watching your breath or you're watching your sensations or watching thoughts that are coming and going, being present with what is..." Her sense of spirituality also extended directly to her clients. "I believe", she told me, "that my client has beings who are walking with them too and sometimes I've asked that...when things have been really difficult if the beings that are supporting this client come to the room and be helpful to us too... even if it's just...the concept of a higher self for this client..."

Clarence, Ruth, Anna-Marie, Zoe, Erin and Max all defined themselves as clearly belonging to an organized religion. Ruth identified herself as "Jewish", while the other four were all affiliated with Christian traditions. For both Ruth and Clarence, their religious practices were also part of their vocational lives. "I'm a Presbyterian...", Clarence said.

I come from a Christian traditional-themed framework that God's self has revealed himself through Jesus and through the apostles and through his act of the good news of the gospel of God, doing the things we can't do... and we are called into a body of people to live as brothers and sisters to live out hopefully a life of love. [There is] also the hard process of seeing the mirror of your own struggles and brokenness and having to seek forgiveness and give forgiveness and serve and take care and love..."

Clarence was an ordained pastor, so he was very committed to his Presbyterianism and his work with a church was a major element of his life and where he had his clinical practice. Clarence reported,

I was going to seminary definitely for my own personal experiences and faith and definitely wanted to go to seminary but primarily as a counselor...but also got my degree in divinity, so where I was trained was definitely coming from a faith-based perspective

Ruth was a Para-Rabbinic Fellow which is

... something that was developed by the Reform movement to help complement where there were not enough Rabbis or, where there weren't any Rabbis and to be able to provide some sort of spiritual guidance to folks who lived in communities where they might not have a Rabbi. My role is primarily to support the Rabbis (at a large congregation) and to fill in where they need me. I've been fortunate that people have really used me regionally, so I've helped out when Rabbis go on vacation or go on maternity leave—things like that. I find that I get a lot out of being able to help people spiritually. I've done funerals, I've done shiva minyans (prayer services that take place in the homes of people observing formal mourning rituals) and every Saturday morning I conduct a lay-led service at our congregation and there's a lot of people that come to that every single Saturday that wouldn't normally come to services but because it's lay-led because [and] it's informal they really enjoy it. I get a lot out of it.

Erin was very clear about her affiliation with the Catholic Church, and defined her religious and spiritual practices solely in terms of her church interactions. Her religious practice was, however, always

evolving...meaning I was raised Catholic and grew up in Catholic school up through high school. And it was...quite wonderful. Structurally [though] you get a lot of the old tenets that get handed to you so you never realize at a younger age how sexist that your faith tradition is. [Realizing this] made me kind of drift away

from [the Church] in undergrad but then I found it again as a graduate student through a Newman Center...and experienced more of a faith tradition through an adult experience rather than through sort of that childhood experience so that was the piece...that developed into my more adult-based faith tradition

She said "It's really tough" dealing with the scandals and the challenges within particular archdioceses so finding the right church was vital for her. Since she did, she told me, "it holds me up in terms of my sense of social justice" and had the right mix of "both faithfulness and rebelliousness.

Zoe's story was a little less clear in terms of her affiliations, and she was finding most of that was coming from within the religious and spiritual communities themselves. As stated earlier, she said she found herself splitting her time between Christian and Buddhist practices, and said she would like to be able to incorporate them. She described her background as "hardcore Southern Baptist" and laughingly told me when she got to college she was "like, wait a second, the King James Version of the bible?" and was generally shocked to discover different versions of the bible and Christianity and religious traditions in general. She said growing up in the Christian South where she did there was only the one way to do it,

and it really kind of shook up the way that I had been raised...and I knew in my heart that I still believe these things, these spiritual experiences. I've seen miracles happen. But I also knew that what I saw was spirituality, but the practice and all of the rules were religion.

She said that at that point in her life she moved away from both religion and spirituality, but as she entered the field of clinical work she began

thinking about how you can really help a person change...and [that] at least spirituality is super important...There's got to be spiritual food, you know something to help sustain me and that's what prompted me to sort of get back into [exploring spirituality and religion].

Anna-Marie defined herself as a Muslim, but told me "I define myself as a Muslim and a spiritual person..." She paused, thinking, then said "Yeah I guess I define myself as a spiritual person first and a Muslim second maybe." She did not discuss her history much, but said, "I've been a very spiritual person my whole life I think and I've been a Muslim for probably the last 15 years." She said her religious and spiritual life had become more "prominent for her" since beginning work as a clinician. Before she began, she said "I wasn't relying much on spirituality as much...and I guess you get to a place where you say okay I'm either going to burn out or something needs to change" and that prompted her to become more active in her practices again.

Max also defined himself as Jewish. Like Anna-Marie, it seems he would defined himself as a spiritual person first, but as he put it

I also have a religious identity that supports my spiritual identity...and part of my Jewish identity really gives me a strength in my life and that strength has a lot to do with family and being part of a community...and those things are really strong for me as well.

He had a clear definition of some of his practices of the last 15 years, which were Tai Chi and meditation. He also sited "journaling" as a part of his semi-regular spiritual practice.

"I just have a general orientation towards...wellness," he told me,

I also have...a spiritual practice that is...an attitude or certain way of viewing my own life experience... I have a basic premise that all of the experiences that I'm having have within them something I can use or that I even need for my own personal development. So that means that I have sort of an inclusive way of looking at my own inner life and outer life so that these things are connected and contributing to my growth. So that would be emotional experience, psychological experience... So, if I'm relating to my own inner experience that's the Self. From there I get to make choices that are free from any particular identification...so what it does for me is it opens up a great deal of psychological freedom to craft a spiritual practice. My spiritual practice is the reason I got into Psychosynthesis [as a clinical methodology]. In meditation what I learned is that I can sit and watch my breath, I can watch my thoughts. Psychosynthesis jumps off from there. It

says, 'All right, so if you have this ability to watch your own thoughts, to watch your breath, to watch your body who's the watcher?' So it establishes the watcher or the observer or what they call the "I" ...the self as the central unifying point in one's own psyche...so that's kind of the beginning point of doing the work of psychological integration [for me], and so it's not just psychological but spiritual...

He told me this tied into an ability to maintain his own practices of Tai Chi and meditation as well.

The remaining participants all had practices they saw as more spiritual than part of a particular faith tradition. Helen said her practice had its roots in faith traditions. "What I'm interested in now" she told me "is ... called the Course in Miracles". I had never heard of this, so she explained it to me. "There are exercises and meditations to do daily...that people use...and some text material that seems like...an ongoing prayer or meditation that's written down. Then 365 lessons for each day of the year ..." She said she had been "practicing since 2006, though I was aware of it before then and practiced a diluted form of it earlier than that..."

Her background was based in Christianity. "I was brought up as Methodist" she said "and we were church goers church goers when I was young" and as she then explored religion and spirituality or, as she put it "in my previous life before this" she "attended church, the Protestant variety, from time to time and I started a meditation practice probably close to 1970 with transcendental meditation..."

Forms of meditation were also very important to Steffany, Catherine and Charlotte as well, though in different ways for each. Steffany used meditation, but for her it had taken the form of the specific Jungian practice of Active Imagination. She defined

the overall process, as discussed earlier, but then shared the specific form her individual practice took. The presence she discussed is

a caretaking presence. She's an African-American woman named Thelma; and I even have a room named after her in my house now. It's where I go and do my practice...and basically it's sort of a form of re-parenting and doing inner-child work. She comes in as the good parent, and not just the "good enough" parent, but the perfect parent. A person that doesn't exist...It really sustains me and I think it has really helped heal some of my wounds so that I'm a little healthier and stronger for my clients.

Charlotte also called on the presence of others for her practice, but they were more corporeal in form. She had created practices over the years that have relied on words of specific teachers and writers. Defining practice, she said

has been easier in the past than it is now. I used to meditate regularly. I think probably still do, but I don't call it that and I don't set the time specifically aside. For about 8 or ten years I listened to the Holosync cds from the Centerpointe Institute (<http://www.centerpointe.com/>). The devised a way to put on headphones and listen to a cd of sounds that help to balance the right and left hemispheres of the brain. It takes you to a meditative place and you do it an hour a day...it helped me over time...I became more organized...it was subtle but I think over time it was very useful. Probably about 4 years ago it had been to a workshop on psychotherapy and spirituality. Someone there suggested I listen to Eckhart Tolle's The power of now, and from that point on I switched to listening to Tolle everyday. I did it first thing in the morning. And it resonated with me...and that was the secret of unlocking Tolle for me...

She cited other teachers who had been important to her as well. She said she had been "both a student and a long term reader of both Jack Kornfield and Stephen Levine." She felt "particularly Stephen Levine has a way of teaching self-care. He says if we could be patient with ourselves a millisecond longer than last time that's good. He frequently says have mercy when people judge themselves".

For Catherine, she was very clear from the beginning that spiritual practice and religious practices

are kind of different for me. For my religious practice I belong to a church and I attend regularly. Attending church regularly as part of that faith community is not necessarily what feeds me spiritually but it is a bunch of really nice people that I've known for a million years. They've watched my daughter grow up. We have known each other for 20 or more years, so it's a very important group of people to me. I'm connected in different ways to church work stuff, but the spirituality I do is kind of separate from that.

She told me, "I am definitely a part of 12-step...so whatever the issue is the recovery is based on maintenance of a good spiritual connection." She explained to me that

it doesn't matter what you decide to call the thing you are connected to; it can be God or a Higher Power or the Cosmos or infinity or whatever you want it to be but that there is a conscious contact maintained on a daily basis. That usually means some type of prayer or meditation...or maybe writing, just paying attention to something greater than the self and something that guides and directs in a positive way...

Reiki was another way Catherine cared for herself, as well as for others in her life. "I primarily use Reiki for self-healing and for people that I am close to friends, family that kind of thing." She told me "I do use the distance-healing part of Reiki for clients just in terms of having their name on a list of people who I send Reiki to every day. It's more like it's kind of like praying for them." The newest element to her practice, she said is that for

the past year I've been involved in something called centering prayer. You can either do it with a thought or a being or an open mind and it's just sort of a group meditation. You spend twenty minutes in silent meditation and after that there's group discussion.

"But," she said, "from that I got into a practice of meditating almost every day which I really love.

Each of these clinicians conveyed through their conversations just how important these practices had been in not only shaping who they were in their lives in general, but also how these beliefs and practices served a role in self-care in terms of feeling

grounded and present for their work with clients. This wasn't always easy, or even close. The clinicians discussed how obstacles arise, for some more often than others, which kept self-care, and the spiritual elements in particular, from happening.

Difficulties maintaining self-care and spirituality

As with many elements of this study, for some of the clinicians the obstacles to maintaining their practices were more concrete or resulting from outside influences, while for others the things getting in their way seemed very internal and more existential in nature. For most, both things were true. Ruth and Anna-Marie in particular, as well as Zoe, found that the way the majority of America think about and deal with issues of spirituality and religious practices had been significant obstacles to their sense of being able to fully engage in their practices. Zoe said it very clearly, stating that "in this field we're all very politically correct and spirituality is a touchy subject". Anna-Marie echoed this, saying "There's not enough room in American life for mindfulness". Ruth too spoke of the "lack of consciousness about religious practices in culture at large." How this had impacted each of their individual abilities to practice had been different.

Ruth told me

one of the problems I experience with living in a Christian country is [that] my religious practices often bump into my ability to do my job or ability to be a fully participating member on non-religious activities)...Saturday is my Sabbath and I try to make it a day of rest...I feel more stressed when I can't maintain or have conflict around practices and it sometimes makes me angry because I feel I am a culturally competent person who is very respectful of the beliefs and traditions of other people and I don't understand how they can be so disrespectful of mine..."

Similarly, Anna-Marie said,

Sure [it can be difficult to maintain my practices]...if I'm out of my routine and getting more into the world and the American life and getting stressed out with

the work and the clients, you know, that whole ballgame. It's the first thing that I usually realize is not right in my life, that my spirituality has gone by the wayside.

She also said that "usually spirituality is the first thing that brings me back" as well.

Like Ruth, though, there was some anger, and she said, "I wish [religion or spirituality] was more of a natural okay thing to talk about. You know sometimes when I'm in session I feel like I have to pussy-foot around this issue I wish that wasn't the case." She went on to say that

I wish it was just a normal... I wish we weren't so damn politically correct sometimes basically. I think that for a lot of people that's what's missing out of their life, the spirituality piece. We talk about money and we talk about life and we talk about work, about getting them to volunteer, but where's the spirituality in that?

For Zoe, the sense of political correctness was also a problem. In addition, she felt the need to "make a choice". "You know," she said,

I think I keep going back and forth between [whether] I going to be Christian or am I going to be Buddhist. I feel like there is this pressure to choose between one and the other. I think that can bring up a lot of discomfort for me now and then. The actual communities, the people who go to meetings or the people who go to church [put] this subtle pressure that [in general] you need pick which way you're going. The Buddhists tell me that 'If you chant it will be revealed to you that this is the way to go,' and the Christians say 'The only way to go is through Jesus Christ'.

She also said that she "think[s] I'm kind of at a point of acceptance where I feel I can do both". But the pressure to be one thing or the other was complex, similar to Ruth's sense of being asked to choose between religious observance and her work and civic activities.

Politics had also been a complicating factor for Erin. When administrative decisions around church sexual scandals "affected peoples' core ethics and people left the church", she said, "that was extremely difficult" For her it was "very painful to see what an administrative body could do to a faith community and to individuals". "The politics

can make it very hard" to maintain practices, she said. "In fact that's probably one of the worst things".

Of all the clinicians, maintenance of practices seemed least difficult for Charlotte. This had been a real process though, she said, and also sited cultural expectations as part of this journey. She told me

I've been on two vision quests and the leader for both of those is someone who believes our culture is as a whole stuck in adolescence...that we expect to get lives without ever growing up and that struck me as true; that the adolescent is still trying to [spiritually] please other people or show what they know, where as [I now think] you can go beyond all that and live your own particular piece of the truth. I don't think we all have it, but I think we need each others' pieces...to see the whole deal.

For example, she said, "I have four children and six grandchildren and I was married for 26 years to an Episcopal priest and I [tried to be] traditionally religious and wasn't very good at it," she said with a gentle laugh. With a more serious tone, she added that she

also wasn't living my own life. I mean I didn't know that at the time, but I must have sensed it The difference between institutionalized religion whatever empowerment comes out of living the life you're born for...that that's been a huge transition and a very important one to me. I was stuck trying to believe what didn't sit for me instead of believing what did. I think (staying inside ourselves) is so much what we need to do and what we get so little encouragement for doing it" in our culture.

That, she said, was probably her biggest challenge.

In addition to broader political and cultural blocks, Zoe also talked about how sometimes simple ennui can seem to be the obstacle after a long week. When asked if she ever felt she had difficulty maintaining her practices she replied, "Definitely...just because of fatigue or you just kind of feel drained of the mental energy. You can get, like, you know I could just stay on the couch... it's Sunday morning I'd rather watch "Real Housewives...". She laughed but then continued, "...instead of getting to church. It

definitely gets more difficult for me with fatigue physical and mental fatigue but I've really been trying to make it a point of trying to go."

Another clinician who also found it can be hardest to maintain her practice in when resting was Catherine. She said, "Sometimes on vacation it's really hard...when you are with somebody else 24-7 and you're in a different place and you don't have the routine to build into my life." She added "on vacation there's usually the added benefit of it being either a stimulating or relaxing time anyway." Family responsibilities can also be a challenge. She told me "it was much harder when my daughter lived at home and things got oriented around her school schedule and her needs...". She said, laughing, that now that's it just her and her husband, they each "have their own routines" and things are just fine. She noticed when she was not keeping spirituality in her routine though.

[I feel] generally more restless and irritable, probably negative. The world is more scratchy than it should be. I'm just reading this book on sensory integration and, listen to the title it's so cute, 'Too Loud, Too Bright, To Fast, Too Tight' so that's sort of how I feel, I guess.

Helen said too that

Definitely it [can be difficult to maintain] the practice. The morning meditations are easier to than the evening meditations, so that even if it's five or ten minutes a lot of times I go home and have supper and it's a challenge to keep up with.

But, she stressed, "It's not something I would want to feel guilty about. It's more a practice, so I'm practicing." She laughed. "We're not getting it perfect here".

The sense of necessity of maintaining practices had changed over time for Clarence. "I'd say consistency is always an up and down aspect," he told me.

I think I used to be... a real source of guilt and shame. But instead of spiritual *disciplines* we call them *means of grace*. [These are] kind of channels through which there is the love of God for us...where He is moving towards us...not something we are doing to make Him love us. So the whole concept switched for

me when I realized that that I'm not doing these things to have Him love me more. I'm doing these things to understand His love to experience that more and to live out that framework more consistently in my life...

He also said, "The physical aspect is so intertwined with the spiritual aspect...because from my faith tradition [there is] a kind of a spirit body nexus...and the lack of taking care of your body effects your spirit and vice versa..." Clarence said he finds, with his busy life, that was one of the parts of his practice that was most difficult to maintain.

Anna told me about this feeling in a more abstract fashion. "There are times," she said

when I can sort of get layered with holding a lot of things and it's harder to...a part of me thinks it's not something I want to sit with...I know one pattern, and it's not consistent because I think there's other times that things are going really well [and] I don't sit, but if I'm feeling really like I want to escape, where I don't want to feel all the stress I'm feeling...I can often go to other things that are that are not me being present...

For Max and Steffany, both life stressors and self-expectations could get in the way. Steffany repeated some of the sentiments expressed by Anna and Helen, saying, "Life gets busy or things start to feel really good and then I'll sort of put the tools down for a while 'cause I'll think I won't need them..." On the other end of the spectrum, during a particularly stressful time, she told me "I think I had sort of let [my spiritual practice go]. I was kind of in survival mode and I just couldn't even access it".

"I find it difficult," said Max, "...I get a little ambitious sometimes in terms of what I want to be able to get to in a given week or month so maybe then I just start to over schedule myself." He laughed and said, "you know I'm rarely out of balance because I rest too much. It's because I have too much on my schedule or if I'm making too much change, so there have been times when I've been trying to manage too much change

without some sort of counter balance for stability somewhere in my life." For him, "those are the most difficult times...".

The reason it is worth the practice and struggle

Despite the history, the political, social and personal obstacles and the need for true practice, each of these clinicians said their religious and spiritual practices ultimately were an important part of their self-care; it was a vital part for each of them of how they continued to both do and enjoy the clinical work in which they engaged on a day-to-day basis. Charlotte talked about the way maintaining her practice helped her have more space, more empathy, for her clients' experiences. "I really believe, she said,

that it's not that we have to have had every experience that the client has had in order to be with them. But if we haven't explored our own humanity in a way that is accepting and caring and forgiving than we're not going to be able to bring that kind of attention to the client...that we'll be rejecting in them whatever we haven't accepted in ourselves.

She said her practice allowed her to be accepting, not rejecting, or both her clients and of herself. Erin put it similarly, and quite simply. When "spirituality is raised to a level of consciousness," she said she "does her work better... ". She knew that she had come to "learn to trust [her] own needs for self-care" in whatever form felt meaningful.

Catherine said, "I find that [all of my spiritual practice and meditation in particular] is very helpful for things like being alert and present... " She laughingly said simply "I feel better". Then she elaborated a bit more, and said

I just I feel calm and centered and more present in my own experience so I'll be more present for everybody in my life including my clients. I think it's a good idea just practically for all people. We should be trying to get better at that, you know trying to live a mindful and have an intentional presence in [our] lives instead of being on autopilot or caught in addictions or over-stimulated, which is really easy to be in our world, in our culture. It's really kind of an antidote to a lot of the of toxic stuff that's in the world in general, I think; the noise or the speed of

things or people's questionable behaviors and values...I don't know, I think it's a really positive antidote and a force that puts good into the um universe to combat some of the negative stuff that's out there. So I feel kind of like there's that selfish part of me that it does something for me, but I think it does something for the for the greater world too...

On a personal level, though, she said that when things feel out of balance, "I have a lot of things I know how to do if that happens and the better shape I'm in the better work I do."

She took the responsibility of her work seriously. She said,

People entrust me with their hearts and their minds and their and their experience. I've done that with therapy for myself in the past and I always think the people I see and that I consult with, that they're taking good care of themselves...

She gave me this analogy: "You know," she said, "the airplane instructions that if you're traveling with somebody else that you need to put on your own air mask first to be able to help them. So that's kind of the rationale behind that." She said, like several of the other clinicians, "The better person that I am, the better I'll be at being a good therapist too".

Anna also expressed a similar sentiment. Practicing her spirituality regularly, she said, "helps you feel not only grounded for yourself but gives you an understanding of part of what's happening for [clients on an energetic sort of level]." She also said that for her, her practice helped her in

sort of a bigger level, because sometimes things can feel so small and constricted and pressured so it can be helpful to me and also it's sort of just nurturing for me to access support energetically. I really *want* to continue to be with difficulty and so I'm in my own edge, growing around [my work]. So meditation or meditation practices helped me in that way...

She also said, "I just feel more supported. Often I'll just ask for help before going down to sit with a client or before going in to work...and then I don't feel as alone in working with people". "I'm humbled," she said, "by how much can happen for people [that] has nothing to do with me but happens in the room..."

While Helen was not always as sure as the other participants that she directly thought of her spirituality specifically as her "self-care routine", she did feel that "religion and religious practice is a part of my life and it has positive affects on me and how I feel about myself, so it effects my self-care" in that way. She then went on to say,

I suppose it's interactional, so if I'm having a harder time I can turn towards my religious practice and that is helpful...I feel more grounded or centered as a person and more able to handle stresses of my life and of my work. It's added more meaning to my life and [made me] more grounded in my worldview. I'm less worried about my own failings; I mean if I don't do it completely right I'm less worried about it now...

Anna-Marie was one of a number of the clinicians that expressed the sense of comfort and confidence that came with being able to trust in something larger than one's self. She said,

A lot of my self-care is my spiritual practice and my spiritual beliefs. You know, knowing that when a client is struggling and there's not much we can do to stop it and they're on their own journey in life, that's based on my own spiritual practices. If I'm struggling with a client or feeling more burnt-out, using prayer, meditation and helps kind ground me back into myself and into my world outside of my work and let's me know there's something else out there in the daily grind and there's more there's meaning. Somehow, there's meaning, hopefully. God has some meaning in all the pain and suffering that we're going through and the pain and suffering that other people are going through. I think it takes away the immediacy of, 'Oh this sucks,' or "Oh this is miserable,' or 'Oh, I can't do this or and this person can't do this' or 'Why does this person have such a miserable life?' and takes me out of that very moment and turns it over to somebody else or some other energy and that's self-care for me.

On a day-to-day basis, she told me, "It keeps me grounded so that when I go into the session I can, whatever else is going on in my life I can leave that out of the session..."

One of the things she said struck me deeply. She said spirituality is "a huge chunk of the wheel of life and if you don't have every chunk of that wheel in place you're not going to roll along nicely".

Zoe said

since I've been [including religion and spiritual practices in my routine] my stress level and just other things I've approached kind of differently have calmed down. When I'm maintaining a spiritual routine the little things don't bother me so much, you know. It's much easier to put things into perspective and look at the bigger picture. It's much easier for me to have compassion and empathy for clients and for my employees. I've also noticed that I've just seemed to have more energy. [The difference] is pretty significant. I think it helps me...pick my battles. I think I have more compassion for my clients particularly. I might even pray or chant for my client. I'll pray that their suffering is eased or I may pray that they gain insight or I may pray for them to be able to forgive... You know, it helps to keep that empathy level or it just kind of critical thinking about the whole case...

She talked about the times in practice,

those moments where you're like 'Oh my gosh somebody did that to another human being,' it's like you can't do anything but turn to your higher power to get over it, understand it, accept it. You know, some of the things you hear you can't believe people can survive.

She said the practices helped "not stress the little things...and help keep things in perspective". She told me

I think it's could really be beneficial to people who come into this work to incorporate [spirituality and religion] into their own self-care because this kind of work requires you to somehow figure out how to rejuvenate yourself and if you don't you get burned out or jaded; I think that in order to prevent that you've got to figure out how to get that spiritual component of you life met...

Max started off by saying, "I feel more present. I feel happier. I feel more available to others. I have more to give. I tend to feel more confident, generally more hopeful about things and I have more energy" when he was maintaining his practices.

If I'm well rested and I'm more present I feel like I can help my clients more. I can be more available to them than if I'm tired or just wishing my sessions would end so I could go get some rest...but I'll tell you...I can be having a very difficult day...and then I can be sitting with a client and everything changes in my day. The practice of sitting with somebody and doing this work can actually change my day in a positive direction. So it's not necessarily when I'm rested and feeling cheerful that that's the time I'm doing my best work. Sometimes I can be in a really difficult place where I feel like I'm doing really good work because I think

the process of psychotherapy forces me and invites me to become more present and when I become more present I feel better.

"The thing that my spiritual practice did" he said was that

it gave me a confidence that no matter what was happening I could trust that I had a certain strength to be with those experiences and that that they would not overwhelm me; that there was some bigger or greater force or power in my life that I could count on to carry me through.

He told me that

the development of the spiritual dimension of my own life has been crucial not only for my own personal growth, but for my ability and my capacity to be of service to others. I just I could not do the work that I do in the psychological realm without the concurrent development of my own spiritual practice. They're not separate, It's not like I have a spiritual practice over here and then over here I have a psychological practice. I could not do the work that I do in the way that I do it without a spiritual practice.

In a way very similar to the other clinicians, Steffany told me, "I have to feel centered and grounded and whole in order to feel capable of sitting with somebody. She said, "I feel less fear. I feel more love. I feel more confident and I feel more adequate that my presence is adequate rather than, you know, I have to think of the perfect intervention to help this person right now." She also said the spiritual practices "provide me with those things, centering and grounding. My own personal journey, my own personal, spiritual growth over the years I've been working has a direct correlation to the quality of my work."

Ruth began on a more logistical level. She said, "We moved a lot...and whenever we moved I would get us involved in a synagogue and the JCC, if there was one, and that was really a big help. It became sort of my anchor". On a more personal level, when we speak over the phone, she said to me

I wish you could see my office because there are two things hanging up that I look at every day that help keep me focused. One of them is called Eden Once Again

and it was written by Judy Chicago...it's a very beautiful poem that Judy Chicago wrote and it focuses me. Then I have out um uh a painting that says Tzdeck Tzdeck Charduf) [Deut. 16.20] which is 'Justice, Justice, Thou shall pursue'. It comes from Deuteronomy and that's what keeps me focused is that I want to create Eden and I want to be a very just person and I want to deal with everybody justly. So that's kind of how my spiritual beliefs keep me focused on what I need to do here [in my office] and be able to listen to people's problems and listen to some very tragic stories and be able to not take it home with me and not become depressed...

When I pray, she said,

it reminds me that there's a power greater than me and greater than any of us and I can't tell you exactly what that power is but I know it's there. That also is helpful to know that I'm not responsible for everybody. I'm really only responsible for myself and that there's a greater power out there that's looking out for all of us...

For Clarence, the sense of a greater power was also very important. The why of his practice being helpful as self-care was multilayered and deep. "I think my beliefs help me," to have a reason to continue counseling people. He said it

is that I believe in a God who's solvent over all things, that rules over all things, and so I don't see the process of coincidences. What happens to people outside of the session [for example]" therefore isn't without meaning. I have hope...that He can take even very dark moments and take them and bring new life out of it, or resurrection, if you will, or restoration, so that even suffering produces good things. There's a number of ways my faith helps me see the process and what people are going through and that brings me hope a sense, of personal hope.

That, he said, despite sometimes thinking,

Boy, that's a devastating story. How do we even begin... You can be overwhelmed, [start thinking] that there's no way. But my religious beliefs help me when I get to a place of feeling overwhelmed to at least stop and say okay, hold on all is not lost. You know, it's hard but good things can come of it...

He went on, saying, "I feel like things are connected and that there are reasons for things and that I have a basis for hope even in the most difficult and overwhelming circumstances". His strong faith and religious practices meant that in times where

I felt like even though I had so much on my plate, I was in the place that brings us such peace during the suffering....Being ministered to by being able to serve

others...not always be in your own stuff but to be reminded of who God is, His care, His ruling over all things and wisdom and to act in accord with what I believe...all [that is] a constant energizing force so there's joy in the midst of suffering.

"Yes," he said, "it's chaotic, but it feels like there is a grander purpose pulling me along...My [spiritual] community helped me to continue that striving [for consistency], knowing I'll never be perfect but find [that I'll find] the energy, the hope, the understanding to keep striving".

For each of these clinicians, the sense of support, of being held and not alone with clients in sessions and the ability to trust in themselves and also something greater enabled them to continue to do their work. That is more than enough for any of us to hope for as we work towards becoming or remaining the kind of clinicians we hope to be as we all strive to continue to do the rewarding, challenging, and inspiring work of clinical professionals.

CHAPTER 5

DISSCUSSION

This research took an in depth look at the self-care practices of 11 clinicians. Specifically, it examined the ways in which each clinician felt that maintaining an individual spiritual or religious practice as a self-care tool had on their ability to continue working in a profession with potentially high rates of compassion fatigue or burnout. Each clinician had a unique way to define these terms within the contexts of their lives. For the purposes of this study, the operational definition of *spirituality*, as defined by Griffin & Griffin (2002) "is a commitment to choose, as the primary context for understanding and acting, one's relatedness with all that is" (p. 15). "*Religion*" they wrote

represents a cultural codification of important spiritual metaphors, narratives, beliefs, rituals, social practices, and forms of community among particular people that provides methods for attaining spirituality, most often expressed in terms of a relationship with the God of that religion p. 17

As much as definitions from each of the 11 participants differed in specific content, these general definitions continued to be sound and overarching.

The literature review for this project focused a good deal on burnout, compassion fatigue, and vicarious traumatization. And, as revealed above, these were issues participants thought about within the context of their own lives. I went into the project believing that there would be some sense of prevention of these things amongst clinicians who maintained a religious or spiritual component to their self-care routines, but I'm not sure I could have imagined just how powerful an antidote it would prove to be, at least amongst this small and

self-selecting sample. None of the clinicians interviewed expressed a desire to leave the field or retire because of any of these negative phenomena. As expressed above, in their own words, it seemed that maintaining a strong connection to something greater than themselves, to a grounding and centering force, kept these clinicians engaged in and excited about their work with clients.

The question addressed is relevant to the practice of social work, both current and future. This is a question that looks not only at the ability of the clinician to care for his or her clients, but also takes into consideration the clinician's ability to care for him or herself in order to better "enhance human well-being". The topic of spirituality as self-care is rich and textured, and the studies I reviewed did not generally examine these issues from a personal perspective but as an attempt to look at a broader, albeit more quantifiable, picture. However, the richness of the information shared by this small sample of clinicians, who truly engaged in and made possible this process, gives a much more in-depth and moving sense of why exactly this form of self-care can be so vital.

Another important concept I intended to examine in greater detail was the potential health benefits of spiritual and religious practices. As discussed in the literature review, research had been conducted on individual's physical and mental health and an engagement in a spiritual or religious, on the ways in which clinicians learn to and practically address the spiritual needs of their clients, and the clinician's direct incorporation of spirituality into practice with clients. While this study did not specifically address issues of physical health, the sense of well-being and connection to

self and others the clinicians each expressed feels holistic and, as Clarence said, there is a sense that there is an intrinsic link between all aspects of self-care and well being.

There is little research on the ways in which clinicians use religion or spirituality as a self-care tool. This study looked specifically at the ways the values of care for self and of care for all human beings was being carried out by 11 remarkable clinicians within their worlds and what allows them to do this to the best of their abilities. It is relevant to students of social work and other therapeutic professions, and could also have an effect on the ways in which clinicians are educated and curriculums are created to help maximize clinician efficacy. This research is particularly relevant to the core values of “service, dignity and worth of the person, importance of human relationships and competence” (NASW, 2008). For the 11 men and women with whom I spoke, the need for religious and/or spiritual self-care is a vital part of what it means to be a truly in-tune, grounded and ethical clinician. I realize that this is a relatively small sample size, but given the in-depth nature of the research and the limited timeframe of the project, more participants than this would not allow for the depth of analysis the project hopes to attain. I believe this work has the potential to expand into a larger study of the potential implications this element of clinician self-care could have on the practice of the psychological care of not only clinicians themselves, but most importantly, for the clients we all strive to serve to the best of our abilities.

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APPENDIX A

Interview Guide

So, as I explained when we went over the Informed Consent Form, I'm interested in talking with you about how having a religious or spiritual component to your life as part of a self-care routine helps you manage while engaged in potentially difficult and stressful work in the mental health field. Do you have any questions?

-If yes, individual questions will be answered at this time to the best of the researcher's ability. The interview will then proceed.

-If no, the interview will proceed immediately.

I'd like to start just by getting some background on your clinical work. How long have you been working as a clinician?

Are you in private practice, or do you work in a clinic setting?

What population do you work with currently?

What do you enjoy about the work?

What things do you find stressful or difficult about the work?

As part of the recruitment for this study, we discussed the fact that you consider religious or spiritual practices an important part of your self-care routine.

How do you define that practice?

Has this practice been a part of your life for a long time?

What is important about it for you?

Are there other things you consider a part of your self-care routine that aid you in maintaining a regular religious or spiritual practice?

Do you ever find it difficult to maintain this routine?

-What do you feel is different when you do versus do not maintain it?

In what ways does it help you care for yourself, specifically around continuing to work with clients?

Have your religious or spiritual practices and self-care routine changed over time?

If yes,

-Can you describe what has changed, and why?

What would you define as the most stressful event or period in your professional life?

-What made it so stressful?

-How did spiritual or religious practices play a part in dealing with the stress?

-If you were in the same situation today, how do you think you would handle the stress?

Is there anything you would change about your religious or spiritual practices as they relate to your self-care routine if you could?

Is there anything else you feel it would be important for me to know?

APPENDIX B

*Are you a clinician engaged in
direct work with clients in a
therapeutic setting?**

Are you interested religion or spirituality and its connection
to self-care and clinical work?

Never think about?

Somewhere in between?

Have an hour?

A Smith College School for Social Work student seeks participants for a
study on religious or spiritual practices as a self-care tool for clinicians.

Individual interviews will be set up to maximize your convenience.

I look forward to talking with you soon!

Interested? Contact Elizabeth Levy at (phone number removed for
researcher confidentiality) or (email address removed for researcher
confidentiality)

*

To participate in this study, you must be at least Masters' level Social Work, Psychologist or Counselor. You may work with any population doing individual, family, or group therapy. Only those who have are still involved in direct service and have been working in the field for at least 5 years are eligible for participation.

APPENDIX C

Informed Consent Form

January 20, 2010

Dear Potential Research Participant:

My name is Elizabeth Levy. I am conducting a qualitative study to examine the ways in which clinicians may or may not use spiritual or religious practices as part of a self-care routine. The research will examine self-care practices as tools to combat compassion fatigue or burnout and what, if any, differences there may be in those clinicians who maintain a regular spiritual or religious practice as part of this routine and those who do not. I will be conducting interviews in order to explore these questions. This research study for my thesis is being conducted as part of the requirements for the Master of Social Work degree at Smith College School for Social Work and future presentations and publications.

Your participation is requested because you have been identified as a clinician in the field of direct service work with clients in a psychotherapy model. If you choose to participate, I will conduct an individual interview with you. I will ask you to provide demographic information about yourself, such as your age, where you are from, how long you have been a clinician, the population with whom you work, etc. I will interview you regarding your ideas about what “religion” and/or “spirituality” are, the presence or lack thereof of specific religious or spiritual practices in your day-to-day self-care practices, and whether or not you feel there is a connection between this and your ability to work effectively with clients on an ongoing basis. The interview will be conducted either in person or over the phone. You and I will determine what works best given our respective geographic locations and with consideration to what will be most convenient for you.

The interview will last for approximately 60-90 minutes. In order to ensure participant confidentiality, I will store your data under a pseudonym. The data will be shared with my research advisor only under the pseudonym. Once my thesis is complete, all recordings and transcripts will be kept for three years, as required by law and then it will be destroyed.

The potential risk of participating in this study may be that during the process of answering personal questions and examining the analysis of the interview data, you may encounter some difficult emotions and some interview questions could trigger uncomfortable thoughts and feelings.

You will receive no financial benefit for your participation in this study. However, you may benefit from the knowledge that the results of this project will be

particularly relevant to students of therapeutic professions as they begin to find ways to support themselves in the early stages of their work as well as fellow clinicians who have been in the field for many years and may be interested in ways to help combat compassion fatigue in themselves or their colleagues. As members of professions dedicated to the enhancement of self-care and well-being, you may feel it is beneficial to contribute to these potential benefits to others in your field and beyond. Additionally, it may also allow you to reflect on positive aspects of your life and work with your clients and serve as a reminder of your ability to continue to do very difficult work. You may also benefit from receiving the opportunity to share your experience and gain a new perspective.

Strict confidentiality will be maintained, as consistent with federal regulations and the mandates of the social work profession. Your identity will be protected, as your chosen pseudonym will be used in the reporting of the data. Your name will never be associated with the information you provide in the questionnaire or the interview. The data may be used in other education activities as well as in the preparation for my Master's thesis. Your confidentiality will be protected by coding the information and storing the data in a secure file for a minimum of three years and after three years it will be destroyed unless I continue to need it in which case it will be kept secured.

Participation in this project is entirely voluntary and you may refuse to answer any question I ask at any point during participation in the project. You may also withdraw from the study for any reason at any point up to April 1, 2010. After this point, I will be unable to remove participants' contribution from the final product of the Thesis work. In order to withdraw from the study, you are asked to inform me of your decision to do so, but not the reasons for doing so. Once Informed Consent has been collected, you must inform me of your decision to withdraw verbally and in writing. If you have any concerns about your rights or about any aspect of the study, I encourage you to call me at (removed for researcher confidentiality) or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Elizabeth Levy
(information removed for researcher confidentiality)

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

SIGNATURE OF PARTICIPANT

SIGNATURE OF RESEARCHER

APPENDIX D



Smith College
Northampton, Massachusetts 01063
T (+13) 585-7950
F (+13) 585-7994

February 27, 2010

Elizabeth Levy

Dear Elizabeth,

That is exactly what you needed to do to make sure you could pursue your topic with the people who respond to your recruitment materials. We are happy now to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your very interesting project.

Sincerely,

A handwritten signature in cursive script that reads 'Ann Hartman / DSW'.

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Michael Murphy, Research Advisor