A Workshop to Improve Experienced Therapists’ Capacity to Integrate a Client’s Cultural and Spiritual Identity

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Atif Shujah, candidate for the degree of Doctor of Psychology in Clinical Psychology, has presented a thesis titled, *A Workshop to Improve Experienced Therapists’ Capacity to Integrate a Client’s Cultural and Spiritual Identity*, in an oral examination held on December 10, 2012. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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Abstract

Spirituality has not been extensively included in the training curriculum of academic programs for therapists. Therapists have expressed a desire for continuing education to support their capacity to be responsive to clients’ spirituality (e.g., Plumb, 2011). In light of a need and desire for training, experienced therapists should have access to continuing educational opportunities to hone their capacity. Workshops are an option for such continuing education (Orlinsky, Botermans, & Ronnestad, 2001). I sought to understand the relevance of a continuing education workshop that was designed to enable therapists to better integrate their clients’ spirituality into therapy. Therapists who participated in the workshop were requested to provide their feedback on the workshop experience. The data were constructed through a semi-structured interview which was followed by a brief open-ended questionnaire. A model of the therapists’ feedback on the workshop was generated through use of Grounded Theory methodology. The therapists’ views were organized into four main themes. The first theme highlights the therapists’ current and future attempts to offer services to their clients. This effort provided the context in which they spoke about the relevance of both prior preparatory experiences (Theme 2) and the workshop experience (Theme 3). The participants reported outcomes of the workshop in Theme 3. Theme 4 entails the participants’ descriptions of the specific elements of the workshop that were believed to contribute to the respective outcomes.

The potential relevance of the findings for the training of other therapists is discussed. I highlight the potential relevance of the workshop as an instructional resource for therapists. In addition, I elaborate on the potential implications of the findings for the design of other educational resources that could facilitate therapists’ sensitivity to clients’
spirituality. In the final chapter, I summarize the implications of this inquiry, discuss limitations of the inquiry, and suggest some possible next steps in both evaluating the workshop as well as broader contentious issues related to training practicing therapists.
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Dedication

Many people have contributed directly or indirectly to my journey towards completing this dissertation. However, I will only highlight a few specific individuals. First, I would like to dedicate this project to the memory of Rafia Shujah. As I was completing my dissertation, I received the sad news that my Mother had passed away. I would like to thank her for her unconditional support that she provided to me over the years. Without her sustained encouragement, I would not be where I am today. Furthermore, during my own times of stress and doubt, I will certainly look upon her life as a personal inspiration. Despite the fact that her physical presence is no longer on this earth, the many seeds that she planted here will surely continue to bear fruit long after her departure.

Secondly, I would like to dedicate this project to my fiancée and my father for their support. My fiancée has been my shoulder to cry on (sometimes literally) and she helped me cope with some difficult circumstances. My father has been the person who has kept me physically alive by feeding me when I was unable to feed myself.

Thirdly, I dedicate this work to my brother and three sisters for their unwavering belief in my potential. In particular, I would like to thank them for their assistance in the completion of this project.
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CHAPTER 1: INTRODUCTION

In the Canadian Charter of Rights and Freedoms, Canada is defined as a multicultural society (Satzewich & Liodakis, 2007). The manner that this ideal is realized is a challenge and an issue of controversy in the post-9/11 world (Satzewich & Liodakis, 2007). There continues to be much discussion on how far the boundaries of multiculturalism should extend and how best to realize multiculturalism in practice. I believe the issue of multiculturalism is central to freedom in Canada. The realization of multiculturalism is an inherent part of allowing individuals to freely express themselves within the Canadian mosaic (Milstein, n.d.). In this inquiry, I hope to contribute to Canada’s actualization of multiculturalism through assisting psychotherapists in their effort to integrate clients’ spirituality into psychotherapy.

The work of psychotherapists is instrumental in allowing individuals to freely express their cultural identity because therapy affects clients’ self-concepts, beliefs, and behaviors (Christopher, 1996). A psychotherapist can provide therapy that is neglectful or disrespectful of a client’s cultural heritage, which may directly or indirectly pressure clients to limit the expression of their cultural identity (Sue, 2006). Conversely, a psychotherapist can provide culturally-integrative therapy that affirms or at least recognizes the phenomenological importance of a specific client’s cultural identity. In the course of receiving such services, clients are empowered to negotiate the expression of their cultural identity in a relatively non-hegemonic environment (Slife, Smith, & Burchfield, 2003). The provision of culturally-integrative psychotherapy is one step in realizing Canada’s multicultural ethos in our national community.
Spirituality is relevant to the cultural identity of some, if not the majority, of Canadians as 58% of individuals describe themselves as *spiritual* (reported in Baetz et al., 2004). However, an individual’s cultural heritage is comprised of various cultural identity dimensions with spirituality being one possible aspect along with other dimensions, such as gender, socio-economic status, and ethnicity (Sue & Sue, 2008). A therapist should not ignore other dimensions in favour of a client’s spirituality when he or she attempts to respond to a client’s specific cultural heritage (Fukuyama & Sevig, 1998). For the sake of simplicity, this inquiry will focus predominately on spirituality (see Sue & Sue, 2008 for adjusting services to other dimensions).

If spirituality is an aspect of a client’s identity, then a therapist should provide the client with the autonomy to choose how he or she expresses his or her spirituality. This prescription has been expressed in the ethical guidelines put forth by various leading professional organizations, including the Canadian Psychological Association (see Truscott & Crook, 2004). However, a therapist sometimes either dismisses a client’s spirituality or is unsure as to how they can integrate a client’s spirituality (Bartoli, 2007). It has been argued that therapists have been inadequately prepared by their academic training to work with a spiritual diversity of clients; spirituality, historically, has not been extensively included in the training curriculum of academic programs (e.g., Brawer et al., 2002). Therapists themselves have also expressed a desire for continuing education to support their capacity to be responsive to clients’ spirituality (e.g., Plumb, 2011). In light of a need and desire for training, experienced therapists should have access to continuing educational opportunities to hone their capacity. Workshops are an acceptable option for continuing education among therapists (Orlinsky, et al., 2001). Unfortunately, currently a
paucity of empirical evaluative research exists that can directly guide the design and implementation of workshops in the effort to foster such capacities (e.g., Bhui et al., 2007). In this inquiry, I will evaluate the implementation of a continuing education workshop that can be utilized to enable therapists to integrate clients’ spirituality into therapy.

In order to gain a better understanding of relevant educational strategies, I have designed and evaluated a single session workshop on cultural competency training with respect to a client’s spirituality. The workshop was administered to 10 experienced therapists (with at least one year of experience providing therapy). The learning objectives of the workshop were based on the Multicultural Counselling Competencies model (see Sue et al., 1998), which advocates: 1) Increase of professionals’ awareness of their worldview with respect to spirituality; 2) Increase of their awareness of the spirituality of their clients; 3) Increase of their effectiveness to implement the appropriate intervention. The workshop provided a context for therapists to reflect on their experiences working with a diversity of clients and to share insights with each other. Therapists were provided with resource materials to assist them to better understand their clients’ spirituality. Therapists were encouraged to envision for themselves how the information provided was relevant for their specific clinical practice.

The evaluation of the workshop entailed requesting the therapists to provide feedback on their understanding of the outcomes of the workshop and the process that contributed to reported gains. The data were generated through a semi-structured interview shortly after the workshop session and a follow-up open-ended questionnaire. I utilized Grounded Theory Analysis in the analysis of the data. After coding the data and
organizing the data into themes, a thematic model was constructed in an attempt to reflect the therapists’ perspectives on the workshop experience.

1.1 Researcher’s motivation for conducting the inquiry

Spirituality and cultural diversity have been topics of my curiosity since I was a child. My fascination with these aspects of human psychology partially grew out of my own experiences with spirituality (having been raised in a household supported by Muslim parents) and my encountering different experiences among others (most of my friends tended to be either agnostic or Christian).

As a child, I felt and witnessed the positive aspects of spirituality in terms of bringing solace to people and connecting individuals to communities. Years later I became more aware of the negative outcomes arising from either spirituality or religion (i.e., intolerance, violence, guilt). My early exposure to spirituality provided me with either a rich appreciation for the positive power of spirituality.

As I have pursued my career in psychotherapy, I have been unsure as to how to integrate a client’s spirituality into therapy. Consequently, like many therapists, I mostly left spirituality out of my interactions with clients. As I gained a better appreciation of the process of psychotherapy, I began experimenting with the integration of spirituality in therapy. In particular, I have tried to utilize a client’s spiritual resources to achieve treatment goals. For example, with one client I utilized her understanding of God’s perspective to reality test her negative self-beliefs. The sense of not knowing how to respond to a client’s spirituality has motivated me to conduct most of my previous research. It is through my previous research that I have been led to a point where this dissertation is the natural next step.
I conducted two previous studies into the nexus of spirituality and psychotherapy. The first study entailed asking Canadian-born Muslim lay persons about their views on psychotherapy as a healing option. Most of the participants considered psychotherapy a viable option for managing emotional distress. A key aspect of their potential choice among interpersonal support options was the nature of the relationship (e.g., safety, confidentiality, knowledge of their background) with the helper. The participants suggested their utilization of psychotherapeutic resources would be partially contingent on their relationship with a specific therapist.

After interviewing lay persons, my curiosity led me to ask therapists who have worked with Canadian Muslim clients about their attempts to be sensitive to clients’ cultural heritage and spirituality. The therapists unanimously agreed that the therapeutic alliance was central to their work with clients. They described making adjustments to a client’s specific identity within the sub-components of the therapeutic alliance (i.e., mutually agreed upon goals and techniques, personal rapport). In other words, their response to their clients was a dynamic process that unfolded in the context of a specific therapist, working with a specific client, who had specific problems and resources.

In undertaking these studies, I came to strongly believe that the essence of respecting cultural diversity among clients lay in constructing an idiosyncratic therapeutic alliance. My next question was how could the construction of such a therapeutic alliance be facilitated. Seeking answers led me to focus on the issue of what training methods are most effective for enhancing such capacity in both myself as a therapist as well as other therapists. Upon further engaging the available literature, I noticed mostly theoretically-derived suggestions as opposed to empirically-derived recommendations. Furthermore, a
considerable proportion of the literature seemed to focus on therapists-in-training as opposed to experienced therapists. Hence, this dissertation was conceptualized as way of bridging these gaps in the current literature by providing empirically guided strategies for the provision of continuing education to experienced therapists.

1.2 Researcher’s perspective on research

My selection of a methodology was guided by my adoption of a hermeneutic epistemological perspective. Positivism (and post-positivism) is the epistemological orientation that has been historically dominant within the field of Psychology (Mertens, 2005). This orientation conceptualizes a researcher’s use of the correct methodology (i.e., the experiment) as leading the researcher to the one truthful interpretation of whatever research question is being pursued (Bryant & Charmaz, 2007; Mertens, 2005). The notion that a methodology will provide a researcher with the one true meaning of a phenomena, however, is premised on the ontological belief that humans can transcend the confines of their social-cultural heritage (Christopher, Richardson, & Christopher, n.d.). In contrast to this ontological belief, hermeneutic philosophy postulates that a person’s interpretations are always confined to the boundaries of the person’s culturally-derived interpretative framework or horizon of understanding (Gadamer, 1975). I have adopted this understanding of human knowledge and, thus, a hermeneutic epistemological orientation informs my methodology.

Hermeneutic philosophy postulates that every interpretation is relative to a person’s horizon of understanding. Nevertheless, it is postulated that some specific interpretations can be more applicable than others (Christopher, et al., n.d.). Unlike from a post-positivistic paradigm, the applicability of an interpretation does not refer to its
correspondence to reality. Rather, the applicability of an interpretation refers to whether the interpretation facilitates an interpreter’s accomplishment of life projects that the interpreter deems as relevant (Martin, 1997). As a researcher’s interpretation is inherently confined to his or her horizon of understanding, no methodology (e.g., experimentation) can be considered superior to any other methodology on the basis of providing a truer (or corresponding) interpretation of the phenomena of interest (Christopher, et al., n.d.). The merit of any methodology is contingent on its capacity to increase the applicability of the researcher’s, participant’s, and audience’s interpretations in the context of a specific inquiry. As will be discussed below I believe that a semi-structured data construction process involving asking therapists about their views on participating in the workshop and a Grounded Theory analysis of their views was the appropriate methodology for this inquiry.

1.3 Objectives of the inquiry and the implications

In the evaluation of the designed workshop, I sought to answer two exploratory questions. The first research question was “what are participants’ perspectives as to how their interaction with their clients may change as a function of participating in this workshop?” The second research question was “what are the participants’ perspectives as to the value of the specific content of the workshop for improving their capacity to be sensitive to a client’s spirituality?”

The conclusions of this inquiry could inform future training efforts through two avenues. First, the findings of this project were used to revise the original workshop curriculum. The revision of the workshop was informed through therapists’ views of how the workshop affected (and did not affect) their clinical functioning and which
pedagogical aspects were most relevant. The redesigned workshop curriculum could be offered as a workshop curriculum that educators could implement in their efforts to improve the capacity of therapists to integrate culture and spirituality into therapy.

Second, the results of the exploratory evaluation of the workshop may also inform other educators in their efforts to design resources to facilitate the continued education of therapists. Other educators can integrate the conclusions regarding the benefits and drawbacks of the workshop in their own curricula for continuing education. In order to realize this potential benefit, the findings will be disseminated through publication in peer reviewed and non-peer reviewed publications and by presenting the findings at academic conferences.

1.4 Organization of the dissertation

The dissertation is organized into eight chapters. In Chapter 2, I outline the imperative faced by practitioners within the field of psychotherapy to offer services that integrate a client's spirituality. Working definitions will also be offered in terms of key concepts for this inquiry (e.g., culture, psychotherapy, spirituality).

In Chapter 3, there is a discussion of different models that have been offered to operationalize the competencies required by therapists to effectively offer culturally-integrative services. After the review of the models, I describe my decision-making process for choosing a particular model to guide my design of the workshop.

In Chapter 4, I outline the practical necessity of this inquiry. I discuss the need for continuing education for therapists in light of current psychotherapy training in Canada. The absence of empirical literature to guide the design and implementation of continuing education resources is highlighted. I hope to add positively to the effort to offer relevant
continuing education to therapists. I outline the workshop in Chapter 4, which is preceded by a description of the process undertaken to design the workshop. An aspect of the design process is an evaluation of the workshop. This evaluation entailed seeking participants’ feedback on what they considered to be the outcome of the workshop and the corresponding process that contributed to these outcomes. Participants were also requested to provide their feedback on what they felt could be improved about the workshop, which in turn was incorporated into the workshop. The final version of the workshop facilitators' manual and student workbook is included in Appendices I and J.

The specific methodology used in undertaking the evaluation is discussed in Chapter 5. Participants were requested to provide their feedback on the workshop. The data were constructed through a semi-structured interview which was followed by a brief open-ended questionnaire. A model of the participants’ feedback on the workshop was constructed using Grounded Theory Analysis, which entailed coding the data, comparing participants’ views, and constructing a thematic model that reflects the participants’ views.

In Chapter 6, the results of the analysis are discussed. The participants’ views are organized into four main themes (See Figures 1 and 2). The first theme highlights the participants’ current and future attempts to cater the services offered to their clients. This effort provided the context in which they spoke about the relevance of both prior preparatory experiences (Theme 2) and the workshop experience (Theme 3). The reported outcomes and gains were elaborated in Theme 3. Theme 4 entailed the description of the workshop experience and the elements of the workshop that the participants viewed as beneficial to expanding their competencies.
In Chapter 7, there is a discussion of the potential relevance of the findings for the training of other practicing therapists. I highlight the potential relevance of the workshop for other therapists as an educational resource. In addition, I elaborate on the potential implications of the findings for the design of other educational resources that could facilitate therapists’ sensitivity to clients’ spirituality.

In the final chapter, I summarize the implications of this inquiry, discuss limitations of the inquiry, and suggest some possible next steps in both evaluating the workshop as well as broader contentious issues related to training practicing therapists.
CHAPTER 2: THE NECESSITY TO PROVIDE CULTURALLY-INTEGRATIVE SERVICES IN CANADA

Every therapist faces the practical challenge of attempting to recognize and cater to a client’s particular cultural heritage (Ivey, Ivey, & Simek-Morgan, 1997). Such a challenge occurs in every therapeutic interaction to some degree as a result of the inherent cultural differences that exist between a therapist and client. A client’s spirituality may be one dimension of this practical challenge. The necessity to effectively overcome this challenge arises out of an ethical imperative to promote the client’s autonomy through provision of culturally-integrative services.

The discussion begins with my conceptualizations of key concepts for the inquiry at hand: culture, psychotherapy, and spirituality. There are no unanimously shared definitions of these concepts, nor is it expected that every reader or workshop participant will concur with the provided definitions. These definitions are provided to orient the reader as to how these concepts are being conceptualized by the author; hopefully therein assisting the reader in critically evaluating this inquiry as it is conceived by the researcher. Following this discussion is an outline of the ethical imperative to provide culturally-integrative services in Canada and a description of the nature of such services.

2.1 Culture and worldview

Controversy exists with respect to the concept of culture (Wierzbicka, 2005); among the criticisms is whether the term culture falsely creates the image of a static perspective that is shared among all individuals in a society. The working definition of cultural tradition utilized in this inquiry is as follows. A cultural tradition is a:

dynamic process involving … ways of living in a physical and social environment that is shared by groups, which are passed from generation to generation and may
be modified by contacts between cultures in a particular social, historical, and political context. (Whaley & Davis, 2007, p. 564)

A cultural tradition is both explicit and implicit, and *way of life* simultaneously refers to both (Berry, Poortinga, Sagall, & Dasesn, 1992). The explicit aspect of a cultural tradition is the observable day-to-day customs and practices that are common among a group of individuals. In comparison, the implicit aspect is the perceptual, cognitive, organizing principles (i.e., schemata, values, attitudes) that underlie the explicit aspect. At a societal level, the interconnection of the various implicit aspects of a cultural tradition forms a symbol-based *web of meaning* (Geertz, 1973).

Cultural heritage is essential to the ontology of any human being. As an individual interacts within the life-world in which they are embedded, the individual necessarily relies on the pre-understandings contained within their worldview in order to interpret phenomena (Christopher, et al., n.d.; Sampio, n.d.; Martin, 1997; Martin & Thompson, 2003). During the process of acculturation, an individual internalizes the implicit aspects of a culture which shape his or her worldview or, in other words, the interpretative framework that the individual utilizes to understand his or her life world. When attempting to interpret something, a person projects onto a phenomenon anticipated meanings derived from his or her worldview. A person arrives at a sense of comprehension by determining which of the anticipated meanings is applicable to achieving the goals that the individual seeks. For example, a client and a therapist will utilize their respective worldviews to interpret the therapeutic interaction and to decide the best course of action. Some degree of overlap usually exists in the relative worldviews that are held by different individuals, especially among those individuals who
share a particular cultural tradition; however, some degree of difference in their relative worldviews always exists as well. This relative difference arises from two potential sources. One source is the degree of variation in the cultural traditions that individuals are exposed to during the acculturation process (Christopher, 2001). A person's unique socio-cultural positioning stemming from their specific cultural identity, such as a person's spirituality, will result in variation in societal messages received.

Humans are not passive recipients of cultural traditions; a second source of differences between the relative worldviews held by individuals. Individuals negotiate within their own particular life-worlds the applicability of the cultural traditions to which they are exposed (Martin & Thompson, 2003; Polkinghorne, 2004). Individuals internalize a cultural tradition somewhat idiosyncratically based on how applicable the meanings are to their interactions within their life world. Each individual intuitively considers specific aspects of the cultural tradition to which they are exposed as most relevant.

Every psychotherapeutic interaction can be conceptualized as an inter-cultural encounter due to the ever-present divergence in the respective worldviews held by a therapist and a client (Ivey et al., 1997; Pedersen, 1999). Individuals will always vary to some degree in their respective worldviews (Ivey, et al., 1997). This variance can lead to divergence between the client and the therapist with respect to their definition of the problem-space (i.e., appropriate goals and techniques) related to the client’s experiences (Arbuthnott et al., 2006). This divergence may affect the therapist’s ability to establish a therapeutic alliance with a client (e.g., Kim, Ng, & Ahn, 2005; Pope-Davis et al., 2002). Disregard for this divergence may result in a therapist implementing goals and techniques
that are incongruent with the client’s cultural heritage (Sue & Sue, 2008). Incongruence may not arise in every therapeutic interaction; nevertheless, practitioners should be conscious of the possibility of such incongruency in any encounter (Fischer, Jome, & Atkinson, 1998).

On the other hand, some conceptualizations of therapeutic interactions characterize only particular therapeutic dyads as inter-cultural (Pedersen, 1999). This position can stem from conceptualizations of culture as something synonymous with a particular ascribed social identity, such as ethnicity (Sue et al., 1998). Such a narrow understanding of culture leads to the conclusion that diversity among clients is only relevant in circumstances when the therapist’s ascribed identity differs from the identity of the client. A therapist who adopts this perspective may overlook the different interpretations that may occur among clients with respect to unappreciated dimensions of identity, such as might be the case with a client’s spirituality (Pedersen, 1999). This potential insensitivity by a therapist may lead to the implementation of therapy that does not integrate a client’s cultural heritage as the therapist assumes that the client and the therapist share the same understanding of the therapeutic encounter.

**2.2 A working definition of psychotherapy**

In 1984, there were 403 different models of psychotherapy, and this number has only grown over the years (Lagos, 1996). Specific models of psychotherapy can vary with respect to the conceptualization of well-being and therapeutic processes that lead to well-being (Csordas & Kleinman, 1996; Ivey, et al., 1997). A broad and non-specific description of psychotherapy is introduced in order to keep the definition inclusive of the various conceptualizations of psychotherapy derived from numerous theoretical models.
Added to the challenge of formulating a definition of psychotherapy is the term *counseling* and its relationship to the term *psychotherapy*. The term *psychotherapy* was once reserved for those circumstances in which the client was experiencing severe distressful experiences, whereas the term *counseling* was reserved for those circumstances in which the client was experiencing less severe distressful experiences (McLeod, 1996). However, today both terms are often used interchangeably as those professionals who identify themselves, or are identified by others, as practicing either mental health *counseling* often work in context of similar problematic situations and apply similar strategies as others who are practicing *psychotherapy* (McLeod, 1996). In this study, *psychotherapy* [therapy] and *psychotherapists* [therapists] will be the preferred terms.

Psychotherapy is a healing technology; clients utilize psychotherapy in their attempt to cope with cognitive, emotional, or social challenges (Lee & Armstrong, 1999). Across societies, people consider a variety of healing strategies as legitimate and viable options for coping with physical, cognitive, emotional, social challenges (see Pappas, Smythe, & Baydala, 2007). Examples of practiced healing strategies include recitation, wearing blessed amulets, divination, and phytotherapy (herbal medicines) as well as more familiar strategies of pharmacotherapy, surgery, and psychotherapy (Lee & Armstrong, 1999).

The healing technology of psychotherapy historically originated within a European, Canadian and American socio-cultural contexts. The historical heritage of psychotherapy has resulted in common conceptualizations of therapeutic objectives and techniques across some of the models of psychotherapy (Fowers & Davidov, 2006; Sue &
Sue, 2008). Previous theorists have criticized some models of psychotherapy for pursuit of objectives and utilization of therapeutic strategies that – implicitly or explicitly – promote potentially problematic values, such as secularism and individualism (Pedersen, 1999; Sue & Sue, 2008). Theorists have also argued that a narrow therapeutic focus on individual-level symptom-reduction denies the etiological relevance of family, societal, and political systems (Crethar, Rivera, & Nash, 2008). In addition, psychotherapy is often practiced within an interpersonal context and some theorists suggest an emphasis on non-directive techniques can be confusing for some clients (Sue & Sue, 2008). The culturally-derived values commonly expressed in the practice of psychotherapy may or may not be congruent with the views of any particular client.

The conceptualization of psychotherapy used in the dissertation rests on a contextual model of psychotherapy. Wampold (2001) proposes two meta-theories to conceptualize the practice of psychotherapy: the medical model and the contextual model. Wampold (2001) describes the medical model as stipulating that the healing significance of psychotherapy lies in the therapist matching the correct intervention with the specific problems experienced by the client. In comparison, a contextual model of psychotherapy postulates that the healing significance of psychotherapy lies in the client and the therapist holding a shared meaning of the therapeutic objectives and techniques. A contextual model is adopted for this project because it is consistent with the well-researched view that the efficacy of psychotherapy is best predicted by the presence of a therapeutic alliance between a client and a therapist (i.e., shared conceptualizations of goals and techniques and an emotional bond between client and therapist) (Lambert & Ogles, 2004). Depending on the specific client’s cultural heritage, the cultural values
present within some of the models of psychotherapy (such as those mentioned in
aforementioned paragraph) may hinder the creation of shared meaning between client and
therapist (Pope-Davis et al., 2002).

2.3 A conceptualization of spirituality

As one potential dimension of a person’s cultural identity, a client's spirituality
can be potentially relevant to his or her worldview. Their phenomenological experiences,
and corresponding conceptualization of their presenting problems, can be shaped by their
beliefs and attitudes associated with their spirituality. Due to the potential significance of
a client's spirituality, a therapist may have to respond to it in their delivery of services to
the client.

There is no unanimously held definition of spirituality, or the related concept of
religion, in either Psychology or in other disciplines. One reason for this lack of
consensus is that any definition is a microcosm of a broader understanding of reality
(Harrison, 2006; Kunin, 2006). Definitions can be categorized into either *theological*
definitions or *natural* definitions (Harrison, 2006). In theological definitions, the defining
characteristics are related to specific theologically-related ontological beliefs (e.g. having
a personal relationship with Jesus). In comparison, a natural definition of spirituality (or
religion) is an attempt to explain spirituality by reference to psychological and societal
forces. Even though natural definitions are generally more widely accepted – due to their
theological neutrality – they still require that a person accepts the existence of the
purported natural forces (Kunin, 2006). For this project, a working natural definition of
spirituality will be offered even though it is not expected to be unanimously accepted by
every reader.
Every definition of spirituality is inclusive of some phenomena and excludes other phenomena (Harrison, 2006; Kunin, 2006). The distinction between spiritual and non-spiritual can be made on the basis of one, or a few essential characteristics, such as a belief in a God. In using an essential characteristics definition, a phenomenon – such as a client’s experiences – is categorized as spiritual when the essential characteristic(s) are present. Reliance on essential characteristics can lead an interpreter to ignore phenomena that may be spiritual but which do not coincide with the characteristics viewed as essential. A more inclusive alternative to utilizing an essential characteristic – but which still maintains a degree of exclusivity – is a family resemblance approach categorization (Harrison, 2006). In this approach, the interpreter uses a group of characteristics to define spirituality while affirming that any specific manifestation of spirituality may only possess a subset of the defining characteristics. A family resemblance approach allows an interpreter to recognize the overlap in related phenomena labeled as spirituality while still permitting an acknowledgment of the differences that can exist.

A family resemblance approach to spirituality will be proposed with two general characteristics: connection and meaning. One prominent theme in the psychological literature on spirituality is the importance of a person’s sense of connection (Dyson, et al., 1997; Gall et. al, 2005; Kelly, 1995). This connection can be with respect to one’s self, others, or God (Dyson, et al., 1997). With respect to the self, a person may experience a sense of wholeness as they feel in touch with their true self. With respect to the others, there can be a connection with other individuals as well as a connection with a community. A sense of connection with God has traditionally been defined using the Judeo-Christian-Islamic tradition of belief in a monotheistic God. But a broader
definition of God may be an object that “provides a force which activates the individual or is an essential principle influencing him/her” (Dyson, et al., 1997, p. 146). Such a conceptualization of God can include non-theistic entities such as Nature or the notion of Tao.

A second prominent theme in the psychological literature is that spirituality assists a person in constructing meaning about the world (Dyson, et al., 1997; Gall et al., 2005; Kelly, 1995). The meanings that a person constructs can be related to their spiritual connection with either themselves, others, or God.

The family resemblance definition of spirituality is fundamentally limited as it glosses over the unique significance that spirituality can have for specific individuals (Harrison, 2006). A sense of connection and the construction of meaning may be common to the spirituality experienced by some but this does not necessarily have to be the case. However, no definition of spirituality will fully capture every individual’s experience (Kunin, 2006). In conceptualizing the spirituality of a specific client, the defining criteria can be what the individual views as their ultimate concern (Dyson, et al., 1997). A therapist’s recognition of what a client views as their ultimate concern will only foster empathy and the establishment of a mutually-constructed therapeutic alliance.

In defining spirituality, it is important to contrast it with the term religion as they are related concepts. Within the literature in the field of Psychology, the term spirituality often refers to an individual’s idiosyncratic perspective whereas religion refers to the individual’s participation in an organized community and identification with a particular tradition (Post & Wade, 2009; Worthington, et al., 2011). In this dissertation, spirituality will be the preferred term that I will use. However, the term religion will also be used in
some places within the dissertation for a three reasons. One reason is that the division of these two concepts is somewhat arbitrary. An individual’s spirituality often comprises of at least some metaphors and concepts derived from the broader religious mosaic that an individual is exposed to even if the individual does not identify with any specific religious tradition (Post & Wade, 2009). In some places in the dissertation the two terms are used together as the division of the two terms could cause confusion in context of the specific topic being discussed. Secondly, in the results section, I intentionally use the term religion when participants made an explicit distinction between religion and spirituality. Thirdly, I also use the term religion when I directly quote, or paraphrase, another person’s words, such as by another author or by a participant.

2.3.1 The association of spirituality and well-being. A person’s spirituality has the potential to facilitate their well-being. Past research findings have generally supported the conclusion that spirituality is related to various aspects of biological (e.g., lower mortality rates) and psychological well-being (e.g., lowered rates of clinically significant emotional distress) (see Miller & Thorsen, 2003). However, a client’s spirituality can be associated also with negative emotional experiences, such as depression, anxiety and psychosis (see Koenig, 2008). In light of the potential positive and negative implications of a client’s spirituality, theorists have moved beyond the broad question of whether spirituality is associated with well-being and are now examining the more complex question of how spirituality is related to well-being (Seeman, Fagan Dubin, Seeman, 2003). The answer to this question can highlight the positive and negative effect of spirituality on well-being and, therein, offer therapists a nuanced framework for integrating spirituality into therapy.
Pargament’s model of coping (Pargament & Brant, 1998) may be the leading model for conceptualizing the functional role of spirituality on well-being as it has been widely adopted by theorists and has been extensively researched (Gall et. al, 2005). In this model, coping is viewed as a dynamic process that unfolds through an individual’s interaction with their social environment. During the coping process, a person appraises the cause of an event. Then, the person utilizes such appraisals to develop the meaning of his or her experiences and to choose a particular behavioural course of coping. The subsequent meaning that is generated, and the effects of the coping behavior, will reciprocally influence a person’s appraisal of the cause of the event. Within the ongoing coping process, spirituality is functionally related to well-being through affecting a person’s causal appraisal of events, meaning-making, and engagement in coping behaviors (Gall et. al., 2005; Pargament & Brant, 1998). The meaning-making and coping behaviors that are derived from a person’s spirituality can have positive and negative effects on a client’s well-being. The positive or negative functional value of a client’s spirituality for a client’s problems is contingent on the casual appraisals, constructed meaning, and the coping strategies utilized (see Gall et al., 2005).

2.4 Multiculturalism and the ethical imperative to provide culturally-integrative services

An ethical imperative exists – based on the right of clients to decide for themselves what beliefs to affirm – for the provision of services that support clients in their expression of their cultural heritage. Such a right is outlined in the Universal Declaration of Human Rights:

[e]veryone has the right to freedom of thought, conscience and religion; this right includes freedom to change their religion or belief, and freedom, either
alone or in community with others and in public or in private, to manifest
their religion or belief in teaching, practice, worship and observance.
(Harrison, 2006, p. 146)

This right to freedom of thought, conscience, and religion is highlighted in the first and
foremost principle of the Canadian Psychological Association (CPA) code of ethics (CPA,
2000). The code proposes that Psychologists are obligated to maintain the natural rights
of their clients and this involves maintenance of a client’s self-determination and personal
liberty (Pettifor, 2001).

An individual’s worldview will be partially informed by their cultural heritage. A
person’s cultural heritage is constantly in flux; a person is expected to shift his or her
adoption of specific cultural traditions (Martin, 1997). What differs between situations is
the nature of this change process. If people have the autonomy to negotiate their own
adoption of specific cultural traditions then such freedom is consistent with their human
rights (Beaman, 2003). A therapist can maintain such autonomy by giving their clients the
space to negotiate whether they want to retain their original cultural heritage or to change
in a manner that they deem appropriate (Merali, 1999; Milstein, n.d.). If a therapist does
not appropriately respond to a client’s cultural heritage, then the therapist may be
applying therapeutic techniques and goals that are incongruent with the client’s preferred
values. In this scenario, the inherent power differential in therapy may result in the client
being coerced to adopt the therapist’s values (Slife, et al., 2003). This implicit, and
sometimes explicit, encouragement to adopt the therapist’s values contravenes the ethos
of autonomy (Slife et al., 2003).

The notion that a person has a right to self-determination in their self-expression
is related to the broader Canadian struggle of achieving equality among individuals.
Charles Taylor (1989), the renowned Canadian philosopher, proposes that democratic societies have used two general approaches for achieving equality among its citizens (Milstein, n.d.). One approach is for a society to strive for equality by encouraging everyone to adopt the same cultural traditions. This approach has been taken in France where all individuals are encouraged to adopt secular practices within public space (Beaman, 2008). A second option to promote equality is by society allowing individuals to freely express their own idiosyncratic cultural heritage traditions and self-identities. This approach is consistent with Canada’s official adoption of multiculturalism (Beaman, 2008), which is a “social-intellectual movement that promotes the value of diversity as a core principle and insists that all cultural groups be treated with respect” (Fowers & Davidov, 2006, p. 609).

Satzewhich and Liodakis (2007) review the historical development of multiculturalism policy in Canada. They described the first phase as occurring between 1971 to 1980. During this phase, the government emphasized the celebration of differences instead of encouraging the populace to become assimilated into an official culture based an Anglo-Canadian traditions. The Federal government was guided by principles supporting the maintenance of distinct cultural groups, the removing of obstacles preventing full participation in society, the encouragement of inter-cultural exchanges as a way of promoting national unity, and assistance of new Canadians to learn one of the two official languages. The first phase was followed by a second phase in the 1980s wherein the multicultural policies became formally adopted in legislation such as through the adoption of the Charter of Rights and Freedoms in 1982 and the passing of the Multiculturalism Act in 1988. During this phase, multiculturalism became a legally
required mandate in Section 15(1) and 27 of the Charter of Rights and Freedoms (Smithey, 2001).

As Satzewich and Liodakis (2007) point out, the official government policy toward multiculturalism is not without its opponents both among those who support the principle of multiculturalism and those that do not. Among proponents of multiculturalism is the critique that official policy has been ineffective. Some proponents argue that government practices have focused on celebrating aspects of diversity that are palatable to the mainstream (e.g., song and dance) but which have not adequately addressed systemic institutional barriers that prevent cultural minority groups from fully participating in Canadian society. Smithey (2001) argues that courts have tended to apply the Charter in a manner that gives priority to status quo governmental and organizational practices over the spiritual or religious practices of individuals in situations where there has been no explicit motivation to promote one belief system over another. Beaman (2003) argues that the acceptance of seemingly benign governmental and organizational practices can potentially maintain the dominant status quo position of Protestant and Catholic religious traditions. Consequently, the guise of common-sense reasonableness, which underlies the acceptance of the status quo, can limit access to power by minority spiritual and religious groups.

In juxtaposition, some opponents of the principle of multiculturalism view government policies as being too effective in promoting diversity (Satzewich & Liodakis, 2007). These opponents argue that multicultural policies potentially dilute a national Canadian identity through the promotion of cultural relativism. Such a critique rests on two assumptions that are problematic. The first problematic assumption is that
there is actually a monolithic, static, national identity that is at risk of being undermined (Satzewich & Liodakis, 2007). Such an assumption neglects the phenomenon that all cultures are under constant dynamic flux due to changes within the constitutions of the cultural group as well as interaction with other cultural groups. Furthermore, the Canadian identity has been historically characterized as a gathering of different identities under one umbrella starting with the three founding peoples (i.e., Aboriginals, French, English) (Satzewich & Liodakis, 2007). It may be the amorphous nature of the Canadian identity that has allowed for a diversity of peoples to retain some semblance of difference while still identifying themselves as Canadian (e.g., Chinese-Canadians, Italian-Canadians).

The second problematic assumption is that multiculturalism will inevitably result in an anything goes cultural relativism (Satzewich & Liodakis, 2007). The concept of multiculturalism itself is one boundary for cultural relativism. As Fowers and Davidov (2006) point out, the concept of multiculturalism has a particular socio-cultural history (post-Enlightenment Euro-American thought). Any effort toward the implementation of multiculturalism begins with an acceptance of multiculturalism as something to be valued. Furthermore, the courts have tended to act conservatively in terms of rejecting Canadian laws in favor of cultural practices that contradict such laws (i.e., female genital circumcision or mutilation) (Beaman, 2003). The fear that Canadians may lose what they most value is a belief that is partially rooted in a neglect of both the aforementioned limitations of relativism as well as the fact that multiculturalism is one aspect of the Canadian identity. Such fears can lead to xenophobic attitudes wherein minority cultural groups are at most merely tolerated by the cultural majority. Xenophobic attitudes may be
undermined in the populace through recognizing the advantages of multiculturalism, such as an economic advantage on the international business stage, promotion of open dialogue that enhances the knowledge base of society, and the maintenance of a rich cultural tapestry that enables Canadians to live a cosmopolitan life-style (e.g., arts, foods) (Fowers & Davidov. 2006; Satzewich & Liodakis, 2007).

2.5 A conceptualization of culturally-integrative services

During the provision of services to a client, a therapist’s responsiveness to a client’s cultural heritage can be practiced at three levels of service delivery (Sue, 2006). The first level entails the therapist’s adequate sensitivity within the therapeutic interaction with the specific client. This is the level that will be discussed in detail within this inquiry. Responsiveness could also be practiced at the two other levels – the organization that houses the service provider and the broader health care system – in order to ensure that all clients are provided with appropriate services.

At the first level of service delivery, a therapist’s responsiveness is embodied by the therapist acting in a culturally intentional manner (Ivey, et al., 1997). Cultural intentionality refers to a therapist purposefully adjusting the implementation of psychotherapy in order to make it suitable for a specific client given the client’s cultural heritage (Ivey et al., 1997; Sue et al., 1998). As stated by Ivey et al. (1997) “intentional, fully functioning individuals are not bound to one course of action but can respond in the moment to changing life situations … The counsellor must reflect, analyze, and choose appropriate responses and techniques” (pp. 14-15). Intentional adjustments can be made at every stage of therapy: referral, initial contact, assessment, intervention, and termination (Hung-Tat & Fung, 2003). If a psychotherapist implements a relatively
inflexible approach when working with their clients, then the psychotherapist may be practicing psychotherapy in a *culturally encapsulated* manner (Ivey, et al., 1997; Pedersen, 1999). Cultural encapsulation may occur because the psychotherapist cannot envision functioning in any other manner or the therapist lacks the behavioural capacity to adjust their approach.

During a therapist’s effort to intentionally adjust therapy, the therapist must retain elements of psychotherapy that are relevant for all psychotherapeutic encounters and, simultaneously, adjust those elements that need to be adjusted for the particular encounter (Draguns, 2002; Fischer, et al., 1998; Lee & Armstrong, 2000; Patterson, 1996). After all, as pointed out by Patterson (1996), “modifying or adapting counseling to … clients cannot lead to abandoning those things that are essential for the therapeutic process” (p. 227). No consensus exists among theorists regarding either which elements of psychotherapy are universally relevant for all clients or which elements are specific for working with particular clients (Draguns, 2002; Lee & Armstrong, 2000). I sought to clarify the nature of these two distinct elements by attempting to understand the perspectives of therapists with respect to their efforts to adjust their services for Canadian Muslim clients (Shujah, 2006). The ten therapists who were interviewed unanimously agreed that the establishment of a therapeutic alliance is relevant for every client, but the components of the therapeutic alliance (i.e., mutually agreed upon goals and techniques as well as the establishment of an emotional bond) should be adjusted for the cultural heritage of the individual client.

In attempting to understand the preferences and needs of Canadian clients, Batz et al. (2004) surveyed the preferences among 46 Canadians who were accessing mental
health services. The sample was religiously diverse and 48% of the sample described themselves as *spiritual*. The majority (53%) of participants desired spirituality to be included in their treatment. In their conceptualization of their problems and treatment, 47% believed that spirituality was often or always relevant in their treatment. This desire and perceived need for spiritual integration is similar to the results of previous studies conducted with client populations in the United States (see Post & Wade, 2009).

With respect to integrating spirituality into therapy, some therapists may have an ethical concern that introducing spirituality into therapy risks undermining a client’s autonomy through the encouragement for the client to adopt particular spiritual or religious beliefs (Zinnabauer & Pargament, 2000; Kelly, 1995). The realization of this potential is contingent on the therapist’s interpretative stance toward spirituality. Zinnbauer and Pargament (2000) demarcate four interpretative approaches that a therapist can take toward spirituality. One approach is a *rejectionist* approach wherein the therapist rejects the relevance of spirituality and encourages the client to adopt such a perspective. A second approach is an *exclusionary* approach wherein the therapist affirms a particular set of spiritual beliefs (such as Christian or Islamic creeds) and encourages a client to adopt these beliefs. A therapist that utilizes either of these two approaches undermines the client’s autonomy if the client does not provide informed consent accepting such transformative pressure. The two other approaches (*constructivist* and *pluralist*) to spirituality support a therapist’s openness to whatever spiritual beliefs the client brings. A constructivist stance entails the therapist believing that there are no absolutely correct interpretations of reality and spirituality is viewed as one possible construction of meaning among others. In contrast, a pluralist stance begins with a belief in a specific
spiritual reality, but it differs from an exclusionary perspective as the therapist believes that there are multiple pathways available to approach this reality.

Furthermore, therapists can be hesitant to integrate spirituality into therapy because of an ethical concern about whether the integration will be more harmful than helpful (Baetz, et al., 2004). However, the conclusions of a recent meta-analytic review of the efficacy literature on spiritually-integrative services did not support the concern of reduced efficacy of treatment (Worthington, et al., 2011). The authors of the study included 46 studies in their meta-analytic review. In comparison to no treatment at all, the administration of a spiritually-integrative service generally led to improvement among clients with respect to psychological measures of well-being. Similarly, in comparison to alternative active treatments, the administration of spiritually-integrative treatment resulted in improved outcome in terms of psychological measures of well-being.

Dismantling studies were less common. These studies are attempts to determine the additive effects of including spirituality into a pre-existing empirically-supported treatment protocol. In these studies, spiritually-integrative treatment had equal efficacy in comparison to similar treatments that did not incorporate clients’ spirituality. Dismantling studies were less common in comparison to the former two forms types of comparative analysis (i.e., comparison to no treatment; comparison to alternative treatment).

Tan (1996) provides a framework for conceptualizing the different manner by which spirituality can be integrated into therapy (implicit and explicit). During an implicit integration, spirituality is not overtly brought into the clinical setting. The client has the lead in deciding whether spiritual issues are addressed in therapy. In this form of integration, the therapist does not initiate a conversation about spiritual issues and does
not systematically utilize spiritual resources in the therapy, but may incorporate such resources in seeking psycho-social treatment goals. In comparison, an explicit approach to integration entails a more overt approach wherein the therapist takes the lead role for integrating spirituality. An explicit approach can involve an in-depth spiritual assessment, the setting of treatment goals that explicitly include a spiritual component, and the utilization of spiritual resources toward reaching treatment goals.

Even though integration of spirituality is being encouraged in this inquiry, I affirm that individual therapists should decide for themselves how they actually integrate spirituality with their clients. In any given therapeutic interaction, the therapist has to decide if, and how to, incorporate a client’s spirituality into therapy. In making this decision, the therapist needs to consider various factors including “a) the client’s needs and preferences; b) the therapist’s training; c) the therapist’s spiritual beliefs and comfort with spiritual/religion techniques; and d) the therapeutic modality” (Smith, 1999, p. 77).

2.6 Summary

In the quest to support clients in the expression of their cultural heritage, psychotherapists face the pragmatic challenge of offering a specific client with culturally-integrative services. The resolution of this challenge is contingent on a therapist intentionally adjusting the administration of services in the context of a client’s preferences and cultural heritage. When a therapist adjusts services for a specific client, spirituality can be a potentially relevant dimension for at least some clients. Such an adjustment does not necessarily lead to the imposition of values, or reduced efficacy, which may be concerns among some therapists.
CHAPTER 3: MODELS OF A THERAPIST’S COMPETENCIES TO OFFER CULTURALLY INTEGRATIVE SERVICES

In a previous chapter, there was a discussion of an ethical imperative for therapists to offer culturally integrative services. A description of the nature of culturally integrative services was also provided. In this chapter, there is a review of the competencies that have been proposed to enable a therapist to provide culturally-integrative services to a specific client.

The Canadian Psychological Association’s guidelines on working with diverse populations state that “competence requires specific knowledge, skills and attitudes used for the benefit of others. Competence also requires self-monitoring of one’s own knowledge base, personal values, experiences, biases, attitudes, and socialization, which influence how they practice” (CPA, 2001, p. 3). The nature of specific knowledge, skills, attitudes, and reflective capacity has been defined differently across the various theoretical models of competencies proposed in the literature.

In this chapter, there is a review of two types of theoretical models of competencies. The first set of models includes previous attempts to describe specific competencies related to responding to cultural diversity. In comparison, the second set of models entails attempts to describe the development of competency to work with clients in general. The review concludes with reasons why the Multicultural Competencies Model was utilized in this inquiry to guide the selection of pedagogical objectives of the workshop.

3.1 Specific multicultural competencies

The infancy period of the cultural competency literature was in the 1980s (Worthington, Soth-McNett, & Moreno, 2007). A growing awareness among therapists of
the need to integrate clients’ cultural heritage led to one of the first models of cultural competency (Worthington, et al., 2007), which was labeled the Multicultural Competency Model (MCC). Subsequently, there have been numerous models proposed both within and outside the field of Psychology. In this section, I review seven specific models of multicultural competency discussed by Ponterotto, Fuertes, and Chen (2000).

3.1.1 Identity theory. Helms’ identity theory model (Helms & Cook, 1999) offers a description of cultural identity development and the effects of this development on a therapist’s ability to comprehend a client’s experiences. Helms originally constructed her model to describe the development of racial identity; however, the model has been extended to other social identities, such as gender and ability level (Ivey, et al., 1997). People possess multiple social identities and each identity develops separately; a person will not be on the same stage for all their identities. For example, an African-American Christian may have a highly developed identity with respect to racial identity, but the person can be at a lower stage of development with respect to spirituality.

A therapist’s stage of development on a particular identity dimension is proposed to influence the therapist’s ability to empathize with clients with respect to experiences related to the particular identity. Helms and Cook (1999) propose five stages of identity development. In general, a therapist’s level of identity development is thought to be positively associated with greater openness to a client’s experiences (Ivey, et al., 1997). The lowest stage of identity is marked by a therapist ignoring the relevance of the particular cultural identity dimension for either their own or their client’s experiences. For example, a therapist at the lowest stage of development regarding spirituality would merely assume that everyone naturally shares the same spiritual beliefs that the therapist
possesses. The middle stages are marked with greater awareness of oneself as a cultural being. At these levels, a therapist is more capable of empathizing with their clients but such empathy can be impeded by either an in-group or out-group favourable bias. At the final stage, the therapist has a transcendental viewpoint wherein the therapist can empathize with the experiences of all people irrespective of whether or not they have the same identity as the therapist.

3.1.2 Acculturation, locus of problem etiology, and goals of counseling model. Atkinson, Thompson and Grant (1993) provide a model that focuses on highlighting the nature of a therapist’s appropriate behavioral response when working with a specific client. The model is a framework for matching particular roles of a therapist with the specific needs of a client. The framework entails three specific dimensions and the selection of an appropriate role is based on the client’s position on the cross-section of the three dimensions. The three specific dimensions are acculturation (low to high), goal of helping (prevention to remediation), and the locus of problem etiology (internal to external) … and the intersection of the client’s standing on the three dimensions leads to one of eight recommended roles for the counselor: advisor, advocate, change agent, consultant, counselor, facilitator of indigenous healing methods, facilitator of indigenous support systems, and psychotherapist. (Ponterotto et al., 2000, pp. 655-656)

3.1.3 Common factor perspective. Fischer, Jome, and Atkinson (1998) highlight common factors that are purported to exist across both psychotherapeutic approaches as well as across other healing approaches in Canada and other societies. To briefly summarize, the authors highlight four common factors that they believe should be present in every therapeutic situation: 1) a therapeutic relationship; 2) a shared worldview
between the client and the therapist; 3) the healer meeting the client’s expectations; and 4) the implementation of healing rituals that are perceived as legitimate by the client.

3.1.4 Model of worldview and change. Trevino’s (1996) model offers a description of how a therapist’s worldview is related to the therapeutic process. Trevino proposes that the respective congruency in worldviews held by the client and therapist can have two effects on the therapeutic process. Trevino proposes that when the client and therapist share general perceptions about the world, then the result is the client ascribing greater empathy and credibility to the therapist. Such ascriptions are theorized to foster the therapeutic alliance. Trevino suggests that during the initial stages of therapy, the therapist should attempt to comprehend the client’s experiences. Trevino suggests that incongruency in the specific beliefs about a client’s experiences may contribute to therapeutic change through fostering a client’s re-conceptualization of his or her problems. Trevino encourages therapists to explore alternate interpretations with their clients during the intervention phase of therapy.

3.1.5 Perceptual schemata model of cultural sensitivity. Ridley, Mendoza, Kanitz, Angermeier, and Zenk (1996) argue that an appropriate behavioral adjustment by a therapist is contingent on the manner that the therapist attends to, organizes, and processes information regarding the client’s idiographic experiences. The authors propose that therapists interpret information about clients using perceptual schemas that are embedded within the therapist's worldview. The activation of these schemas tend to result in the processing of information (i.e., guiding attention and reasoning) in a manner that maintains the therapist’s initial beliefs. Ridley et al. (1996) postulate that cultural
competency is premised on five specific processes involved during the interpretation of the client’s experiences:

1) Self-processing (the degree to which the counselor is open and active in examining personal experiences, beliefs, values, and expectations); 2) purposefully applying schemata (the counselor’s ability to purposefully apply the cultural perceptual schema to gather and organize client information in gaining a meaningful understanding of the client’s experiences; 3) maintaining plasticity (the degree to which the counselor is able to maintain flexibility in the application of cultural schema and to avoid stereotyping clients); 4) active-selective attention (the counselor’s ability to attend actively to select aspects of cultural stimulus material); and 5) motivation (the counselor’s willingness to engage in the previous four sub-processes) (Ponterotto, et al. 2000, pp. 658-659)

3.1.6 Integrative model of cross-cultural counseling. Leong (1996) attempts to provide a model that is “integrative, sequential, and dynamic” (Ponterotto, et al., 2000, p. 659). In describing the characteristics of culturally-competent therapists, Leong integrates information processing and personality theory (Ponterotto, et al., 2000). Leong attempts to offer an account of the dynamic inter-subjective interaction that occurs between the client and the therapist.

Five main concepts form the foundation of Leong’s model (Ponterotto, et al., 2000). One principle is the concept of out-group homogeneity effects, which refers to a cognitive tendency to perceive greater homogeneity among groups to which one does not belong. The second principle is that culturally competent therapists utilize sophisticated culture schema to interpret their client’s experiences. The third principle is that each individual is a complex adaptive system comprised of individual, group, and universal characteristics. The fourth principle is that similarity between the client and therapist (complementarity) is positively associated with therapeutic efficacy and client satisfaction. The fifth principle is that a therapist’s ability to be mindful will enable the
therapist to develop sophisticated cultural schema through avoiding reasoning biases, such as the out-group homogeneity effect.

3.1.7 Multicultural counseling model. The MCC model (Sue et al., 1998) describes a culturally-competent therapist as possessing competency in three dimensions: a therapist’s awareness of his or her own worldview, a therapist’s awareness of the worldview of the specific client, and the therapist’s ability to implement the appropriate intervention strategies with the client. Each of these dimensions is operationalized in terms of knowledge, attitude, and skills (see Table 1), which informed the pedagogical objectives of the designed workshop. Each of the three dimensions is briefly discussed.

3.1.7.1 A therapist’s awareness of his or her own worldview. Every therapist inherently relies on his or her worldview to interpret the therapeutic interaction and to guide the implementation of the intervention (Polkinghorne, 2004). With awareness, it is proposed that a therapist can manage the influence of their initial views on their interpretation of the client’s problems. A self-aware therapist is proposed to be more capable at generating an applicable understanding of the specific client’s problems.
Table 1: MCC model

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Beliefs</th>
<th>Knowledge</th>
<th>Skill</th>
</tr>
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<tbody>
<tr>
<td>A therapist’s awareness of his or her own worldview.</td>
<td>1. awareness and sensitive to their own cultural heritage and to valuing and respecting differences 2. aware of how their own cultural background and experiences, attitudes, and values, and biases influence psychological processes 3. recognize limits of competency 4. comfortable with differences between them and clients</td>
<td>1. knowledge of how background shaped understanding of normality and abnormality 2. understand how racism and stereotyping effects their work 3. understand their impact on their clients</td>
<td>1. seek out training, consultation, and other resources to enhance capacity 2. seek to understand themselves as cultural being and to become less discriminatory</td>
</tr>
<tr>
<td>A therapist’s awareness of the client’s worldview.</td>
<td>1. Aware of their negative emotional reactions 2. Aware of their stereotypes</td>
<td>1. Specific knowledge about groups to whom they provide services 2. understand how culture effects person’s functioning 3. Understand how socio-political institutions can oppress minority groups</td>
<td>1. Familiarize themselves with the latest research on treating specific groups 2. involved with minorities groups outside of counselling</td>
</tr>
</tbody>
</table>
3.1.7.3 Therapist's skills for applying appropriate interventions. The therapist’s awareness – of his or her own perspective and the client’s perspective – provides the therapist with an appreciation for the potential differences in his or her own and the client’s conceptualization of the therapeutic encounter (Sue et al., 1998). This appreciation can be incorporated into the therapist’s attempt to offer the client appropriate interventions. Such appreciation may be utilized by the therapist in the attempt to build and maintain a therapeutic alliance with the client (Sue, 2006). In order to customize the therapeutic alliance, a therapist should attempt to negotiate with the client the goals and techniques utilized.

3.2 General competencies among therapists

This section is a discussion of three specific models that attempt to account for the development of expertise among therapists to work with clients in general. Previous theorists have described a historical lack of integration in the literature between models of general therapist competency and specific competencies that support cultural integration (e.g., Jennings, Goh, Skovholt, Hanson, Banerjee-Stevens, 2003). The three models reviewed give insight into the nature of training needs across the career development of therapists and they expand on some of the competencies discussed in the previously reviewed models.

3.2.1 Ronnestad & Skovholt’s (2003) therapist development model. The authors of this model followed and interviewed 100 counsellors and therapists who were at various stages of their professional careers. This empirically-derived method of constructing a competency model is somewhat unique (Ronnestad & Skovholt, 2003).
This model is a leading model in the attempt to understand the development of therapists as it commonly referenced in the literature.

The authors attempted to understand the phases that are involved in the development of therapists as they gain greater expertise. The authors developed five phases of career development that they viewed as relevant to understand the unique experiences and needs of therapists. These phases are briefly summarized in Table 2 with descriptions taken directly from Ronnestad and Skovholt (2003). The five phases encompass the time before a therapist enters professional training, their initial experiences as a student, their experiences in becoming a senior student, and their experiences beginning and advancing in a career as professional.

The authors describe 14 themes relevant to the development of expertise. In these themes, the authors postulate that the development of competency is a life-long process partially involving integration of knowledge and a greater sense of self-efficacy. Lay helpers have their own theory of helping others. They come to compartmentalize this theory during their professional training as they are initially introduced to theoretical models. A therapist in these early stages of career development can feel anxiety stemming from a low sense of professional self-efficacy, which can lead them to seek comfort offered by adhering to specific theoretical models. At the early stages of development, it is suggested that the therapist prefers didactic training methods because of the directly applicable guidance they can provide.
<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Lay Helper Phase</td>
<td>- experience helping others before they enter professional training.</td>
</tr>
<tr>
<td>Beginning Student Phase</td>
<td>- start of their professional training.</td>
</tr>
<tr>
<td>Advanced Student Phase</td>
<td>- Towards the end of training, the modal student is working as a counselor/therapist at settings such as internship, practicum, clerkship or field placement, and is receiving regular and formalized supervision.</td>
</tr>
<tr>
<td>Novice Professional</td>
<td>- the first years after graduation although individual paths vary</td>
</tr>
<tr>
<td>Experienced Professional Stage</td>
<td>- practicing for a number of years and has typically had experience with a wide variety of clients in different work settings.</td>
</tr>
<tr>
<td>Senior Professional Phase</td>
<td>- practitioner is a well-established professional who is regarded as a senior by others. Although some attain this senior status in mid-career, the modal senior professional has practiced for 20 to 25 years or more and many are approaching retirement.</td>
</tr>
</tbody>
</table>
According to this model, the characteristics of therapists shift as they gain experience. Over time and across clinical experiences, the therapist is believed to hone a conceptual map that underlies their expertise in working in their specific domain of practice. They are guided by their own idiosyncratic theories, which at the latter stages of professional development entail a synthesis of personal beliefs and the professional theoretical models. The authors conclude that the development of expertise among therapists is not an inherent occurrence arising from gaining experience; rather expertise requires the therapist to actively reflect on their practice. Without such reflexivity, the therapist’s development is believed to stagnate. As the therapist develops their expertise and experiences success in therapy, they gradually gain a sense of greater professional self-efficacy.

3.2.2 Declarative, procedural, reflective model (DPR). Bennett-Levy (2006) introduced his model in an attempt to provide a theoretical framework to guide the training of therapists. The author developed his model partially through extending the model developed by Binder (1999). The DRP model has three principal systems (declarative, procedural and reflective) whose interactions are conceptualized as the basis of the development of expertise among therapists. The author proposes educational strategies that are likely most relevant for developing each system.

The declarative knowledge system is conceptualized as the cognitive system that contains factual knowledge, such as the cognitive-behavioural model of depression or the theological beliefs of Christians. This system contains knowledge of theories (conceptual knowledge), knowledge of interpersonal functioning, and technical skills. The authors
propose that declarative knowledge is acquired through didactic training approaches such as lectures, reading assignments, observational learning, and supervision.

The procedural knowledge system is conceptualized as the cognitive system that guides the application of skills and knowledge in practice. It is viewed as containing rules, plans, and procedures that tacitly guide therapists in their interactions with clients. This system encompasses a therapist’s beliefs of himself or herself as a therapist and as a person, along with interpersonal relational skills, conceptual skills, and technical skills. As the therapist gains experience, it is believed that he or she builds a “formidable repertoire of representative if-then rules, plans, procedures, and skills (e.g., when a patient has a clinical depression and is withdrawn, then assess level and kind of activity, as well as achievement and pleasure, using the weekly Activity Schedule)” (Bennet-Levy, 2006, p. 59).

The authors propose that a therapist must reflect in order to refine their application of skills and therein build their procedural knowledge:

The experienced therapist already knows the mechanics of setting up behavioural experiments in a variety of situations. However, when s/he faces a difficulty engaging a particular patient in an experiment, there may be an apparent mismatch between the therapist’s current knowledge and the challenge the patient presents. The therapist’s curiosity is aroused. S/he may reflect afterwards on this difficulty, and perhaps take it to a supervisor, who poses a series of questions to help the therapist conceptualize the difficulty, and develop potential strategies. In this example, the therapist may end up not so much learning new skills de novo like the novice therapist; rather, through reflection, s/he may apply existing knowledge and skills from other contexts to the new situation. (Bennet-Levy, 2006, p. 60)

Bennet-Levy subsumes three components in the reflective system that determines a therapist’s ability to reflect. One aspect is focused attention or in other words a therapist’s direction of attention to internal processing. The second aspect is autonoetic
consciousness or the therapist’s ability to represent the past, present and future. The third aspect is the application of cognitive operations that are utilized in the effort to “analyze, expand, compare, contrast, and evaluate the contents of autonoetic consciousness. Examples of such operations are: following trains of thought, persistent self-questioning, logical analysis, and problem-solving” (Bennet-Levy, 2006, p. 61).

The author propose that the training of experienced therapists should be focused on refining the application of skills (i.e., building procedural knowledge) in contrast to novice therapist training that requires greater focus on the acquisition of basic knowledge and skills. The author propose that the acquisition of skills requires didactic training methods (e.g., lectures) followed by experiential methods to practice the skills (e.g., role play).

3.3.3 Micro-skills model. The micro-skills model proposed in Ridely, Mollen, and Kelly (2011) model is also an attempt to guide training by expanding on the various understandings of competencies. This model encompasses elements of competency that are not extensively discussed in some of the other models of competency, such as consulting with others and working in the context of a broader system. The authors conceptualize overall competency as a “set of competencies, and each competency consists of subsets of micro-skills, both behavioural and cognitive. In demonstrating their competence, clinicians must co-ordinate and integrate these competencies and micro-skills as a means of determining, facilitating, evaluating, and sustaining therapeutic outcome” (Ridley, Mollen, & Kelly, 2011, p. 835). In this understanding of competency, the management of cultural diversity is part of the broader effort to achieve positive outcomes. They propose twelve subordinate competencies (see Table 3). The utilization
<table>
<thead>
<tr>
<th>Subordinate Skills</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Self-appraising</td>
<td>Therapist assess own work</td>
</tr>
<tr>
<td>Structuring therapy</td>
<td>Therapist guides the process as it unfolds</td>
</tr>
<tr>
<td>Building a therapeutic alliance</td>
<td>Sustainment of collaboration with the client</td>
</tr>
<tr>
<td>Applying a map of cognitive change</td>
<td>Therapist’s conceptual path to achieving therapeutic goals</td>
</tr>
<tr>
<td>Using therapeutic techniques</td>
<td>Therapist can apply specific interventions</td>
</tr>
<tr>
<td>Self-correcting</td>
<td>Therapist corrects mistakes</td>
</tr>
<tr>
<td>Surmounting obstacles</td>
<td>Therapist strives to solve challenges</td>
</tr>
<tr>
<td>Leveraging opportunities</td>
<td>Therapist uses unexpected opportunities to achieve goals</td>
</tr>
<tr>
<td>Managing special situations</td>
<td>Therapist manages emergencies and ethical challenges</td>
</tr>
<tr>
<td>Working with other systems of care</td>
<td>Therapist works effectively within the broader health care system</td>
</tr>
<tr>
<td>Consulting other sources</td>
<td>Therapist effectively consults literature, colleagues, and supervisors as needed</td>
</tr>
<tr>
<td>Terminating therapy</td>
<td>Therapists closes therapy</td>
</tr>
</tbody>
</table>
Table 4: Metacognitive skills

<table>
<thead>
<tr>
<th>Integrating Deep Structures</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Purposefulness</td>
<td>Therapist directs activities toward goals</td>
</tr>
<tr>
<td>Motivation</td>
<td>Therapist’s degree, type, and source of effort</td>
</tr>
<tr>
<td>Selection</td>
<td>Therapist decides which competencies to use</td>
</tr>
<tr>
<td>Sequencing</td>
<td>Therapist executes the selected competencies in the best order to achieve goals</td>
</tr>
<tr>
<td>Timing</td>
<td>The therapist executes selected competencies at the proper pace</td>
</tr>
</tbody>
</table>
of these sub-ordinate competencies toward the achievement of therapeutic objectives requires intentional and co-ordinate action. They propose five meta-cognitive skills that underlie usage of the twelve competencies and which enable effective actions to determine, facilitate, evaluate, and sustain positive outcomes (Table 4).

3.3 Review of the theoretical models

The above review of the theoretical models provides a synopsis of the respective models. I will now discuss criticisms of these models and the current state of literature on the competencies that underlie cultural sensitivity.

A repeated voiced criticism by previous theorists is the limited empirical validation of the models that have been proposed in the literature (Owen, Leach, Wampold, & Rodolfa, 2011; Ponterotto, Fuertes, & Chen, 2000). Many models have been proposed based on the theoretical synthesis of scholars or groups of scholars. Infrequently have the models been directly studied to determine their actual links to training or clinical outcomes. There are pragmatic reasons for this lack of empirical research including

“methodological difficulties (e.g. experimental studies with control groups are usually inappropriate and/or unfeasible); complexity of the issues (training programs may extend over many months, have multiple components, usually multiple trainers with different styles, with trainees from a variety of backgrounds); and apparent difficulties in obtaining funding for training research (Binder, 1999), which falls uncomfortably between psychotherapy and education.” (Bennett-Levy, 2006; p. 58).

Given the current state of literature, three models stand out as having greater empirical support: MCC model, Identity theory model, and the model by Ronnestad and Skovholt (2003). Since the 1980s the MCC (Sue et al., 1998) and Identity Theory model (Helms & Cook, 1999) have been the basis of ongoing research studies and have been linked to clinical outcomes in both analogue studies and studies with actual clients in therapy.
(Ponterotto, Fuertes, & Chen, 2000). These studies have highlighted the associative link between acquisition of the competencies with culturally sensitive service delivery and improved client outcomes. Consequently, previous research findings have tended to support the conceptual and predictive validity of these two models. On a different vain, the model by Ronnestad and Skovholt is unique as the authors developed the model through an examination of the experiences of a range of actual therapists. From its conceptualization the model was grounded in the reported experiences of therapists. This developmental approach gives credence to the model in offering insight for at least a subset of therapists. Future research on these three models and the other models will further clarify the relative validity and clinical utility of the respective models.

With respect to the description of competencies, there seems to be a growing appreciation of a holistic perspective in describing factors that underlie overall competency. There are different aspects to this conceptual broadening. One aspect that stands out is the increasing elaboration of the meta-cognitive processing strategies relevant for cultural competency. Identity Theory and the MCC contain indirect reference to the relevance of meta-cognitive processing but do not delve into the nature of the relevant meta-cognitive strategies. The models by Ridley et al. (1996) and Leong (1996) seemed to be novel attempts to provide a description of the meta-cognitive strategies that support cultural competency Some recent models, such as by Ridely, Mollen, and Kelly (2011) or by Bennet-Levy (2006) have added to the initial descriptions of meta-cognitive processing. Another aspect of the broadening seems to be a greater reference to a therapists’ self concept. Namely, Bennet-Levy (2007) offers a description of the link between therapist self-concept and clinical behaviour that is more sophisticated than in
previous models. Another area ignored in many models is the relevance of a therapist working within a larger system of service delivery. The model by Ridley, Mollen, and Kelly (2011) offers a description of individual based competencies that are linked to effective operation in a broader system.

Another major limitation of the literature to date is the failure to link specific competencies to particular methods of training (Bennet-Levy, 2007). Theorists have tended to propose prescriptive models of what a therapist should possess without delineating an instructional path to achieving such characteristics. This limitation inhibits the potential linking of the models to actions that can be taken in training. The model proposed by Ronnestad and Skovholt (2003) and Bennet-Levy (2007), in particular, are clear elaborations on the developmental resources that can contribute to the advancement of competencies. While the propositions need to be further examined in future research; nevertheless, these two models open up avenues for inquiry and training program development.

3.4 Choice of a theoretical model to guide the pedagogical objectives of the proposed workshop

The MCC model will be adopted in this inquiry for two reasons. First, this model has more evidence supporting its construct validity for describing culturally competent therapists than the other existing models (Worthington, et al., 2007). One source of evidence is affirmation by experts in the field; it is the most widely endorsed model and such endorsement includes the American Psychological Association and the American Counseling Association (Worthington, et al., 2007). A more specific source of evidence for construct validity is derived from research on the predictive association between the
proposed competencies and either process or outcome objectives. The MCC model has been studied more than any other model of cultural-competency and the results of such studies suggest that the model can be predictive of whether a therapist will function in a culturally integrative manner with their clients (see Worthington et al., 2007).

In addition to being the forerunner model of cultural competency, the model also possesses the strength of being able to integrate other models of cultural competency. Ridley et al. (1994) point out that various concepts (e.g., cultural competency, cultural sensitivity, or culturally-skilled) have been used to refer to the essential characteristics that a therapist must possess in order to operate in a culturally-intentional manner. Ridley et al. argue that such divergence partially occurs because the concepts themselves can refer to different aspects of cultural competency. Some concepts refer to the prerequisites of culturally-intentional behavior (e.g., reflection, awareness) and other concepts refer to the behavioral expression (e.g., appropriate therapeutic alliance). The MCC model describes both requisites (e.g., awareness, knowledge) for culturally integrative therapy as well as behavioral expressions (e.g., skills) that lead to the actualization of culturally integrative services. In describing both elements, the model has the potential to incorporate the other models into an organizing framework. Some of the models discussed above can be used to supplement the MCC model especially with respect to the requisites of cultural competency.

Some of the reviewed models elaborate on the conceptual maps that underlie the proposed competencies in the MCC. Specifically, Bennet-Levy’s (2006) distinction between declarative and procedural knowledge expands on the concept of knowledge of the client’s worldview presented in the MCC model. The knowledge referenced in the
MCC model for the most part overlaps with declarative knowledge; it does not elaborate on how this knowledge is transformed into meaningful action (e.g. procedural knowledge).

Furthermore, the MCC model offers a relatively simplified conceptualization of a therapist’s self-awareness. The model assumes that awareness alone will lead to a countering of the effects of the therapist’s worldview on his or her comprehension of a client’s experiences. However, even with self-awareness, the therapist’s initial beliefs can still subtly guide a client’s attention and reasoning in a manner that reduces the therapist’s openness to alternative interpretations (Arbuthnott, et al., 2006; Byars-Winston & Fouad, 2006; Ridley et al., 1994). A therapist has to engage in meta-cognitive processing in order to effectively manage the influence of their initial beliefs on their interpretation of the client’s experiences.

A therapist’s engagement in meta-cognitive processing is contingent on their motivation and their skills for doing so (Arbuthnott, et al., 2006). By highlighting the importance of self-awareness, the MCC model partially addresses the motivation for engaging in meta-cognitive processing to control for the effects of initial schemas. Helms and Cook’s model may also offer insight into who may be motivated to use meta-cognitive skills. As therapists gain better appreciation of themselves as cultural beings and the respective experiences of others, they may be more motivated to use their meta-cognitive skills to monitor and control for the effects of beliefs on their interpretations. However, motivation is not sufficient for effective meta-cognitive processing. As Ridley et al. (1994) suggest, the therapist also needs to be mindful of what information they attend to and how they process this information. The strategies of active-selective
processing and maintenance of plasticity that is discussed in the Perceptual Schemata model can be incorporated into the MCC model in the effort to increase a therapist’s openness to a client’s cultural heritage.

### 3.4 Summary

Various models of competencies have been proposed to account for the development of a therapist’s capacity to integrate a client’s cultural heritage into therapy. The MCC model highlights three specific competencies (i.e., a therapist’s awareness of their own worldview, awareness of a client’s worldview, and application of appropriate interventions). This model was adopted both because it is the most researched of the specific multicultural competency models and it allows for integration of other models. The other models reviewed offer insights that elaborate on the nature and development of the specific proposed competencies in the MCC model.
CHAPTER 4 – TRAINING OF PSYCHOTHERAPISTS TO SUPPORT CULTURAL COMPETENCY

In order to ensure that clients are provided with appropriate services, the field of psychotherapy should ensure adequate competency among therapists. Training therapists to enhance competency integrating a client’s spirituality can take place at various junctures of a therapist’s career trajectory: during professional education or as part of post-graduate continuing education (Ridley, Mendoza, & Kanitz, 1996). Some therapists may be inadequately prepared by their academic training. Continuing education can foster the capacity to integrate a client’s spirituality into therapy. However, there is currently limited empirically evaluated guidance for the development and implementation of appropriate continuing education resources for experienced therapists. In context of this absence, a workshop to foster experienced therapist’s capacity to respond to a client’s spirituality was developed and evaluated in this inquiry.

4.1 Need for continuing education

Cultural competency training should be an aspect of the formal professional training for novice psychotherapists in order to prepare therapists for the inevitability of cultural diversity among clients. Ridley et al. (1996) outline various instructional designs for incorporating cultural competency training within professional training programs. These strategies range in their degree of inclusiveness with the least inclusive being discrete workshops alongside traditional courses, followed by separate courses on cultural competency, and then by a specialized area of concentration on multicultural therapy. The most inclusive program design is an integration design wherein multicultural training is incorporated into every course.
Gradually since the 1960s psychotherapists have increasingly recognized the importance of responding to a clients’ spirituality; however, therapists generally receive insufficient training to respond specifically to a client’s spirituality (Bartoli, 2007). This claim is supported by research findings that spirituality is a neglected topic in the training of therapists from a range of disciplines (see Hage, Hopson, Siegel, Payton, & Defanti, 2006).

With respect to the training of psychologists in Canada, Hertzsprung and Dobson (2000) surveyed Directors of Training for the professional psychology programs that exist in Canada. The directors were requested to provide information regarding the nature of diversity training in their respective programs. The directors were least likely to endorse religion as essential for diversity training relative to other cultural dimensions – i.e., ethnicity, gender, sexual preference, disability, and economic status. This disregard for the relevance of religion (and spirituality by extension) is likely to be reflected also in the content of the curricula of these programs. This pattern of neglect is consistent with the conclusions derived in previous research on the training experiences of psychologists (Brawer, et al., 2002; Shafranske & Malony, 1990).

In a recent survey of the experiences of Canadian therapists, most therapists felt they were inadequately prepared by their academic professional training (Plumb, 2011). The researcher surveyed 341 Canadian therapists; and only one-third of therapists felt satisfied with the preparation for managing spiritual diversity that they received from their professional programs (Plumb, 2011). The majority of these therapists expressed a desire for continued education to improve their capacity to integrate clients’ spirituality.
into therapy. In Plumb’s study, 40% of participants reported an explicit desire for such continuing education and only 20% desired no further continuing education on the topic.

In the context of inadequate training and at least some therapists’ desire for further training, continuing education is necessary in the effort to ensure that clients are provided with appropriate services. Two reasons support the imperative of continuing education. One reason is that currently practicing therapists may not have received cultural competency training during their studies in a professional program (Bartoli, 2007). A therapist’s development of cultural competency is a lifelong process and it does not end once a therapist graduates from a professional program (Sue et al., 1998). Supplementary training can foster the development of competency. Secondly, experienced therapists are involved in the training of novice therapists. Consequently, continuing education for experienced therapists will indirectly improve the training of novice therapists (Bartoli, 2007).

4.2 Workshops for continuing education

Various options exist for the administration of continuing education. Participation in a workshop is one viable option. Psychotherapists may be willing to utilize workshops for continuing education. For example, this possibility is reflected in an international survey of 4000 therapists who were asked to rate the importance of life experiences that contributed to their competency as professionals (Orlinsky, et al., 2001). The participants believed that the most positive influences were interpersonal experiences: 1) experiences with clients; 2) formal supervision; 3) personal therapy; 4) personal life outside of therapy; and 5) informal case discussion with colleagues. The therapists attributed a secondary, but positive influence, to other educational experiences including taking a
course or workshop seminar. Neimeyer, Taylor, and Phillip (2010) surveyed 1,146 licensed psychologists in the United States, and the vast majority (over 90%) of psychologists reported that their continuing educational experiences enhanced their professional practice; most (91%) reported being at least sometimes involved in on-site continuing education training such as workshops.

Participation in workshops has the potential to enhance the capacity of a therapist to integrate a client’s culture. Such a possibility is reflected in O’Brien et al.’s (2001) review of the efficacy literature on workshops utilized for the continuing education of health professionals. The authors reviewed 32 studies that encompassed about 3000 health professionals in a diversity of health professional fields, including mental health workers. The authors sought to answer the question of whether workshops increased the specific clinical behaviours that were the focus of the workshop. They concluded the workshops did generally increase the targeted behaviours. However, the instructional format of the workshop influenced the outcome. Specifically, workshops that only included a didactic instructional format were not effective in increasing the targeted behaviour. Interactive workshops were the most effective strategy followed by instructional formats that included both didactic and interactive works. The authors concluded that further process evaluative research is required to understand how to best combine didactic and interactive instructional formats.

### 4.3 Curricula to train psychotherapists

Theorists have proposed various curricula to promote psychotherapists’ competency to integrate a client’s spirituality; however, few studies exist that actually evaluate the influence of specific curricula (see Table 5). A failure to evaluate the
<table>
<thead>
<tr>
<th>Authors of the Evaluation</th>
<th>Participants Involved in Training</th>
<th>Nature of Training</th>
<th>How Training was Evaluated</th>
<th>Effects of Training</th>
</tr>
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<tbody>
<tr>
<td>Baich (1999)</td>
<td>Doctoral students in a clinical psychology program</td>
<td>One-day workshop. It entailed didactic instruction, reflective exercises, and discussion.</td>
<td>Pre-workshop and post-workshop self-report questionnaires</td>
<td>Participants had increased awareness of spiritual issues; participants’ experienced increased awareness of their own views on spirituality</td>
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<tr>
<td>Curtis &amp; Glass (2002)</td>
<td>Master-level students training in Counseling</td>
<td>A semester course. It entailed reflective, didactic, and skills training.</td>
<td>Pre-course and post-course self-report questionnaires</td>
<td>Participants experienced increased self-efficacy with respect to addressing spiritually associated clinical issues; no change in attitude towards the use of spiritual beliefs in therapy; no change in judgment towards different perspectives.</td>
</tr>
<tr>
<td>Souza (2002)</td>
<td>First year Master-level Counseling Program</td>
<td>4 seminars, 1 hour each. Seminars entailed readings, didactic instruction, reflection, guided discussion.</td>
<td>Qualitative feedback</td>
<td>Students felt comfortable discussing their spiritual views in the seminar after being initially hesitant; some students were hesitant defining spirituality in any absolute sense; students differed in their beliefs about whether a client or a counselor should introduce spiritual issues into therapy.</td>
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<tr>
<td>Grabovac, Clark, &amp; Mckenna (2008).</td>
<td>3rd and 4th year Psychiatric Residents</td>
<td>6 hour course (1 hour week for six weeks). Course entailed didactic instruction and case-based modules.</td>
<td>Pre-course and post-course self-report questionnaires. Compared experimental group to a control group. Qualitative written feedback.</td>
<td>Participants had increased knowledge and skills for integrating spirituality into therapy. No change with respect attitude towards either their own spirituality or the value of spirituality for others</td>
</tr>
<tr>
<td>Schredardus (2008)</td>
<td>Practicing therapists</td>
<td>Ten hour workshop. Entailed didactic presentation of knowledge and skills training.</td>
<td>Pre-workshop and post-workshop self-report questionnaires. Compared experimental group to a control group.</td>
<td>Participants had increased knowledge and skills for integrating spirituality into therapy. Changes occurred irrespective of the therapist’s original attitude toward spirituality</td>
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<tr>
<td>Baggs, Wolf, Moro, Puig, &amp; Fukuyama (2010)</td>
<td>Master-level students in a counseling program</td>
<td>Semester long course; not clear the content of course</td>
<td>Pre-course and post-workshop self-report questionnaires; open-ended evaluation</td>
<td>Participants had increased self-awareness; knowledge; skills; and comfort integrating spirituality</td>
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outcomes of cultural competency training curricula reflects a broader pattern of the literature on cultural competency training for various health professionals. Bhui et al. (2007) found that less than ten percent of articles on models of cultural competency training contain any evaluation of training recommendations. Evaluation of curricula is essential to the continued improvement of training methods and to ensure maximal gains derived from the expenditure of finite training resources (e.g., fiscal, time, human capital).

The results of the limited evaluation research suggest that cultural competency training does have the potential to increase therapists’ competency to integrate a clients’ spirituality. Increased competency was observed for training that was delivered either in a single day or was spaced out over extended time periods (see Table 5). The results of the evaluation research suggest that training is more effective at improving capacity with respect to specific aspects of cultural competency than other aspects. The MCC model of cultural competency can be extended to describe competency with respect to integrating a client’s spirituality (i.e., a therapist’s awareness of his or her views of spirituality; awareness of client’s spirituality, and skills to implement appropriate therapies). Using this framework for defining competency, the findings of the evaluative research listed in Table 5 suggest that evaluated training contributed to improvement of therapists’ knowledge of clients’ spirituality and the therapeutic skills to implement appropriate interventions.

As shown in Table 5 (on page 77), the evaluated training curricula varied in their capacity to improve therapists’ awareness of their views about spirituality. The curricula evaluated in Baich (1999) and Baggs et al. (2010) were effective at improving therapists’ awareness. However, the implementation of alternative curricula (e.g., Curtis & Glass,
2002; Grabrovac, Clark, & Mckenna, 2008) showed increase in the other two dimensions of cultural competency without any change in therapists’ awareness of their own views on spirituality. Fowers and Davidov (2006) argue that a potential risk exists in the pattern of change characterized by a therapist’s improved knowledge and skills without corresponding change in self-awareness. They suggest that a therapist who possesses knowledge of the client’s spirituality and skills to intervene will be effective at implementing change processes. However, without self-awareness, a therapist may unintentionally impose their own values and a therapist who is effective at implementing change processes will be more likely to shift client’s values than a therapist not as effective in facilitating change. To counter this potential risk, the designers of curricula have to provide focus on improvement of a therapist’s self-awareness along with the other two dimensions of competencies.

The curricula that have been evaluated do show potential to improve the cultural-competency of therapists across each of the three dimensions; however, these curricula offer limited guidance for the training of experienced practitioners. As shown in Table 5 (on page 77), of the six curricula that have been evaluated, only one was designed for experienced therapists as opposed to training or novice therapists. Experienced therapists may have different learning needs than training therapists and, so, the findings from studies of training therapists may not be directly relevant for training experienced practitioners.

A relevant implementation of cultural-competency training for experienced therapists requires using curricula that fulfill their unique learning needs for constructing knowledge. As therapists gain clinical experience, they can potentially become more
adept at the provision of therapy to clients. With adequate reflection on their own experiences, therapists continue to gain depth in the interpretative lens (or perceptual schema) that they use to comprehend clients’ experiences (Ronnestad & Skovholt, 2003). These interpretative lenses enable therapists to more effectively customize solutions to clients’ unique experiences (Polkinghorne, 2004). As previously mentioned, a therapist’s interpretative framework entails a synthesis of their general life experiences, their exposure to theoretical models, and knowledge gained from practical experiences. This integration allows therapists to construct procedural knowledge that is applicable for the clinical context within which the therapist operates (i.e., populations served, specific issues, therapeutic format). In contrast, novice therapists with little or no experience construct procedural knowledge through their direct internalization of newly acquired knowledge of how to implement therapy (such as learning about the cognitive-behavioural model of therapy). Consequently, the relevant learning strategies for training novice therapists, such as didactic resources, may not be as relevant for at least some experienced therapists.

In summary, there is currently limited empirical guidance to develop and implement curricula for training experienced therapists to integrate spirituality into therapy with their clients. The present inquiry attempts to close this research gap and, ultimately, to improve the delivery of continuing education for experienced therapists. Specifically, in this inquiry I will design, facilitate, and evaluate a one-day training workshop that aims to improve experienced therapists’ competency for appropriately responding to a clients’ spirituality.
4.4 Design of the proposed workshop

In this section, I will describe the process utilized in developing the workshop that is evaluated in this research endeavor. I will begin by describing my perspective towards education. The development of the workshop was a multi-staged process (see Table 6) and I will discuss the various steps in the following section. At the end of the chapter, there will be an outline of the workshop that was evaluated in this research project.

4.4.1 Researcher’s perspective on pedagogy. In addition to pursuing a career as a therapist, I have also pursued a career as an educator. Thus far my pursuits have culminated in teaching two undergraduate courses in psychology. As an educator, I believe that every individual learner has a unique learning experience as they idiosyncratically construct knowledge. Therein, the ideal pedagogical approach is specific to the learner. In my professional work and in this research, I have striven to provide a meaningful experience to each learner through the implementation of my philosophy of teaching, which is rooted on two pillars.

The first pillar is that instructional activities should be learner-centered. Every individual learner has a unique set of learning needs in terms of both processing information and constructing knowledge that is relevant for their life (e.g. specific clinical work). In facilitating the learner’s construction of knowledge, I attempted to enable each learner to think critically about presented material for relevance to their own clinical work. Furthermore, I provided them with supplementary educational resources that they could utilize as they believed relevant.
Table 6: Steps used to design the workshop

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<tr>
<td>1.</td>
<td>Select theoretical model to guide the development of the workshop</td>
</tr>
<tr>
<td>2.</td>
<td>Identify specific pedagogical objectives</td>
</tr>
<tr>
<td>3.</td>
<td>Design exercises to be used in the effort to realize pedagogical objectives</td>
</tr>
<tr>
<td>4.</td>
<td>Review of workshop curriculum by others</td>
</tr>
<tr>
<td>5.</td>
<td>Administration, evaluation, and revision of the workshop</td>
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</tbody>
</table>
The second pillar is that learners within a setting inherently comprise a community. I believe that an individual’s learning experience is not contingent solely on his or her relationship with the instructor; it is also enhanced or hindered by the learner’s relationship with the other learners in the community. I attempted to create a supportive learning environment, wherein learners support each other in allowing for a meaningful learning experience by every single community member. I worked toward this objective by attempting to create inter-personal space in the workshop where there was respect for the knowledge that each learner brought to the community. Furthermore, in order to sustain a supportive learning environment, I also attempted to encourage the learners to work collaboratively, through exercises and discussion space, in their pursuit of learning objectives.

4.4.2 Overview of the design of the workshop. The first step in the development of the workshop was to select a theoretical model to guide the pedagogical objectives of the workshop. Various models have been theorized to potentially delineate the factors that define therapists’ competencies. As was discussed in Chapter 2, I chose the MCC model to guide the development of the workshop.

The second step was to choose the pedagogical objectives. Sue et al. (1998) proposes thirty-one components of belief, knowledge, and skills that operationally define competency on each of the three dimensions of MCC model. Learning objectives were formulated by contextualizing the components proposed in Sue et al. (1998) in order to make the components refer specifically to a therapist’s integration of a client’s spirituality. A limited number of objectives are targeted during the workshop due to the finite time available in a single session. Furthermore, the designed workshop is merely
one instructional resource among other resources that therapists can draw upon to facilitate their ongoing continuing development of competency.

The primary focus of the workshop is on enhancing a therapist’s self-awareness regarding their views on spirituality. The development of this competency may be the most difficult to achieve relative to the other competency dimensions outlined in the MCC model. However, the development on this dimension of cultural competency is particularly relevant for improving the integration of spirituality by experienced therapists.

In addition to focusing on enhancement of a therapist’s self-awareness, a secondary focus of the workshop is to enhance the therapist’s knowledge of client’s spirituality. The focus is on the nature of spirituality and how it is related to well-being. The workshop does not include extensive discussion of specific spiritual or religious traditions. The latter are excluded because of insufficient time in a single workshop session to have an adequate overview of the multitude of different traditions that exist. However, participants are requested to reflect on the spirituality of their clients and then are given resources that they could utilize in their future efforts to become more knowledgeable about specific traditions. In the final section of this chapter, there will be a discussion of the specific pedagogical objectives targeted in the workshop (see Table 7) and the instructional strategies utilized in the attempt to accomplish these objectives.
Table 7: Learning objectives for workshop

<table>
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<tr>
<th>Competency</th>
<th>Learning Objective</th>
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| A Therapist’s Awareness of their Views on Spirituality | 1) To increase the therapists’ awareness of their own cultural heritage which may shape their views on the link between spirituality and well-being  
2) To increase the therapists’ awareness of the relativity of their views and to make them comfortable with potentially divergent views  
3) To increase therapists’ awareness of their own limits in competency  
4) To increase therapists’ capacity to continue developing their awareness                                                                                   |
| Awareness of Clients’ Spirituality              | 5) To make therapists aware of their stereotypes and negative emotional reactions toward individuals from particular spiritual/religious traditions  
6) To increase understanding of the links between spirituality and well-being                                                                                     |
| Intervention Skills for Integrating Spiritually | 7) To increase the therapist’s ability to tailor their relationship, strategies and intervention plans to the specific client’s spiritual orientation                                                                 |
After selecting the goals for the workshop, the next step was to select exercises that could be utilized in the effort to accomplish the respective objectives. To find the appropriate exercises, I reviewed literature for specific strategies and exercises for training therapists to work with a spiritual diversity of clients. I sought exercises that others had utilized and found to be beneficial. In particular, I drew upon Bartoli (2007), Kim and Lyons (2003), and Lagos (1996).

Once I completed a draft of the workshop curriculum, I forwarded the curriculum to other individuals for their review and feedback. The individuals who were asked to review the workshop included psycho-therapeutic practitioners as well as theorists in the area of Psychology and Religious Studies. As part of this review, I conducted a walk-through of the entire workshop with the individual who was recruited to facilitate the administration of the workshop. Based on feedback, specific changes were made to the curriculum: shortening the workshop; presentation of clinical examples to represent concepts being discussed in the workshop; and expansion of included references.

The next step in the process of developing the workshop was to administer it to experienced therapists. Therapists were requested to provide their open-ended feedback on their experiences of participating in the workshop and the potential resulting change to their clinical practice. The evaluation data were used to guide further revisions of the workshop in order to make the workshop potentially more relevant for other therapists (see Chapter 7 for changes made).

4.5 Overview of the Workshop

The following sections outline the workshop that is evaluated in this study (See Appendices A and B for workshop curriculum). The outline of the workshop is organized
based on the three main competencies proposed by the MCC. The outline includes the exercises utilized for each specific pedagogical objective related to each competency.

4.5.1 A therapist’s awareness of their views on spirituality. Four specific learning objectives are pursued in the workshop with respect to the spiritual dimension of cultural-competency: 1) To increase the therapists’ awareness of their own cultural heritage and how this heritage may shape their views on the link between spirituality and well-being; 2) To increase the therapists’ awareness of the relativity of their views and to make them comfortable with potentially divergent views; 3) To increase therapists’ awareness of their own limits in competency; 4) To increase therapists’ capacity to continue developing their awareness. These objectives are pursued during the beginning phase of the workshop.

The initial portion of the proposed workshop comprises exercises implemented to build therapists’ awareness of their own views on spirituality. Gaining such self-awareness requires therapists to possess both a motivation to reflect on their own beliefs as well as the skills to do so (Kim & Lyons, 2003). As all therapists, in the workshop voluntarily chose to participate, it can be assumed that therapists have some intrinsic motivation for taking part in the workshop. To solidify such motivation prior to the attempt to build self-awareness, there is a discussion of the ethos of multiculturalism propagated by professional bodies (such as the Canadian Psychological Association; CPA, 2000) and the relevance of a client’s spirituality to realizing this ethos.

Guided discussion exercises are implemented in the attempt to support a therapist’s capacity for self-awareness (Bartoli, 2007). The guided discussion is implemented to facilitate therapists’ awareness of their own views and to showcase the
relativity of these views – via comparing their individual views with those views held by other therapists. During the guided discussion, the following questions are asked: “What is the meaning of spirituality or religion?”; “What role, if any, did religion/spirituality play in your life when you were growing up? What role does it play now?”; “Has the role of spirituality in clinical work been addressed in your training program and professional environment?” (Bartoli, 2007). During the discussion, the therapists are requested to answer the questions in silence and then to bring forth their answers for group discussion.

Another guided discussion exercise is utilized to further highlight the therapists’ views on the relationship between spirituality and well-being (Bartoli, 2007). In this exercise, therapists are requested to draw three columns on a sheet of paper. In the first two columns, the therapists are requested to record the attributes that they ascribe to someone who is spiritual and religious. In the third column, therapists are requested to record the attributes they ascribe to someone who is mentally healthy. Upon recording information in all three columns, therapists are requested to contemplate any possible areas of conflict and congruence. Therapists are requested to provide a summary of their recordings and reflections to the group in order to facilitate a group discussion of the range of views held by the various therapists.

A therapist’s reflection on his or her views on spirituality can potentially result in strong affective experiences. This affect can arise as the therapist recalls previous experiences and discusses possibly divergent views with other therapists (Kim & Lyons, 2003). Without a sense of safety, therapists may resist self-reflection and the workshop can devolve into an antagonistic debate about which views are right. In the attempt to establish a safe environment – as an aspect of the initial introduction – therapists are
requested to mutually construct ground rules for the workshop space (Bartoli, 2007). Therapists are requested to outline rules of conduct that they believe will maintain respectful interactions between therapists with the purpose of making therapists feel safe. Furthermore, in the effort to build a sense of safety, the initial part of the workshop entails a discussion of the multiple views on spirituality that therapists have been exposed to during their lives. Such a discussion can bring forth divergent views (Bartoli, 2007). During this discussion, the workshop facilitator is encouraged to adopt a non-judgmental stance and to validate each therapist’s viewpoint and, thereby, encourage therapists to share divergent views.

In summary, reflectivity exercises are utilized in the attempt to make the therapists more aware of their own views (learning objective 1) and the limitations of their views (learning objective 3). The therapists’ discussion of their views with one another is implemented to increase the therapist’s awareness of the relativity of their own views and to become comfortable with different views (learning objective 2). The discussion of therapists’ ethical obligation to provide culturally integrative services is implemented to increase the therapists’ motivation for continuing self-reflection after the workshop (learning objective 4).

4.4.2 Awareness of clients’ spirituality. In addition to enhancement of a therapist's self-awareness and the impact that he or she may have on a client, the workshop was also designed to improve the therapists’ awareness of clients’ spirituality. Two specific learning objectives were pursued with respect to this dimension of cultural competency: 5) Make therapists aware of their stereotypes and negative emotional reactions toward individuals from particular spiritual/religions traditions; 6) Increase
understanding of the links between spirituality and well-being. These objectives will be pursued during the middle phase of the workshop.

During the middle phase of the workshop, exercises were introduced to facilitate a therapist’s awareness of the worldviews held by their clients. It is impossible to gain a complete comprehension of client’s spirituality before meeting with the client. Every client will have a somewhat idiosyncratic spirituality and, therefore, a therapist must gain knowledge about the client’s spirituality through direct interaction with the client (Fukyama & Sevig, 1998). However, a therapist can prepare for this interaction in order to facilitate the therapist’s understanding. In the workshop, this preparation was facilitated by attempting to highlight for the therapists the distorting effects of their own views, by increasing the therapists’ familiarity with the functional link between spirituality and mental well-being, and by providing the therapists with assessment strategies.

This portion of the workshop commenced with a discussion of how the therapists’ views on spirituality may distort their processing of information regarding the client’s spirituality. The discussion entails that the workshop facilitator didactically present information in the manner that a therapist’s beliefs on spirituality may affect interpretation of the client’s experiences; specifically, how these beliefs may guide the therapist’s attention and how this may affect the therapist’s reasoning processes (Arbuthnott, et al., 2006; Byars, Winston & Fouad, 2006; Ridley et al., 1994). Therapists were presented with concrete illustrations of this biasing effect. A second aspect of the discussion involved introducing meta-cognitive strategies (Arbuthnott, et al., 2006) that could assist the therapist to more effectively attend to information (e.g., by actively
seeking out disconfirming information) and to process information (e.g., by generating and testing multiple hypotheses).

Next was a discussion of the functional relationship between spirituality and psychological well-being. The discussion entailed presenting the coping model developed by Pargament (see Chapter 1; Gall et al., 2005). This discussion involved a didactic presentation of the model along with clinical illustrations. Therapists were requested to discuss how the model could be used to inform the development of a therapeutic alliance.

The following instructional activities are utilized in order to facilitate therapists’ understanding of the views held by their clients. Therapists are provided with a list of questions that they may use in their assessment of clients’ spirituality. They are also requested to generate their own questions. In addition, they were provided with a written annotated list of spirituality assessment tools that they could use during the assessment of a client.

During the workshop, there is no extensive coverage of specific spiritual or religious traditions because of the time and complexity required in such a discussion. However, information is presented regarding the general demographic trends in Canada regarding spiritual or religious traditions. Therapists were requested to contemplate the traditions that are most relevant for their current or future clients. In order to support development after the workshop, therapists were provided with a written list of texts and websites they may reference in their ongoing attempts to understand specific traditions.

In summary, reflexivity exercises and meta-cognitive skills training are implemented in the workshop to attempt to make therapists aware of the potential to stereotype clients and to make therapists more capable of avoiding such stereotyping.
(learning objective 5). A model for linking spirituality and well-being was introduced in order to assist the therapists in comprehending how spirituality can be related to well-being (learning objective 6).

4.4.3 Improving intervention skills for integrating spirituality. One learning objective is targeted with respect to fostering therapists’ skills for integrating spirituality: (learning objective 7) To increase therapists ability to tailor their relationships, strategies, and intervention plans to the client’s specific spiritual orientation. All the training exercises contribute to this learning objective to varying degrees. However, during the final phase of the workshop, specific instructional activities are administered with the objective of building therapists’ capacity to adjust the therapeutic alliance.

The pursuit of this learning objective among experienced therapists requires instructional designs that are appropriate for the unique characteristics of experienced therapists as opposed to novices. Appropriate instruction requires a didactic presentation of information balanced with exercises that challenge therapists to determine their own answers with limited guidance (Schmidt, Loyens, Gog, & Pass, 2007). An imbalance between these two instructional strategies (i.e., didactic instruction, minimal-guidance instruction) may result in faulty procedural knowledge construction that would limit the efficacy of applying the newly acquired information and skills. Insufficient instructional support, or scaffolding (Woolfolk, Winne, & Perry, 2000), may result in a therapist not sufficiently grasping the concepts and, thereby, constructing knowledge in a manner that may actually reduce efficacy (Krischner, Sweller, & Clark, 2006). In contrast, the provision of too much support may result in a therapist internalizing the information but in a manner that compartmentalizes it from the knowledge that they use when attempting
to solve real problems (Schmidt, et al, 2007). Therein, the information is not broadly utilized by the therapist in guiding clinical behavior.

In any continuing education workshop, there is diversity among trainees with respect to their initial degree of competency. This variety leads to the challenge of ensuring that each individual is provided with appropriate scaffolding (i.e., not too much and not too little). The instructional resources (e.g., time and attention) have to be utilized in a manner that results in every trainee receiving the appropriate degree of instructional support. Three strategies are implemented to meet this challenge.

The first strategy is to limit the training workshop to therapists who have real world experience in clinical settings (i.e., therapists who are independent practitioners). This strategy ensures that the therapists all have a minimal degree of expertise. Therein, it is assumed that the therapists in the workshop have the basic micro-skills to build rapport with clients, to conduct assessments, and to implement change strategies. This background expertise permits the implementation of relatively non-directive instruction that still meets the therapists’ need for scaffolding.

The second strategy attempts to provide scaffolding to all the therapists (Hmelo-Silver, Duncan, & Chinn, 2007). The transfer of knowledge from the instructional context to a clinical setting requires that therapists practice applying skills (Simons, 1996). Therapists are requested to discuss their approach to solving a clinical scenario in the attempt to foster a transfer of learning. Prior to the discussion, scaffolding is provided in terms of linking spirituality to well-being and through the discussion of this link for establishing a therapeutic alliance. Furthermore, after the discussion, additional scaffolding is presented via introduction of an expert’s perspective on the case. This case
is drawn from a book that has accounts of therapists’ experiences working with a spiritual diversity of clients (e.g., Nielsen, 2004).

The third strategy to ensure that each therapist is provided with sufficient amount of scaffolding is to utilize learning groups wherein therapists of varying competency level can support the learning of one another (Woolfolk, et al., 2000). This strategy is implemented through a small group discussion of the case wherein therapists work together in resolving a clinical scenario (Ridley et al., 1996). In a mixed group, more competent therapists could provide scaffolding to the less competent therapists (Woolfolk, et al., 2000).

4.5 Summary of chapter and research questions

Some practicing therapists may not have received adequate academic training to effectively manage the potential spiritual diversity of clients. Such therapists can enhance their capacity for managing spiritual diversity, and more general cultural diversity, through post-graduate continuing education. Limited empirically-derived guidance exists for the development and implementation of educational resources specifically for experienced therapists. In context of this absence, a workshop to foster experienced therapists’ capacity to respond to a client’s spirituality was developed and evaluated in this inquiry. The development and outline of the workshop is discussed in this chapter.

There has been a call for an increase in empirical inquiry into the question of whether specific cultural competency training programs enhance clinical outcomes (such as Owen, Leach, Wampold, Rodolfa, 2011). This research is partially needed to justify the necessity of such training within a health care system that is increasingly informed by
evidence-based practices (Vega, 2005). Beyond outcome focused research, there is also a need for greater research on the process by which training components influence clinical outcomes (e.g., Williams, 2007; O’Brien, et al., 2011). This type of research would allow for guidance in the selection of training content and delivery (Bartoli, 2007). I hope that the current inquiry adds to the literature by providing a resource that been evaluated as well as providing greater insight into the strategies for designing instruction aimed at enhancing the competencies of experienced therapists to integrate a client’s cultural spirituality. The inquiry will encompass an attempt to answer two explorative research questions: During the evaluation of the workshop, answers were sought to two exploratory research questions: 1) What are the participants’ perspectives as to how their interaction with their clients may change as a function of participating in the workshop?; 2) What are the participants’ perspectives as to the value of the specific content of the workshop for improving capacity to integrate a clients’ spirituality?
CHAPTER 5: METHODOLOGY

Among the challenges in conducting research to link training with clinical outcomes is choosing a source of information for data construction (Ridley & Shaw-Ridley, 2011). In the evaluation of outcome and processes, there can be some degree of inconsistency in reports by clients, therapists, or third-party assessors (see Kendall, Holmbeck, & Verduin, 2004). In the context of such inconsistency, there has been contention as to what source of information is ideal for making conclusions about effects of training. Seeking clients' perspectives is an important source of information as their satisfaction with services determines whether the services are utilized (Owen, et al., 2011).

Some theorists have also promoted greater study of therapists’ perspectives in the effort to enhance the practical relevance or clinical utility of clinical outcome research (e.g., Polkinghore, 2004). While there is merit seeking clients’ perspectives, as described above, clients would not be as aware as a therapist himself or herself of the therapist’s training needs and process of change related to professional development (Ridley & Shaw-Ridley, 2011). Furthermore, Ridley and Shaw-Ridley (2011) argue that in comparison to therapists, clients may not be adequately versed in theory to provide as meaningful commentary on the requisite components of competency (e.g., knowledge, meta-cognitive skills, awareness, affective elements). Therapists would be more informed of their own previous clinical training, domains of practice, and their internal processing than other parties. Consequently, in comparison to a client’s perspective, a therapist’s perspective can be utilized to construct a richer description of how specific aspects of training contribute to clinical interactions. Among the limitations of seeking therapists’
perspectives is that specific therapists can vary in their respective ability to reflect on potential change (Ridley & Shaw-Ridley, 2011). Furthermore, their sense of self-efficacy can be divergent from their degree of competence (Ridley & Shaw-Ridley, 2011). Nevertheless, considering the advantages of seeking the perspectives of therapists, their views were sought in this inquiry.

The inquiry attempts to answer two exploratory research questions associated with the implementation of the workshop. One research question is: What are the participants’ perspectives as to how their interaction with their clients may change as a function of participating in the workshop? The second research question is: What are the participants’ perspectives as to the value of the specific content of the workshop for improving capacity to integrate clients’ spirituality? What follows is an outline of the manner by which the participants’ perspectives with respect to the two research questions were constructed and analyzed.

A qualitative approach, as opposed to quantitative approach, to data generation and analysis is utilized in this inquiry (Polkinghorne, 2005). Qualitative approaches are “specifically constructed to take account of the particular characteristics of human experience and to facilitate the investigation of experience” (Polkinghorne, 2005, p. 138). Given these attributes of a qualitative approach, it is particularly suited to comprehend participants’ experiences in a workshop and in their clinical practice.

Semi-structured interviews were used to inquire into the participants’ perspectives. Humans can use language-based accounts in their attempts to authentically communicate their experiences to others (Polkinghorne, 2005). An interview provides the participants with an interpersonal forum to communicate about their experiences of
participating in the workshop and about what changes they envisioned in their clinical practice. A qualitative account of a person’s experience, however, is a co-construction between a speaker and listener (Hanninen, 2004; Polkinghorne, 2005; Spence, 1986). The semi-structured nature of the interview can enable the participant to be the primary author of the account, with the researcher providing the participant with the freedom to speak about what they view as relevant (Arksey & Knight, 1999). A semi-structured interview schedule, however, also ensures that each participant offers his or her account of the specific issues reflected in the preformatted interview questions (Arksey & Knight, 1999). An overly open-ended interview schedule might have led to participants not addressing these specific issues.

I sought to use an analytic approach that would retain the richness of the descriptions that were provided by the participants within the qualitative data. In light of this objective, different strategies were available to analyze the constructed accounts, including Phenomenological research, Narrative Analysis, and Grounded Theory Analysis (Polkinghorne, 2005). In considering the various options I ultimately chose Grounded Theory Analysis for two reasons.

The first reason in using Grounded Theory analysis was that I hoped that the participants’ would inform my understanding of the potential relevance of the workshop in novel ways relative to my initial understandings. Similar to some other strategies for analyzing qualitative data, Grounded Theory Analysis emphasizes the usage of inductive logic and the formulation of interpretations that are not confined to the researchers’ initial preconceived beliefs (Glaser & Strauss, 1967). This focus on novel understandings is in
contrast to analytic strategies, such as hypothesis testing, that predominately constitute theory verification.

The second reason I chose Grounded Theory Analysis was to facilitate interpretations that were not confined to descriptions of specific accounts provided by individuals. In using Grounded Theory Analysis it is hoped that the developed theory could apply to all the participants. This inclusiveness may indirectly be transferable to the attempt to comprehend the experiences of at least some future therapists who might participate in the workshop. Grounded Theory Analysis has been described as “a systematic, yet flexible methodology for collecting and analyzing qualitative data to the construct theories that are grounded in the data themselves” (Charmaz 2006, p. 2). A key approach to constructing theory is a constant comparison by the researcher of multiple accounts provided by different participants (Glaser & Strauss, 1967). As a result of comparing across accounts there is a de-emphasis on exclusively understanding the idiographic nature of any individual account relative to other forms of qualitative analysis, such as phenomological analysis and some forms of narrative analysis.

In selecting Grounded Theory Analysis I had to choose between the different schools of Grounded Theory. I will describe the development of these schools and my selection of a particular approach. The initial school came about from the first published reference to Ground Theory Analysis in the ground-breaking publication authored through the collaboration of Glaser and Strauss (1967). This represented the original attempt to describe the philosophy and practices that define Grounded Theory Analysis. These two authors would not co-publish again (Dushner & Morgan, 2004). Rather, each individual would author or co-author additional books that elaborated on their specific
beliefs as to the ideal manner to conduct a Grounded Theory Analysis. Latter schools of
Grounded Theory Analysis developed through the independent works of by Glaser and
Strauss.

The contention between Glaser and Strauss has been referred to as the *forced* vs. *emergent* debate (see Dushner & Morgan, 2004). Strauss offered different interpretative strategies that added to the initial co-authored book. He proposed that the original document was a starting point and that his latter works represented an evolution of the original process (see Dushner & Morgan, 2004). Glaser argued, however, that Strauss's recommendations were incongruent with the initial spirit of Grounded Theory Analysis. Namely, Glaser felt that Strauss’s revised approach would not allow for theory to *emerge* from data and this newer approach could potentially confine, or *force*, the analysis process to the interpreter's initial interpretative framework. Glaser suggested that a researcher need only to *trust* the process and the data would speak for itself in the form of an emerging theoretical model. As a result of this ongoing debate, different schools of Grounded Theory Analysis developed, organized primarily along the positions held by Glaser and Strauss (Dushner & Morgan, 2004).

Second generation theorists, such as Charmaz (2006), criticized the earlier works by Glaser and Strauss on Grounded Theory Analysis on the basis of lacking epistemological clarity. They criticized Glaser and Strauss (1967) for potentially implying that Grounded Theory Analysis would result in a construction of a model that was *really*, or objectively, embedded in the data as opposed to merely facilitating *one interpretation* of the data which in turn resulted in a construction of a model. These theorists added
additional analytical practices which they believe would promote the interpretative process, such as examination of discourse (Charmaz, 2006; Dushner & Morgan, 2004).

In my utilization of Grounded Theory Analysis I adopted particular views and analytic strategies. I take the stance that the model that is constructed will be one interpretation of the data as opposed to a model that objectively reflects what is in the data. I identify my practice of Grounded Theory Analysis with the initial writings on Grounded Theory Analysis by Glaser and Strauss (1967). I take this approach because I believe that the latter schools only built on the established foundation as opposed to refuting what was proposed. Further, I have experience with the approach based on Strauss and Glaser (1967) and can successfully apply this approach where as I am less practiced in alternative approaches.

Proposed in Glaser and Strauss (1967), and consistent across all schools of Grounded Theory Analysis, are various common practices: concurrent data construction and analysis; theoretical sampling, coding and categorization of data; comparative analysis across accounts; theoretical integration; and memoing (Dushner & Morgan, 2004; Hutchison, Johnston, & Breckon, 2011). Upon initial collection of data, the data are analyzed and the developing results inform the generation of further data. Additional data are sought that can further enrich the analysis towards the objective of theoretical saturation wherein additional information is consistent with the developing theory or model. The data are initially coded line by line and through comparative analysis the initial codes are linked to develop broader themes. These themes are integrated together, sometimes in connection to a selected central theme, to form a model of the results. To facilitate the construction of a model that is grounded in the data as opposed to reflect
only the interpreter's beliefs, the interpreter should record their thoughts throughout the process of generating and analyzing data. Each of the essential elements of the Grounded Theory methodology are reflected in the approach used in this inquiry and will be described below. See Figure 1 for an overview of the methodology.

5.1 Sample

The proposed workshop was designed for experienced psychotherapists. For the purpose of sampling, the operationalization of the concept experienced therapist is a therapist with at least one year of practice. This operationalization is partially based on the stage model developed by Ronnestad and Skovholt (2003). This model was chosen because it was derived from an empirical study of the developmental trajectory of therapists. The intention behind selecting an exclusion criterion of at least one year of clinical experience was to exclude therapists at the earliest stages of their career development; namely, lay helpers with intentions to become therapists and students who are beginning their clinical training with little or no clinical experience. Therapists in the subsequent stages of career development would be included using the one year criterion; namely advanced students who have had numerous clinical experiences to more advanced therapists who have increasing amounts of experience (e.g., novice, advanced, and senior therapists). The inclusion criterion for selecting eligible individuals allowed for therapists to be included irrespective of their professional designation, the clinical population they worked with, their therapeutic modality, or their theoretical orientation.
Figure 1: Overview of Methodology
A purposeful sampling strategy was utilized to recruit therapists for this study (Mertens, 2005). Namely, an attempt was made to obtain at least one individual in each of the four stages of therapist development that follows the *novice student stage* (i.e., *advanced student, novice professional, advanced professional, senior professional*). Individuals were solicited through two main recruitment strategies. The first strategy was to forward recruitment materials (see Appendix C) to professional organizations that may employ therapists (such as hospitals) or that are affiliated with therapists (such as professional organizations, training programs). This strategy was not useful as it led to only a few responses and no successful recruitments. One reason for this ineffectiveness may have been the failure of the recruiting material to reach eligible participants. During the process of recruitment, a few contact persons (such as administers) whom I spoke to mentioned that their organization restricted the communications to their staff or members based on appropriateness (e.g., not SPAM mail or junk mail). In many cases, it was unclear if the notice for recruitment was disregarded during an organization's vetting process or if it was forwarded to the relevant parties. The second recruitment strategy utilized was snowball sampling, which entails the researcher locating prospective participants by having one potential participant identify another prospective participant (Mertens, 2005; Polkinghorne, 2005). This strategy led to the recruitment of all my participants.

During the recruitment process, I attempted to communicate two specific messages in order to build interest for participating in the workshop. One message was that the workshop was being administered as part of a research project to improve the training of therapists. I highlighted for eligible participants that their participation would
contribute to the scientific endeavour of providing greater understanding of training methods. The second message was that the workshop would provide space for experienced therapists to reflect on their own experiences working with a diversity of clients and to share their insights with other therapists.

Upon contacting the researcher, recruitment material and a digital copy of the consent form was forwarded to the potential participant (see Appendix D for consent form). The participants were requested to bring a signed copy of the consent form to the workshop session. Participants were explicitly reminded of their right to withdraw from the study before, during, and after the implementation of the workshop. The participants were provided with a $50 honorarium. The research was approved by the Research Ethics Board at the University of Regina (Appendix K).

The sample was composed of 10 therapists who participated in the workshop and completed an evaluation interview. Initially 11 participants were recruited; however, one participant withdrew during the workshop. It is unknown why the participant withdrew. The participants had either professional training in social work (BSW, MSW) or in professional psychology (doctoral students with Master degrees). The participants varied in their overall amount of previous work experience that they possessed (see Table 8). The least amount of experience was about 2.5 years of clinical experience while the most experienced therapist had over 35 years of clinical experience. The participants were heterogeneous in terms of their experience with clinical populations. One participant worked exclusively with adolescents while the remainder worked exclusively with adults or a combination of children and adults. The participants all had experience in individual therapy; however, some of the participants also had experience with group therapy,
Table 8: Characteristics of the sample

<table>
<thead>
<tr>
<th>Gender</th>
<th>Professional Training</th>
<th>Years Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>M.A. Psychology; Doctoral-level student</td>
<td>~ 2.5 years</td>
</tr>
<tr>
<td>M</td>
<td>M.A. Psychology; Doctoral-level student</td>
<td>~ 3.0 years</td>
</tr>
<tr>
<td>F</td>
<td>M.A. Psychology; Doctoral-level student</td>
<td>~ 3.5 years</td>
</tr>
<tr>
<td>F</td>
<td>B.SW</td>
<td>~ 5 years</td>
</tr>
<tr>
<td>M</td>
<td>M.SW</td>
<td>~ 10 years</td>
</tr>
<tr>
<td>F</td>
<td>M.A. Psychology; Doctoral-level student</td>
<td>~ 10 years</td>
</tr>
<tr>
<td>F</td>
<td>M.SW</td>
<td>~ 15 years</td>
</tr>
<tr>
<td>F</td>
<td>M.SW</td>
<td>~ 15 years</td>
</tr>
<tr>
<td>F</td>
<td>M.SW</td>
<td>~ 25 years</td>
</tr>
<tr>
<td>M</td>
<td>M.SW</td>
<td>~ 35 years</td>
</tr>
</tbody>
</table>
couples therapy, and family therapy.

The extent to which the sample does not represent other types of psychotherapists in Canada limits the transferability of the conclusions derived from the inquiry to other context. Transferability refers to the hermeneutic equivalence of external validity (Mertens, 2005). Ultimately, it is up to the reader of any research project to determine how applicable the conclusions are to any other particular context. To facilitate the reader’s ability to make such a judgement, a description of the participants is provided in terms of the therapists’ years of clinical experience, professional training, therapeutic modality, and their spiritual orientation (See Table 8; Theme 1 in the Results chapter). This data were constructed through the questions asked during the interview.

5.2 Procedure for implementation of the workshop

The participants were divided across two separate administrations of the workshop. The individual participants chose for themselves (as opposed to random assignment) whether they wanted to be part of a specific workshop occurring at a particular time, place, and date. The researcher observed both groups but was not an active participant in either group. Both groups were audio-recorded.

A facilitator was recruited to implement the workshop (See Chapter 4 for overview of workshop content and Appendices A and B for completed workshop curriculum). The facilitator was a female senior-level professional psychology student. She had established competency for facilitating workshops as determined by her various previous successful experiences facilitating psycho-education groups. Two main strategies were used to foster the facilitator’s familiarity with the workshop curriculum. One strategy was to foster self-study of the workshop curriculum by providing her with
the workshop curriculum and materials used in its development. The second strategy was to conduct an implementation of the workshop with the person to be the facilitator for the study. I administered the complete workshop to the selected individual in a one-on-one session.

In evaluating the effects of the workshop intervention, it is important to clarify the fidelity with which the proposed intervention was administered (Mertens, 2005). Such clarity enables making meaningful connections between the outcomes and what was intended to be administered. To clarify the fidelity with which the workshop curriculum was followed, I interviewed the workshop facilitator about her experiences facilitating the group. The interview was conducted in person and was subsequently transcribed (Appendix E for consent form; Appendix F for Interview Questions).

The facilitator was asked to describe her experiences transferring the curriculum into the workshop experience. She was asked to describe how closely she followed the workshop curriculum. She reported that she covered every topic section in the workshop (which was consistent with the researcher’s observations). She reported that during her coverage of the workshop sections, she limited discussion in topic areas where she felt less familiar with, such as a section on information processing. She reported that her pace in covering the material was also guided by time allotment with more time spent on the earlier parts of the workshop than the latter parts (which was also consistent with researcher’s observation).

The practical implementation of the workshop varied in some specific ways. In terms of size, the first workshop had three individuals and the second workshop had seven individuals. The participants in each group knew each other prior to the workshop
but the nature of this relationship was different. The participants in the first group knew each other in their personal lives whereas the participants in the second worked for the same service organization. In terms of level of clinical experience, the first workshop group had a narrow range as it consisted of individuals who were in the relatively early stages of their careers (i.e., advanced students). The range in the second group was broader as there were novice professionals, advanced therapists, and senior therapists. In terms of timing, the first workshop was conducted in a 3 hour session in one day whereas the second workshop consisted of two 1.5 hour sessions that occurred one week apart. The splitting of the workshop into two sessions during the latter group was to accommodate the participants' availability to participate in the training.

5.3 Data construction

Participants were invited to provide evaluative feedback on their experiences in the workshop and the potential changes to their clinical practice. Their perspectives would inform my attempt to better comprehend the outcomes of the workshop and what aspects of the workshop contributed to the respective outcomes. The primary objective of the data construction was to provide adequate opportunity for participants to openly express their views.

In the interview and in the follow-up questionnaire, participants were requested to provide a description of changes they anticipated might occur in future efforts to integrate spirituality into psychotherapy with their clients. Also, the participants were asked to provide a description of how specific aspects of the workshop might have facilitated their competency for integrating spirituality into psychotherapy. Finally, they were invited to comment on how the workshop could be improved (see Appendices G and H).
The questions asked in an interview or questionnaire can vary in their degree of structure from structured (i.e., only pre-set closed-ended questions) or to unstructured (i.e., one or few open-ended questions). Overly structured questions can inhibit participants from openly expressing their perspectives because they may not be permitted to speak about topics outside the domain of the pre-set questions. Conversely, when using unstructured questions, participants may not address the issues most pertinent for the research (Arksey & Knight, 1999). In this inquiry, a semi-structured interview guide was utilized to ensure that similar topics were covered with each participant while still allowing the participants to discuss topics that they deemed relevant. The follow-up questionnaire consisted of a few open-ended questions to allow the participants to add to their earlier comments as they felt appropriate.

In Grounded Theory Analysis, there should ideally be integration of the data construction and the analysis of the data. As data analysis progresses, the researcher should attempt to obtain information that provides further insights. In this inquiry, adjustment to data construction was operationalized via changes in the content of the interviews. Specifically, initial review and coding of the early interviews led to the development of preliminary themes of interest. In subsequent interviews, participants were asked all the same open-ended questions in the interview schedule; however, in later interviews I asked the participants additional follow-up questions to flesh out my initial areas of interest (such as questions on reflection, taboo nature of spiritual discussion, conversational space, and organizational context of practice).

The initial plan was to obtain the feedback via a semi-structured interview within a week of the workshop and a follow-up written questionnaire four weeks after the
workshop (see Appendix F). Due to scheduling conflicts, the interviews were conducted between two to four weeks after the workshop and the follow-up questionnaire was given within two weeks of the initial interview. All the interviews were conducted in-person. The participants were given a copy of the interview schedule prior to the interview. The interviews were audio recorded and I transcribed each of the audio recordings. After all the interviews were completed, an open-ended questionnaire and the transcripts of the interview were forwarded to the participants. The participants were given the option to add to their earlier comments in the questionnaire and to request another interview. Three participants provided additional data during the follow-up questionnaire, which were incorporated into the analysis. Participants were also provided a copy of the written results section for their feedback and a few participants provided their feedback. This feedback was considered during the process of finalizing the analysis.

From a hermeneutic epistemological paradigm, the evaluation of the quality of data is partially based on credibility (the parallel of internal validity for quantitative research) which refers to the extent that the data represents the participants’ viewpoint (Mertens, 2005). Qualitative data is inherently a co-construction involving the researcher and the participant (Spence, 1986). The credibility of qualitative data is partially contingent on the type of interaction that occurs between a researcher and a participant (Polkinghorne, 2005). Rapport between the researcher and a participant will affect the credibility of the constructed data. In the context of this research project, the establishment of good rapport was crucial for two reasons in the effort to construct a credible account of the participant’s experiences. First, the establishment of rapport was required to ensure that the participants could speak about potentially affect-

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experiences that may have taken place during the training. Secondly, rapport was necessary to enable participants to openly provide their feedback about the workshop (Polkinghorne, 2005).

The interaction with the participants may have been partially shaped by specific aspects of the interaction; namely their response to me as an interviewer and researcher. As a middle aged male of Pakistani-Canadian descent who is a doctoral-level clinical psychology student, I believe that two dimensions of my identity were particularly relevant during the data generation process. First, as a member of a visible minority of Pakistani descent, I am sometimes ascribed the identity of a Muslim. One specific participant asked me if I was a Muslim. I had a sense that a few other participants wondered if I was or ascribed to me a Muslim identity. I did not believe that any of the participants felt uncomfortable with me. I thought, however, in a few instances they did not delve into references about specific religious traditions, such as Christianity or Buddhism, because they did not believe I was familiar with them. Secondly, as a dissertation student, the participants may have felt a demand characteristic, or in other words, a social desire to provide positive feedback about their experiences with the workshop. I attempted to control for the expression of such a demand characteristic by trying to maintain a non-judgmental stance, validating the participant’s experiences, and purposefully seeking mixed feedback. It is uncertain to what degree a particular participant felt demand characteristics; however, each participant felt sufficiently comfortable to provide feedback in terms of what they believed was positive about the experience and what could be improved.
From within a hermeneutic epistemological paradigm, the quality of data is considered to be partially contingent on the researcher capturing and anticipating changes in participants’ perspective. This is referred to as dependability (Mertens, 2005). In comparison, reliability (the post-positivist criterion that parallels dependability) is a criterion for evaluating the trustworthiness of data based on data remaining stable across time (Mertens, 2005). It is anticipated that change in participants’ perspectives toward their own work, and the relevance of the workshop, will occur across time. One source of this change may be the participants’ involvement in the initial research interview. During the process of reflecting on the content of the workshop and their own experiences, participants may change their initial perspectives. Secondly, change is expected to occur as the participants continue to work with their clients. As the participants have experiences integrating spirituality into psychotherapy, they may shift their views on how the workshop may have contributed to their work.

In order to enhance the dependability of the data in this study, the participants were asked to participate in a follow-up data construction process at least one-month following the workshop. Secondly, participants were given a copy of the transcription for their feedback in terms of whether they had anything to change or add. Individuals vary in the degree that they can reflect on their past and future experiences and this limitation of self-report can hinder the dependability of the results (Polkinghorne, 2005). During the interview, I used active listening techniques to facilitate participants’ ability to be reflective. While participants were providing answers to questions, I probed their answers by open-ended questions and reflections to construct accounts that are not based on
shallow reflections. I have honed my active listening skills through both my training as a psychotherapist as well as my extensive experiences as a research interviewer.

5.4 Data analysis

Grounded Theory Analysis was utilized in my effort to build a descriptive model for outlining the participants’ perceived influence of the workshop on their clinical functioning. In the attempt to build a theoretical model, I utilized three general steps during my analysis of the data: coding, theory construction, and assessing the applicability of the model (Corbin & Strauss, 2008). I outline these steps to provide the reader with an idea of the general sequence that followed in my analysis of the data. During the actual analysis, these three steps were followed in a non-linear sequence. Specifically, the analysis entailed moving back and forth through the various steps.

A presentation of the thematic concepts in the Results chapter outlines the answers to each of the two specific research questions (i.e., how the therapist’s clinical functioning may have changed; how the workshop facilitated this change). The answers to these two specific research questions are integrated in the construction of a model describing the perceived link between the workshop activities and therapeutic interactions. The constructed thematic model refers to the experiences of the specific participants (a substantive model) as opposed to making a statement about how the workshop might affect other therapists beyond those who participated in the workshop (a formal model) (Corbin & Strauss, 2008; Kelle, 2007). The potential implications of the results for the training of other therapists will be outlined in the Discussion chapter.

5.4.1 Coding. The first step in the data analysis process was to code the data into concepts (Corbin & Strauss, 2008). My identification of concepts formed the basis of the
theory generation. During the coding process, I constructed categories that represented my interpretation of the discrete ideas in the participants’ accounts (Corbin & Strauss, 2008). An interpreter can use various analytic tools in the attempt to identify concepts within qualitative data (see Corbin & Strauss, 2008). In coding the data, I relied predominately on three specific analytic tools: micro-coding, constant comparison of the data, and posing questions of data.

I will briefly describe the three analytic tools that were used to identify concepts (Corbin & Strauss, 2008). The micro-coding strategy involved my close reading of the data in order to identify relatively discrete ideas represented in participants’ statements. Discrete ideas may be reflected in a particular word, sentence, or combination of sentences. The second analytic strategy was to compare the discrete ideas with one another. The process of constant comparison assisted my identification of categories and description of the characteristics of the identified categories. The third strategy entailed my posing specific questions to the data. As I was interpreting the data, specific questions were generated that I attempted to answer during my reading of the data. The questioning tool was used after I was somewhat familiar with the content of the data. The other two tools were used from the onset of coding.

The coding was recorded using WEFT, which is a qualitative analysis shareware program. Transcripts were imported into the program and I recorded the codes using the program. This entailed going through each line of text and demarcating a specific concept. The software indexed the codes which enabled my efficient retrieval of concepts and their respective associated quotes in the text. Such ready accessibility of the coded data facilitated my ability to compare perspectives and to seek answers to specific
questions that I may have imposed when attempting to understand the data.

The identified concepts varied in their level of abstraction (Corbin & Strauss, 2008; Kelle, 2008). Some concepts were relatively concrete representations of the participants’ statements and other concepts represented more abstract ideas that I perceived in the participants’ statements. Upon identification of the various concepts, I organized the concepts into subthemes and themes. I attempted to integrate the various themes and subthemes into a model that described the process of change resulting from participation in the workshop. I attempted to ensure that the higher-order subthemes and themes were representative of (or grounded in) the participants’ viewpoints by trying to be conscious of the link between these higher-order themes and subthemes and considering how the concepts were associated with specific expressions.

5.4.2 Theory construction. Based on a hermeneutic epistemological framework, the construction of the final thematic model stemmed from my interpretations (Byrant & Charmaz, 2007). Theorists have debated the ideal manner for a researcher to negotiate the challenge of constructing a model that is grounded in the data in context of the researcher’s preconceived understandings (Byrant & Charmaz, 2007; Kelle, 2008). In negotiating this challenge, I adopted the general strategies recommended by Corbin and Strauss (2008) discussed in the previous section.

During the construction of the theory, I attempted to identify a main concept in the data and build a model by connecting the other concepts to this main concept. In proposing links between the various concepts (Kelle, 2007), I drew upon my understanding of the relationship between therapists’ training and their ability to provide culturally-integrative services. Central to my understanding is the belief that therapists
construct their own knowledge from the information that they are exposed to in training. I believe an educator’s facilitation of this construction requires the implementation of pedagogical strategies that meet the unique learning needs of the individual participant (e.g., requisite information, learning style).

After the thematic model was constructed, I represented the processes contained in the model through two strategies (Corbin & Strauss, 2008). One strategy was to present a diagram or schematic to illustrate the process links between the various concepts. The second strategy was to describe the processes in the model through a narrative account. The narrative account was a composite account of a typical participant.

5.4.3 Assessing the applicability of the model. As the sole researcher, the proposed descriptive account is limited by the biases inherent to my own horizon of understanding (Martin, 1997). In analyzing the data, I attempted to control for these biases through maintaining self-reflectivity during the analytic processes (Mertens, 2005). One aspect of this self-reflectivity was to record my interpretative decisions using memos (Corbin & Strauss, 2008). The memos, summarized below, were recorded on paper and in digital format. Nevertheless, my own pre-understandings and biases intuitively shaped my interpretations in ways that I was blind to even upon self-reflection. One relevant bias was an allegiance effect, which refers to my tendency to see positive results as a function of my having designed the curriculum (Kazdin, 1998).

These limits to my interpretation of the data hinder the confirmability of the conclusions. Confirmability is the hermeneutic equivalence of objectivity and it refers to the interpretation being traceable to the original data source as opposed to interpretations that are groundless through straying from the content of the data (Mertens, 2005). In
order to improve the confirmability of the model, I solicited feedback from the participants. They were forwarded a copy of the model and I requested that they assess the accuracy of the model for describing their experiences. The participants who provided their feedback described the results as reflecting their views on the workshop.

5.5 Summary of memos and reflectivity

While conducting the data construction and analysis, I kept a memoir of my thoughts about the process and my ongoing interpretations. I recorded these notes both on paper and in digital format (e.g., text files; electronic organizer; audio files). In the discussion of the experience, I summarize key challenges I had during the analysis process.

In conducting the coding and analysis, I experienced a challenge to control for my own prior interpretations and knowledge base. Using a particular theoretical model (MCC) in the construction of the workshop, I was concerned from the beginning of the analysis to ensure that the results would not be merely a replication of the ideas that I already held prior to the workshop. While I could not escape my prior understandings, I felt that I was able to capture the participants' perspectives. I attempted to do so by keeping the analysis fairly descriptive and, therein, rooted in the specific content of the participants’ reports. In addition, I regularly asked myself what new understandings I had achieved.

Another challenge in writing up the results was controlling for my own desire to see positive results. I designed the workshop and naturally would want to hear that the workshop was successful. I realized at the time of the interviews that the feedback was nuanced in terms of the participant's satisfaction. In coding and analyzing the results, I
actively attempted to find both positive and negative feedback. I believed that I was able to represent the participants mixed feedback in terms of the specific aspects of the workshops.

As I wrote the results section, I realized that I had to think further about the nexus between awareness, reflection, and the discussion. In my initial draft, I had the broad summaries but needed to delve even further into changes to awareness, reflection, and discussion space and how these aspects of the workshop experience were influencing each other. For example, one challenge was distinguishing codes that referred to outcome variables and process variables that contributed to the outcome.

When integrating the codes into a model, I was challenged to think about how I could organize the codes in a manner that captured the participants’ perspectives and would be relatively easy for a reader to follow. In particular, the information contained in the Results Chapter under Theme 3 (outcomes of the workshop) and Theme 4 (aspects of the workshop contributing to outcomes) was reorganized a few times. Specifically, I initially had themes that were based on each of the specific subthemes presented in Theme 3. In my initial conceptualization, under each theme I had planned to discuss what aspects of the workshop contributed to this change. In the end, I believe that having two separate themes for the reported outcomes and the content of the workshop highlights the participants’ perspectives in a manner that is most accessible to another interpreter (i.e., a reader)

5.6 Ethical issues in this inquiry

Three ethical issues were particularly poignant for this research project. One issue is the possibility of an individual being identified by the public as a participant in the
study (Hadjistavropoulos & Smythe, 2001). The participants were drawn from a community of psychotherapists and this population likely consists of a relatively small number of individuals. The risk to a participant's anonymity was dealt with in four ways. First, this risk was communicated to each participant in the consent form and when participants were given an opportunity to review the results. Secondly, pseudonyms were used in an effort to mask each participant's identity. Thirdly, personal information that may identify a participant (such as specific place of employment) was not included in the final version of the results. Fourthly, when each participant was given a copy of results, they were allowed the opportunity to delete any of their comments from the public document.

Another relevant ethical issue was to protect the anonymity of third parties, such as clients, mentioned by participants in their accounts (Hadjistavropoulos & Smythe, 2001). To ensure that these parties remain anonymous, I did not include identifying markers mentioned by participants during the interviews.

A third relevant ethical issue is the obligation of psychologists to maximize benefit and to minimize harm when conducting research. A potential relevant source of harm was risk to the participants' autonomy (CPA, 2000). Among the training goals for the workshop was to foster the therapists' respect toward their clients' spirituality. The workshop was designed partially to shape the therapist's values and, therein, the workshop may have potentially undermined the participants’ autonomy for choosing the values that they wish to uphold. The management of this potential threat to autonomy entailed the researcher providing the participants with the ability to choose whether they wanted to be exposed to the transformative influence of the workshop.
Autonomy was provided to the participants through the process of informed consent. This involved ensuring that participants were made aware of what they may encounter during the workshop and ensuring they were not coerced to participate or not to participate (Truscott & Crook, 2004). Even though a participant can be made aware of the training objectives and pedagogical strategies entailed in the workshop, the participant cannot be made fully aware of what he or she may be exposed to during the workshop. The workshop space is an inter-subjective field and so what may occur within this workshop is somewhat unpredictable as it partially depends on what the participants themselves bring forth in discussion. To overcome the limits of this uncertainty with respect to informed consent, participants were made aware that they were permitted to withdraw their consent as they became more informed regarding the nature of the workshop (Smythe & Murray, 2000). In this study, participants were allowed to withdraw their consent at any point and they were explicitly reminded of this before and after the implementation of the workshop.
CHAPTER 6: RESULTS

The participants were requested to provide their views as part of an evaluation of the workshop. Participants were requested to comment on their views about the outcome of the workshop and what they felt contributed to any potential change in their practices. Their views were coded and were organized into four main themes with respective subthemes (see Figure 2 for list of themes and subthemes). The themes are chronologically associated with one another (See Figure 3). Theme 1 refers to the participants' domain of practice and their desire to customize services to current and future clients. Theme 2 refers to the therapists' preparation before the workshop for working in their domain of practice; whereas Theme 3 refers to their perceived capacity after having participated in the workshop. Theme 4 refers to time in the workshop and the perceived relevance of the various aspects of the workshop for changes in their capacities as therapists.

6.1 Modal participant’s experience

The following is a narrative description of a modal, or examplar, participant from the sample. This account does not refer to any one individual but is an attempt to describe what a typical participant experienced. It is being presented here to provide the reader with a synopsis of the participants’ reported experiences in narrative form (Corbin & Strauss, 2008)
Theme 1: Catering services for the client
   Domain of Practice.
   Spirituality of clients.
       Future change
       Spirituality's link to well-being
       Not talk about spirituality.
   Following the client.
   Managing competency.

Theme 2: Therapist Preparation
   Academic Training.
       Need for more training in spirituality.
       Messages given in the program.
   Other classroom experiences.
   Learning from clinical work.
   Family background.
   Meeting others.
   Spiritual journey as source of knowledge.

Theme 3: Perceived gains from the workshop
   Awareness of conceptualization of spirituality.
   Openness to client’s experiences.
   Proactive approach.
   Effects on conceptual framework for understanding.
       Change in conceptualizing clients’
           Experiences.
       Effect on knowledge of spiritual or
           religious traditions.
   Skills for inquiring.
   Expanding options for treatment.
   Changing organizational practice.

Theme 4: Important elements of the workshop
   Reflection space is valuable.
   Didactic presentation of literature and skills.
       Literature.
       Skills training.
   Case review.
       Spiritual dilemma.
<table>
<thead>
<tr>
<th>Suggestions for other cases.</th>
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<tr>
<td>Case review placed at end of workshop.</td>
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<tr>
<td>Diversity of views.</td>
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<td>Facilitation.</td>
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<td>Size of the group.</td>
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<td>Working with strangers.</td>
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<td>Working with more advance therapists.</td>
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**Figure 2: Listing of themes and subthemes**
The modal participant provides individual therapy to adults and tends to see some spiritual diversity among clients. The participant tries to adapt her services to the unique preferences and needs of the specific client with whom they are working. The participant's professional and non-professional life experiences have contributed to her capacity to work with her clients. These experiences have provided the participant with attitudes and knowledge that facilitates her capacity to provide services to her clients. However, the participant may have hesitation about speaking about spirituality as a result of these background experiences. After participating in the workshop, the participant gained awareness into her beliefs about spirituality and into her clinical practices. Such awareness potentially contributed to more acceptance of clients' views as well as greater purposefulness in integrating spirituality into therapy. The participant is more comfortable, and perhaps more skilled, at assessing a client's spirituality. The participant affirms that she will have a holistic perspective in the future when attempting to understand a client's experiences. The participant is open, perhaps more so, to the possibility of incorporating spirituality into treatment. However, the participant recognizes she may need further skill development to be able to administer such treatment. In terms of her experiences in the workshop, the participant highlighted the value of reflecting on the workshop. The participant viewed some aspects of the content of the didactic presentation as beneficial. The participant also benefited from examining practical issues during the case discussion at the end of the workshop. The participant described the group discussion as enhancing the content of the workshop.

6.2 Theme One: Catering services to client

This theme consists of a description of how the participating therapists attempt to
provide customized services to their clients. The discussion begins by describing the type of clients seen by the participants. The participants vary somewhat in the age of clients typically seen and the therapeutic modality utilized. During their provision of services, participants reported attempting to adjust their delivery of services to a specific client’s preferences and needs. In the discussion of subsequent themes, the value of preparatory experiences including the workshop experience will be contextualized in terms of the participants’ reported capacity to adjust their service delivery for a client.

**6.2.1 Domain of practice.** This subtheme contains a description of the type of clients seen by the participants. In terms of age of clients, the majority of the participants work with or are intending to work with adult clients. One participant worked exclusively with adolescents. Some participants worked with families and by extension saw child clients in the context of a family system. All participants reported that they provide individual psychotherapy. A minority of participants reported that they also practice family therapy. One participant reported that he currently provides group therapy and a few participants reported that they had provided group therapy in the past. Participants described working predominately with outpatients and other people in the community (as opposed to in-patients). They described working with a range of clinical issues including depression, anxiety, stress, family issues, and couple's problems.

**6.2.2 Spirituality of clients.** This subtheme summarizes the participants’ descriptions of the spirituality of their clients. Across participants, there was variation in the description of religious populations, or specific spiritual traditions, that a particular therapist has worked with in the past. Most participants reported they have worked with clients who identified themselves as Christians. Aboriginal spirituality was the second
most referenced tradition and other mentioned traditions included Islam and Judaism.

6.2.2.1 Future change. Some participants also described anticipated changes in the future regarding the spirituality of their expected clients. Specifically, it was suggested that in the future there may be a greater range of diversity in the clients who attend therapy. This change was viewed as occurring because of demographic shifts in the Canadian population resulting from immigration. For example, one participant described his work and some anticipated changes as follows:

Primarily Aboriginal people focused spiritualities. Some of the traditional spiritualities. I think primarily the majority of people I worked with probably would describe themselves as being informed by a Christian background. I have worked with people with a Jewish connection to spirituality as well as some Muslim people, or those who define themselves as Islamic. Less of that population I think. It seems to be a newly emerging kind of experience...that multicultural aspect [is] starting to change more rapidly than it has in the years up to now.

Other participants also anticipated that in the future, spirituality might be less prominent among second generation and later generation Canadians. It was suggested that spirituality and religion were not a particularly salient aspects of the self-identity of new generations of Canadians. One participant states while discussing her therapeutic work with families:

Their parents might have a faith background but they don't really adhere to that. I see more and more kids from the younger generations with that kind of approach. They have a spiritual peace to them, as we all do, but they don't have a faith or a particular religious background. And not really wanting one. I see that as a shift as the generations come along.

6.2.2.2 Not talk about spirituality. Participants suggested that some of their clients are hesitant to discuss spirituality with the therapist. Some participants suggested that a client could be hesitant to discuss spirituality because of the client not trusting, or
feeling safe with, the therapist. In particular, it was mentioned that some Aboriginal and
teenage clients may be hesitant disclosing to at least some therapists.

6.2.2.3 Spirituality's link to well-being. Across participants was affirmation that a
client’s spirituality could potentially have a functional relationship to the client’s
presenting problems. Participants specifically mentioned the significance of spirituality
for offering a client meaning, coping strategies, and a community. Participants suggested
that the nature of the link with well-being has to judged in a specific context for the
significance of a client’s spirituality, as the link could be either be beneficial or
detrimental. For example, as one participant suggested the association to community is
nuanced as it can be either a source of isolation (negative effect) or a source of social
support (positive effect). Similarly, across clients there was mention of how spiritually-
derived meaning can lead to both negative emotions (e.g., guilt) or positive emotions
(e.g., hope).

6.2.3 Following the client. This subtheme reflects a value that was expressed by
the majority, if not all the participants, for personalizing their services to a particular
client. Participants described a desire to follow a client, or to take a client’s lead in
guiding the customization of services.

Among the participants, different reasons were given for a desire to adjust
services, which included not wanting to impose one’s values or to proselytize to the
client, fostering a stronger therapeutic alliance, and maintaining efficacy of the services
provided. In the attempt to customize the delivery of services, participants described
following a client’s preferences as well as respecting the client’s unique therapeutic
needs. Such a desire is reflected in the following quote by a participant who is talking
about the value of reading up on a particular religious tradition:

I guess when I work with clients, I could do some readings in different cultural areas, which would be very beneficial. But I always try to let the client lead and to understand where they are coming from. Again it is that watching my own stuff and trying not to impose on anybody. And trying to understand what the person's needs are, and how they are affected by their own cultural and spiritual beliefs. When you are working with clients and you have a client-centered approach, it is really helpful not to let your stuff get in the way. It is really what the client brings, what is their background, their experience, how can I assist them in the goals they are trying to reach.

In the above quote, the participant seems to describe how she tries to allow the client’s experiences to inform the direction of the therapy interaction. Some participants referred explicitly to following the client’s preferences. This notion is seen in the following quote:

The other in all of this, if I was a practitioner who was very religious, and spirituality was the centre of my life, it would be just as important that I don't make spirituality more central to therapy than the individual who is consulting me would want either...not to make spirituality more important than it might really be for the person who is seeking support. People might want to talk about behaviours and cognition.

Implied in the above quote is an affirmation to adjust services in a manner that is congruent with the client’s desires. The participant discusses the importance of not incorporating spirituality into therapy more than the client prefers as opposed to integrating spirituality into therapy with all clients. The participant refers to clients for whom spirituality is not a part of their identity or relevant to their phenomenological experience of their presenting problem. With such clients, the therapist’s attempt to follow the client’s lead could entail not integrating spirituality into the therapeutic services.

6.2.4 Managing competency. In the participants’ attempts to provide customized
services to clients, they described potentially experiencing circumstances wherein they viewed their competency as inadequate for realizing the appropriate customization of services. Some participants described this as a boundary or limit to what they believed were appropriate services that they could offer. For example, the participant in the following quote implies such:

I know in some of the examples you gave, I don't ever see myself probably being a counsellor that works a lot with scripture for example basically because I don’t have too much familiarity. Having discussion and really hearing their understanding their meaning construction. And I think there was an example about irrational beliefs and using scripture to unpack that a little bit. That looked great. I don't ever see myself probably ever familiar enough with Christian scripture or other scriptures to every probably fully work that way. But I like to work better in a way that fits with what I might be able to offer.

Some participants described that in the past they managed the challenge by referring a client to another person (e.g., other mental health professional, religious figure). In other circumstances, if the therapist felt sufficiently prepared to continue working with the client, then he or she would engage in attempts to enhance their competency such as through self-study (e.g., reading) and by speaking to others (e.g., peers, supervisors, and individuals with knowledge of relevant traditions).

Another approach taken by a minority of participants was to avoid speaking extensively about spirituality with the client. They described this hesitation as stemming from a concern of offending the client by appearing incompetent. As will be seen in Theme 3, after the workshop, these participants reported intending to take a more proactive approach in the future as a result of feeling more competent to explore the significance of a client’s spirituality.

Participants described being intrinsically motivated to work with a greater
diversity of clients. The participants appreciated working in clinical circumstances that were challenging but within their scope of competency. Among the reasons given was the value of challenges for facilitating growth of their competency. Participants also viewed the challenge of their work as making the job emotionally rewarding.

**6.3 Theme two: Therapist preparation**

This theme consists of a description of the life experiences, prior to the workshop, that the participants viewed as contributing to their capacity to adjust their therapeutic services to their clients’ needs and preferences. Participants affirmed the importance of both professional experiences as well as other general life experiences. Participating therapists specifically described how their experiences contributed to their attitudes, knowledge of religious and spiritual traditions, and greater awareness of their own views. In terms of drawbacks, some participants described a hesitation to explore a client’s spirituality during therapy because of these previous experiences.

**6.3.1 Academic training.** This subtheme expresses the participant’s views on the academic training that they had received. Each participant reported having professional training in either professional psychology or in social work. Four participants reported that they were doctoral level graduate students in either clinical or counselling psychology. Each of the remainder of the six participating therapists reported professional training in social work. One participant reported a Bachelor of Social Work and the other individuals stated having social work training with at least a Master of Social Work. None of the six participants with social work training reported currently being enrolled in an academic program.

**6.3.1.1 Need for more training in spirituality.** Participants described their degree
of satisfaction with their formal academic professional training. A majority of participants described a need for greater focus on clients’ spirituality in the training programs that they attended. The following is a representative quote that reflects this pattern:

I: What was your previous training in cultural competency especially with respect to spirituality?

P: Pretty limited I would say. More talked about in classes in terms of student presentations. In the Ph.D. seminar someone did their special topic presentation on spirituality but it was like 5 minutes. I do not think that I got much formal training. Mostly it has been someone who asked a question or addressed in an ethical dilemma; very indirectly.

Participants provided different possible reasons for the relative neglect of spiritual issues in their training: limited time; competing priorities in topics covered; de-valuing of spirituality relative to other aspects of diversity; and lack of faculty capacity for instruction.

The participants described spirituality as being a topic that was covered either in its own course or discussed in a class in the context of others issues. Most of the participants described spirituality as a topic that was discussed within at least one of their classes.

6.3.1.2 Messages about spirituality given in training. As summarized in this subtheme, participants discussed messages about spirituality that they received from their academic programs. The majority of the participants attributed to their training programs a message that cultural diversity, and spirituality as one aspect of such diversity, was something to be acknowledged and responded to in one’s practice. Participants discussed the relationship between cultural competency training in general and training for spirituality specifically. The participants commonly described greater training in
managing multicultural diversity in general than a specific focus on managing spiritual diversity. Some participants described coverage of cultural diversity as being integrated into a range of courses included in their academic training program. Training in cultural competency was viewed as assisting the therapists to provide services with an attitude of openness to the client’s experiences. For example, one participant described gains made in his professional training even though there was limited coverage of spirituality in particular:

Yeah, it [spirituality] might have been thrown in as one of those dimensions that are important for how we understand culture. When I did my Masters, I did a lot of exploration and training. I did a six month intensive training in narrative therapy. And a lot of the readings and theoretical interests I had were constructivism and social construstivist kind of theory and deconstructionism. That was not hugely focused on spirituality necessarily, but what I took from that when in session, with families or individuals, to really let their knowledge be the centre, their experience and understanding of the world to be at the centre of the therapeutic content. So I think that was really informative around a lot of pieces, like spirituality. So if someone experiences spirituality as a really important piece of their life then because it is important to them, it has a role in the counselling session. That is how I have approached it.

Contradicting this message of being responsive to a client's experiences, some participants described receiving training with an implicit message to ignore a client’s spirituality during the provision of services. These participants described a perceived taboo about speaking about spirituality. This taboo is referenced in the following quote:

I don't know if it is too blunt, it seems to me there can be an anti-spirituality kind of sentiments for counsellors. That it is really not psychology, or professional counselling, or whatever. Focus more on thoughts and behaviours and everything....They (messages) might be handed to us through training, through the models we use, or whatever...Those can be personal messages based on my own negative experiences or positive experiences. But it is also something that is handed to us professionally.
6.3.2 Other classroom experiences. Another identified subtheme of therapist preparation involved other classroom experiences. Participants mentioned the value of other formal educational experiences outside the confines of specific academic professional training. A few participants mentioned that they had been enrolled in undergraduate courses that they believed assisted in preparing them for the challenge of managing spiritual diversity. Religious studies courses were described as beneficial in providing the participant with knowledge about religious and spiritual traditions that exist. Participants also suggested that they valued classroom discussions regarding spirituality because such experiences made them both more aware of the relativity of their own perspectives and more accepting of the views of others.

A few participants mentioned participating in continuing education experiences that assisted them in their efforts to provide care to their clients. Specifically, a few participants completed workshops and seminars on Aboriginals in Canada with some focus on Aboriginal spirituality.

6.3.3 Learning from clinical work. In this subtheme of the more general theme of therapist preparation, participants describe the developmental benefit of their past clinical work. They highlighted two sources of change for improving their ability to adjust their services to their clients’ needs and preferences. One source of change was to learn directly from the client about specific spiritual and religious traditions. The other source of change was consultation with other professionals in context of their attempts to provide culturally and spiritually integrated services to their clients. In this case, participants described gaining knowledge of other traditions through their interactions with their colleagues.
6.3.4 Family background. Therapist preparation also involved personal experiences due to family background. Some participants described their family of origin as providing them with attitudes that influenced their approach to managing spiritual diversity. Family heritage was viewed across participants as potentially fostering greater or lesser sensitivity to a client’s experiences. A few of the participants described how they adopted a sense of acceptance of other people’s spirituality as a result of internalizing messages of tolerance communicated from their family of origin.

In contrast, one participant described being hesitant in the past to integrate a client’s spirituality into therapy due to messages that he received from his family. Specifically, he received the message that discussion of spirituality is a source of conflict. He was hesitant to explore a client’s spirituality because of a concern about creating antagonism with clients.

6.3.5 Meeting others. Another subtheme related to therapist preparation involved participants having met a diversity of individuals in their life. Participants described the significance of meeting people they knew from their social life as well as individuals that they met while travelling in different societies. These interactions with others were considered as facilitating awareness of personal views and greater acceptance of the views of others.

6.3.6 Spiritual journey as source of knowledge. All the participants reported that they were raised in households wherein some form of Christian religious tradition was the family religion. Participants varied with respect to how they defined their current spirituality and the congruency of their definition with the specific religious traditions in which they were raised. A few participants identified themselves with the religious
tradition of their heritage. However, most were uncertain of their specific positioning or voiced an explicit rejection of their background religious traditions. Even though the participants may not have identified with the religious tradition of their childhood, this background experience was described as offering potential insights into clients who may identify with the same specific religious tradition. As such, a further subtheme describing therapist preparation for dealing with client spirituality included therapists’ spiritual journeys as sources of knowledge. For example, one participant describes her experiences working with a diversity of clients:

Some clients really talk about it; some clients are pretty strictly religious. That is why I felt it was a benefit as a former Catholic and having read the Bible. I know what they are talking about. I feel it is beneficial that I have that background, what it’s about, the traditions, and the Church.

In describing the development of their particular spiritual orientation, some participants highlighted gains to competency made through their self-directed efforts to explore spirituality in their own life. For example, one participant described reading up on Buddhism out of personal interest for her own spiritual development. She cited this experience as giving her knowledge about Buddhist traditions and potential insight into clients who identify with this religious tradition.

6.4 Theme three: Perceived gains from the workshop

This theme focuses on the participants’ perceptions of the gains derived from the workshop. Participants reported increased awareness of spirituality and potential connection to provision of therapy, changes to their conceptual framework for understanding clients' spiritual experiences, capacity for spiritually integrative assessment and treatment services, and potential change to the organization of practice to include spiritual issues. However, some participants described limited gains with respect to
knowledge of specific spiritual traditions and with respect to skills for administering interventions.

6.4.1 Awareness of conceptualization of spirituality. A majority of participants stated that they gained greater awareness of their beliefs about spirituality. This awareness encompassed recognition of one’s own conceptualization of spirituality, stereotypes, and strategies for integration of spirituality into clinical practice. The first two of these aspects are discussed in this subtheme. The third aspect is discussed in a separate subtheme as the significance of awareness of clinical practice seemed to be related to the broader issue of skill development.

Participants suggested that they became more aware of their conceptualization of spirituality as a result of participating in the workshop. Specifically, some participants described being more aware of how they contrasted spirituality with religion. The following quote is an example of a participant becoming more aware of their conceptualization of spirituality:

And also just being challenged to contemplate those questions as they relate to myself and my history. For example, I never realized how much I have difficulty separating spirituality from religion in my own head….Just thinking about those definitions was one example of something that I did not realize until I did the workshop. I really compounded the two aspects. That is probably because in my history, spirituality was organized religion. Being challenged to think about the development of some of those views.

In addition, some participants became more aware of their beliefs about the link between spirituality and well-being. This gain is represented in the following quote:

P: The one thing I did find useful was looking at the three columns piece. Spiritual, religious, and health, and trying to relate those three things together.

I: Do you think it helped increase your self-awareness to a degree?
P: Certainly recognizing. Again reminding me how those three things are connected. And that there is always integration between.

A minority of clients reported that they were also more cognizant of stereotypes that they held with respect to specific religious groups. One participant described how her increased awareness could facilitate her capacity to understand a client’s perspective regarding spirituality. The following quote is from a participant who is speaking about her reflections and her insights into some of her clients:

I: How do you think the workshop has affected your capacity to implement treatment that integrates a client's spirituality?

P: Again it is about asking questions to get clarity and understanding and to be more direct. And, I think that with some of our students who come from more middle Caucasian families, I do not even think about addressing spirituality with them because I have this idea in my head that maybe they do not have a sense of that. And they do not attend any religious institutions. I probably should make more of an effort to explore those options with those students.

6.4.2 Openness to client’s experiences. A subtheme describing perceived gains from the workshop participation involves potentially greater acceptance of clients’ perspectives. Participants described gaining a greater appreciation of the developmental factors that contributed to their specific beliefs. They suggested that this appreciation contributed to greater recognition and acceptance of potentially different beliefs held by clients. Such perceived gains are described in the following quote:

I think it challenged me to think about what are my beliefs because I realized in the workshop that I do have very distinct experiences and beliefs about my past and seeing how that compares and contrasts to other people in the workshop. I think there is this experience where you’re like sort of Caucasian, middle class, Canadian, and all these factors, you feel part of the dominant culture so just think you do not have culture or spirituality, unless you are of a specific religion. But again that experience of being with other people and realizing that you do have a distinctive culture and views on spirituality and which are not at the forefront of your brain because you are not challenged to think about. You are not put in a
lot of situations where you are different...realizing that I have a lot of customs that I take for granted as being “normal” whereas that is a very specific set of customs. And so, I think that experience made me realize that, yeah, I do have distinct customs and beliefs and thoughts about different things. And they do differ from other people.

In this quote, the participant suggests that prior to the workshop she was not as aware of the uniqueness of her perspective on spirituality. She attributes this insight to working with others in the workshop, which will be discussed in greater detail in the Theme 4 in the section on discussions.

6.4.3 Proactive approach. Another subtheme of perceived gains includes the intention to take a more proactive approach to integrating spirituality into therapy. The majority of participants affirmed that they intend to take a more proactive approach to integrating spirituality into therapy than in the past. Participants viewed this gain as potentially allowing them to better understand a clients’ perspective and thereby more effectively follow a client’s lead. The intention to be more active in the future is expressed in the following quote:

I think it has increased my awareness that it should be part of the realm of questions being asked, especially when you are talking about healing from trauma that is going on. Their spirituality, or spiritual background, might impact how they are able to enter into that healing process. So I think it is important to ensure that their needs are being met that way. It is more on the radar now rather than it not being as prominent as a thought for me.

This participant states that spirituality will be more on her radar during her future interactions with her clients. This participant implies that her attention will be focused more on her clients’ spirituality than it has in the past. A similar perspective about being more proactive was also shared by other participants, such as in the following description of what the participant would do differently if working with a specific client worked with in the past:
I would be more open to exploring the meaning of beliefs and the context of how [the client] came to develop those beliefs without feeling the fear of going into that religious zone. I think that would be another change. I never really considered gathering as much information about the importance and meaning of spirituality in the assessment process. So, if I had that information right from the get go I might have more understanding of the client, which I now I don't think in the past my regular interviews have focused as much on spirituality or culture besides asking where do you come from. I never necessarily asked “what is the importance of spirituality in your life,” or something like that.

A few participants discussed their thoughts on whether increased attention might be a transient phenomenon or something that would be incorporated more permanently into their future clinical work. These participants hoped and believed the change would be a permanent aspect of their clinical practice.

Of those participants who reported that after the workshop they felt more comfortable to actively integrate spirituality into therapy, two sources of greater confidence were discussed. One source was a greater sense of self-efficacy for being able to integrate spirituality into therapy. This view was mentioned by the participants at the earlier stages of their career. Such increased self-efficacy and corresponding comfort was described in the following quote:

Yeah, before I was totally lost...I feel now that at least I have a framework, or some guidelines and direction, and understanding of how to move forward with it. So that is a plus right there…. It definitely highlighted how important it can be. And really highlighted that I underplayed it in my previous clinical experiences by not asking about it and not exploring it. That highlighting or re-emphasising that it is an important part of people's lives. And that overlaps a lot with the clinical psychology goals and overlaps with their emotional well-being and really shouldn't be ignored. And that was really a big thing. The fact that I had that workshop after having experiencing a few new clients that had brought up religious themed issues really hammered for me “Yeah, this can be really important to a lot of people”. It really cemented in my mind that it is something I want to incorporate as an overall competent clinician. Competency and comfort in addressing spiritual and religious issues with my clients.
Another source of confidence described was a sense of permission gained from the workshop to integrate spirituality into therapy. One participant stated that they gained a greater sense of confidence in talking about spirituality because they no longer viewed it as a taboo topic at least in the organization where they worked. One participant described becoming more aware of the norms regarding what is considered permissible within her service agency when offering services to clients. She reported that in the past, she heard the message from others that she should not be encouraging discussion of spirituality with her clients:

I think it was more than anything, awareness to some extent. Taking an issue and bringing it into focus. But permission giving, to sit with colleagues and clinical supervisors, and to hear that “Yeah, we can ask these questions and explore these issues with clients”. Like I said earlier, I felt in different settings that it is not okay, there is fear of imposing values, there is fear of proselytizing, there is fear that this is not our expertise or mandate. And so, leave it alone. I say that would be what changes for me, is to be aware that this is a setting where I can ask the questions and find out whether this is something that is important to people and include it to the extent that it is.

6.4.4 Skills for inquiring. Participants described having increased capacity for collecting information about a client’s spirituality as a consequence of having participated in the workshop. Increased skill for inquiring into spirituality is a subtheme identified within the general theme of perceived gains from workshop participation. As mentioned previously, participating therapists discussed how they anticipated they would be more proactive in their attempts to integrate spirituality into their clinical practice and, beyond this intention, participants referred to specific gains with respect to their capacity to assess a client’s spirituality.

Some participants also described how they had obtained guidance as to potential strategies for gathering information about a client’s spirituality. Of these participants,
most referred to their improved insight for leading a discussion and generating questions in their attempts to gather relevant information from a client. As one participant states:

And I thought there was a section there was a list of ways you can ask about it. The questions. Something more than just the how. At least you have an anchor to go about it in some ways. I think that the way you ask a question, and go about it, is important, and the availability of the resource to refer back to was really helpful for me. The concreteness was a necessary and helpful part.

In addition to reporting an increased ability to ask spiritually-related questions, some participants implied that their meta-cognitive awareness may have been enhanced through the workshop. Such capacity would enable the therapist to potentially control and adjust their processing of information in their attempt to understand a client’s perspective. Such a potential gain is described in the following quote:

Table 11 [in handout] I thought was really excellent. About meta-cognitive skills. I loved that you had it in there. Everyone should practice it. It is my absolute favourite. I feel that here, when you look at people in my profession, I think that we have to be so much more aware of this. Whether we work with domestic violence, or whatever we work with, you are not doing your clients a favour if you come from the wrong kind of perspective. We all have to be researchers in the field. It was really good that you had that in.

6.4.5 Framework for understanding clients’ experiences. Also part of the perceived gains described by workshop participants was changes to the conceptual framework that participants bring with them when working with a client. They described changes to their conceptualization of how spirituality is associated with well-being and potential use of resources from the workshop to foster greater depth of knowledge.

6.4.5.1 Change in conceptualizing clients’ experiences. Some participants reported having a more holistic conceptualization of their clients’ experiences after having participated in the workshop. These participants suggested that in the future they
would consider spirituality as one aspect of a client’s presentation and would attempt to understand how this is related to other aspects of a client’s presentation, such as cognitions. One participant refers to such a change in his perspective in the following quote:

Psychology in a way is a secular spiritualism. There is an implicit atheism or a-spiritualism to it in that we are just looking at the brain and the emotions and cognition. And so, if someone is hesitant to go there, it is all too easy to use those frameworks to ignore it completely. The workshop emphasized that is missing an element of people's life. That aspect implicitly has been left in the past. I found that interesting and good.

Other participants implied that prior to the workshop they already utilized a holistic conceptualization in their efforts to understand clients’ problems. These participants did not describe the workshop as radically changing their framework for understanding clients’ spirituality. However, some participants described having a greater holistic perspective as a result of being reminded in the workshop of their initial views on the potential relevance of spirituality for well-being.

6.4.5.2 Effect on knowledge of spiritual or religious traditions. Within the theme of gains from workshop participation, participants suggested that they did not gain any new information about a particular spiritual or religious tradition. This pattern is reflected in the following comments by a participant describing how her knowledge had or had not changed:

I would not say it affected my knowledge. If I learned something new about say Muslim traditions then I would say that it changed my knowledge. But I do not think I got that out of it. I cannot think of anything that I would say is new knowledge for me.

Some participants described the limited coverage of specific religious and spiritual traditions as appropriate given the time constraints and the content covered in
other sections. However, they reported that it would have been helpful if there was
coverage of specific groups expected to be part of the therapists' domains of practice.
Such information was seen as preparation for their clinical work through providing them
greater background knowledge.

Participants suggested that whatever their background knowledge, the client needs
to be the ultimate source of information for guiding the administration of services. The
participating therapists suggested that in utilizing group-level information on religion and
spirituality in the process of providing services, such information would have to be
judged against a client's experiences to determine the degree of congruency. This idea can
be seen in the following quote where the participant points to the need to gain
confirmation or disconfirmation from a client:

I think that with any tradition there is what the literature is going to say
and tell you this is how it is, and then there is how that person is, is
interpreting it and living it. The background might be helpful but the main
source might be the person themselves.

Reflecting on how their knowledge base could change through participating in the
workshop, therapists described how the workshop offered them resources that they could
utilize in their attempts to gain group-level information about specific traditions. Namely,
some participants viewed the online and textual references about specific traditions
included in their workbook as potentially beneficial for their understanding of clients’
perspectives. At the time of the follow-up evaluation, one participant had looked at the
online resources. Other participants suggested that they might look at the resources in the
future.

Of the participants who described the contexts in which they might use the
provided resources, most described a desire to be proactive in obtaining knowledge about
specific religious or spiritual issues. However, they suggested that the actualization of this desire is stifled by limited time for pursuing continuing education. They suggested that the primary reason for seeking out continuing education resources is reacting to a particular scenario wherein there is a need to better understand a specific client. These participants suggested that they would utilize the provided resources when they realize they do not have sufficient background familiarity with a client’s specific spiritual orientation.

6.4.6 Expanding strategic options for intervening. Also within the theme of gains received from participating in the workshop, therapists discussed the changes they believed that occurred with respect to their ability to implement interventions or change techniques during therapy. Participants described two gains in terms of capacity to implement treatment. They could envision new possibilities for potentially integrating spirituality in their work with their clients. They now could conceptualize previously unrecognized forms of integration, such as thought experiments and referrals to other helpers. The following quote highlights this ability to envision new possibilities:

That was something I found interesting. In the case example, they examined the religious beliefs in the same manner you might examine other beliefs and gather evidence, textual evidence, and things like that to assess the belief. That was not something I considered before. I always explicitly thought that maybe religious beliefs or faith based beliefs may somehow be off limits to more standard therapeutic approaches like assessing for evidence, and things like. Well, seeing how they did it there was like “well, there is no reason for it to be off limits”. You might take a different approach, you might be looking at different kinds of evidence, like going through the religious texts to find evidence there or looking at different religious figures or interpretations. It is really interesting to find that just because it is religious or spiritual subject matter does not mean untouchable by therapeutic approaches and skills. We might just have to take a slightly different tact or perspective with them, but still exploring similar skills. It seems silly now to think it was untouchable.
Other participants suggested that the workshop did not provide them with previously unconsidered possibilities for treatment. Rather the workshop made them more cognizant of their initial theoretical framework which in turn highlighted the value of incorporating more spirituality into interventions in the future. Such recognition was viewed as leading to more focus or purposefulness for integrating spirituality into treatment. The following is a quote by a participant who describes becoming more aware of one’s views:

“I think that technique-wise, the way I work with people is client-centered. I don’t think it will change so much into that. But I am more aware. What it also did for me was remind me of how important it is to include that with clients. Especially clients who I am less familiar with their background and how important it is to ask about open feedback on how we’ve been working, what we’re doing, is it really helpful for them? And what kind of suggestions they have for what is missing. What it did was get me thinking about what I did and what I didn't do. I feel even stronger to use outcome measures and the feedback than before. To really get that feedback from clients. ‘Is my approach working for you. Do you think that something is missing and what are particular issues you may not feel comfortable working with me about?’ I really want to let them be the experts in their own life and inviting them to give that feedback. I will do that more and I have already started to do that. I have spent more time on generating feedback then get them to fill it out in the end.”

In terms of gains from workshop participation, therapists reported that substantial change was limited with respect to their treatment skills. Those who conceptualized new possibilities for treatment did not feel fully competent at this juncture to be able to actualize the new possibilities. They believed they needed greater skill development in their ability to implement the envisioned treatment. For example, one participant envisioned new possibilities for challenging spiritually or religiously derived thoughts, but he also suggested in the interview that he is not prepared to utilize such an approach:

“I would probably need to do more preparatory work for specific techniques. So off the top of my head, I can see it more of a relationship
type approach where I would be more comfortable at this point. I do not know, something like cognitive restructuring, I probably, I do not feel prepared as of yet as to how that might look.

6.4.7 Changing practices in the organization. The participants in the second workshop participated together in ongoing peer-to-peer consultation. Participants reported that through the workshop, they realized spirituality is one aspect of cultural diversity that has been infrequently discussed in peer-to-peer consultation. For example, one participant stated that:

And after the first session, the homework, I talked to my partner about it, telling him what we were doing and the fact that we have done so much training, I mean I have been here for 12 years, and we had peer for 12 years and we never talked about spirituality. Isn't that interesting? I mean what is that all about. It sort of was like the door has always been there but we never opened it and I was really curious as to why we did not. Because I am actually quite holistic about talking about spirituality but we never did that in the group and I am quite interested as to why we did not. I know that people here are quite spiritual. Maybe, the only thing that I can think about is that there is some type of boundary that you do not talk about it to other people.

In the above quote, the participant suggests that spirituality has not been discussed in detail. She expresses confusion as to why this is the case and implies that it may be due to a taboo about discussing spirituality. The potential origins of such a taboo are discussed in Theme 2. A few participants suggested that spirituality may be a topic that is discussed more in peer-to-peer consultation in the future:

I think the interesting will be when we do case consultations; we have not done that since the workshop, if we are actually going to talk about spirituality about a case. We bring cases for supervision to talk about for help. We never talked before about spirituality. Is that going to be something that we talk about? Is this person a spiritual person? How do they practice? That would be interesting. I think that we probably will now and that is major. Maybe we will have some people come in and talk about different spiritual practices too, I mean, that would be interesting.
6.5 Theme Four: Important elements of the workshop

This theme focuses on outlining the elements of the workshop that the participants believed contributed to their respective gains. The participants spoke of the significance of being able to reflect in the workshop, the didactic presentation of information, the case presentation, and discussion between workshop participants.

6.5.1 Space for reflection. Participants described how the reflective capacity created by the workshop was beneficial. As discussed previously, reflections were viewed as enabling the participants to become more aware of their conceptualization of spirituality and their clinical practices pertaining to clients’ spirituality.

Participants highlighted a need for continual reflection in their quest to offer their clients spirituality-sensitive services. The value of continual reflection is described in the following quote:

It opens up doors. It makes you rethink things. Pushes your own limits or your own biases on it. In thinking about my own spiritual biases and perspective, how do I maintain those without influencing the client in that way. So there is always trying to define where the boundary is. Trying to sort that out. I think that is an ongoing thing and you need to be reminded of it over time, whether with spirituality or other moral dilemmas, that is why you have to keep bringing it up.

During the workshop, participants were encouraged to reflect on their personal background and their perspective towards spirituality. Participants were requested to complete specific exercises to assist them in their reflections as well as to reflect during group discussions. Participants described this encouragement as a useful opportunity to reflect. As one participant explains, “space like that is precious and hard to come by and valuable”.

Time constraint was viewed as one factor that inhibited the participants’ ability to
reflect during the workshop. Participants suggested that the workshop could facilitate greater in-depth reflection if time permitted. This perspective is shared in this quote:

But I do not think in the time, there was so much important information to cover it felt there was not too much time. Certainly there was room for questions, but maybe I might have not explored some stuff as much as I may have wanted to because I was aware of the time limit. So maybe more time for discussion.

Another participant suggested that one way to manage the limited time is to have reflective exercises outside the workshop session. This participant gave the suggestion of splitting the group into two sessions and having reflection exercises between the sessions. Participants had described continuing to reflect on the questions and issues posed by the workshop during other times outside of the workshop. These participants described speaking to other individuals outside of the workshop about their own reflective experiences in the workshop.

6.5.2 Didactic presentation of literature and skills. In the workshop, there was a didactic presentation of theoretical literature related to spirituality as well as strategies for the assessment of clients’ spirituality.

6.5.2.1 Literature. The provision and discussion of literature was an important element identified by participants in the workshop. Participants highlighted the value of the summary of research regarding spirituality that was presented in the workshop. The value of the presentation of research is described in the following quote:

Even just by the virtue of having a discussion about it was helpful. But having discussion with other clinicians and hearing their thoughts on it as well having someone lead with research literature and what we already know from the research that was what led to the most insights.

As the participant suggests, the value of presenting information was enhanced by
discussing the information with others.

One aspect of the information presented was the Pargament model which describes the potential link between spirituality and well-being. Participants described the presentation of the model as facilitating their capacity to take a holistic perspective, as was discussed in Theme 3. One participant believed that the value of discussing the model was that it introduced the existence of models that attempt to relate spirituality to well-being. However, this participant believed he would have to read more about the model to effectively incorporate it in his work.

6.5.2.2 Skills training. Another important element identified in the workshop was the coverage of skills. For some participants, the workshop provided an introduction to data collection strategies to gather information about a client’s spirituality in therapy. These participants suggested that even if they do not wholly implement the strategies, the coverage provided them with a foundational start to build upon in the future.

For other participants, the presentation of skills to assess spirituality was important because it stimulated reflection on currently used practices. Participants suggested that such reflection would make them more purposeful in choosing spiritually sensitive assessment strategies when working with future clients. Such a perspective is reflected in the following quote:

Concrete skills would be good. But you are directing it more towards people who have worked in the field for some time and so that might be too elementary as well as something that people could take and develop on their own. For me the concrete stuff is helpful more often than not. I would be saying “I do not think I would do it that way, I think I would do it that way”. But the fact there is a starting point is still helpful.

6.5.3 Case review. At the end of the workshop, a case scenario was presented for small group discussion. This case review was identified as important for participants
because it makes the workshop real. Participants suggested that there was an added benefit in looking at issues in a practical case along with coverage of relatively abstract information (e.g., research literature). The practical relevance of a case review is expressed in the following quote:

I know for that is what happens with most things. I learn something in school but until I am in a situation that applies to it does not become concrete….I thought it was all good information that was presented but maybe just expanding on that. It can be a bit abstract when you speak about it in general but seeing different examples of how that plays out in a clinical setting is useful; so maybe having a couple of vignettes or maybe a couple of opportunities to explore other cases. I know when other participants spoke about specific cases they had that was really helpful for me to think about different ways how it comes up in clinical practice. So more of that applying it directly to practice and the experiential and discussion component.

6.5.3.1 Spiritual dilemma. A few participants highlighted the importance of the dilemma presented in the specific case that was reviewed. The specific case in the workshop enabled the participants to consider how they could manage a dilemma between following a client’s lead and abiding by one’s own values. This perspective is discussed in the following quote:

I already considered being open about others people's religious views. But I think the workshop went a level deeper. I mean if there is a situation where you do have a reaction to someone's problem and spirituality is a part of it. So, great you are open to it, and you think that you’re understanding of people's situation but what happens when you’re not. What if you find yourself in a situation you do not agree with or you have….I mean like in the situation in the case, where she blames herself for being sexually assaulted, that conflicts with my views with, not necessarily religion, but about blame and what have you. And so, that made me aware of that it does not matter if I am open to, or if I am trying to be understanding, that is a situation where I had views that conflicted with their spiritual views. And what to do in this case? That sort of made me sensitive to, what happens when you do not…or there is resistance, you do not really agree with what's happening. Can you still move forward in a way that is respectful to your client and that can help.
6.5.3.2 Suggestions for other cases. A few participants suggested that the workshop could be further enhanced by more coverage of specific cases. Participants offered two suggestions for types of cases. Some suggested that the cases could be derived from the therapists’ own experiences. Namely, the participants themselves could bring forth cases that they want to discuss and review. The second approach suggested was to discuss cases that might involve populations typically seen by the specific participants.

6.5.3.3 Case review placed at end of workshop. A minority of participants commented on the order of the workshop. They liked the order of the topics covered; namely, that it was beneficial to discuss the presented case at the end of the workshop after having reflected on their views and participated in the didactic presentation. This perspective is described in the following quote discussing the value of the case presentation:

P: Yeah, it gave me some more higher-level, or specific-level, things to think about that the general aspects do not necessarily get you to think about. That was particularly interesting and worthwhile.

I: You saw the first part of the workshop as preparatory for the later part?

P: The general prep and background gets you ready for the complex specific case study.

6.5.4 Diversity of views. Listening to a diversity of views expressed by participants in the workshop was identified as a helpful element. Participants described the conversation in the workshop as positively contributing to their development of spiritual awareness in therapeutic contexts. Specifically, participants seemed to appreciate hearing a diversity of views on the topics discussed in the workshop. This perspective is expressed in the following quote:
And I always appreciate hearing other people’s discussion and how they see spirituality and again seeing it from another perspective, another possibility. And it just always intrigues me how we can get six or eight people in a room and everyone has a different perspective on it. It makes me think, that is interesting what is it I think about that? It is a way of balancing off my own understanding, and open understanding too.

Hearing different perspectives from one’s own seemed to contribute to increased self-awareness as well as enhancing the value of the didactic material presented in the workshop. Increased self-awareness is expressed in the previous quote as well as in the following:

P: And so, I think that experience made me realize that, yeah, I do have distinct customs and beliefs and thoughts about different things. And they do differ from other people.

I: By comparing and contrasting to people.

P: In the group, yeah, seeing other students that are in similar life circumstances right now, and realizing that we all have very different beliefs and views on those topics.

Participants also referred to the benefit of the discussion for enhancing the value of the didactic materials that were presented:

What has done that is not just the information that was delivered, but it was delivered and we sort of reflected on that information and that giving it back to the group and having that input as well, that was the biggest effect on the capacity. Having it reflected in a number of different ways from a number of different perspectives was the most illuminating. I could have read that stuff in a book, but great.... Having others, in that moment, having their perspective on the same issue I was just reflecting.

Here the participant implies that the didactic material presented in the workshop could have been delivered to a student through a self-study format (such as reading). However, he suggests that presenting the material and discussing it as a group was a superior method of delivering the material. Other participants also explicitly made the same comparison and reached the same conclusion.
6.5.4.1 **Facilitation.** Facilitation was identified by participants as an important element of the workshop because it promoted discussion. Participants discussed their views of the workshop facilitator. These participants considered the facilitation in the group as enabling discussion among participants. The facilitator was praised for her ability to synthesize and to reflect ideas. She was also praised for moving the workshop along in a timely fashion while still enabling in-depth reflection and discussion among participants.

6.5.4.2 **Size of the group.** Participants offered some insights into what they believed would be the ideal size for the group. Participants expressed the need for a balance between being large enough to have a range of perspectives in the workshop, yet small enough number to allow for each person to speak. Participants in both workshops described being relatively satisfied with the size of the group. A few participants in the second and larger group suggested that it might have been helpful to either have a smaller group or to break the larger group into small discussion groups.

6.5.4.3 **Working with strangers.** The familiarity participants had with each other was an important element of the workshop. Some participants suggested that it was easier to disclose when working with people they knew because they already had established trust. Other participants suggested that they could possibly feel more safe working with strangers because they would be less concerned how the strangers would react. This reduced concern seemed rooted in there being potentially less future long-term interactions with participants and hence less potential problems in the future.

6.5.4.4 **Working with more advance therapists.** Another aspect of the workshop was the relative experience levels of participants. Participants who had similar amount of
experiences suggested there would be potential drawbacks in having someone in the
group who was considerably more experienced. Specifically, they suggested a potential to
be less likely to discuss their own perspective, keeping silent, at least with respect to
some questions, and wanting to defer to the opinion of more experienced therapists.

6.6. Summary of findings in the context of the research questions

In Chapter 2, I considered the ethical imperative to provide psychotherapy
respectful of a client's cultural identity, including a client's spirituality. In order to ensure
that clients are provided with culturally respectful services, it seems the field of
psychotherapy should ensure adequate competency among therapists. Continuing
education can foster a therapist's capacity to integrate a client’s culture identity and
spirituality into therapy. However, currently there is limited empirically-derived guidance
for the development and implementation of continuing education resources for training
experienced therapists with respect to managing spiritual diversity among clients (e.g.,
see Bartoli, 2007). In an effort to fulfil this research gap, a workshop to foster
experienced therapists’ capacity to respond to a client’s spirituality was developed,
implemented, and evaluated.

As discussed in Chapter 4, answers were sought to two exploratory research
questions in the effort to evaluate the designed workshop. One research question is: What
are the participants’ perspectives as to how their interaction with their clients may change
as a function of participating in the workshop? The answer to this question is discussed
prior to the answer to the second research question: What are the participants’
perspectives as to the value of the specific content of the workshop for improving
capacity to integrate their clients’ spirituality? The participants’ views were collected
through follow-up interview and a questionnaire. The initial feedback was collected in the interview between two weeks and one month after the workshop and follow-up data about two weeks after the interview. The feedback was analyzed by using Grounded Theory Analysis and the findings were summarized in the thematic model that is presented in this chapter.

The thematic model, which I call the *Workshop Experience*, entailed four main themes. The themes are associated chronologically to one another (see Figure 3). Theme 1 refers to current and future attempts by a therapist to adjust their services to their client’s cultural heritage. The participants described their preparation prior to the workshop for this task in Theme 2; subsequently, they outline gains to their competencies after the workshop in Theme 3. Theme 4 refers to the time of the workshop itself. In the following section, I outline how the results of the analysis relate to the two evaluation research questions. Potential implications of the findings for other therapists are discussed in the next chapter.

6.6.1. What are the participants’ perspectives as to how their interaction with their clients may change as a function of participating in the workshop? Participants contextualized their reported gains from the workshop; they described contributions to their competency to better follow their clients' lead. The participants reported that when providing services to their clients, they customized services based on a client's preferences and needs. Across participants, there was some variation in the specific type of clients seen and the therapeutic modality utilized in providing treatment.
Figure 3: Thematic model: *Workshop Experience*
The participants described gains that broadly affected their competencies. The Canadian Psychological Association’s guidelines on working with diverse populations state that “competence requires specific knowledge, skills and attitudes used for the benefit of others. Competence also requires self-monitoring of one’s own knowledge base, personal values, experiences, biases, attitudes, and socialization, which influence how they practice” (CPA, 2001, p. 3). Gains were described with respect to self-monitoring, attitudes, knowledge, and skill. In addition, participants also described potential change to the culture of the organization that they work for.

6.6.1.1 Awareness of attitudes and practices. The participants reported that their involvement in the workshop fostered an increased awareness into their conceptualization of spirituality and the potential role that spirituality has in therapy. Participants described greater awareness of their definition of spirituality, their stereotypes about clients, and assessment and treatment strategies used.

From this awareness, the participating therapists experienced a change in their attitude; specifically, the therapists reported being more accepting of a client's perspective. A change in attitude is an outcome that has been found inconsistently through evaluation research on training focused on spirituality. Such change has been found in training described in Souza (2002) but not in others (e.g., Grabovac, Clark, & Mckenna, 2008). Among the participants in this inquiry, a shift in attitude seemed to be facilitated through the therapists’ increased awareness of their own views toward spirituality and the developmental experiences contributing to these views.

A therapist's own spiritual developmental history can potentially influence a therapist's approach to integrating spirituality into therapy (e.g., Watkins van Asselt &
Baldo-Senstock, 2009). Participants reported being more conscious of the negative messages during their socialization with spirituality (such as a taboo about speaking about spirituality), which in turn fostered an intention to be more responsive towards a client's spirituality in future clinical interactions. Some theorists have suggested that greater spiritual and religious identification can be linked to greater acceptance of strategies for integrating spirituality into treatment (e.g., Chou & Bermender, 2011; Watkins van Asselt & Baldo-Senstock, 2009). The results of the evaluation suggested a more nuanced relationship. Among the participants, some messages facilitated openness whereas other messages stifled acceptance of a client's spirituality.

Greater awareness of their clinical practices resulted in a change in their intention to implement treatment with future clients. The participants suggested greater purposefulness in taking an active role in assessing a client's spirituality, integrating spiritual experiences into the conceptualization of a client's problems, and utilizing a client’s spirituality when appropriate in treatment. These latter two benefits of the therapists' awareness are discussed below the section on declarative knowledge and skills.

Therapists suggested that increased awareness of their potential hesitation to approach spirituality with clients resulted in an intention to actively integrate spirituality into therapy. Participants described overcoming their hesitation as boosting their capacity to establish rapport with clients, and working collaboratively with clients. A similar hesitation towards speaking about spirituality has been disclosed by therapists in previous research (e.g, Cornish, Wade, & Post, 2011). Such hesitation can potentially impede the formation of therapeutic alliance. Participants described some clients as being reluctant to
speak about their spirituality even though it may be relevant to their experiences. This communication pattern has been suggested previously to occur in at least some segment of clients seeking services (Morrison, Clutter, Pritchett & Demmitt, 2009). In light of a potential hesitation by clients to discuss their spiritual experiences, the achievement of collaborative care may require a therapist taking a proactive approach wherein the therapist solicits information and, therein, potentially makes the client more comfortable at broaching the topic of spirituality.

6.6.1.2 Declarative knowledge. Participants also reported that, following the workshop, a change in their conceptualization of spirituality resulted in better appreciation for the potential effect of spirituality on a client’s well-being. The participants suggested that in the future, their understanding of clients' experiences will be different and that they would be more likely to consider the function of the client's spirituality in the case conceptualization. Therapists described these gains as a function of increased awareness of their views on spirituality and the links with well-being as well as reflecting on the model proposed by Pargament (Pargament & Brant, 1998) that was presented in the workshop.

Therapists described their attempt to build declarative knowledge in preparation for working with clients and cited the role of the workshop in this endeavour. If a therapist believed that he or she required greater knowledge about a client then he or she would be more inclined to seek information that would inform the attempt to work with the specific client. The participants acknowledged, however, that group-level information about a specific religious or spiritual tradition may or may not be relevant for working with a specific client. The information gathered would have to be judged for validity.
through assessing congruency with information collected from the client.

Participants described the workshop as motivating them to seek further knowledge about spiritual diversity in their effort to be better prepared for working with clients. The therapists who participated in the workshop described practical concerns (such as time) that would limit the translation of this motivation to the actual seeking of new information. Participants suggested that in the past they gained declarative knowledge about spiritual and religious traditions from a variety of life experiences, both academic and non-academic. They described the references included in the workshop as a resource that they could use in their efforts to become more knowledgeable about the potential experiences of a particular client.

6.6.1.3 Skills. Following the workshop, participants suggested increased refinement of their procedural knowledge and a possible richer behavioural repertoire for assessing a client's spirituality. This change seemed due to both the didactic presentation of skills as well as reflection on clinical practices. Participants suggested that they experienced an enrichment of their procedural knowledge in terms of expanding the option for strategies that they could utilize to collect information from a client regarding spirituality. Specifically, they spoke about different strategies for interviewing, formulating questions, and potentially utilizing spirituality assessment tools, which were topics that were covered in the didactic component of the workshop.

Participants suggested change to the meta-cognitive strategies that they use to collect and analyze the information from their clients. They affirmed the value of the didactic presentation of meta-cognitive skills; however, they did not include descriptions of using any particular meta-cognitive strategies covered in the workshop.
Therapists attributed to the workshop experience a change to their procedural knowledge for implementing treatment. This change partially stemmed from increased awareness of the congruency of their current practices with their initial ideal about how to intervene (such as trying to be client-centred). Participants suggested they re-envisioned how they could possibly integrate spirituality into therapy, such as different ways to test beliefs in cognitive-behavioural therapy. These participants recognized limitations to their competency in implementing the newly considered treatment possibilities. They felt they lacked the corresponding intervention skills to effectively implement the new treatment options that they now considered. They expressed an increased motivation for seeking additional educational experiences to further enrich their treatment skills. In addition, to ensure that a client received appropriate treatment, therapists who participated in the workshop suggested a greater willingness to refer clients if the therapist felt they lacked requisite skills.

The increase in the therapists' procedural knowledge seemed to enhance their sense of confidence for managing the diversity of clients seen in their clinical practice; namely, they gained comfort incorporating spirituality. The incorporation of didactically presented assessment and treatment strategies in the workshop gave the participants a stepping-stone to further refine their procedural knowledge. They suggested that their increased confidence would result in a more active and intentional integration of a client’s spirituality into assessment and therapy.

**6.6.1.4 Organization-based practices.** Participants suggested that the workshop experience potentially may have contributed to a change in the service organizations’ culture where they practice, leading to greater discussion of clients' spirituality during
peer-to-peer consultation. The participants who reported these gains were from the same service organization where they practised ongoing peer-to-peer consultation. Participants reported that in the past during peer support, there had been limited discussion of clients' spirituality and some participants hoped that there would be more discussion in the future.

Potential change to organizational practices has not been a topic of inquiry in other curriculum evaluation that addresses increasing sensitivity towards spirituality. The absence of such discussion partially stems from most of the previous research being conducted with therapists in training who may not be a member of a service agency. However, organization-based influences may potentially hinder or facilitate the transfer of any continuing education into clinical practice (Beidas & Kendall, 2010).

6.6.2 What are the participants’ perspectives as to the value of the specific content of the workshop for improving capacity to integrate clients’ spirituality? As outlined in Theme 4, the participants highlighted specific aspects of the workshop as being pertinent to their continuing development of expertise for managing spiritual diversity. Specifically, the participants highlighted the importance of reflection in the workshop, the didactic presentation of information, the case review, and the discussion space in the workshop. These aspects of the workshop are considered below as related to the process of developing a sense of positive change in competency.

6.6.2.1 Reflection. Participants identified the encouragement of reflection as a vital component of the workshop. Similar to the results of this inquiry, the importance of active reflection was affirmed as important by therapists in some other studies evaluating curricula focused on spirituality (e.g., Curtis & Glass, 2002; O’Connor, 2004). The
participants described the reflection questions, didactic exercises, case review and group discussion as promoting their capacity to reflect. In Theme 4, participants described the ongoing benefit of reflecting on their views towards spirituality and the significance of its potential role in facilitating their delivery of therapy. Greater awareness of beliefs and attitudes seemed to increase a sense of capacity to customize services by potentially leading to greater responsiveness to a client's needs and preferences.

Following the workshop, a change in participants’ understanding of spirituality and clinical practice seemed to be a *transformative learning experience*. This concept was first postulated by Jack Mezirow (1990) to explain how adult learners construct knowledge, which shapes the actions in their lives. Mezirow suggests that learning among adults entails “the process of using a prior interpretation to construe a new or revised interpretation of the meaning of one’s experience in order to guide future action” (p. 162). Transformation is postulated to occur when a learner reflects on their views and practices (such as clinical practices). Reflection has been defined by Boud et al. (1985) as “a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation” (p. 19). Through reflecting on their beliefs and experiences, an individual can potentially experience a profound shift in their meaning structures and subsequently ways of being in the world. However, achieving in-depth reflection for a transformative experience may be difficult to achieve both among novice and experienced therapists, such as among other health care practitioners (e.g., Mann, Gordon, & MacLeod, 2009).

The theoretical literature on the development of therapists highlights the importance of reflection (Bennet-Levy, 2006). Some theorists have suggested that
reflection is the key factor that enables continued development of expertise among practicing therapists (e.g., Ronnestad & Skovholt, 2003). Reflective practice can also potentially enhance the competencies of therapists with respect to managing spiritual diversity. Reflection can enable a therapist to better appreciate their understanding of spirituality and how they attempt to incorporate it into psychotherapy. This appreciation can facilitate continued growth in competency by fostering new understandings (e.g., declarative and procedural knowledge) and changes in action.

There are different types of reflection in which a therapist can engage (Bennett-Levy, 2006). Reflection-on-action refers to a therapist reflecting on their actions either prospectively or retrospectively with regards to the time of actual clinical practice (Mann, et al., 2009). The reflective exercises used during the workshop fostered reflection-on-action. Participants described valuing the opportunity to engage in such reflection during the discussion and in the review of the clinical case at the end of the workshop. In comparison, reflection-in-action occurs when a therapist reflects on their actions during real-time when working with a specific client and the resulting shifts in behaviour occur during the real-time interaction (see Mann, et al., 2009). Some participants implied that their capacity for reflection-in-action may have been enhanced by workshop. Specifically, there was a didactic presentation of meta-cognitive skills that participants could use to reflect-in-action and regulate their processing of information about a client.

**6.6.2.2 Didactic and experiential learning.** The workshop was comprised of both didactic exercises (i.e., lecturing) as well as experiential methods (e.g., reflection, working through a case) (Bennet-Levy, 2006; Kim, & Lyons, 2003). The participants highlighted the contribution of both forms of instruction.
The participants described the didactic presentation of information as helpful for building their procedural knowledge in responding to clients’ needs and preferences associated with spirituality. Participants described change to their procedural knowledge that came through reflecting on what was being discussed during the workshop. Some therapists seemed to add to their knowledge base through a relatively direct transfer of knowledge based on the specific strategies mentioned in the workshop. The value of the didactic presentation among the participating therapists was dissimilar to some of the previous conclusions about the ideal form of instruction for experienced therapists. Specifically, some theorists have de-emphasized the role of didactic methods in favour of experiential exercises for instruction to experienced therapists (e.g., Ronnestad & Skovholt, 2003).

With respect to experiential exercises in the workshop (excluding reflection exercises discussed above) participants also affirmed the importance of working through a clinical case at the end of the workshop. The participants were requested to generate an assessment and treatment approach to the case that was presented. Participants suggested that this applied exercise increased the practical significance of the other workshop content (i.e., reflections and didactic presentation). This opportunity may have allowed for refinement of their perspective via offering them an impetus to reflect-on-action and to also hear different views from other therapists’ about their approach to the same case. Participants recommended more applied cases for discussion, particularly those that are closer to their domain of practice.

6.6.2.3 Atmosphere for Discussion. The participating therapists suggested that the group discussion facilitated their capacity for reflection-on-action. Participants suggested
that hearing the views of others in the workshop enabled greater awareness of both their own views and the relativity of their perspectives. The participants described deriving a similar awareness of the relativity of their views through their past experiences meeting persons in other areas of their life (such as in classroom or travelling). The potential benefit of hearing other views is consistent with past research findings on spirituality-focused training (e.g., O’Connor, 2004). Furthermore, Ronnestad and Skvolholt (2003) in their research on therapists’ development suggested that interpersonal learning experiences become increasingly more important as the therapist gains experience.

The workshop was purposefully structured to allow for a sharing of perspectives by participants while de-emphasising delivery of information from facilitator and participants. In such an environment, individuals were encouraged to discuss their views. The facilitator made attempts to increase comfort for participants to be able to discuss potentially contentious clinical issues, such as the role of spirituality within therapy. As the participants suggested in their feedback, they felt the workshop exercises encouraged reflection and the interpersonal environment permitted an open discussion of the complex issues related to integrating spirituality within therapy. Participants described potential hesitations about sharing in specific interpersonal contexts. They described feeling safe working in small groups but less so in large groups. Participants described feeling potentially hesitant based on the nature of their relationship with the other participants in a workshop; some preferred working with strangers and others with known individuals.
CHAPTER 7: DISCUSSION

The Canadian Psychological Association (CPA, 2001) prescribes in their ethical
guidelines the implementation of services that are respectful of a client's cultural heritage
including a client’s spirituality. Spirituality is a diversity issue that may be insufficiently
implemented into training programs for therapists. In view of the ethical imperative, this
limited preparation in therapist training is potentially problematic. Continuing education
resources could be utilized to promote the delivery of services that are responsive to a
client's cultural heritage, including the client's spirituality.

The field of psychotherapy faces the dual challenge of facilitating the delivery of
culturally-integrative services while further clarifying the appropriate means for
delivering effective continuing education. Unfortunately, a scarcity exists as to curricula
that have been evaluated in any capacity to show their potential relevancy to therapists
and only one previous study focused exclusively on training practicing therapists
(Schregardus, 2008) as opposed to student therapists. This inquiry is one step in the effort
to resolve these two challenges.

The present inquiry adds to the somewhat nascent empirically-based literature on
the training of psychotherapists for managing spiritual diversity. The primary contribution
of this inquiry is to offer an educational resource that can be readily utilized by other
instructors and by therapists. The workshop curriculum was evaluated and refined based
on participants' feedback on their experiences in the workshop. This contribution is
discussed in the next section. Following that section is a discussion of the second main
contribution of the study — the offering of possible insights into strategies for design and
administration of instruction to other practicing therapists with respect to spiritual aspects
of a client's cultural identity.

7.1 Relevance of the workshop for practicing therapists

The findings of the evaluation suggest that the workshop was beneficial to the participating therapists with respect to their competencies for managing cultural and spiritual diversity. As discussed in the previous chapter, the participants attributed to the workshop an increased capacity to offer culturally-integrative services to specific clients. The gains described included increased self-awareness, greater acceptance of clients' spiritual experiences, and more capacity to assess a client's spiritual experiences and to implement treatment that integrates a client's spirituality. The workshop was reported to be a meaningful learning experience for participating therapists; as such, the workshop may also be potentially meaningful to other practicing therapists. The workshop curriculum is an educational resource that can be readily utilized in the continuing education of practicing psychotherapists, such as at conferences or in-house training.

Based on feedback from participants, changes were made to the workshop curriculum in order to improve its potential relevancy for the continued development of other practicing therapists who might attend the workshop (see Appendices I and J for revised workshop materials). Participants described being satisfied with the content of the workshop but offered suggestions as to what might be added to make it more meaningful for their own professional development. However, participants also recognized the limited time for activities in a 3-hour workshop. Mindful of time limitations, I incorporated the suggested additions as optional exercises that the facilitator could implement. These exercises could be used when time permits or when the instructor believes they might be more appropriate for the particular therapists being trained.
Two additions were incorporated into the curriculum as supplementary exercises to the main content of the curriculum. Participants requested more opportunity to reflect on their experiences. In light of this suggestion, an additional reflection exercise was added to the workshop. This exercise entails reflecting on family history and its influence on the therapist’s own spiritual identity. Second, participants also suggested it would be helpful to discuss additional cases that were relevant to their clinical work. To incorporate this suggestion, participants are asked to think about a particular case they worked with in the past and how they might work differently with the same case in the future in terms of assessment and treatment.

7.2 Implications for the training of other therapists

Neimeyer, Taylor, and Phillip (2009) describe two different phases in a therapist's journey to refine their competency. The first stage focuses on the acquisition of foundational competencies to practice in the field. This stage involves the individual participating in a training program usually in the context of an academic institution. Upon the establishment of requisite competencies, the therapist faces the developmental challenge of maintaining currency and building upon their competencies. In this latter phase, the therapist is responsible for self-regulating their usage of learning resources to build on their competencies. The discussion to follow will focus on training in the latter, namely, on the potential continuing education needs of practicing therapists.

Instruction on the topic of spirituality can be beneficial to at least some currently practicing psychotherapists. Participants in this study described not being satisfied with the limited degree that spirituality was covered as a topic in their academic psychotherapy training. The results of the study were consistent with the descriptions of
other practicing therapists who have also expressed concerns about insufficient preparation for managing spiritual diversity. For example, Plumb (2011) surveyed Canadian therapists and the majority of the individuals reported a need for greater focus on spirituality in the training program that they participated.

While there is a current need for continuing education on spirituality, these needs might be potentially different for novice or future therapists due to changing training practices. Kiselica and Ramsey (2001, citing Wehrly, 1999) in their historical survey of multiculturalism within the training of therapists categorize different historical phases in the incorporation of diversity issues into academic training of therapists. In the first historical phase, *mono-culturalism*, the relevance of cultural diversity among clients was either ignored or described in denigrating terms within training programs. A growing appreciation for the importance of diversity among clients occurred in the 1960s culminating in a major shift since the 1980s wherein an appreciation for multiculturalism was more engrained within training programs. Diversity issues are now accepted as a reality of clinical practice and training programs are required by professional bodies to prepare therapists to work with a diversity of clients (Kiselica & Ramsey, 2001). In context of the acceptance of multiculturalism, the coverage of spirituality in formal academic training has also increased since the 1990s and still continues to be increasingly widespread and integrated (Bartoli, 2007). Consequently, in the future, novice therapists and students will have had different training experiences than some currently practicing therapists and, therefore, potentially different needs for continuing education.

Participation in continuing education is generally viewed as a positive endeavor by practicing therapists. Psychologists who were asked about their continuing education
experiences were satisfied with their past experiences (Neimeyer, Taylor, & Phillip, 2010). Continuing education can be delivered through a variety of different methods and practicing psychotherapists consider a range of approaches as acceptable. The Psychologists surveyed in Neimeyer, Taylor, and Phillip (2010), reported most frequently using in-house training, online training, and usage of self-study resources (such as books) for their learning needs in pursuit of life-long learning.

In the following discussion, there will be an elaboration on strategies for offering continuing education to practicing therapists with respect to a clients’ spirituality. The discussion on the strategies for providing continuing education to currently practicing therapists is organized into five main sections. The discussion entails issues related to therapists' own attitudes and beliefs; reflective practice; therapist’s knowledge of client’s spirituality; and then a section on skills for implementing culturally-integrated therapy. In the final section, I discuss the implications of the organizational context in which practicing therapists work in their efforts to provide services.

7.2.1 Therapists’ attitudes and beliefs. A therapist's attitudes and beliefs towards spirituality potentially can have an influence on the therapist's attempts to integrate spirituality into therapy. Participants in this study affirmed various life experiences contributed to the formation of attitudes and beliefs that guide their attempts to integrate spirituality into therapy. Participants in the current evaluation described possessing attitudes of openness and acceptance that they suggested facilitated their capacity to integrate a client's cultural and spiritual identity into therapy. They emphasized an accepting attitude to both training in cultural competency as well as through other life experiences, including their family background and the development of
their own spiritual identity.

While encouraging an accepting attitude towards diversity should be done with every aspect of a client's cultural identity, a particular focus on spirituality may be warranted in the provision of continuing education to practicing therapists to help counter negative attitudes that may arise out of professional training. Participants in this study described receiving a message from previous training experiences that spirituality is a taboo topic for discussion. Other theorists have also suggested a concern among some practicing therapists about speaking about spirituality with their clients (e.g., Crook-Lyon et al., 2011; Cornish, et al., 2011). Similar attitudes of novice and practicing therapists can potentially hinder a therapist's attempt to offer collaborative care to their clients. A therapist's reluctance to explore a client's spirituality can be particularly problematic in light of at least some potential clients being hesitant to initiate conversations about spirituality (Morrison, et al., 2009). An active focus on spirituality by therapists may be necessary to make clients more comfortable in disclosing their spiritual experiences.

One strategy to ensure that practicing therapists have positive attitudes towards spirituality, and other diversity issues, would be to select for entrance into the profession individuals who are already accepting of diversity. O’Donovan and Dyck (2001) argue that “if we know that therapist characteristics are important to outcome, and if we know that training tends not to influence relevant therapist characteristics, then we need to select for appropriate personal characteristics” (p. 94). Taking up this argument, there are the important practical questions such as how to operationalize these values in an academic program to promote multiculturalism (see Winterowd, Adams, Miville, & Mintz, 2009). Furthermore, the main criterion for selection is often high academic
achievement, which may or may not be associated with aptitude for managing diversity (O’Donovan & Dyck, 2001). This brings forth the significant challenge of how the evaluation of an accepting attitude could be incorporated into the selection process.

Personally held attitudes are not immutable to change as implied by O’Donovan and Dyck (2001). Therapists can be encouraged to adopt an accepting attitude towards spirituality, which would allow for greater responsiveness to a client’s needs and preferences. A transformative learning experience can be used to shift a therapist's views. Transformation of even deeply ingrained attitudes is possible through a learning experience as was suggested by the participants in this study. Participants reported a shift in attitude towards being more open to exploring the integration of a client's spirituality. The workshop material offers instructors a potential resource that can be useful for facilitating the delivery of a transformative learning experience to encourage acceptance. Other evaluated curricula that have shown the potential to encourage a transformative experience include O’Connor (2004) and Souza (2002) for student therapists and Schregardus (2008) for practicing therapists.

7.2.1.1 Self-efficacy. Therapists’ self-efficacy can potentially influence their clinical practice (Bennett-Levy, 2006), including their attempts to integrate a client's spirituality into their clinical interactions. Participants in this study who reported a low sense of self-efficacy regarding their capacity for integrating spirituality also reported that they would avoid the topic of spirituality with their clients even if potentially relevant to the client’s experiences. A positive (but realistic) sense of self-efficacy could facilitate a therapist to make a more intentional choice of their therapeutic approach, as opposed to the therapist being bound by a course of action merely because a therapist feels they do
not have the ability to implement any other approach. One of the developmental challenges faced by practicing therapists is to become more confident and build realistic self-efficacy as a therapist. Therapists in the earlier stages of development have been hypothesized to possess a low sense of efficacy relative to other therapists at latter stages (e.g., Hill, Sullivan, Knox, & Schlosser, 2007; Ronnestad & Skovholt, 2003). In this light, novice therapists may not feel capable of effectively integrating a client's spirituality even though they might possess that capacity.

With respect to self-efficacy for cultural integration, training can facilitate a positive change in self-efficacy. The amount of training may not be as important as the perceived quality of the training. Watkins van Asselt and Baldo-Senstock (2009) asked practicing therapists about the experiences that contributed to their efficacy for managing spiritual diversity; the therapists in that study identified helpful training as boosting their self-efficacy as opposed to the overall amount of training experience. Similarly, participants in this inquiry described the skills training component of the workshop as increasing their sense of efficacy through giving them skills they could utilize. They suggested the workshop would not have facilitated a change in self-efficacy if the skill training was not included. Self-efficacy can be also increased through other life experiences outside of training. Participants in the current study also highlighted gains to their perceived competency from life experiences outside of training, such as meeting others and their own spiritual development. Future research is needed to better understand how life experiences outside of training can be utilized in the training of therapists to establish self-efficacy (Watkins van Asselt & Baldo-Senstock, 2009).

A practicing therapist’s sense of self-efficacy can influence their potential usage
of relevant continuing educational resources (Watkins van Asselt & Baldo-Senstock, 2009). A therapist's self-efficacy for integrating spirituality does not necessarily coincide with either their ability levels or their actual clinical practices. Concern has been expressed that novice therapists can naïvely overestimate their capacity to work in a particular domain of practice due to not appreciating the complexities involved (e.g., London, 2011). Conversely, a therapist can be more competent than they perceive themselves to be, as can be the case with experienced therapists. Making an accurate assessment of competency can allow a therapist to practice with greater purposefulness within their boundaries of competency.

Pursuit of life-long learning can enable therapists to manage the ongoing challenges that might occur in their clinical practice, such as responding to the unique needs of a client whose spirituality is relevant to their treatment. Life-long learning refers to the continual growth of a therapist's competency beyond what the therapist gained while a student in training (Wise et al., 2010). Motivation for seeking learning opportunities in pursuit of life-long learning has been highlighted in the past as an important personal variable that promotes the development of expertise among practicing therapists (e.g., King et al., 2008). Greater awareness of limitations to competency can foster a therapist's motivation to participate in continuing education in the pursuit of life-long learning.

Experienced therapists face the task of assessing their competencies which requires an ability previously called meta-competency and defined as “knowledge about knowledge....knowing what you know and what you don’t know” (Hatcher & Lassiter, 2007, p. 53). Participants in this inquiry suggested that making a judgment of their
competency was an imperative in their efforts to appropriately manage spiritual diversity among clients. The self-assessment assists the participants to clarify the boundaries of the services they felt were appropriate for them to offer in context of their abilities. Self-assessment tools have been prescribed as a resource that therapists' can potentially utilize in their efforts to become more aware of their limitations (Karel et al., 2012). These tools may be of value in providing an estimate of general competency but may not answer the question of the appropriateness of working with a specific client in a specific interaction. In addition, a therapist’s reflection on his or her competencies can potentially help the therapist make a real-time decision to work with a specific client (Mann, et al., 2009)

7.2.2 Reflection. Concern has been expressed there can be insufficient focus in psychotherapy training placed on having therapists reflect on attitudes and beliefs relative to the focus on acquisition of knowledge and skills for managing the external realities of clinical practice. For example, Schwebel and Coster (1998) surveyed the heads of 107 Psychology departments about the practice of reflection; the curricula in the respective programs had limited emphasis on active reflection of students’ views. While the practice of reflection is important, nevertheless, the promotion of reflection among practising therapists can present some challenges.

Therapists and instructors vary in their acceptance of undertaking reflection in their clinical training. Wong-Wylie (2007) asked doctoral level psychology students to describe their obstacles to the implementation of reflection in their academic training. Participants in that study described instructors’ and other students’ hesitation for practicing reflection as a major obstacle to their reflection during their training. Schwebel and Coster (1998) hypothesize that part of the hesitancy about incorporating reflection
into training stems from prevalent epistemological beliefs regarding clinical practice. The belief that practicing therapists construct their own knowledge can lead to a valuing of reflection alongside traditional forms of instruction (i.e., didactic presentations). The implementation of reflection can be encouraged by having faculty and students examine their epistemological beliefs and informing them about the potential value of reflection for building competency (e.g., Mann, Gordon, & Mcleod, 2009; Ronnestad & Skovholt, 2003; Souza, 2002).

Among other challenges to the practice of reflection among practicing therapists is that individuals can vary in their capacity to reflect (Bennett-Levy, 2006). Along with motivation and willingness, deliberate reflection requires the usage of meta-cognitive strategies (Arbuthnott, et al., 2006; Byars-Winston & Fouad, 2006). Therapists-in-training can vary in their initial meta-cognitive capacity to reflect on their experiences (Bennett-Levy, 2006). The limited empirical data on training on reflection capacity among practicing health professionals suggests that it can be honed; however, it is not yet clear if refinement occurs without focused training (see Mann, et al., 2009). Given the importance of reflection and the potentially differing abilities to reflect, instruction that focuses on building reflective capacity may be warranted in the training of novice therapists as well as in the continuing education of practicing therapists. Ridley, Mollen, and Kelly (2011) calls the incorporation into training program of meta-cognitive skills training the *new frontier*, as the potential of meta-cognitive training is only beginning to be appreciated and utilized.

Beyond enhancing personal capacity, reflection among therapists can also be facilitated through having therapists speak with other practitioners who comprise the
therapist's community of practice. Participants in this study cited powerful learning experiences stemming from interpersonal experiences. They described the benefit of speaking to a host of individuals in both their professional and non-professional lives, including other participants in the workshop. Previous research on the development of therapists (e.g., Ronnestad & Skovholt, 2003) and on the effects of training focused on spirituality (e.g., O’Connor, 2004) have also suggested the instructional benefits of having therapists train with other practitioners. In reflecting with others, a therapist can be potentially exposed to views that are held by other members of the community. The comparative perspective could be used by a therapist to become aware, and to critique, their own respective beliefs. Such an experience can potentially result in a transformative learning experience wherein the learner has new understandings and ways of practicing therapy with their clients.

In working with others from their communities of practice, a transformative learning experience among practicing therapists could be facilitated through encouraging dialogue. Dialogue refers to a communication exchange between various parties with the purpose of obtaining a mutually agreeable interpretation that transcends the interpretations that were possible by either party prior to undertaking the communication exchange (Christopher, 2001; Martin, 1997). Dialogue requires openness for discussion by participants. To commence a dialogue, the parties need a particular orientation towards the perspectives expressed by the other parties (Polkinghorne, 2004). Specifically, parties must be willing to recognize that they do not have a complete comprehension of the topic at hand, such as the role of spirituality in therapy. Furthermore, parties must also view other individuals’ perspectives as entailing some valid insight. With these beliefs toward
their own and others’ views, the parties can pursue a dialogue by mutually striving toward a richer understanding in contrast to trying to convert another party to adopt a specific stance.

Reflection and dialogue requires structuring the interpersonal learning environment in a manner that supports the sharing of views by participants. Lack of instructional support can impede reflections among learners (Mann et al., 2009). Reflection would be inhibited if the method of instruction entailed that the educator provides information with little or no discussion. An alternative structure enables greater sharing of perspectives and wisdom. In such a learning community, the emphasis is on allowing individuals in the learning group to construct their own knowledge that they can then utilize for actions in their own lives and clinical practice.

A sense of safety is needed in the discussion space. Reflections and sharing of perspectives in a discussion can bring about potentially intense emotions. Individuals will not openly disclose their emotions or disclose in a potentially disruptive manner if a sense of safety is not felt by the participants. Participants in this study shared some reservations about sharing their views about spirituality. However, they generally described feeling sufficiently comfortable in the workshop to openly share their views. They attributed this comfort to the relatively small size of the group, and to knowing and trusting the other individuals in the group prior to the beginning of the workshop.

7.2.3 Therapist knowledge. Increased acquisition of knowledge of a diversity of spiritual and religious traditions can be potentially helpful to practicing therapists in their attempts to integrate a client's spirituality into therapy. Participants in this study described such knowledge as preparing them for working with clients in general. They qualified
this gain by saying that the a priori knowledge they possessed about spiritual traditions would have to be assessed for congruency with the views of their respective clients. The coverage within training programs of spiritual and religious traditions present in Canada can be challenging. Limited opportunity exists for such coverage within formal psychotherapeutic training programs and while working in clinical practice. As participants reported, there are both finite time and competing demands that exist for the potential refinement of competencies.

Beyond finite time, the coverage of spiritual traditions is challenging as the coverage should be ideally complemented by an attitude of acceptance and openness to promote such an attitude towards a client's own spirituality (Bartoli, 2007). Historically, spirituality has been viewed by various psychological theorists in a negative light, such as being primitive, irrational, and inconsistent with science (Bartoli, 2007); such a legacy is still present today within the field among practitioners and trainers. Participants in the current study reported receiving a message from their academic training programs that spirituality is a taboo topic of discussion during psychotherapy. An increased coverage of spiritual traditions in training that only instils negative attitudes about spirituality may hinder the therapist's growing capacity for effective integration of spirituality into therapy. Instructors and training faculty have to be prepared to effectively communicate a message of respect toward spirituality and religion in order to ensure such attitudes among therapists (Bartoli, 2007). Fortunately, since the 1980s there has been a more acceptance towards spirituality in the field reflecting the expanding recognition of the importance of multiculturalism (Bartoli, 2007).

Self-study resources can be used to supplement prior knowledge when attempting
to improve competency when working with a specific client. For example, participants in this study described benefiting from the availability of online resources referenced in the workshop. Self-study resources can be beneficial for the life-long professional development of therapists. Self-study enables a learner to direct the focus of their learning and, thereby, to make the experience relevant to their specific life-long developmental needs. For example, participants described seeking resources based on their attempts to work with a specific client. In addition, a self-selected pace for reviewing learning material may result in greater consolidation of knowledge into the participant’s interpretative framework. Self-study, as opposed to lessons directed by others, is advantageous in allowing learners to pace the processing and coverage of information at a speed that is not cognitively overwhelming, which in turn would facilitate the transfer of information into long-term memory (Clark, 2009).

7.2.4 Skills. Debate has occurred with respect to the appropriate manner to provide skills training via the selection of didactic and experiential approaches to instruction. Various theorists have suggested that the training of practicing therapists should by delivered primarily through experiential training methods (e.g., Beidas, & Kendall, 2010; Ronnestad & Skovholt, 2003). The unilateral encouragement of experiential over didactic methods can be potentially detrimental to the learning effectiveness of the instruction. For example, in a systematic review of the effects of continuing education workshops among health professionals, the exclusive usage of experiential methods was suggested to be less effective for changing clinical behaviour than both didactically delivered workshops and mixed methods of instruction (mixed methods being the most effective) (see Forsetlund, et al., 2009). In addition, participants
in this inquiry affirmed that both methods of instruction are important and complement one another. The current state of the literature has been described as offering limited empirically-based guidance to design and implement meaningful strategies for education.

O’Donovan and Dyck (2001) argue that:

In practice, we mainly don’t know how teacher variables, content variables, process variables, and student variables interact to determine the outcome of our training courses. We don’t know who will benefit from training, or even what the exact benefits might happen to be. In fact, we don’t know nearly enough about what contributes to effective training to be dogmatic about what any training program needs to comprise. (p. 22)

The ideal manner of combining didactic and experiential methods may be contingent on the attributes of the learner in terms of their current level of expertise.

Among experienced therapists, like experts in other domains, the didactic presentation of skills for assessment and treatment can potentially stifle positive long-term change in behaviour. Clark (2009) suggests that the provision of strategies to experienced learners can interfere with their usage of previously developed skills that they refined through practice. Those with established expertise may benefit more from instruction that allows them to construct their own strategies, as opposed to instruction focused on transferring of knowledge through didactic methods of instruction (Bennet-Levy, 2006; Clark, 2009). For example, the participants in this inquiry appreciated the opportunity to reflect on their practices while discussing the didactic presentation, which they affirmed led to gains based on insights.

In contrast, novice therapists (who possess limited procedural knowledge) may benefit from the didactic presentation of directly usable strategies for effectively negotiating a problem, such as the clinical situation of integrating a client's spirituality (Bennet-Levy, 2006). Some of the participants with limited prior training on spirituality
appreciated the presentation of strategies for improving their competency. It has been theorized that if insufficient guidance is provided to a novice learner, then the novice is forced to generate their own solutions and strategies; the resulting cognitive burden can overwhelm the learner (see Clark, 2009; Krischner, et al, 2006). As a result, the presented strategies are not effectively consolidated into long-term memory and hence not effectively transferred to long-term clinical practice.

Experiential exercises can facilitate a transfer of lessons to clinical practice among therapists of all phases of development. In the process of acquiring skills, a therapist, similar to learners in other domains, may utilize a range of skills when approaching a clinical situation. The incorporation of a newly taught skill into practice can be a slow process entailing learning why to use one strategy and why not use previously utilized strategies (Siegler & Shipley, 1995). Practice of a skill in an applied context can facilitate the process of changing the frequency of skill usage as the learner realizes the benefit of a new approach over an old approach (Clark, 2009). Providing the therapist with a range of situations that highlights the advantages of a new approach can promote generalization to the plurality of clinical situations experienced by any particular therapist (Clark, 2009). For example, participants suggested the potential benefit of reviewing and practicing more cases representative of their domains of practice.

In a group of experienced therapists, there will likely be differing degrees of competency with respect to working with spirituality. This diversity offers a challenge to instructors to balance the selection of didactic and experiential instructional strategies. One way of offering effective training across the potential of diversity of expertise is to didactically present a range of skills training and information that vary in potential
relevance for novice and expert therapists. This approach was used in this workshop to the benefit of the participants. Participants described the workshop as one of their initial instructional experiences for developing specific skills for either assessing a client's spirituality or for incorporating spirituality into treatment. They described benefiting from the coverage of skills and knowledge in this workshop. For other participants who already had refined capacity with respect to assessment and treatment, the coverage of the didactically presented material, particularly in context of the case review, was beneficial as it cued their reflection-on-action. Through this reflection, the participants were able to determine for themselves the ideal shift in their skills usage for assessment and treatment.

The workshop curriculum can be used by instructors as a tool for designing their own instruction for teaching skills. In the workshop, there was a more thorough coverage of skills related to assessment as opposed to treatment. This guide to provide instruction on assessment could facilitate the design of other instructional courses; other potentially helpful resources include the workshop curricula in Schregardus (2008) and resources referenced in Pargament and Krumrei (2009). The workshop did not have extensive coverage of skills related to treatment; a focus on implementing treatment occurred in the workshop curricula for practicing therapists evaluated in Schregardus (2008). For training resources on how to incorporate spirituality into pre-existing treatment modules, Richards and Bergin (2004) has case examples showing how others have integrated a client's spirituality into a range of treatment modalities and approaches (such as psychodynamic, humanistic, and cognitive-behavioral). Specific cases with actual clients that represent a range of spiritual and religious traditions can also be found in Richards and Bergin (2004).
**7.2.5 Organization context of practice.** Among practising therapists, lessons derived from training and resulting changes in behavior will not be sustained over the long-term without support from the service organization that employs the therapist (see Beidas & Kendall, 2010). Like any other therapeutic behavior, implementation of clinical practices is not contingent solely on the competencies possessed by the therapist as the behavior occurs within a contextual system. In the present study, research participants described how messages from their organizations could potentially stymie their attempts at providing psychotherapy that integrates a client's spirituality. Other therapists have identified organizational culture as being a potentially negative influence on their own capacities as therapists for responding to diversity (Tummala-Narra, Singer, Esposito, & Ash, 2012).

Given the potential relevance of organizational context, emphasis should be placed on future training efforts potentially including interventions that target organizational practices. None of the previously evaluated curricula on spirituality training, nor the one evaluated in this study, included any pedagogical objectives targeting change to organizational practice. However, as discussed in the results section, the workshop may have facilitated organizational cultural change. Some of the participants were involved together in peer-to-peer interaction. The workshop may have changed the peer-to-peer practices that some of the participants engaged in together (e.g., encouraging more discussion of clients' spirituality). Further research is needed to determine the most effective manner to build organizational cultures that support the integration of a client's spirituality into therapy (Tummala-Narra, et al., 2012).
CHAPTER 8: CONCLUSIONS

In the first four chapters of this dissertation, I outlined the ethical necessity of training therapists to work with the spiritual diversity of clients and how the present inquiry is one step in the broader effort to provide relevant training to practicing therapists. A workshop focused on clients’ spirituality was designed and implemented with a group of practicing therapists in order to gather their feedback about the workshop experience. As outlined in Chapter 6, the participants in the workshop affirmed gains (e.g., to attitude, knowledge, skills, and reflective practice) and they provided a profile of what they considered to be important aspects of the workshop. In Chapter 7, there was a discussion of both the potential relevance of the workshop for training other therapists as well as insights that possibly stemmed from the design and administration of spiritually focused training. In this final chapter, I will discuss the limitations of the inquiry, future research projects, and implications.

8.1 Limitations

One limitation of the inquiry is that the sample of psychotherapists in the study is not representative of the broad spectrum of psychotherapists working in Canada. Limitations of the sample include not having individuals with professional training outside of psychology or social work, such as psychiatrists or nurses; and not having therapists who grew up in homes characterized by minority religious traditions (e.g., non-Christian). These limitations could confine the transferability of the evaluation results to other therapists.

Another limitation of the present study is that the evaluation conducted in this inquiry is not a comprehensive evaluation of the effects of the workshop. Kilpatrick
(1996) proposed a model entailing four levels of evaluation. The first level, *reaction*, involves asking participants about their views on the relevance of the workshop. In the second level, *learning*, there is an assessment of whether the learners acquired the requisites for change in practice (e.g., knowledge, skills, and attitudes). At the third level, *behavioral* change, the transfer of the learning to performance, or change in behavior, is evaluated. Level four, *results*, determines the effects of change in practice on the functioning of the organization, including cost effectiveness as well as outcomes of the services provided to agency clients.

Each of the four levels provides information that is pertinent to understanding the implications of participating in an educational intervention. The evaluation conducted in this inquiry was at the first and second levels of Kilpatrick's (1996) model. Potential change in clinical practice and organizational functioning was not systematically evaluated in the present study and only assessed indirectly through the data generation process. The evaluation of the workshop in this inquiry could be one step in a broader process of conducting a systematic evaluation of the workshop.

The evaluation of the workshop was based on the participants' descriptions of the effects of the workshop on their ability to function in their domain of practice. A limitation of self-report is that individual participants may not be fully aware of potential changes that may have occurred. Individuals vary in their capacity to report their past experiences or to anticipate future experiences (Polkinghorne, 2005). In addition, experienced therapists may utilize affective, behavioral, cognitive, and meta-cognitive strategies in an automatic manner; strategy usage that falls outside of conscious awareness will not be fully reported by participants in self-reports (Ridley, et al., 2011).
The data analysis was conducted by a sole interpreter, which is a potential limitation to the inquiry. My own horizon of understanding, or in other words my perceptual limitations, necessarily confine and shape the interpretations I derived from the data. I attempted to control for the potential biasing effects of my own views by trying to communicate my biases to the reader and to remain reflective in every stage of conducting this research. To facilitate my reflections, I solicited participant feedback at different points in the data construction process. The feedback that I received suggested that the participants felt that their perspectives were represented in the write-up of the findings. Ultimately, it is left to the reader as an interpreter, to determine for himself or herself whether the findings are meaningful and how the findings can potentially inform new understandings and practices.

8.2 Next steps in the research

A next step in the evaluation of the workshop would be to systematically examine the effects of the workshop on clinical behavior and organization functioning — levels three and four of Kilpatrick’s (1996) evaluation model. Past evaluative research on training focused on spirituality has emphasized mostly reactions and learning using self-report measures of potential change to behavior (see Table 5 in Chapter 4 for a review of previous studies). Outside of self-report of clinical behavior, other sources of information can also potentially highlight change in clinical practice and broader functioning in a service organization. Clients can be a source of information about potential changes as they can be asked about their experiences working with a therapist who has participated in the workshop. Another source of potential data would be to have third party observers who assess for change in clinical behavior by examining real clinical interactions of

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therapists who received the training. Challenges in evaluating clinical behavior include the potential resources (e.g., time and human resources) required to conduct a systematic evaluation of potential change in clinical behaviors, and difficulty recruiting participants from a diversity of religious and spiritual groups (Arthur & Lalande, 2009).

In addition to the further evaluation of the workshop, there are other research questions that seem to be relevant based on the findings of this evaluation and the current status of the research literature, as presented in the discussion section. These questions include:

- How does a therapist’s self-efficacy effect their integration of spirituality? What experiences can promote a therapist’s self-efficacy to integrate spirituality?
- How can didactic and experiential methods be combined to meet the needs of practicing therapists, especially with respect to preparation for dealing with spiritually diverse clients?
- What are the effects of diversity training focusing on the effect of spirituality on practice within a service organization? What methods can be used in the effort to create an organizational culture that supports the implementation of spiritually-integrative services?

8.3 Implications of the study and final remarks

There are two main contributions this study makes to the current body of literature on training therapists to integrate cultural and spiritual diversity in their practice. The primary contribution is to offer instructors and researchers an educational resource that can be readily utilized to train novice and practicing therapists. The workshop has the potential as judged by participants' feedback to facilitate and refine
competencies associated with integrating a client's cultural identity and in particular their spirituality. While other curricula do exist in the literature, few have been evaluated in any capacity and only one (Schregardus, 2008) seems to focus on the unique needs of practicing therapists. It is hoped that the present curriculum will either be implemented directly in training therapists or used as a resource to design other curricula.

The redesigned workshop curriculum can be offered as a resource that educators can implement in their efforts to improve the capacity of therapists to integrate culture and spirituality into therapy. Such educators may include the participants in this study. I will forward a copy of the revised workshop to them for use in their future efforts at training other therapists. I give permission to any reader or educator to use any materials in the workshop for appropriate and ethical means. In addition, as an educator, I intend to also offer this workshop to other therapists in the field. I intend to offer the workshop at psychotherapy training institutes as part of in-house training for services agencies and as a continuing education resource for professional associations.

The other main contribution that this study makes is to provide further empirical data to assist educators in the design of other curricula. Specifically, the findings of the inquiry provide further support for the necessity of encouraging reflection among therapists for continued professional development. The results may foster insights into pedagogical strategies for the dissemination of declarative knowledge about spiritual traditions as well as the synthesis of didactic and experiential based learning in skills training. This study also highlights the necessity of considering the organizational context of practicing therapists in fostering change in clinical practice. I intend to publish this
research in a peer reviewed journal in an effort to have the empirical findings read by other individuals in the field.

Besides contributing to the current body of the literature, another main contribution of this inquiry is that the workshop may have resulted in a change in the clinical practice among the participating therapists (and by extension, future participants in the workshop). In doing so it is hoped that the changes would make services more accessible to individuals within Canada's spiritual mosaic. This contribution to improving access to services would ultimately help reduce suffering and improve well-being in the community (Arthur & Lalande, 2009).

The challenge of realizing multiculturalism in Canada may be more prominent in the future due to changing societal demographics and the presence of xenophobia among some Canadians in the post-9/11 era. Nevertheless, I feel more confident after this inquiry that as a society Canada will continue to realize its ideal of multiculturalism. I am more optimistic about this in light of the respectful attempts communicated by participants in this study to manage diversity among their clients and the importance of the workshop in their efforts. These practitioners exist in a societal nexus wherein cultural identities meet and are potentially transformed. If their work is an omen of things to come, then Canada will continue to be a world leader in bringing peoples together into one community.
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Appendix A: Workshop Booklet for Facilitator

Introduction to Workshop

A practical and ethical imperative exists to provide culturally-integrative psychotherapeutic services to every client. The Canadian population is becoming increasingly multicultural due to shifts in demographics. In context of this increasing diversity, leading psychotherapeutic organizations, such as the Canadian Psychological Association, affirm an ethical principle to provide each client with services that are respectful of the client’s self-identity and cultural heritage. Psychotherapists need to be prepared to deal with the inherent challenges posed by fulfilling the imperative to provide culturally-integrative services to their clients. Participation in this workshop is one educational avenue that experienced therapists can utilize in their strivings to enhance their capacity to be responsive to their clients, especially with respect to spiritual diversity.

The pedagogical objectives of the workshop are informed by the Multicultural Cultural Competency model that was initially proposed in Multicultural counseling competencies: Individual and organizational development (Sue et al., 1998). This model highlights three specific competencies that are possessed by therapists who can appropriately respond to a client’s cultural heritage, including the client’s spirituality. These competencies are a therapist’s awareness of his or her own worldview, awareness of the client’s worldview, and the ability to provide the appropriate interventions. Based on these three competencies, the broad aims of the workshop are to make therapists aware of their beliefs regarding spirituality, increase their awareness of their clients’ spirituality, and improve the therapists’ potential to implement therapy that incorporates clients’ spirituality. Finer pedagogical objectives are derived from an operationalization of the three broad objectives (see Table 1 below).

Various educational strategies are incorporated in the workshop in order to accomplish the pedagogical objectives. Didactic exercises are included in order to allow the facilitator to provide the participants with relevant information regarding spirituality and psychotherapy. Guided discussion exercises are included to allow the participants to be reflective of their own views and to share their wisdom with one another. A role-play is included to facilitate the transfer of knowledge gained from the workshop to real clinical work.

Table 1: Learning Objectives for Workshop

<table>
<thead>
<tr>
<th>Competency</th>
<th>Learning Objectives</th>
<th>Exercises</th>
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<tbody>
<tr>
<td>Therapists’ awareness of their views on spirituality</td>
<td>1) To increase the therapists' awareness of their own cultural heritage and how this heritage shapes their views of the link between spirituality and well-being 2) To increase the therapists' awareness of the relativity of</td>
<td>1) Group discussion of the definition of spirituality 2) Reflective exercises on the therapists’ life history and how it shaped their views on spirituality</td>
</tr>
<tr>
<td>Therapists awareness of clients' spirituality</td>
<td>Therapists ability to implement the appropriate intervention strategies for the client</td>
<td></td>
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<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td></td>
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<tr>
<td>5) Make therapists aware of their stereotypes and negative emotional reactions toward individuals from particular spiritual/religious traditions</td>
<td>7) To increase therapists’ ability to tailor their interventions to the specific client’s spirituality.</td>
<td></td>
</tr>
<tr>
<td>6) Increase understanding of the links between spirituality and well-being</td>
<td>7) Discussion of common factors</td>
<td></td>
</tr>
<tr>
<td>4) Presentation of a model linking spirituality and well-being</td>
<td>8) Small group role play of a clinical scenario</td>
<td></td>
</tr>
<tr>
<td>5) Discussion of how meta-cognitive processing is linked to the assessment of spirituality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Discussion of strategies for assessing a client’s spirituality</td>
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</tbody>
</table>

**Structure of the Workshop**

**Group Size**
A group of 4-8 persons is recommended. Sufficient size is required to enable group discussions. However, too large of a group may stifle such discussion by making the group less intimate and by discouraging focus on individual perspectives.

**Seating**
Optimum seating arrangement is circular or semi-circular. It is essential that chairs are movable so that participants can do the activities.

**Discussion and use of flip chart/whiteboard/blackboard**
Use a board, preferably with flip chart paper, to record key points and catch phrases as they emerge for visual reinforcement.

**Handouts**
Give out the handouts at the beginning of the session so that participants can use them to record answers upon reflection of their perspective and discussion with other participants.
Ethical Considerations in Training

The workshop will inherently involve a discussion of opinions and the expression of emotions. Given this aspect of the workshop, the facilitator of the workshop has ethical obligations towards the participants.

1. The facilitator must explain the intentions and objectives at the start of the workshop session and activities. It needs to be clear to participants what they will be involved in. Furthermore, it must be stated clearly to the participants that they can withdraw from the workshop at their own discretion without the risk of being penalized.

2. The facilitator should discuss the need for confidentiality as a protection to each participant’s privacy and as an encouragement to honest and open participation. Consensus needs to be reached as to the degree of confidentiality and privacy that participants can expect. Such consensus can be reached through a discussion of ground rules and an exercise for this purpose will be presented below.

3. The facilitator needs to be alert to signs of emotional distress in any participant. The facilitator should be aware of such signs so to minimize distress, provide support to participants and to make appropriate outside referrals.

Section 1: Opening of the Workshop

A key objective of the workshop is to enhance a therapist’s awareness of his or her own beliefs regarding spirituality and the effects of these beliefs on his or her therapeutic interactions. A safe interpersonal environment will encourage participants to explore their own views and to share them with one another. Such safety entails the participants feeling that they will not be attacked or negatively judged by other participants or the facilitator. Furthermore, the participants have to feel that they have adequate privacy and confidentiality.

Two specific exercises (ice-breaker exercises; generation of rules of conduct) can be implemented at the beginning of the workshop to create and maintain a safe interpersonal environment that is conducive to both self-exploration and disclosure.

Ice Breaker Exercise

An ice-breaker exercise should be implemented at the beginning of workshop. It increases participants’ familiarity with each other and the facilitator. Sufficient, but not excessive, time (<10 minutes) should be committed to the completion of an exercise that is chosen.

Generation of Rules of Conduct

The participants, as a group, should be encouraged to generate rules of conduct for the workshop. Each participant should feel comfortable expressing him or herself during the workshop in order to make the workshop experience rewarding for him or herself and for
the other participants. During the generation of rules of conduct, each participant should be given an opportunity to have his or her specific concerns addressed. The facilitator can provide this opportunity by posing the following discussion question to the group.

*It is important that each individual feels safe to express his or her opinion during the workshop. What rules or principles of conduct can be implemented during the workshop to ensure that you feel safe?*

Draw out participants' responses and write them on the board. In addition, the following should be discussed:

- levels of privacy
- level of confidentiality
- not attacking others even if one disagrees with their view points.

The discussion should proceed until everyone has had an opportunity to express their opinions and the group has reached consensus with the proposed rules.

**Section 3: The Nature of Cultural Competency**

This section will involve a discussion of the nature of cultural-competency and how the training will facilitate a therapist’s ability to be culturally-competent.

**A. What is Cultural Competency?**

*Every client’s specific cultural heritage entails an overlap of various cultural identity dimensions. Commonly relevant identity dimensions include gender, ethnicity, spirituality, religion, age, socio-economic status, and able-bodiness.*

What other identity dimensions can you think of?

*An individual’s cross-section of identity dimensions determines the societal messages that the individual is exposed to during acculturation. As the messages become internalized they shape the individual’s worldview. A person’s worldview is the cognitive framework that an individual utilizes to perceive the world, including the therapeutic interaction. The relative salience of a specific identity dimension for a person’s worldview will vary across specific individuals. The therapist should respond to the client’s identity dimensions as salient to the client and the therapeutic work. For example, Ashley, a female Catholic, based her ideal gender roles on feminist literature as opposed to orthodox Catholic beliefs. The workshop will focus on improving your ability to respond to a client’s spirituality. This focus should not be taken as an encouragement to dismiss the relevance of other identity dimensions but instead to increase sensitivity to this one dimension.*

*The ethical codes of many professional associations (including the CPA and APA) affirm that therapists have an obligation to be responsive to the cultural heritage of a specific client. Given that therapists can be unsure of their ethical responsibilities when*
responding to a client’s spirituality, we shall discuss such responsibilities. What are the ethical reasons for responding to a client’s cultural heritage, including their spirituality?

Draw out participants’ responses and write them on the board. In addition, you might consider:

- client’s right to ascribe to the beliefs of their choice
- potential increase in therapeutic efficacy

What are the ethical challenges in responding to a client’s cultural heritage, including their spirituality?

Draw out participants’ responses and write them on the board. In addition, you might consider:

- competency
- potential decreased therapeutic efficacy in particular situations

The administration of culturally-integrative services is a function of three levels of service delivery, as listed in the workbook under Figure 1. The first level entails the therapist’s adequate sensitivity within the therapeutic interaction with a specific client. This is the level that will be discussed in detail within this workshop. In order to ensure that all clients are provided with appropriate services, responsiveness should also be practiced at the two other levels: 1) the organization that houses the service provider and 2)the broader health care system. In the handouts there are a few references that you can use to read about how to be sensitive at these two other levels.

At the first level of service delivery, responsiveness entails a therapist purposefully adjusting the implementation of psychotherapy in order to make it suitable for a specific client given the client’s cultural heritage. The therapist must reflect, analyze, and choose appropriate responses and techniques. Deliberate adjustments can be made at every stage of therapy: referral, initial contact, assessment, intervention, and termination.

The Multicultural Counseling Competencies (MCC) is a widely-endorsed theoretical model that describes the characteristics of therapists who can appropriately adjust their therapeutic services at the first level. The MCC model describes a culturally-competent therapist as possessing three particular competencies: a therapist’s awareness of his or her own worldview, a therapist’s understanding of the worldview of the specific client, and the therapist’s ability to implement the appropriate intervention strategies with the client. This workshop is one resource that you can utilize in your continuing effort to improve your competency on each of these three dimensions with respect to spirituality. A synopsis of the workshop is included in Table 1 of your handout.

Section 4: Awareness of One’s Own Worldview

The following exercises will focus on making the therapists more aware of their views on spirituality and its link to well-being.
A. Definition of Spirituality

This section will focus on assisting you to become more aware of your views on spirituality. We will begin by examining your definition of spirituality. Many different definitions of spirituality (and religion) exist. The specific definitions held by a therapist will influence the manner by which the therapist responds to a client’s spirituality. What is your definition of spirituality?

Draw out participants' responses and write them on the board. In addition, you might consider:
- connection with others, nature, a higher force
- a source for meaning and purpose
- spirituality as an individual phenomena whereas religion is an institutional level phenomena

The discussion question is posed to make therapists aware of both their own beliefs and the relativity of these beliefs. To accomplish the latter learning objective, the facilitator should highlight for the participants the commonalities and differences that exists across the definitions that are provided.

What role, if any, did religion/spirituality play in your life when you were growing up? What role does it play now?

Has the role of spirituality in clinical work been addressed in your training program and professional environment?

B. Perception of how spirituality is linked to well-being

The next exercise is designed to assist therapists in becoming more aware of how they associate spirituality with a client’s well-being. Brainstorm attributes (descriptive, positive, or negative) that might come to your mind when thinking of a “spiritual person” and a “religious person,” considering each one separately. These do not have to be attributes that you subscribe to but simply the range of messages you have been exposed to during your personal history regarding spirituality or religion.

After developing a collective list under each heading, then consider the third column “mental health qualities.” In this column you should list the qualities that you believe that clients should acquire if treatment is successful treatments (e.g., self-respect, ability to identify and care for one’s needs).

After having made a satisfactory list under all three headings, you should consider the entire page. This final step will allow each psychotherapist to identify potential areas of congruence and conflict when working with religious or spiritual clients. Notice whether
attributes that you ascribe to a spiritual or religious person are congruent or in conflict with attributes that describe a healthy client.

What themes do you recognize? Do these attributes or qualities appear to be in harmony or in potential conflict with each other?

An individual’s spirituality has the potential to facilitate a person’s well-being. Past research findings have generally supported the conclusion that spirituality is related to various aspects of biological (e.g., lower mortality rates) and psychological well-being (e.g., lowered rates of clinically significant emotional distress) (e.g., see Miller & Thorsen, 2003). Consequently, theorists have moved beyond the broad question of whether spirituality is associated with well-being and are now examining the more complex question of how spirituality is related to well-being (e.g., Seeman, Fagan, Dubin, & Seeman, 2003). The answer to this question can highlight the positive and negative effect of spirituality on well-being and, therein, offer therapists a nuanced framework for integrating spirituality into therapy.

Assessment of a client’s spirituality should occur within the context of a theoretical model of how spirituality functions, its relationship to client problems, and how spirituality may be part of the client’s solutions. Such a framework would assist in your making the distinction between forms of spirituality that support well-being versus those forms that are problematic.

Based on your understanding of spirituality, how can spirituality support a person’s well-being?

Based on your understanding of spirituality how can spirituality undermine a person’s well-being?

We will discuss one conceptual model that you can utilize in your attempt to comprehend how a client’s spirituality is related to his or her experiences.

Pargament’s Transactional Model of Coping (Pargament & Brant, 1998) may be the leading model for conceptualizing the functional role of spirituality on well-being. It has been widely adopted by theorists and has been extensively researched (Gall et al., 2005). In the Transactional Model, an individual’s adjustment to a stressor is viewed as a dynamic process that unfolds within a social and cultural environment. Spirituality is conceptualized as operating at several levels of the coping process. It can affect personal factors, causal appraisals, coping behaviors, coping resources, and generation of meaning.

At the personal level, spirituality can play a significant role in determining a person’s beliefs about self, others, and the world. This cognitive framework can shape a person’s interpretation and reaction to life events. The person uses their beliefs to both comprehend the stressor in terms of the cause (primary appraisal), such as “It’s God’s will” and to conceptualize their ability to cope (secondary appraisal). A positive manifestation of spirituality tends to support a feeling of hope and the engagement in
coping responses. Its negative manifestation may undermine such hope and can lead to avoidance of coping responses.

A person’s spirituality could also result in specific behaviors or social supports that a person could use to either respond to the stressor (problem-focused) or associated emotional reactions (emotional-focused). The potential harm or benefit of a particular practice should be assessed in context of the client’s specific situation. The effects are dependent on the particularities of the coping situation such as the timing of the usage of a coping resource; the personal meaning attached to the resource; the particular symptoms; and alternative coping practices (Gall et al., 2005).

In addition, spirituality can also facilitate the generation of meaning when a person is faced with a stressor. The generation of meaning in and of itself can provide relief and support well-being. In contrast, when a person cannot generate meaning this can lead to a spiritual crisis wherein the person is forced to re-examine their spiritual beliefs.


Section 5 – Familiarity with a client’s spirituality
This section will provide the therapist with practical, educational, and meta-cognitive strategies for understanding the spirituality of their clients.

We examined your beliefs about spirituality and now we will focus on the second competency of the MCC model: understanding the client’s spirituality. During the assessment of a client, a therapist works with the client to develop a conceptualization of the problem-space with respect to a client’s experience. Such a conceptualization consists of four general elements: 1) an understanding of the client’s current state of being; 2) the sought for treatment objectives; 3) the available resources to support movement toward the sought for objectives; 4) potential obstacles that might hinder movement toward the sought for treatment goals. A client’s experiences are always somewhat unique and, so, the problem-space and corresponding solution will be somewhat customized.

A therapist’s understanding of the problem-space is inherently filtered through the therapist’s cognitive processes. When a therapist appreciates the nature of this ‘filter’, the therapist can become more effective at generating applicable conceptualizations of the problem-space.

A central aspect of the “cognitive filter” is that some types of information can be more influential than other types in shaping a therapist’s perceptions. Two types of information tend to be particularly influential in the interpretative process engaged in by therapists: information that a therapist is aware of and the therapist’s own prior beliefs. These types of information are influential as a result of certain heuristics, or interpretation biases, that humans commonly use to conserve cognitive resources. The usage of these heuristics simplifies both the scope of information considered and the analytical process. Such
simplification partially underlies the clinical efficiency that is gained by experience. However, a non-reflective usage of heuristics by therapists can also lead to faulty understandings, such as when the client’s life experiences are radically different from the therapist’s experiences or those with whom the therapist tends to work with. We will discuss some meta-cognitive strategies that a therapist can use to control the potential effects of these two types of information.

A. Information present effects

We will now focus on the influence of the information that a therapist is aware of. Our understanding of the world is inherently filtered by our attention. We are bombarded by countless pieces of information but our attention is selectively focused on a limited selection of this information. Of the select information considered during the interpretative process, a person’s views can be strongly shaped by information that is present early on in the interpretative process and by information that a person is considering at the moment in contrast to the other pieces of information that are absent. For example, Micah reported feeling depressed and described feeling lonely due to being estranged from his wife and children. In a future session, he reported the main cause of his depression as being alienated from his God due to feeling guilty about not fulfilling his perceived family obligations. A therapist might miss the significance of the client’s latter disclosure if the therapist is focused on the earlier information.

Our attention can become drawn to specific stimuli though two methods. One method involves a person being automatically drawn towards stimuli. This occurs as the potential relevance of the stimuli is intuitively processed. A second method involves a person intentionally drawing their attention to stimuli based on a deliberate seeking of specific pieces of information. To counter a potential narrow focus, or a tunnel-vision, created by selective attention, a therapist can intentionally seek to expand the information that they consider. Such expansion can involve the usage of strategies both prior to the clinical interaction with a client as well as during the interaction.

I) Preparation prior to the clinical interaction

As you can see in your handout in Table 2 there is a diversity of religious and spirituality traditions represented in the Canadian population. Furthermore, as demographics change minority traditions are growing in their prominence. This diversity means that it is inevitable that clients seeking treatment will have a range of traditions. However, each therapist only works with a subsection of the population. Think about the clients that you see in your clinical practice.

What specific spiritual or religious traditions are common among the clients that you see?

Which other traditions are also present or will be present among the clients that you see?
How knowledgeable are you about these traditions?

How can you seek out information about these specific traditions?

In addition to the answers provided for the previous questions the following strategies can be mentioned as well:

- lectures
- seminars
- group discussions
- research activities
- reading the literature
- cultural consultants
- case study discussion
- experiential approaches
- direct therapeutic practice

In your workbook is a list of some texts and on-line references that you can use in your attempt to gain further information about some particular spiritual or religious traditions.

2) Assessment of the client

Your preparation prior to a clinical interaction can potentially provide insight into the experiences of an individual client. However, group-based information is not wholly applicable to the specific client because each client’s spirituality is partially idiosyncratic. For example, Ali identified himself as a Muslim. Among Muslims recreational drug usage is often viewed in a negative manner. However, Ali believed that smoking hashish was acceptable. As such, preparation prior to the clinical interaction would be insufficient for an accurate understanding of this client’s experiences. There always needs to be an active attempt to understand the spirituality of the individual client.

We will now discuss some practical approaches to assessing the spirituality of a client. First, a therapist needs to decide the extent that they will be explicit in their assessment of spirituality. An explicit approach entails direct questioning about spirituality, such as asking the question “what role does spirituality have in your life?” The advantages of an explicit approach include communication to the client that they have permission to speak about spirituality and the potential saving of time during the assessment process. In contrast, an implicit approach entails assessing spirituality without necessarily overtly mentioning spirituality, such as asking the question “how do you cope with problems?” An implicit approach complements an explicit approach as it can be helpful for clients who are hesitant to discuss spirituality with the therapist or for clients who do not conceptualize their experiences in spiritual terms.
A multi-gate assessment approach is one concrete strategy for assessment that has been proposed in the literature. This approach involves two successive gates or levels. The first level is to gain a general appreciation of a client’s spiritual beliefs, practices, and community affiliations. Such an assessment occurs alongside the broad assessment of the client’s bio-psycho-social functioning. A list of possible questions for a level one assessment is listed in the workbook.

Can you think of any others?

In addition, in the workbook there is a list of some structured spiritual assessment tools that can also be utilized.

Upon gathering information about the client’s spirituality, the therapist must determine whether spirituality is relevant for a client’s problems or to the solutions to his or her problems. Such a determination would occur on the basis of a theoretical model of how spirituality functions, such as the Paragnost Transactional model that was discussed or any other model that you find helpful in your clinical work. If spirituality does seem relevant then the therapist should engage in the second level of assessment. In such an assessment, the therapist attempts to understand in greater detail the causal relevance of the client’s spirituality for their presenting problems and the potential utilization of the client’s spirituality as a therapeutic resource.

A list of questions is included in your workbook for the process of conducting a level two assessment?

Can you think of any other useful questions?

B. Compensation for prior beliefs

During the assessment process, a therapist not only has to cope with the inherent interpretative challenge of considering only finite amounts of information. The therapist also has to manage how their perceptions are potentially shaped by the therapist’s initial beliefs, such as those beliefs discussed earlier. Individuals tend to process information in a manner that confirms the accuracy of initial beliefs. Such confirmation bias can potentially arise through three heuristics or cognitive short-cuts.

One heuristic is that an individual might test only the appropriateness of hypotheses that are consistent with their initial beliefs. For example, in an attempt to understand a client’s desire to pray, a given therapist formulates the sole hypothesis that a client’s praying is a reflection of an underlying compulsion.

Second, the individual might collect only information that confirms the accuracy of their hypothesis as opposed to potentially invalidating the hypothesis. For example, the above mentioned therapist might only ask the question “does the client’s praying reduce anxiety?”
Third, a therapist may give greater credibility to information that is consistent with the therapist’s initial views than to contradictory information. For example, the therapist may dismiss the relevance of the client’s report of enjoying praying due to connecting the individual to a larger fellowship or community.

A therapist can compensate for a potential confirmation bias through utilizing a deliberate approach when analyzing assessment data. Specifically, a therapist can test a range of hypotheses both consistent and contradictory to the therapist’s initial views. In analyzing assessment data, a therapist can seek out information to both confirm and disconfirm the tested hypothesis. Furthermore, the therapist can maintain a critical stance by not either readily accepting information consistent with their own views or readily dismissing contradictory information. Later on in the workshop you will have an opportunity to practice these approaches to hypothesis testing during a role-play exercise.

Section 5 – Application of the appropriate intervention strategies

Thus far, we have discussed the importance of self-awareness and the possession of knowledge regarding a client’s experiences. We now move to the final section of the workshop where we will discuss and practice the potential implementation of using a client’s spirituality into the therapeutic process.

The role of spirituality for any particular case must be determined by the therapist in the broader effort to conceptualize the appropriate intervention. An appropriate intervention rests on the answer to the question: what type of treatment by the specific therapist will be effective for the specific client who is experiencing a specific problem? The particular answer to this question will be, at least partially, idiosyncratic to the unique combination of therapist, client, and problem. When working with a client, it is up to you as a therapist to determine if and how to incorporate spirituality in your clinical work.

In designing an intervention, a therapist should maintain constant those elements of therapy that are necessary for success in any clinical interaction. Such elements are sometimes referred to as “common factors” because they are “factors” that are “common” to all successful therapies irrespective of the nature of the clinical interaction. Common factors need to be retained in order to maintain the efficacy of the intervention.

A therapist’s theoretical understanding of the nature of clinical problems and the therapeutic process will shape his or her conceptualization of whether “common factors” exist and what these factors may be.

Based on your own theoretical understanding, please write in your workbook what you conceptualize as “common factors” or as elements of therapy that are necessary for success in any clinical interaction?
In your handout is a list of common factors based on a literature review by Lambert and Ogles (2004). Please take a moment to review your answers and to compare it to the provided list. Does anyone want to share his or her thoughts on the congruence of your answer to the list? Is there anything you feel should be added to the list or taken away?

We shall now discuss in detail one common factor that has been highlighted in previous research findings: therapeutic alliance. The therapeutic alliance is the common factor that has been most consistently and strongly associated with therapeutic efficacy (Lambert and Ogles, 2004). The therapeutic alliance refers to the working relationship between the client and the therapist. It consists of three elements: 1) mutually agreed upon goals, 2) mutually agreed upon therapeutic techniques, and 3) personal rapport between the client and therapist. The presence of a therapeutic alliance may be necessary for successful therapy; nevertheless, the content of the three elements of the alliance will be contingent on the conceptualization of the problem-space shared by the client and therapist.

A client’s spirituality can be relevant to the three dimensions of the therapeutic alliance. Spirituality can be incorporated into the therapeutic goals and techniques as well as it can shape the rapport between client and therapist.

Based on your understanding of spirituality and the therapeutic process, how do you think spirituality can be incorporated in the goals of therapy?

If you think back to the three columns, this might give you insight into some of the goals that you may set in your practice. With this insight, you might be more aware of potential congruency and incongruency with the perspective brought by an individual client.

Based on your understanding of spirituality and the therapeutic process, how do you think spirituality can be incorporated in the therapeutic techniques?

In your workbook is a list of some possible strategies for such incorporation and readings related to each strategy. This information is presented for your own review.

Based on your understanding of spirituality and the therapeutic process, how do you think spirituality affects personal rapport between client and therapist?

In addition to the answers provided, you can mention the following.
- Managing the language requirements of the client, such interpreters for those clients that use English as a second language.
- Transference related to in- and out-group boundaries. This can affect the level of trust and credibility ascribed to the therapist
- Counter-transference related to in- and out-group boundaries may affect the therapist’s judgment of the client.
In your workbook is a clinical scenario that you are to discuss with others in a smaller group (for example, like 3 people). During the discussion, outline how as a therapist you could practice the assessment of the client, the establishment of a therapeutic alliance, and application of an intervention. There is no absolutely right or wrong way to fulfill these tasks. Include the potential integration of the client’s spirituality for each task. It is an opportunity for you to get some practice using what was discussed during the workshop. For your information there is a summary of what one therapist did when working with the actual client from this scenario. After completion of the discussion, consider your answers to the discussion questions that are listed in your handout related to the scenario.

Section 6 – Conclusion

In this workshop, we discussed your beliefs about spirituality, strategies for assessing a client’s spirituality, and avenues for integrating spirituality into an intervention. In your handout are some references that you can use in your ongoing professional development. Upon reflecting on your current competency for integrating spirituality into therapy, what do you see as the next steps that you need to engage in to further enhance your competency for responding to a client’s spirituality?
Appendix B: Workbook for Workshop Participants

Spirituality Competency Training Workshop

Answer Box 1
Rules of Conduct

Answer Box 2
What is cultural competency?

Figure 1: Levels of Service Delivery
Level 1: Therapist – Client Interaction
Level 2: Organization
Level 3: Health Care System

Reference Box 1: References for Level 2 and 3
<table>
<thead>
<tr>
<th>Competency</th>
<th>Learning Objectives</th>
<th>Exercises</th>
</tr>
</thead>
</table>
| **Therapists’ awareness of their views on spirituality** | 1) To increase the therapists’ awareness of their own cultural heritage and how this heritage shapes their views of the link between spirituality and well-being  
2) To increase the therapists’ awareness of the relativity of their views and to make them comfortable with potentially divergent views  
3) To increase therapists’ awareness of their own limits in competency  
4) To increase therapists’ capacity to continue developing their awareness | 1) Group discussion of the definition of spirituality  
2) Reflective exercises on the therapist’s life history and how it shaped their views on spirituality |
| **Therapists’ awareness of clients’ spirituality**    | 5) Help therapists become aware of their stereotypes and negative emotional reactions toward individuals from particular spiritual/religious traditions  
6) Increase understanding of the links between spirituality and well-being | 4) Presentation of a model linking spirituality and well-being  
5) Discussion of how meta-cognitive processing is linked to the assessment of spirituality  
6) Discussion of strategies for assessing a client’s spirituality |
| **Therapist’s ability to implement the appropriate intervention strategies for the client** | 7) To increase a therapists’ ability to tailor their interventions to the specific client’s spirituality | 7) Discussion of common factors  
8) Small group role play of a clinical scenario |

**Answer Box 3**

What is your definition of spirituality?

**Answer Box 4**


What role, if any, did religion/spirituality play in your life when you were growing up? What role does it play now?

Answer Box 5
How has the role of spirituality in clinical work been addressed in your training program and professional environment?

Answer Box 6
<table>
<thead>
<tr>
<th>Spiritual Person</th>
<th>Religious Person</th>
<th>Mental Health Qualities</th>
</tr>
</thead>
</table>

Answer Box 7
Based on your understanding of spirituality, how can spirituality support an individual’s well-being?

Answer Box 8
Based on your understanding of spirituality how can spirituality undermine an individual’s well-being?
Table 4: Elements of the Problem-Space

1. An understanding of the client's current state of being
2. The sought for treatment objectives
3. The available resources to support movement toward the sought for objectives
4. Potential obstacles that may hinder movement toward the sought for treatment goals

Table 5: Cognitive Filters

1. Information Present
2. Prior Beliefs

Table 6: Expanding the information considered

Prior to Clinical Interaction

Assessment of individual Client

Table 7: Demographics as reported in 2001 Canadian Census

<table>
<thead>
<tr>
<th>Title</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>12,921,285</td>
</tr>
<tr>
<td>Protestant</td>
<td>8,654,845</td>
</tr>
<tr>
<td>No religion</td>
<td>4,796,325</td>
</tr>
<tr>
<td>Christian Orthodox</td>
<td>495,245</td>
</tr>
<tr>
<td>Christian (not otherwise identified)</td>
<td>780,450</td>
</tr>
<tr>
<td>Muslim</td>
<td>579,645</td>
</tr>
<tr>
<td>Jewish</td>
<td>329,990</td>
</tr>
<tr>
<td>Buddhist</td>
<td>300,345</td>
</tr>
<tr>
<td>Hindu</td>
<td>297,200</td>
</tr>
<tr>
<td>Sikh</td>
<td>278,415</td>
</tr>
<tr>
<td>Aboriginal spirituality</td>
<td>29,825</td>
</tr>
<tr>
<td>Pagan</td>
<td>21,080</td>
</tr>
<tr>
<td>Baha'i</td>
<td>18,020</td>
</tr>
</tbody>
</table>

Answer Box 9

What specific spiritual or religious traditions are common among the clients that you see?

Answer Box 10

Which other traditions are also present or will be present among the clients that you see?
Answer Box 11
How knowledgeable are you about these traditions?

Answer Box 12
How can you seek out information about these specific traditions?
- lectures
- seminars
- group discussions
- research activities
- reading the literature
- cultural consultants
- case study discussion
- experiential approaches
- direct therapeutic practice
- others:

Reference Box 3
The following websites contain basic information, such as beliefs, and references for a range of spiritual and religious traditions.

http://www.cmp-cpm.forces.gc.ca/pub/rc/index-eng.asp


http://www.religioustolerance.org/

The following three books contain a discussion of how to provide culturally-integrative therapy as well as basic information and references for a range of spiritual and religious traditions.


Table 8: Level 1 Assessment involving a general appreciation of a client’s spiritual beliefs, practices, and community affiliations.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) What are the current spiritual or religious, beliefs of the client?</td>
<td></td>
</tr>
<tr>
<td>2) What are the current spiritual or religious practices, rituals, or affiliations of the client?</td>
<td></td>
</tr>
<tr>
<td>3) Does the client perceive spiritual or religious issues to be important in their life?</td>
<td></td>
</tr>
<tr>
<td>4) What are the spiritual or religious beliefs and behaviours of the family of origin?</td>
<td></td>
</tr>
<tr>
<td>5) What is the client’s sense of the role that his or her beliefs have in the production of symptoms or the presenting problems and concerns?</td>
<td></td>
</tr>
<tr>
<td>6) What is the client’s sense of the importance of spirituality in the treatment process?</td>
<td></td>
</tr>
<tr>
<td>7) Does the client have specific spiritual or religious concerns that he/she needs to discuss in therapy?</td>
<td></td>
</tr>
<tr>
<td>8) Would the client be interested in discussing spiritual or religious issues in therapy as they pertain to the presenting problem?</td>
<td></td>
</tr>
</tbody>
</table>

Answer Box 13

Other questions

Table 9: Quantitative measures reviewed by Standard, Sandhu, & Painter (2001)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual Assessment Inventory (SAI; Hall &amp; Edwards, 1996)</td>
<td>“The SAI is a newly developed instrument still in the process of revision and investigation. Initial data suggest that the theoretical basis for the instrument is sound. Further investigation is needed to determine the meaning of the Grandiosity scale. The validity of the Defensiveness scale has yet to be fully addressed. Convergent, discriminant, and criterion validity must be established for all scales, and norms need to be developed. In its current form, the instrument may be helpful as a research instrument and as a tool for counselors to use in assessing a client’s spiritual strengths and weaknesses from a Judeo-Christian perspective. This perspective limits it” (Stanard, Sandu, &amp; Painter, 2001, p. 206)</td>
</tr>
<tr>
<td>Index of Core Spiritual Experiences</td>
<td>“The INSPIRIT scale is a promising brief instrument for assessing spirituality. It may be a quick, helpful tool to assist counselors in the assessment of a client’s core experience of God or a Higher Power and as such is limited to use with those holding these beliefs. This information may be useful in stimulating discussion of the issues in counseling and integrating the findings into treatment planning” (Stanard, Sandu, &amp; Painter, 2001, p. 207)</td>
</tr>
<tr>
<td>Spiritual Well-Being Scale (SWBS; Ellison, 1983)</td>
<td>“The lack of norms for the SWBS along with the ceiling effect limits this instrument’s use for clinical purposes. Its reliance on an acceptance of the concept of God also limits its usefulness to those whose spirituality includes such a concept. It is brief and easily administered, and information gleaned from it could be used to stimulate exploration of the client's attitudes as they relate to counseling issue” (Stanard, Sandu, &amp; Painter, 2001, p. 206)</td>
</tr>
</tbody>
</table>
“The early results from the validation of the SHI provide sufficient encouragement for continued development. At this time, its primary use is that of a research instrument. The authors suggest that further development include additional items to strengthen the subscales and testing on additional cohorts to estimate the reliability and validity of the scale with individuals in various phases of illness” (Stanard, Sandu, & Painter, 2001, p. 208)

“The SS is a brief, easily administered, and easily scored instrument that seems to measure spirituality from an Afrocultural perspective. As such, it has particular validity for use with individuals from that cultural background. To date, the instrument has only been validated with children, preadolescents, and college age populations. Further investigation is warranted using older adult populations. The gender differences are also of interest and warrant further investigation” (Stanard, Sandu, & Painter, 2001, p. 208)

“A definite strength of the SAS is its conceptualization. It does not rely on the assumption of any religious background, making it a useful tool for a wider range of people. It has high face validity. The findings of factor analysis supported the four concepts in the researchers' theoretical model of spirituality. To date, this instrument has only been validated by its developer. Its strong theoretical basis and psychometric data suggest that further investigation of the instrument is warranted” (Stanard, Sandu, & Painter, 2001, p. 209)

Table 10: Level 2 Assessment of how spirituality is related to the client’s presenting issues

1) In what ways are the client’s spiritual or religious beliefs and lifestyle affecting his or her presenting problems and issues?
2) What is the religious or spiritual problem-solving style of the client?
3) Does the client have a sound understanding of the teachings of their faith system or religious tradition?

Table 11: Effects of Prior Beliefs

<table>
<thead>
<tr>
<th>Heuristic</th>
<th>Meta-cognitive Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only test the appropriateness of hypotheses that are consistent with their initial beliefs</td>
<td>Test a range of hypotheses both consistent and contradictory to the therapist’s initial views</td>
</tr>
<tr>
<td>Collect information that confirms the accuracy of their hypothesis</td>
<td>Seek out information to both confirm and disconfirm the tested hypothesis</td>
</tr>
<tr>
<td>Give greater credibility to information that is consistent with the therapist’s initial views</td>
<td>Maintain a critical stance by not either readily accepting information consistent with their own views or readily dismissing contradictory information</td>
</tr>
</tbody>
</table>
**Answer Box 15**

What common factors exist?

---

**Table 12: Common Factors identified by Grencavage and Norcoss (1990)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Commonality</th>
</tr>
</thead>
</table>
| Relationship elements     | Development of alliance  
                          | Engagement  
                          | Positive transference |
| Change process            | Opportunity for catharsis  
                          | Acquisition and practice of new behaviors  
                          | Provision of rationale  
                          | Foster insight/awareness  
                          | Emotional and interpersonal learning  
                          | Feedback/ reality testing  
                          | Suggestion  
                          | Success and mastery experiences  
                          | Persuasion  
                          | Contingency management  
                          | Education/information provision |
| Treatment structures      | Use of techniques or rituals  
                          | Exploration of emotional issues  
                          | Adherence to theory  
                          | A healing setting  
                          | Explanation of therapy and participants’ roles |
| Client Characteristics    | Positive expectation/hope or faith  
                          | Distressed client  
                          | Patient actively seeks help |
| Therapist Quality         | Cultivates hope  
                          | Positive regard  
                          | Empathic understanding  
                          | Socially sanctioned healer  
                          | Acceptance |
Table 13: Spiritual Interventions

<table>
<thead>
<tr>
<th>Intervention Strategy</th>
<th>Sample Readings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use spiritual language and metaphors</td>
<td>Fukuyama &amp; Sevig (1999); Prest &amp; Keller (1993)</td>
</tr>
<tr>
<td>Reference sacred writings</td>
<td>Frame (2003); Richards &amp; Bergin (2005)</td>
</tr>
<tr>
<td>Clarify spiritual values</td>
<td>Fukuyama &amp; Sevig (1999)</td>
</tr>
<tr>
<td>Prayer</td>
<td>Frame (2003); McCullough &amp; Larson (1999); Tan (1996)</td>
</tr>
<tr>
<td>Mediation</td>
<td>Marlatt &amp; Kristeller (1999); McMinn &amp; McRay (1997)</td>
</tr>
<tr>
<td>Use spiritual community and spiritual programs</td>
<td>Oman &amp; Thoresen (2003); Tan (1996)</td>
</tr>
</tbody>
</table>

Table 14

Aisha is a 24-year old single woman. Aisha is an international graduate student from a country with a substantial Muslim population. She reported that her family lives in her home country and that she has a limited social network in this city. Aisha identifies herself as a Muslim (if you are playing this character and feel that you do not know enough about Islam to portray the character then choose a tradition that you are more familiar with). She reports that she follows the Sunna, the code of ethical and religious behaviour derived from Muhammed’s sayings and deeds. She reports that she heeds the five daily calls to prayer,
gives alms to the poor, abstains from pork and alcohol, and fasts daily during the month long celebration of Ramadan.

Aisha voluntarily seeks therapy from you due to ongoing emotional concerns. Aisha hesitantly discloses to you that she was sexually assaulted during the previous year. She reports that she has not told anybody else about the events of that day. Aisha reports that women from her home country are often considered responsible for sexual trauma if they allow themselves to be in a “comprising situation”. Aisha believes that she is responsible for the assaults due to her actions. Aisha describes symptoms consistent with Posttraumatic Stress Disorder related to the assault. Such symptoms included fear during the assault, later flashbacks, nightmares, and physiological arousal upon experiencing cues that remind her of the assault. She also describes symptoms consistent with moderate depression, including a sense of worthlessness, persistent guilt, difficulty sleeping, limited appetite, and a desire to die without having an actual plan as to how she would kill herself.

<table>
<thead>
<tr>
<th>Influence of Client’s Faith</th>
<th>Influence of Therapist’s Faith</th>
<th>Spiritual Interventions Used</th>
</tr>
</thead>
</table>
| The client’s faith made her willing to examine the effects of her religious understandings on her emotions. The client’s beliefs in scriptural writings made her willing to discuss scriptural teachings in therapy | The therapist’s faith in God caused him to view religion and spirituality as important in the treatment process. His belief in the value of scriptural teachings led him to use scriptural rationales to dispute the client’s irrational beliefs | Rational disputations of irrational religious beliefs  
Used scriptures to challenge irrational beliefs |

Table 15

Answer Box 19
What issues emanate from your background that you need to be aware of when working with this client?

Answer Box 20
How helpful would it be to you to have an understanding of the cultural norms and expectations of this client’s culture?

Answer Box 21
What may have been the client’s expectations of the therapeutic process?
Answer Box 22
Apart from the readily identifiable issues, what other factors might influence the therapeutic relationship?

Answer Box 23
What do you see as the next steps that you need to engage in to further enhance your competency for responding to a client’s spirituality?
Appendix C: Recruitment Material

To Whom It May Concern,

My name is Atif Shujah and I am a doctoral-level graduate student at the University of Regina. I am conducting a study on the effectiveness of continuing education strategies for the facilitation of psychotherapists' and counsellors' competency to integrate a client’s spirituality into therapy. I am inviting experienced psychotherapists and counsellors (at least 1 year of field experience) to participate in study as a participant in the workshop.

In order to gain a better understanding of relevant educational strategies, I have designed, and will evaluate, a single session workshop on cultural competency training with respect to a client’s spirituality. The learning objectives of the workshop are based on the Multicultural Counselling Competencies model: 1) Increase professionals awareness of their worldview with respect to spirituality; 2) Increase their awareness of the spirituality of their clients; 3) Increase their effectiveness to implement the appropriate intervention. The workshop will provide a space to reflect on one's own experiences working with a diversity of clients and to share one's insights with others. Participants will be also provided with resource materials that may assist them to better understand their client’s spirituality. Participants will be encouraged to envision for themselves how the provided information is relevant for their specific clinical practice.

A workshop session will be held on November 19th (9:00 am – 12:00 pm) at the University of Regina (126 College West). Light refreshments will be served. Participants will be requested to participate in two interview sessions following the workshop and depending on your convenience the interview can be conducted either in-person or on the phone. The first interview (45 minutes) will take place within a week of the workshop and a second session at one-month follow-up (15 minutes). Participants will be provided with a copy of the proposed final conclusions in order to gain their feedback. Participants will receive a $50 honorarium for their participation.

If you choose to participate in this study, efforts will be made to ensure your anonymity by the removal of identifying markers and the use of pseudonyms; however, a risk exists that people that know you may recognize your participation in this study. Prior to any information being released to the public, you will have an opportunity to review and edit any information that relates to your participation. You are under no obligation to participate. Any information that relates to your participation will be destroyed if you choose to participate and then remove your consent at any future point.

I appreciate your consideration of these matters. If you are interested, or if you have any questions or concerns that you wish to have addressed prior to making your decision, then please contact me at either shujah2a@uregina.ca (best way) or 306-585-4203 at the Narrative Hermeneutics Research Lab; or my research supervisor Dr. Angelina Baydala at (306)585-4187.
PARTICIPANT’S INFORMED CONSENT FORM
A Workshop to Improve Experienced Therapists’ Ability to Integrate a Clients’ Spirituality into Therapy

Atif Shujah
306-737-4225; shujah2a@uregina.ca
Department of Psychology; University of Regina

PURPOSE OF THE STUDY. The purpose of the research is to provide insight into educational strategies for the facilitation of a therapists’ competency to integrate a client’s spirituality into therapy.

ROLE OF THE PARTICIPANTS. Participants will be requested to participate in a 3-hour workshop and provide feedback. The general objective of the workshop is to help therapists respond to a client’s spirituality. This broad learning objective will be sought through pursuit of the following general learning objectives: a) promotion of therapists’ awareness of their views on spirituality, b) offering strategies to better understand client’s spirituality, c) improvement of the therapists’ capacity to integrate spirituality into a treatment program. The workshop session will take approximately 3 hours. The workshop will be facilitated by a competent individual other than the main researcher. The workshop session will be video recorded for review purposes. Participants will be requested to provide their feedback on the workshop in two one-to-one interviews and written answers to three questions. The first interview (45 minutes) will commence two days after attendance at a workshop session. At one-month follow-up, the participants will be either mailed or emailed three questions (15 minutes) and then there will be a second interview to clarify and elaborate on their written responses (15 minutes). Participants will be given a copy of the proposed final conclusions to solicit their feedback (30 minutes). The participant will be given a $50 honorarium as a recognition of the time spent. The honorarium will be given after the second interview is completed. Once the participant completes the workshop the honorarium will be provided irrespective the participant later chooses to withdraw from the study.

POTENTIAL BENEFITS. The information collected in this study is intended to facilitate more effective training of psychotherapists. You, as an individual, may not experience any direct personal benefit. Alternatively, your own capacity to practice therapy with a diversity of clients may be enhanced through participation in the workshop.
POTENTIAL RISKS AND DISCOMFORTS. During the workshop, it is possible that you may experience discomfort. You are free to decline to participate in any component of the workshop. Furthermore, you are free to discontinue your participation in the study at any point.

As a participant in this study, your anonymity cannot be guaranteed. First, if you choose to participate in the study and do attend a workshop, your fellow workshop participants will be able to identify you as research participant. A request will be made for participants to respect other participant confidentiality and anonymity but this request does not ensure that other members of the group do not violate the participant’s right for confidentiality and anonymity. Secondly, psychotherapists are members of a relatively small community. If you choose to participate in this study, every effort will be made to ensure your anonymity by removing identifying markers and using pseudonyms when presenting the results. However, a risk exists that people that know you may recognize your participation in this study. Prior to the any information being released to the public, you will have an opportunity to review and edit the data that relates to your participation.

CONFIDENTIALITY OF DATA. The data generated during the interview will be transcribed into a computer file by Atif Shujah. In addition to Atif Shujah, Dr. Angelina Baydala, research supervisor, will have access to the original audio recordings and computer files. No other individual will have access to either the computer files or the original data. All audio-recordings, computer files, paper data, and any other identifying information will be kept in locked cabinets. This material will be destroyed five years following the completion of the study.

Only the information that you have consented to will be released to any third party. However, the researcher is under obligation to release information to the appropriate authorities if there is information regarding current child abuse or serious physical harm to any individual, or if the information is subpoenaed by a court of law.

WITHDRAWAL FROM THE STUDY. Your decision to participate in this research is completely voluntary. You are free to withdraw your consent at any time. Your decision to either participate, not to participate, or to withdraw consent in the future, will not in any foreseeable manner disadvantage you either now or in the future.

OFFER TO ANSWER QUESTIONS: If there is anything in this consent form that you do not understand, or if you have a desire to further discuss what is mentioned in this consent form, then please contact me, Atif Shujah at (306) 337-8293 or by e-mail at shujah2a@uregina.ca; or my research supervisor Dr. Angelina Baydala at (306)585-4187

This project is approved by the Research Ethics Board of the University of Regina. If you have any questions or concerns about your rights or treatment as research participants, you may contact the Chair of the Research Ethics Board at 585-4775 or by e-mail: research.ethics@uregina.ca.
I understand the nature and procedures of this study. I agree to serve as a participant in the study.

__________________________________________
Participant’s Signature

__________________________________________
Researcher’s Signature

Date

I have received a copy of the informed consent form. ______ (Initials)
Please keep your copy of this consent form for future reference.
FACILITATOR’S INFORMED CONSENT FORM
A Workshop to Improve Experienced Therapists’ Ability to Integrate a Clients’ Spirituality into Therapy

Atif Shujah
306-337-8353; shujah2a@uregina.ca
Department of Psychology; University of Regina

PURPOSE OF THE STUDY. The purpose of the research is to provide insight into educational strategies for the facilitation of a therapists’ competency to integrate a client’s spirituality into therapy.

ROLE OF THE PARTICIPANTS. The participants will be requested to facilitate two one-session workshops as a part of an evaluation of the workshop. The workshop session will take approximately 3 hours. The workshop session will be video recorded for review purposes. Through participation in a one-to-one interview, the participant will be requested to provide feedback on their experiences administering the workshop curriculum. The interview (45 minutes) will commence two days after the completion of the second workshop session. Upon completion of the qualitative data analysis, the participant will be given a copy of the proposed final conclusions to solicit their feedback (30 minutes). The participant will be given a $100 honorarium per session as a recognition of the time spent. The honorarium will be given after a workshop session and it will be provided irrespective the participant later chooses to withdraw from the study.

POTENTIAL BENEFITS. The information collected in this study is intended to facilitate more effective training of psychotherapists. You, as an individual, may not experience any direct personal benefit. Alternatively, your own capacity to administer a workshop, or to practice therapy with a diversity of clients, may be enhanced through facilitation of the workshop.

POTENTIAL RISKS AND DISCOMFORTS. During the workshop, it is possible that you may experience discomfort. You are free to decline to participate in any component of the workshop. Furthermore, you are free to discontinue your participation in the study at any point.

As a participant in this study, your anonymity cannot be guaranteed. First, if you choose to participate in the study and do facilitate a workshop, your fellow workshop participants will be able to identify you as research participant. A request will be made for participants
to respect other participant confidentiality and anonymity but this request does not ensure that other members of the group do not violate the participant’s right for confidentiality and anonymity. Secondly, psychotherapists are members of a relatively small community. If you choose to participate in this study, every effort will be made to ensure your anonymity by removing identifying markers and using pseudonyms when presenting the results. However, a risk exists that people that know you may recognize your participation in this study. Prior to the any information being released to the public, you will have an opportunity to review and edit the data that relates to your participation.

CONFIDENTIALITY OF DATA. The data generated during the interview will be transcribed into a computer file by Atif Shujah. In addition to Atif Shujah, Dr. Angelina Baydala, research supervisor, will have access to the original audio recordings and computer files. No other individual will have access to either the computer files or the original data. All audio-recordings, computer files, paper data, and any other identifying information will be kept in locked cabinets. This material will be destroyed five years following the completion of the study.

Only the information that you have consented to will be released to any third party. However, the researcher is under obligation to release information to the appropriate authorities if there is information regarding current child abuse or serious physical harm to any individual, or if the information is subpoenaed by a court of law.

WITHDRAWAL FROM THE STUDY. Your decision to participate in this research is completely voluntary. You are free to withdraw your consent at any time. Your decision to either participate, not to participate, or to withdraw consent in the future, will not in any foreseeable manner disadvantage you either now or in the future.

OFFER TO ANSWER QUESTIONS: If there is anything in this consent form that you do not understand, or if you have a desire to further discuss what is mentioned in this consent form, then please contact me, Atif Shujah at (306) 337-8293 or by e-mail at shujah2a@uregina.ca; or my research supervisor Dr. Angelina Baydala at (306)585-4187.

This project is approved by the Research Ethics Board of the University of Regina. If you have any questions or concerns about your rights or treatment as research participants, you may contact the Chair of the Research Ethics Board at 585-4775 or by e-mail: research.ethics@uregina.ca

I understand the nature and procedures of this study. I agree to serve as a participant in the study.

Participant’s Signature

Researcher’s Signature Date

I have received a copy of the informed consent form. _______ (Initials)
Please keep your copy of this consent form for future reference.
Appendix F: Interview Questions for the Workshop Facilitator

1) How closely did you follow the written guidelines for facilitating the workshop?

2) What do you believe are the relative strengths and weaknesses of the written guidelines?

3) What challenges did you experience during your facilitation of the workshop?

4) What changes do you think could be made to improve the written guidelines or the overall design of the workshop?
Appendix G: Interview Questions for the Workshop Participants

Describe your previous clinical work (e.g., number of years worked; populations)?

What, if any, is the relevance of spirituality in your own life?

What was your previous training in cultural competency, particularly with respect to spirituality? Or any other relevant life experiences?

In what ways do you think that your clinical interactions with your clients will change after having participated in the workshop? Goals? Techniques? Relationship?

How, if at all, did the workshop affect your self-awareness regarding your own perspective on spirituality?

How could the workshop be improved to further increase your self-awareness regarding your views on spirituality?

How, if at all, did the workshop affect your knowledge of clients’ spirituality?

How do you think the workshop could be improved to further increase your knowledge of clients’ spirituality?

How, if at all, do you think the workshop has affected your capacity to implement treatment that integrates a client’s spirituality?

How, if at all, could the workshop be improved to further increase your capacity to implement treatment that integrates a client’s spirituality?
Appendix H: Follow-up Questions for Workshop Participants

Upon further reflection, please add anything that you feel is appropriate about how your clinical interactions with your clients changed after having participated in the workshop?

Please add anything that you feel is appropriate with respect to how the workshop may have affected your self-awareness, knowledge of clients, or your ability to implement an accommodating therapy?

Please add anything that you feel is appropriate to add with respect to how the workshop can be improved to increase a therapist’s self-awareness, knowledge of clients, or ability to implement an accommodating therapy?
Appendix I: Workshop Booklet for Facilitator

**Introduction to Workshop**

A practical and ethical imperative exists to provide culturally-integrative psychotherapeutic services to every client. The Canadian population is becoming increasingly multicultural due to shifts in demographics. In context of this increasing diversity, leading psychotherapeutic organizations, such as the Canadian Psychological Association, affirm an ethical principle to provide each client with services that are respectful of the client’s self-identity and cultural heritage. Psychotherapists need to be prepared to deal with the inherent challenges posed by fulfilling the imperative to provide culturally-integrative services to their clients. Participation in this workshop is one educational avenue that experienced therapists can utilize in their strivings to enhance their capacity to be responsive to their clients, especially with respect to spiritual diversity.

The pedagogical objectives of the workshop are informed by the Multicultural Cultural Competency model that was initially proposed in *Multicultural counseling competencies: Individual and organizational development* (Sue et al., 1998). This model highlights three specific competencies that are possessed by therapists who can appropriately respond to a client’s cultural heritage, including the client’s spirituality. These competencies are a therapist’s awareness of his or her own worldview, awareness of the client’s worldview, and the ability to provide the appropriate interventions. Based on these three competencies, the broad aims of the workshop are to make therapists aware of their beliefs regarding spirituality, increase their awareness of their clients’ spirituality, and improve the therapists’ potential to implement therapy that incorporates clients’ spirituality. Finer pedagogical objectives are derived from an operationalization of the three broad objectives (see Table 1 below).

Various educational strategies are incorporated in the workshop in order to accomplish the pedagogical objectives. Didactic exercises are included in order to allow the facilitator to provide the participants with relevant information regarding spirituality and psychotherapy. Guided discussion exercises are included to allow the participants to be reflective of their own views and to share their wisdom with one another. A role-play is included to facilitate the transfer of knowledge gained from the workshop to real clinical work.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Learning Objectives</th>
<th>Exercises</th>
</tr>
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| Therapists’ awareness of their views on spirituality | 1) To increase the therapists’ awareness of their own cultural heritage and how this heritage shapes their views of the link between spirituality and well-being
2) To increase the therapists’ | 1) Group discussion of the definition of spirituality
2) Reflective exercises on the therapists’ life history and how it shaped their views on spirituality |
awareness of the relativity of their views and to make them comfortable with potentially divergent views
3) To increase therapists’ awareness of their own limits in competency
4) To increase therapists’ capacity to continue developing their awareness

| Therapists awareness of clients’ spirituality | 5) Make therapists aware of their stereotypes and negative emotional reactions toward individuals from particular spiritual/religious traditions
6) Increase understanding of the links between spirituality and well-being |
| 4) Presentation of a model linking spirituality and well-being
5) Discussion of how meta-cognitive processing is linked to the assessment of spirituality
6) Discussion of strategies for assessing a client’s spirituality |

| Therapists ability to implement the appropriate intervention strategies for the client | 7) To increase therapists’ ability to tailor their interventions to the specific client’s spirituality. |
| 7) Discussion of common factors
8) Small group role play of a clinical scenario |

**Structure of the Workshop**

**Group Size**
A group of 4-8 persons is recommended. Sufficient size is required to enable group discussions. However, too large of a group may stifle such discussion by making the group less intimate and by discouraging focus on individual perspectives.

**Seating**
Optimum seating arrangement is circular or semi-circular. It is essential that chairs are movable so that participants can do the activities.

**Discussion and use of flip chart/whiteboard/blackboard**
Use a board, preferably with flip chart paper, to record key points and catch phrases as they emerge for visual reinforcement.

**Handouts**
Give out the handouts at the beginning of the session so that participants can use them to record answers upon reflection of their perspective and discussion with other participants.
Ethical Considerations in Training

The workshop will inherently involve a discussion of opinions and the expression of emotions. Given this aspect of the workshop, the facilitator of the workshop has ethical obligations towards the participants.

1. The facilitator must explain the intentions and objectives at the start of the workshop session and activities. It needs to be clear to participants what they will be involved in. Furthermore, it must be stated clearly to the participants that they can withdraw from the workshop at their own discretion without the risk of being penalized.

2. The facilitator should discuss the need for confidentiality as a protection to each participant’s privacy and as an encouragement to honest and open participation. Consensus needs to be reached as to the degree of confidentiality and privacy that participants can expect. Such consensus can be reached through a discussion of ground rules and an exercise for this purpose will be presented below.

3. The facilitator needs to be alert to signs of emotional distress in any participant. The facilitator should be aware of such signs so to minimize distress, provide support to participants and to make appropriate outside referrals.

Section 1: Opening of the Workshop

A key objective of the workshop is to enhance a therapist’s awareness of his or her own beliefs regarding spirituality and the effects of these beliefs on his or her therapeutic interactions. A safe interpersonal environment will encourage participants to explore their own views and to share them with one another. Such safety entails the participants feeling that they will not be attacked or negatively judged by other participants or the facilitator. Furthermore, the participants have to feel that they have adequate privacy and confidentiality.

Two specific exercises (ice-breaker exercises; generation of rules of conduct) can be implemented at the beginning of the workshop to create and maintain a safe interpersonal environment that is conducive to both self-exploration and disclosure.

Ice Breaker Exercise

An ice-breaker exercise should be implemented at the beginning of workshop. It increases participants’ familiarity with each other and the facilitator. Sufficient, but not excessive, time (<10 minutes) should be committed to the completion of an exercise that is chosen.

Generation of Rules of Conduct
The participants, as a group, should be encouraged to generate rules of conduct for the workshop. Each participant should feel comfortable expressing him or herself during the workshop in order to make the workshop experience rewarding for him or herself and for the other participants. During the generation of rules of conduct, each participant should be given an opportunity to have his or her specific concerns addressed. The facilitator can provide this opportunity by posing the following discussion question to the group.

*It is important that each individual feels safe to express his or her opinion during the workshop. What rules or principles of conduct can be implemented during the workshop to ensure that you feel safe?*

Draw out participants' responses and write them on the board. In addition, the following should be discussed:

- levels of privacy
- level of confidentiality
- not attacking others even if one disagrees with their view points.

The discussion should proceed until everyone has had an opportunity to express their opinions and the group has reached consensus with the proposed rules.

**Section 3: The Nature of Cultural Competency**

This section will involve a discussion of the nature of cultural-competency and how the training will facilitate a therapist’s ability to be culturally-competent.

**A. What is Cultural Competency?**

*Every client’s specific cultural heritage entails an overlap of various cultural identity dimensions. Commonly relevant identity dimensions include gender, ethnicity, spirituality, religion, age, socio-economic status, and able-bodiness.*

*What other identity dimensions can you think of?*

*An individual’s cross-section of identity dimensions determines the societal messages that the individual is exposed to during acculturation. As the messages become internalized they shape the individual’s worldview. A person’s worldview is the cognitive framework that an individual utilizes to perceive the world, including the therapeutic interaction. The relative salience of a specific identity dimension for a person’s worldview will vary across specific individuals. The therapist should respond to the client’s identity dimensions as salient to the client and the therapeutic work. For example, Ashley, a female Catholic, based her ideal gender roles on feminist literature as opposed to orthodox Catholic beliefs. The workshop will focus on improving your ability to respond to a client’s spirituality. This focus should not be taken as an encouragement to dismiss the relevance of other identity dimensions but instead to increase*
sensitivity to this one dimension.

The ethical codes of many professional associations (including the CPA and APA) affirm that therapists have an obligation to be responsive to the cultural heritage of a specific client. Given that therapists can be unsure of their ethical responsibilities when responding to a client’s spirituality, we shall discuss such responsibilities. What are the ethical reasons for responding to a client’s cultural heritage, including their spirituality?

Draw out participants’ responses and write them on the board. In addition, you might consider:

- client’s right to ascribe to the beliefs of their choice
- potential increase in therapeutic efficacy

What are the ethical challenges in responding to a client’s cultural heritage, including their spirituality?

Draw out participants’ responses and write them on the board. In addition, you might consider:

- competency
- potential decreased therapeutic efficacy in particular situations

The administration of culturally-integrative services is a function of three levels of service delivery, as listed in the workbook under Figure 1. The first level entails the therapist’s adequate sensitivity within the therapeutic interaction with a specific client. This is the level that will be discussed in detail within this workshop. In order to ensure that all clients are provided with appropriate services, responsiveness should also be practiced at the two other levels: 1) the organization that houses the service provider and 2) the broader health care system. In the handouts there are a few references that you can use to read about how to be sensitive at these two other levels.

At the first level of service delivery, responsiveness entails a therapist purposefully adjusting the implementation of psychotherapy in order to make it suitable for a specific client given the client’s cultural heritage. The therapist must reflect, analyze, and choose appropriate responses and techniques. Deliberate adjustments can be made at every stage of therapy: referral, initial contact, assessment, intervention, and termination.

The Multicultural Counseling Competencies (MCC) is a widely-endorsed theoretical model that describes the characteristics of therapists who can appropriately adjust their therapeutic services at the first level. The MCC model describes a culturally-competent therapist as possessing three particular competencies: a therapist’s awareness of his or her own worldview, a therapist’s understanding of the worldview of the specific client, and the therapist’s ability to implement the appropriate intervention strategies with the client. This workshop is one resource that you can utilize in your continuing effort to improve your competency on each of these three dimensions with respect to spirituality. A synopsis of the workshop is included in Table 1 of your handout.
Section 4: Awareness of One’s Own Worldview

The following exercises will focus on making the therapists more aware of their views on spirituality and its link to well-being.

A. Definition of Spirituality

This section will focus on assisting you to become more aware of your views on spirituality. We will begin by examining your definition of spirituality. Many different definitions of spirituality (and religion) exist. The specific definitions held by a therapist will influence the manner by which the therapist responds to a client’s spirituality. What is your definition of spirituality?

Draw out participants' responses and write them on the board. In addition, you might consider:

- connection with others, nature, a higher force
- a source for meaning and purpose
- spirituality as an individual phenomena whereas religion is an institutional level phenomena

The discussion question is posed to make therapists aware of both their own beliefs and the relativity of these beliefs. To accomplish the latter learning objective, the facilitator should highlight for the participants the commonalities and differences that exists across the definitions that are provided.

What role, if any, did religion/spirituality play in your life when you were growing up? What role does it play now?

Has the role of spirituality in clinical work been addressed in your training program and professional environment?

A.2. (Optional Exercise, 30 minutes) Spiritual Genogram

We will now focus on the life experiences that have contributed to your beliefs regarding spirituality. You are requested to construct a genogram to help you identify such influences.

Genograms usually include a person’s family members in the past three generations and depict information regarding gender (e.g., females are often depicted as circles, males as squares), date of birth (e.g., placed inside the circle or square), relationship (e.g., marriages, remarriages, partnerships, and divorces, which may be characterized by a variety of different lines, such as dotted, cut-through, etc.), and death. In constructing a genogram of your spiritual development you may choose to indicate one or more of these variables as they appear relevant to your personal history.
After having drawn a picture of all family members for the past three generations, one may choose to use different colors to depict members adhering to different religious traditions (e.g., red for Catholic, yellow for Buddhist), to place brackets around a person to depict shifts in religious or spiritual orientation, to draw a two-way arrow between any two family members to depict closeness among family members in religious or spiritual orientations, and a jagged line, between any two family members, to depict religious or spiritual conflicts (Frame, 2001). It is important for you to be included in the genogram as well. An example of a genogram is included in your handout.

After drawing the genogram, each participant should reflect on the following questions, which are also found in the handout. Subsequently, participants should be encouraged to share their answers with the group.

1. What role, if any, did religion/spirituality play in your life when you were growing up? What role does it play now?

2. What specific religious/spiritual beliefs do you consider most important for you now? How are those beliefs a source of connection or conflict between you and other family members?

3. What religious/spiritual rituals did you participate in as a child or adolescent? How important were they in your family of origin? Which ones do you still engage in? Which ones have you let go? What new rituals have you adopted as an adult? How do these rituals connect to your religious/spiritual belief system?

4. What view did/does your religious/spiritual tradition hold about gender? About ethnicity? About sexual orientation? How have these beliefs affected you and your extended family?

5. What patterns of behavior and relationship resulting from religion/spirituality emerge for you as you study your genogram? How are you currently maintaining or diverting from those patterns?

6. How does your religious/spiritual history connect with your attitudes toward working with clients’ religious or spiritual issues? What new insights or concerns occur to you based on the discoveries made through the genogram?
B. Perception of how spirituality is linked to well-being

The next exercise is designed to assist therapists in becoming more aware of how they associate spirituality with a client’s well-being. Brainstorm attributes (descriptive, positive, or negative) that might come to your mind when thinking of a “spiritual person” and a “religious person,” considering each one separately. These do not have to be attributes that you subscribe to but simply the range of messages you have been exposed to during your personal history regarding spirituality or religion.

After developing a collective list under each heading, then consider the third column “mental health qualities.” In this column you should list the qualities that you believe that clients should acquire if treatment is successful treatments (e.g., self-respect, ability to identify and care for one’s needs).

After having made a satisfactory list under all three headings, you should consider the entire page. This final step will allow each psychotherapist to identify potential areas of congruence and conflict when working with religious or spiritual clients. Notice whether attributes that you ascribe to a spiritual or religious person are congruent or in conflict with attributes that describe a healthy client.

What themes do you recognize? Do these attributes or qualities appear to be in harmony or in potential conflict with each other?

An individual’s spirituality has the potential to facilitate a person’s well-being. Past research findings have generally supported the conclusion that spirituality is related to various aspects of biological (e.g., lower mortality rates) and psychological well-being (e.g., lowered rates of clinically significant emotional distress) (e.g., see Miller & Thorsen, 2003). Consequently, theorists have moved beyond the broad question of whether spirituality is associated with well-being and are now examining the more complex question of how spirituality is related to well-being (e.g., Seeman, Fagan, Dubin, & Seeman, 2003). The answer to this question can highlight the positive and negative effect of spirituality on well-being and, therein, offer therapists a nuanced framework for integrating spirituality into therapy.

Assessment of a client’s spirituality should occur within the context of a theoretical model of how spirituality functions, its relationship to client problems, and how spirituality may be part of the client’s solutions. Such a framework would assist in your making the distinction between forms of spirituality that support well-being versus those forms that are problematic.

Based on your understanding of spirituality, how can spirituality support a person’s well-being?

Based on your understanding of spirituality how can spirituality undermine a person’s well-being?
We will discuss one conceptual model that you can utilize in your attempt to comprehend how a client's spirituality is related to his or her experiences.

Pargament’s Transactional Model of Coping (Pargament & Brant, 1998) may be the leading model for conceptualizing the functional role of spirituality on well-being. It has been widely adopted by theorists and has been extensively researched (Gall et. al., 2005). In the Transactional Model, an individual’s adjustment to a stressor is viewed as a dynamic process that unfolds within a social and cultural environment. Spirituality is conceptualized as operating at several levels of the coping process. It can affect personal factors, causal appraisals, coping behaviors, coping resources, and generation of meaning.

At the personal level, spirituality can play a significant role in determining a person’s beliefs about self, others, and the world. This cognitive framework can shape a person’s interpretation and reaction to life events. The person uses their beliefs to both comprehend the stressor in terms of the cause (primary appraisal), such as “It’s God’s will” and to conceptualize their ability to cope (secondary appraisal). A positive manifestation of spirituality tends to support a feeling of hope and the engagement in coping responses. Its negative manifestation may undermine such hope and can lead to avoidance of coping responses.

A person’s spirituality could also result in specific behaviors or social supports that a person could use to either respond to the stressor (problem-focused) or associated emotional reactions (emotional-focused). The potential harm or benefit of a particular practice should be assessed in context of the client’s specific situation. The effects are dependent on the particularities of the coping situation such as the timing of the usage of a coping resource; the personal meaning attached to the resource; the particular symptoms; and alternative coping practices (Gall et al., 2005).

In addition, spirituality can also facilitate the generation of meaning when a person is faced with a stressor. The generation of meaning in and of itself can provide relief and support well-being. In contrast, when a person cannot generate meaning this can lead to a spiritual crisis wherein the person is forced to re-examine their spiritual beliefs.


**Section 5 – Familiarity with a client’s spirituality**

This section will provide the therapist with practical, educational, and meta-cognitive strategies for understanding the spirituality of their clients.

We examined your beliefs about spirituality and now we will focus on the second competency of the MCC model: understanding the client’s spirituality. During the assessment of a client, a therapist works with the client to develop a conceptualization of the problem-space with respect to a client’s experience. Such a conceptualization consists of four general elements: 1) an understanding of the client’s current state of being; 2) the sought for treatment objectives; 3) the available resources to support movement toward
the sought for objectives; 4) potential obstacles that might hinder movement toward the sought for treatment goals. A client’s experiences are always somewhat unique and, so, the problem-space and corresponding solution will be somewhat customized.

A therapist’s understanding of the problem-space is inherently filtered through the therapist’s cognitive processes. When a therapist appreciates the nature of this ‘filter’, the therapist can become more effective at generating applicable conceptualizations of the problem-space.

A central aspect of the “cognitive filter” is that some types of information can be more influential than other types in shaping a therapist’s perceptions. Two types of information tend to be particularly influential in the interpretative process engaged in by therapists: information that a therapist is aware of and the therapist’s own prior beliefs. These types of information are influential as a result of certain heuristics, or interpretation biases, that humans commonly use to conserve cognitive resources. The usage of these heuristics simplifies both the scope of information considered and the analytical process. Such simplification partially underlies the clinical efficiency that is gained by experience. However, a non-reflective usage of heuristics by therapists can also lead to faulty understandings, such as when the client’s life experiences are radically different from the therapist’s experiences or those with whom the therapist tends to work with. We will discuss some meta-cognitive strategies that a therapist can use to control the potential effects of these two types of information.

A. Information present effects

We will now focus on the influence of the information that a therapist is aware of. Our understanding of the world is inherently filtered by our attention. We are bombarded by countless pieces of information but our attention is selectively focused on a limited selection of this information. Of the select information considered during the interpretative process, a person’s views can be strongly shaped by information that is present early on in the interpretative process and by information that a person is considering at the moment in contrast to the other pieces of information that are absent. For example, Micah reported feeling depressed and described feeling lonely due to being estranged from his wife and children. In a future session, he reported the main cause of his depression as being alienated from his God due to feeling guilty about not fulfilling his perceived family obligations. A therapist might miss the significance of the client’s latter disclosure if the therapist is focused on the earlier information.

Our attention can become drawn to specific stimuli though two methods. One method involves a person being automatically drawn towards stimuli. This occurs as the potential relevance of the stimuli is intuitively processed. A second method involves a person intentionally drawing their attention to stimuli based on a deliberate seeking of specific pieces of information. To counter a potential narrow focus, or a tunnel-vision, created by selective attention, a therapist can intentionally seek to expand the information that they
consider. Such expansion can involve the usage of strategies both prior to the clinical interaction with a client as well as during the interaction.

1) Preparation prior to the clinical interaction

As you can see in your handout in Table 2 there is a diversity of religious and spirituality traditions represented in the Canadian population. Furthermore, as demographics change minority traditions are growing in their prominence. This diversity means that it is inevitable that clients seeking treatment will have a range of traditions. However, each therapist only works with a subsection of the population. Think about the clients that you see in your clinical practice.

What specific spiritual or religious traditions are common among the clients that you see?

Which other traditions are also present or will be present among the clients that you see?

How knowledgeable are you about these traditions?

How can you seek out information about these specific traditions?

In addition to the answers provided for the previous questions the following strategies can be mentioned as well:

- lectures
- seminars
- group discussions
- research activities
- reading the literature
- cultural consultants
- case study discussion
- experiential approaches
- direct therapeutic practice

In your workbook is a list of some texts and on-line references that you can use in your attempt to gain further information about some particular spiritual or religious traditions.

2) Assessment of the client

Your preparation prior to a clinical interaction can potentially provide insight into the experiences of an individual client. However, group-based information is not wholly applicable to the specific client because each client’s spirituality is partially idiosyncratic. For example, Ali identified himself as a Muslim. Among Muslims recreational drug usage is often viewed in a negative manner. However, Ali believed that smoking hashish was acceptable. As such, preparation prior to the clinical interaction
would be insufficient for an accurate understanding of this client’s experiences. There always needs to be an active attempt to understand the spirituality of the individual client.

We will now discuss some practical approaches to assessing the spirituality of a client. First, a therapist needs to decide the extent that they will be explicit in their assessment of spirituality. An explicit approach entails direct questioning about spirituality, such as asking the question “what role does spirituality have in your life?” The advantages of an explicit approach include communication to the client that they have permission to speak about spirituality and the potential saving of time during the assessment process. In contrast, an implicit approach entails assessing spirituality without necessarily overtly mentioning spirituality, such as asking the question “how do you cope with problems?” An implicit approach complements an explicit approach as it can be helpful for clients who are hesitant to discuss spirituality with the therapist or for clients who do not conceptualize their experiences in spiritual terms.

A multi-gate assessment approach is one concrete strategy for assessment that has been proposed in the literature. This approach involves two successive gates or levels. The first level is to gain a general appreciation of a client’s spiritual beliefs, practices, and community affiliations. Such an assessment occurs alongside the broad assessment of the client’s bio-psycho-social functioning. A list of possible questions for a level one assessment is listed in the workbook. Can you think of any others?

In addition, in the workbook there is a list of some structured spiritual assessment tools that can also be utilized.

Upon gathering information about the client’s spirituality, the therapist must determine whether spirituality is relevant for a client’s problems or to the solutions to his or her problems. Such a determination would occur on the basis of a theoretical model of how spirituality functions, such as the Pargament Transactional model that was discussed or any other model that you find helpful in your clinical work. If spirituality does seem relevant then the therapist should engage in the second level of assessment. In such an assessment, the therapist attempts to understand in greater detail the causal relevance of the client’s spirituality for their presenting problems and the potential utilization of the client’s spirituality as a therapeutic resource.

A list of questions is included in your workbook for the process of conducting a level two assessment?

Can you think of any other useful questions?

**A.3. Optional Exercise – Assessment of past client (15 minutes)**

Take a few minutes to think about a case that you worked with in the past in
which spirituality was relevant for the client’s problems and solutions. This could be either a case that was you thought was successful or did not go as well as you had hoped for. In recalling the case, think about your approach to assessing the client’s experiences, particularly with regards to spirituality. What did you think was helpful during the assessment process? What do you think could have been different or better in the assessment process? If comfortable share your insights with the group.

B. Compensation for prior beliefs

During the assessment process, a therapist not only has to cope with the inherent interpretative challenge of considering only finite amounts of information. The therapist also has to manage how their perceptions are potentially shaped by the therapist’s initial beliefs, such as those beliefs discussed earlier. Individuals tend to process information in a manner that confirms the accuracy of initial beliefs. Such confirmation bias can potentially arise through three heuristics or cognitive short-cuts.

One heuristic is that an individual might test only the appropriateness of hypotheses that are consistent with their initial beliefs. For example, in an attempt to understand a client’s desire to pray, a given therapist formulates the sole hypothesis that a client’s praying is a reflection of an underlying compulsion.

Second, the individual might collect only information that confirms the accuracy of their hypothesis as opposed to potentially invalidating the hypothesis. For example, the above mentioned therapist might only ask the question “does the client’s praying reduce anxiety?”

Third, a therapist may give greater credibility to information that is consistent with the therapist’s initial views then to contradictory information. For example, the therapist may dismiss the relevance of the client’s report of enjoying praying due to connecting the individual to a larger fellowship or community.

A therapist can compensate for a potential confirmation bias through utilizing a deliberate approach when analyzing assessment data. Specifically, a therapist can test a range of hypotheses both consistent and contradictory to the therapist’s initial views. In analyzing assessment data, a therapist can seek out information to both confirm and disconfirm the tested hypothesis. Furthermore, the therapist can maintain a critical stance by not either readily accepting information consistent with their own views or readily dismissing contradictory information. Later on in the workshop you will have an opportunity to practice these approaches to hypothesis testing during a role-play exercise.

Section 5 – Application of the appropriate intervention strategies

Thus far, we have discussed the importance of self-awareness and the possession of knowledge regarding a client’s experiences. We now move to the final section of the
workshop where we will discuss and practice the potential implementation of using a client’s spirituality into the therapeutic process.

The role of spirituality for any particular case must be determined by the therapist in the broader effort to conceptualize the appropriate intervention. An appropriate intervention rests on the answer to the question: what type of treatment by the specific therapist will be effective for the specific client who is experiencing a specific problem? The particular answer to this question will be, at least partially, idiosyncratic to the unique combination of therapist, client, and problem. When working with a client, it is up to you as a therapist to determine if and how to incorporate spirituality in your clinical work.

In designing an intervention, a therapist should maintain constant those elements of therapy that are necessary for success in any clinical interaction. Such elements are sometimes referred to as “common factors” because they are “factors” that are “common” to all successful therapies irrespective of the nature of the clinical interaction. Common factors need to be retained in order to maintain the efficacy of the intervention.

A therapist’s theoretical understanding of the nature of clinical problems and the therapeutic process will shape his or her conceptualization of whether “common factors” exist and what these factors may be.

Based on your own theoretical understanding, please write in your workbook what you conceptualize as “common factors” or as elements of therapy that are necessary for success in any clinical interaction?

In your handout is a list of common factors based on a literature review by Lambert and Ogles (2004). Please take a moment to review your answers and to compare it to the provided list. Does anyone want to share his or her thoughts on the congruence of your answer to the list? Is there anything you feel should be added to the list or taken away?

We shall now discuss in detail one common factor that has been highlighted in previous research findings: therapeutic alliance. The therapeutic alliance is the common factor that has been most consistently and strongly associated with therapeutic efficacy (Lambert & Ogles, 2004). The therapeutic alliance refers to the working relationship between the client and the therapist. It consists of three elements: 1) mutually agreed upon goals, 2) mutually agreed upon therapeutic techniques, and 3) personal rapport between the client and therapist. The presence of a therapeutic alliance may be necessary for successful therapy; nevertheless, the content of the three elements of the alliance will be contingent on the conceptualization of the problem-space shared by the client and therapist.

A client’s spirituality can be relevant to the three dimensions of the therapeutic alliance. Spirituality can be incorporated into the therapeutic goals and techniques as well as it can shape the rapport between client and therapist.
Based on your understanding of spirituality and the therapeutic process, how do you think spirituality can be incorporated in the goals of therapy?

If you think back to the three columns, this might give you insight into some of the goals that you may set in your practice. With this insight, you might be more aware of potential congruency and incongruency with the perspective brought by an individual client.

Based on your understanding of spirituality and the therapeutic process, how do you think spirituality can be incorporated in the therapeutic techniques?

In your workbook is a list of some possible strategies for such incorporation and readings related to each strategy. This information is presented for your own review.

Based on your understanding of spirituality and the therapeutic process, how do you think spirituality affects personal rapport between client and therapist?

In addition to the answers provided, you can mention the following.
- Managing the language requirements of the client, such interpreters for those clients that use English as a second language.
- Transference related to in- and out-group boundaries. This can affect the level of trust and credibility ascribed to the therapist
- Counter-transference related to in- and out-group boundaries may affect the therapist’s judgment of the client.

Optional Exercise (15 minutes) Treatment of past client

Take a few minutes to think about a case that you worked with in the past in which spirituality was relevant for the client’s problems and solutions. This could be either a case that was you thought was successful or did not go as well as you had hoped for. In recalling the case, think about your approach to treating the client? What did you think was helpful during the treatment process? What do you think could have been different or better in the manner you responded to the client’s spirituality? If comfortable share your insights with the group.

Case Review

In your workbook is a clinical scenario that you are to discuss with others in a smaller group (for example, like 3 people). During the discussion, outline how as a therapist you could practice the assessment of the client, the establishment of a therapeutic alliance, and application of an intervention. There is no absolutely right or wrong way to fulfill these tasks. Include the potential integration of the client’s spirituality for each task. It is an opportunity for you to get some practice using what was discussed during the workshop. For your information there is a summary of what one therapist did when working with the actual client from this scenario. After completion of the discussion, consider your answers to the discussion questions that are listed in your handout related to the scenario.
Section 6– Conclusion

In this workshop, we discussed your beliefs about spirituality, strategies for assessing a client’s spirituality, and avenues for integrating spirituality into an intervention. In your handout are some references that you can use in your ongoing professional development. Upon reflecting on your current competency for integrating spirituality into therapy, what do you see as the next steps that you need to engage in to further enhance your competency for responding to a client’s spirituality?
Appendix J: Revised Workbook for Workshop Participants

Spirituality Competency Training Workshop

Answer Box 1

Rules of Conduct

Answer Box 2

What is cultural competency?

Figure 1: Levels of Service Delivery

<table>
<thead>
<tr>
<th>Level 1: Therapist – Client Interaction</th>
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<tr>
<td>Level 2: Organization</td>
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<td>Level 3: Health Care System</td>
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Reference Box 1: References for Level 2 and 3


Table 1: Learning Objectives for Workshop

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<tr>
<td><strong>2) To increase the therapists’ awareness of the relativity of their views and to make them comfortable with potentially divergent views</strong></td>
<td><strong>3) To increase therapists’ awareness of their own limits in competency</strong></td>
<td><strong>4) To increase therapists’ capacity to continue developing their awareness</strong></td>
</tr>
<tr>
<td><strong>Therapist’s awareness of clients’ spirituality</strong></td>
<td><strong>5) Help therapists become aware of their stereotypes and negative emotional reactions toward individuals from particular spiritual/religious traditions</strong></td>
<td><strong>4) Presentation of a model linking spirituality and well-being</strong></td>
</tr>
<tr>
<td></td>
<td><strong>6) Increase understanding of the links between spirituality and well-being</strong></td>
<td><strong>5) Discussion of how meta-cognitive processing is linked to the assessment of spirituality</strong></td>
</tr>
<tr>
<td><strong>Therapist’s ability to implement the appropriate intervention strategies for the client</strong></td>
<td><strong>7) To increase a therapists’ ability to tailor their interventions to the specific client’s spirituality</strong></td>
<td><strong>7) Discussion of common factors</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>8) Small group role play of a clinical scenario</strong></td>
</tr>
</tbody>
</table>

**Answer Box 3**

**What is your definition of spirituality?**

**Answer Box 4**

**What role, if any, did religion/spirituality play in your life when you were growing up?**
**What role does it play now?**
Answer Box 5
How has the role of spirituality in clinical work been addressed in your training program and professional environment?

Answer Box 6
<table>
<thead>
<tr>
<th>Spiritual Person</th>
<th>Religious Person</th>
<th>Mental Health Qualities</th>
</tr>
</thead>
</table>

Answer Box 7
Based on your understanding of spirituality, how can spirituality support an individual’s well-being?

Answer Box 8
Based on your understanding of spirituality how can spirituality undermine an individual’s well-being?
Table 4: Elements of the Problem-Space

1. An understanding of the client’s current state of being
2. The sought for treatment objectives
3. The available resources to support movement toward the sought for objectives
4. Potential obstacles that may hinder movement toward the sought for treatment goals

Table 5: Cognitive Filters

1. Information Present
2. Prior Beliefs

Table 6: Expanding the information considered

Prior to Clinical Interaction

Assessment of individual Client

Table 7: Demographics as reported in 2001 Canadian Census

<table>
<thead>
<tr>
<th>Title</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>12,921,285</td>
</tr>
<tr>
<td>Protestant</td>
<td>8,654,845</td>
</tr>
<tr>
<td>No religion</td>
<td>4,796,325</td>
</tr>
<tr>
<td>Christian Orthodox</td>
<td>495,245</td>
</tr>
<tr>
<td>Christian (not otherwise identified)</td>
<td>780,450</td>
</tr>
<tr>
<td>Muslim</td>
<td>579,645</td>
</tr>
<tr>
<td>Jewish</td>
<td>329,990</td>
</tr>
<tr>
<td>Buddhist</td>
<td>300,345</td>
</tr>
<tr>
<td>Hindu</td>
<td>297,200</td>
</tr>
<tr>
<td>Sikh</td>
<td>278,415</td>
</tr>
<tr>
<td>Aboriginal spirituality</td>
<td>29,825</td>
</tr>
<tr>
<td>Pagan</td>
<td>21,080</td>
</tr>
<tr>
<td>Baha’i</td>
<td>18,020</td>
</tr>
</tbody>
</table>

Answer Box 9

What specific spiritual or religious traditions are common among the clients that you see?
Answer Box 10
Which other traditions are also present or will be present among the clients that you see?

Answer Box 11
How knowledgeable are you about these traditions?

Answer Box 12
How can you seek out information about these specific traditions?
- lectures
- seminars
- group discussions
- research activities
- reading the literature
- cultural consultants
- case study discussion
- experiential approaches
- direct therapeutic practice
- others:

Reference Box 3
The following websites contain basic information, such as beliefs, and references for a range of spiritual and religious traditions.

http://www.cmp-cpm.forces.gc.ca/pub/rc/index-eng.asp


http://www.religioustolerance.org/

The following three books contain a discussion of how to provide culturally-integrative therapy as well as basic information and references for a range of spiritual and religious traditions.


Table 8: Level 1 Assessment involving a general appreciation of a client’s spiritual beliefs, practices, and community affiliations.

1) What are the current spiritual or religious beliefs of the client?
2) What are the current spiritual or religious practices, rituals, or affiliations of the client?
3) Does the client perceive spiritual or religious issues to be important in their life?
4) What are the spiritual or religious beliefs and behaviours of the family of origin?
5) What is the client’s sense of the role that his or her beliefs have in the production of symptoms or the presenting problems and concerns?
6) What is the client’s sense of the importance of spirituality in the treatment process?
7) Does the client have specific spiritual or religious concerns that he/she needs to discuss in therapy?
8) Would the client be interested in discussing spiritual or religious issues in therapy as they pertain to the presenting problem?

Answer Box 13

Other questions

Table 9: Quantitative measures reviewed by Standard, Sandhu, & Painter (2001)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual Assessment Inventory (SAI; Hall &amp; Edwards, 1996)</td>
<td>“The SAI is a newly developed instrument still in the process of revision and investigation. Initial data suggest that the theoretical basis for the instrument is sound. Further investigation is needed to determine the meaning of the Grandiosity scale. The validity of the Defensiveness scale has yet to be fully addressed. Convergent, discriminant, and criterion validity must be established for all scales, and norms need to be developed. In its current form, the instrument may be helpful as a research instrument and as a tool for counselors to use in assessing a client's spiritual strengths and weaknesses from a Judeo-Christian perspective. This perspective limits it” (Stanard, Sandu, &amp; Painter, 2001, p. 206)</td>
</tr>
<tr>
<td>Index of Core Spiritual Experiences (INSPIRIT; Kass, Friedman, Leserman, Zuttermeister, &amp; Benson, 1991)</td>
<td>“The INSPIRIT scale is a promising brief instrument for assessing spirituality. It may be a quick, helpful tool to assist counselors in the assessment of a client's core experience of God or a Higher Power and as such is limited to use with those holding these beliefs. This information may be useful in stimulating discussion of the issues in counseling and integrating the findings into treatment planning” (Stanard, Sandu, &amp; Painter, 2001, p. 207)</td>
</tr>
<tr>
<td>Spiritual Well-Being Scale (SWBS; Ellison, 1983)</td>
<td>“The lack of norms for the SWBS along with the ceiling effect limits this instrument's use for clinical purposes. Its reliance on an acceptance of the concept of God also limits its usefulness to those whose spirituality includes such a concept. It is brief and easily administered, and information gleaned from it could be used to stimulate exploration of the client's attitudes as they relate to counseling issue” (Stanard, Sandu, &amp; Painter, 2001, p. 207)</td>
</tr>
</tbody>
</table>
Spiritual Health Inventory (SHI; Veach & Chappel, 1992)

“The early results from the validation of the SHI provide sufficient encouragement for continued development. At this time, its primary use is that of a research instrument. The authors suggest that further development include additional items to strengthen the subscales and testing on additional cohorts to estimate the reliability and validity of the scale with individuals in various phases of illness” (Stanard, Sandu, & Painter, 2001, p. 208)

Spirituality Scale (SS) (Jagers & Smith, 1996).

“The SS is a brief, easily administered, and easily scored instrument that seems to measure spirituality from an Afrocultural perspective. As such, it has particular validity for use with individuals from that cultural background. To date, the instrument has only been validated with children, preadolescents, and college age populations. Further investigation is warranted using older adult populations. The gender differences are also of interest and warrant further investigation” (Stanard, Sandu, & Painter, 2001, p. 208)

Spirituality Assessment Scale (SAS) (Howden, 1992).

“A definite strength of the SAS is its conceptualization. It does not rely on the assumption of any religious background, making it a useful tool for a wider range of people. It has high face validity. The findings of factor analysis supported the four concepts in the researchers' theoretical model of spirituality. To date, this instrument has only been validated by its developer. Its strong theoretical basis and psychometric data suggest that further investigation of the instrument is warranted” (Stanard, Sandu, & Painter, 2001, p.209)

Table 10: Level 2 Assessment of how spirituality is related to the client’s presenting issues

1) In what ways are the client’s spiritual or religious beliefs and lifestyle affecting his or her presenting problems and issues?
2) What is the religious or spiritual problem-solving style of the client?
3) Does the client have a sound understanding of the teachings of their faith system or religious tradition?

Answer Box 14

Other questions

Table 11: Effects of Prior Beliefs

<table>
<thead>
<tr>
<th>Heuristic</th>
<th>Meta-cognitive Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only test the appropriateness of hypotheses that are</td>
<td>Test a range of hypotheses both consistent and</td>
</tr>
<tr>
<td>consistent with their initial beliefs</td>
<td>contradictory to the therapist's initial views</td>
</tr>
<tr>
<td>Collect information that confirms the accuracy of their</td>
<td>Seek out information to both confirm and disconfirm</td>
</tr>
<tr>
<td>hypothesis</td>
<td>the tested hypothesis</td>
</tr>
</tbody>
</table>
Give greater credibility to information that is consistent with the therapist’s initial views

Maintain a critical stance by not either readily accepting information consistent with their own views or readily dismissing contradictory information

Answer Box 15

What common factors exist?

Table 12: Common Factors identified by Grencavage and Norcoss (1990)

<table>
<thead>
<tr>
<th>Category</th>
<th>Commonality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship elements</td>
<td>Development of alliance</td>
</tr>
<tr>
<td></td>
<td>Engagement</td>
</tr>
<tr>
<td></td>
<td>Positive transference</td>
</tr>
<tr>
<td>Change process</td>
<td>Opportunity for catharsis</td>
</tr>
<tr>
<td></td>
<td>Acquisition and practice of new behaviors</td>
</tr>
<tr>
<td></td>
<td>Provision of rationale</td>
</tr>
<tr>
<td></td>
<td>Foster insight/awareness</td>
</tr>
<tr>
<td></td>
<td>Emotional and interpersonal learning</td>
</tr>
<tr>
<td></td>
<td>Feedback/ reality testing</td>
</tr>
<tr>
<td></td>
<td>Suggestion</td>
</tr>
<tr>
<td></td>
<td>Success and mastery experiences</td>
</tr>
<tr>
<td></td>
<td>Persuasion</td>
</tr>
<tr>
<td></td>
<td>Contingency management</td>
</tr>
<tr>
<td></td>
<td>Education/information provision</td>
</tr>
<tr>
<td>Treatment structures</td>
<td>Use of techniques or rituals</td>
</tr>
<tr>
<td></td>
<td>Exploration of emotional issues</td>
</tr>
<tr>
<td></td>
<td>Adherence to theory</td>
</tr>
<tr>
<td></td>
<td>A healing setting</td>
</tr>
<tr>
<td></td>
<td>Explanation of therapy and participants’ roles</td>
</tr>
<tr>
<td>Client Characteristics</td>
<td>Positive expectation/hope or faith</td>
</tr>
<tr>
<td></td>
<td>Distressed client</td>
</tr>
<tr>
<td></td>
<td>Patient actively seeks help</td>
</tr>
<tr>
<td>Therapist Quality</td>
<td>Cultivates hope</td>
</tr>
<tr>
<td></td>
<td>Positive regard</td>
</tr>
<tr>
<td></td>
<td>Empathic understanding</td>
</tr>
<tr>
<td></td>
<td>Socially sanctioned healer</td>
</tr>
<tr>
<td></td>
<td>Acceptance</td>
</tr>
</tbody>
</table>
Answer Box 16

How is spirituality related to goals?

Answer 17

How can spirituality be associated with psychotherapeutic techniques?

Table 13: Spiritual Interventions

<table>
<thead>
<tr>
<th>Intervention Strategy</th>
<th>Sample Readings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use spiritual language and metaphors</td>
<td>Fukuyama &amp; Sevig (1999); Prest &amp; Keller (1993)</td>
</tr>
<tr>
<td>Reference sacred writings</td>
<td>Frame (2003); Richards &amp; Bergin (2005)</td>
</tr>
<tr>
<td>Clarify spiritual values</td>
<td>Fukuyama &amp; Sevig (1999)</td>
</tr>
<tr>
<td>Prayer</td>
<td>Frame (2003); McCullough &amp; Larson (1999); Tan (1996)</td>
</tr>
<tr>
<td>Mediation</td>
<td>Marlatt &amp; Kristeller (1999); McMinn &amp; McRay (1997)</td>
</tr>
<tr>
<td>Use spiritual community and spiritual programs</td>
<td>Oman &amp; Thoresen (2003); Tan (1996)</td>
</tr>
</tbody>
</table>

Answer Box 18

How does spirituality affect the therapeutic relationship?

Table 14

Aisha is a 24-year old single woman. Aisha is an international graduate student from a country with a substantial Muslim population. She reported that her family lives in her home country and that she has a limited social network in this city. Aisha identifies herself as a Muslim (if you are playing this character and feel that you do not know enough about Islam to portray the character then choose a tradition that you are more familiar with). She reports that she follows the Sunna, the code of ethical and religious behaviour derived from Muhammed’s sayings and deeds. She reports that she heeds the five daily calls to prayer, gives alms to the poor, abstains from pork and alcohol, and fasts daily during the month long celebration of Ramadan.
Aisha voluntarily seeks therapy from you due to ongoing emotional concerns. Aisha hesitantly discloses to you that she was sexually assaulted during the previous year. She reports that she has not told anybody else about the events of that day. Aisha reports that women from her home country are often considered responsible for sexual trauma if they allow themselves to be in a “comprising situation”. Aisha believes that she is responsible for the assaults due to her actions. Aisha describes symptoms consistent with Posttraumatic Stress Disorder related to the assault. Such symptoms included fear during the assault, later flashbacks, nightmares, and physiological arousal upon experiencing cues that remind her of the assault. She also describes symptoms consistent with moderate depression, including a sense of worthlessness, persistent guilt, difficulty sleeping, limited appetite, and a desire to die without having an actual plan as to how she would kill herself.

<table>
<thead>
<tr>
<th>Influence of Client’s Faith</th>
<th>Influence of Therapist’s Faith</th>
<th>Spiritual Interventions Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>The client’s faith made her willing to examine the effects of her religious understandings on her emotions. The client’s beliefs in scriptural writings made her willing to discuss scriptural teachings in therapy</td>
<td>The therapist’s faith in God caused him to view religion and spirituality as important in the treatment process. His belief in the value of scriptural teachings led him to use scriptural rationales to dispute the client’s irrational beliefs</td>
<td>Rational disputations of irrational religious beliefs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Used scriptures to challenge irrational beliefs</td>
</tr>
</tbody>
</table>

**Table 15**

**Answer Box 19**
What issues emanate from your background that you need to be aware of when working with this client?

**Answer Box 20**
How helpful would it be to you to have an understanding of the cultural norms and expectations of this client’s culture?

**Answer Box 21**
What may have been the client’s expectations of the therapeutic process?
### Answer Box 22

Apart from the readily identifiable issues, what other factors might influence the therapeutic relationship?

### Answer Box 23

What do you see as the next steps that you need to engage in to further enhance your competency for responding to a client’s spirituality?
Appendix K – REB Approval Form

UNIVERSITY OF REGINA

OFFICE OF RESEARCH SERVICES

MEMORANDUM

DATE: July 7, 2009

TO: Afif Shujah
54 Bartlett Avenue
Toronto, Ontario M5H 3E6

FROM: Dr. Bruce Plouffe
Chair, Research Ethics Board

Re: A Workshop to Improve Experienced Therapists’ Ability to Integrate a Client’s Spirituality into Therapy (8750809)

Please be advised that the University of Regina Research Ethics Board has reviewed your proposal and found it to be:

☐ 1. APPROVED AS SUBMITTED. Only applicants with this designation have ethical approval to proceed with their research as described in their applications. For research lasting more than one year (Section 1F). ETHICAL APPROVAL MUST BE RENEWED BY SUBMITTING A BRIEF STATUS REPORT EVERY TWELVE MONTHS. Approval will be revoked unless a satisfactory status report is received. Any substantive changes in methodology or instrumentation must also be approved prior to their implementation.

☐ 2. ACCEPTABLE SUBJECT TO MINOR CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB. **Do not submit a new application.** Once changes are deemed acceptable, ethical approval will be granted.

☐ 3. ACCEPTABLE SUBJECT TO CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB. **Do not submit a new application.** Once changes are deemed acceptable, ethical approval will be granted.

☐ 4. UNACCEPTABLE AS SUBMITTED. The proposal requires substantial additions or redesign. Please contact the Chair of the REB for advice on how the project proposal might be revised.

Dr. Bruce Plouffe

cc: Dr. Angelina Beydala – Psychology

**supplementary memo should be forwarded to the Chair of the Research Ethics Board at the Office of Research Services (Research and Innovation Centre, Room 109) or by e-mail to research.ethics@uregina.ca**

Phone: (306) 585-4770
Fax: (306) 585-4853

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