

Spiritually Integrated Psychotherapy— A Review of Kenneth Pargament's Book

by Ted Bowman and Marge Grahn-Bowman

Starting with the sentence, "Spirituality is an extraordinary part of the ordinary lives of people," Kenneth Pargament invites readers of his impressive volume to ponder, be attentive to, and to integrate spirituality into their work with individuals and families. His skills as a clinician and researcher are evident in *Spiritually Integrated Psychotherapy*. The book is not, as too many spiritually focused books are, an opinion or a one-sided volume. Rather, as he asserts, "I have avoided the temptation to idealize spirituality, stressing instead the need for clinicians to recognize a basic fact of life: that spirituality can be a part of the solution and a part of the problem."

Pargament's dual strengths might create a challenge for some readers. Clinicians of a therapeutic or educational orientation may find the discussions of various research efforts and results a bit much. Rather than pass quickly from those pages, I urge practitioners to linger and read carefully for questions used by this skilled researcher. Variations of his inquiries could be easily and appropriately asked in many grief and bereavement settings. Further, his clinical strengths become all the more potent because of his research abilities. Striving for what is often called best practice can only be accomplished when rigorous research and skilled practice intersect and inform one another. Again and again Pargament inserts tables or guidelines for clinical work. For example, there is a brief table of conversational methods for spiritual coping, which can easily be adapted in grief and bereavement work.

Pargament is also keen about the power of words. One of his case studies involves the hurtful power of words for a woman who came to counseling, as she put it, "contaminated." Her earlier rape led her to embody what she thought of as violations of the sacred. Failure to address the spiritual meanings of her rape would have been poor clinical practice. It would have also denied her a powerful source for healing.

At the recent MCDES workshop led by Pargament (see Jan Bergman's discussion), registrants had the opportunity to see his dramatic demonstrations of skills, theory, and knowledge, informed by a human heart, all of which mirrored the richness of this book. For attendees, the book will reinforce your experiences. For those unable to attend the workshop, purchase the book. It is ripe for spiritual harvesting by a wide range of human service workers.

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can be called upon as an important participant in provision of spiritually integrated health care or psychology.

In the end, Pargament cautioned the audience to avoid the "Twin Dangers" inherent to practicing spiritually sensitive care. Just as it can be negative to ignore or reject the role of spirituality in the provision of care, professionals

must be mindful of and transparent about their own biases so as to avoid spiritual coercion or interfering with a patient's spiritual autonomy.

In my own work as medical social worker and hospice grief counselor, I have occasionally found myself maneuvering around in the gray zone of spirituality—believing it important to address a relevant spiritual issue

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that has come up, but feeling unqualified to do so. This workshop gave me permission to explore such issues further and offered appropriate, practical guidelines for this purpose. But the conference was an introduction, a survey of a large and complex body of knowledge, not a tutorial. To learn more about integrating spirituality into your practice, please consult Dr. Ken Pargament's writings.

Book Review: When Professionals Weep

Edited by Renee S Katz and Therese A Johnson

Reviewed by Abby Dawkins

“When Professional Weep,” is a must-read, a most compelling, and provocative read for anyone who is in the business of listening to the heart-felt stories of others. I was asked to read and review this book in order to give you a taste of what you might expect at the MCDES Conference on May 15, 2009. My perspective is that of a Clinical Social Worker with 32 years of “practice,” listening to shared stories of joy, pain, sadness, grief, and loss throughout life’s ages and stages. These are stories about illness, divorce, murder, trauma, and other disruptive life events. Grief and loss are universal experiences! *“Being present to the suffering of another human being can drive us to the heights of altruism, compassion, and advocacy, or sink us to the depths of cowardice, denial and fear.”*

This book was thought-stopping for me. Having spent the past year immersed in reading memoirs, I didn’t expect to be drawn into a clinical book. For me, a first “stopped” moment came with the following definition: Countertransference is the *“abbreviation for the totality of our responses to our work: emotional, cognitive, and behavioral.”* And further, countertransference is *“the totality of feelings experienced by the clinician toward the patient—whether conscious, or unconscious, whether prompted by the client’s dynamics or by issues or events in the clinician’s own life.”* No wonder grief work draws on all our resources, even our very souls!

Reading through the wide variety of chapters/topics, I found myself stopping to re-think my own cases, my own responses and to ponder some of the big questions. How do the folks who deal with grief and loss take care

of themselves—the doctors, nurses, therapists, first responders, clergy, volunteers. This question is answered many times in many ways throughout the book. *“Awareness of countertransference responses holds enormous potential.”* Personally, as a clinician in a solo practice, I rely on my trusted group of colleagues, my consultation group. We six experienced therapists meet regularly to discuss the “hard” cases and our responses to this work. After reading this book, I feel comfortable acknowledging that what we deal with is often countertransference issues!

Each of the 18 chapters in this rich volume presents a unique issue which is dealt with through case examples carefully interwoven with helpful text. Whether the topic is suffering, spirituality, assisted suicide, ethics, or parallel process, one is drawn in, challenged, supported and finally, informed. I found the ethics discussion a good example, *“Our responsibility is to remain conscious of all the forces that determine our actions. If we are not conscious of our beliefs and judgments that give rise to our countertransference, we will unknowingly make or participate in decisions influenced by these biases, often harming our patients and ourselves.”* We are not judged here, only reminded to be fully self-aware.

Part III opens us to “Specific Populations and Settings.” I was not expecting to find a piece in every chapter, every setting, to which I was able to resonate either via my countertransference or via client stories. For example; the chapter dealing with the Holocaust spoke in many ways to survivors of murder with whom I have worked and, also, could be applied to the survivors of the 35W Bridge disas-

ter: *“Their profound sense of isolation, loneliness and alienation...exacerbated their mistrust of humanity...”*

Part IV humbly presents Personal-Professional Reflections. The three narratives are rich in human detail; memoirs of experiences which now inform all the work done by these three clinicians. The reader “gets” countertransference ever more deeply here.

The final chapters in Part V, Implications for Practice: Models to Address Countertransference in End-of-Life Care, offer hands on tools to assist any helper with the difficult scenarios presented at the end of life. I have, for example, done several “Advance Directives” with clients and have completed my own. I have never tried, however, to broach the subject with a person who is close to death. This is vital material to help a clinician master the awkward aspects of opening such a conversation.

“The Journey Inside,” the final chapter, helps us examine our countertransference once again. There are very important tables to follow through which one can check him/herself, can understand the phenomenon and can determine whether or when he/she should seek therapy or consultations because, “awareness of countertransference holds enormous potential.” “The object is not to eliminate countertransference, but to follow and understand it—so that we can more deeply know our patients, without acting out our own issues”.

I believe you can expect an exciting, stimulating, thought-provoking day on May 15, 2009 at the Spring MCDES conference.