

The Silent Dimension: Speaking of Spirituality in Addictions Treatment

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Abstract

Professionally trained addictions clinicians are often required to discuss uncomfortable subjects such as abuse, trauma, sexuality and finances during their course of treatment. However, ambivalence about discussing spirituality in the therapeutic relationship (Canda et al., 2004; Frame, 2003; Humphreys & Gifford, 2006; Kriegelstein, 2006; Rice & McAuliffe, 2009; Sheridan, 2009) confirms Miller's (1999) original labeling of spirituality as "the silent dimension" of the social science of addictions. Despite the ambivalence, since the 1990s interest in the clinical impact of spiritual interventions has increased (Sherr et al., 2009). Research on attitudes and behaviors of clinicians has appeared in the literature, along with debate about the benefits, harms and appropriateness of a variety of spiritual interventions (Canda & Fuhrman, 1999; Gilligan & Furness, 2006; Hodge, 2011; Rice & McAuliffe, 2009). Consensus has emerged, however, on the need for an ethical model that will provide context-sensitive but systematic guidelines for ethical practice when incorporating spirituality into treatment (Canda, 2004; Rice & McAuliffe, 2009; Sheridan, 2009). In this paper, using client narratives, we outline why it is important and ethi-

cally appropriate to address clients, notwithstanding the inherent challenges. We identify several ethical dangers in discussing spirituality in the context of addictions treatment and evaluate competing ethical models for managing these dangers and integrating spirituality ethically into professional practice.

Keywords: spirituality, ethics, addictions, treatment, empowerment

1. Why the Ambivalence?

There are several reasons why discussing spirituality with clients is uncomfortable for clinicians. First, in many countries, addiction treatment has been historically divided into two, often disconnected, camps. One camp is comprised of both 12-step groups (populated by those who have experienced addictions) and faith-based substance abuse treatment programs. In the 12-step tradition, addiction is seen as, in part, a spiritual disease (McGrady et al., 2002) and discussion of spirituality is integrated into the recovery process, within the confines of the program. Faith-based treatment programs are, by definition, focused on the spiritual dimension of recovery (Lyons et al., 2011).

The other camp is secular in nature. It comprises professionally trained clinicians offering evidence-based treatments such as Cognitive-Behavioral Therapy (Emmelkamp & Vedel, 2006) and Motivational Interviewing (Lewis et al., 2011; Miller & Rollnick, 2002). These approaches emphasize theoretical testability and do not routinely include a spiritual component (Galanter, 2008; Hodge, 2011; Krieglstein, 2006). One of the consequences of this bifurcation is that secular clinicians may simply refer clients who have spiritual needs to the 12-step community, faith-based treatment or other designated pastoral care providers. As we will show, this is an insufficient response.

The second reason clinicians are ambivalent about discussing spirituality is lack of training (Canda et al., 2004; Frame 2003; Gilligan & Furness, 2006; Hodge, 2011; Morgan et al, 2008; Sheridan, 2009). Humphreys and Gifford (2006) have noted that addiction training programs either do not discuss spirituality or give it only a cursory overview. Social work training is also impoverished despite the leadership demonstrated by the Council on Social Work Education (2008) in its call to include religion in social work education (Furman et al., 2004; Rothman, 2009; Sheridan, 2009). Lack of training leaves clinicians at a disadvantage in understanding their clients' spiritual beliefs or helping them cope with their spiritual struggles without harming or proselytizing them (Canda et al., 2004; Frame, 2003; Hodge, 2011; Krieglstein, 2006; Kuczewski, 2007; Sheridan, 2009).

The third reason why spirituality remains in the shadows is because secular addiction treatment services are often a public service, subject to secular norms and accountability. By contrast, spiritual matters have been considered a private affair, best left to the realm of pastoral care (Guss Jr., 2011; Morgan et al., 2008; Muldoon & King, 1995). Additionally, as social work sought the recognition of its professional status in the 20th century, it distanced itself from its moralistic religious roots (Krieglstein, 2006). Therefore the inclusion of a spiritual focus in treatment now may feel uncomfortable for some. Unless spiritual interventions are clearly

therapeutically indicated and consented to by clients in the United States, they could be interpreted as violating the separation of church and state (Frame, 2003). The assumptions inherent in the public-private distinction are contestable; however without an explicit ethical model articulating the therapeutic imperative and offering guidelines that would correct for inappropriate boundary crossing, clinicians are constrained.

In sum, we identify three reasons why spirituality is a silent dimension in addiction treatment: it is overlooked in evidence-based approaches to treatment, it requires knowledge and training secular-based clinicians lack, and it appears to risk violating the religious neutrality embraced both by secular theoretical and liberal political orientations.

2. What Is Spirituality and Why Is It Relevant to Addiction Treatment?

"Spirituality" as a concept is broader than "religion." For the purpose of this paper, we understand religion to be "an organized, concrete form and expression of a *particular* spirituality experienced and practiced in a particular community of faith with specific scriptures, rituals and traditions" (Guss Jr., 2011). It is important to recognize "spirituality" encompasses phenomena that are not captured in the definition of religion. For clinical purposes, therefore, focusing on spirituality is more inclusive.

In the academic literature, there are varying definitions of "spirituality," with convergence on some fundamentals. Most definitions emphasize the meaning of life, the integration of ultimate values, and connectedness with the transcendent. The transcendent is viewed variously as the natural world, God, the divine, or the community; Notwithstanding the variation in the "sources" or "objects" of transcendent value, seeking meaning through connectedness to ultimate values is part of the human condition.

A novel account of spirituality offered by Rolheiser (1999) helpfully expands on the cognitive/relational account offered above by introducing the further element of eroticism into our

understanding. According to Rolheiser, as humans, we all have divinely-given powerful energies flowing through us, and spirituality (healthy or not) is about how these energies are directed. The addition of the erotic dimension is illuminating because it highlights how clients themselves often experience their addictions. Clients with substance use or gambling problems frequently refer to their urges as “uncontrollable impulses”, or even a “kind of madness.” This is erotic energy gone awry; a thrust in a direction that puts them at odds with their ultimate values or compromises their attempts at integration and meaning-making (Gedge & Querney, 2012).

The erotic energies of others may be implicated in addictions too. Clients struggling with childhood sexual abuse, violence, or parental substance abuse are coping with the effects of the misdirected erotic energies of others. Our working understanding of spirituality, therefore, presupposes that the appropriate direction of erotic energies is a key component of spiritual health, and is importantly linked to the spiritual goals of finding meaning, integration and connectedness to the transcendent. When the erotic is misdirected, as in the case of addictions, there is a risk of spiritual crisis.

Based on the above, we take spirituality to encompass cognitive/relational and affective/erotic dimensions. The cognitive/relational orients the person towards that which they value. The affective/erotic is the driving force facilitating spiritual connection. However, that drive may be misdirected, as in the case of addictions.

3. Why Breaking the Silence Matters

Despite the discomfort around spirituality, conversations about spiritual issues are important for client recovery. Consider the following anonymized client narratives:

3.1. Disconnection From the Transcendent (Abandonment)

Alice, former treasurer at her church, attended treatment because she had stolen money from the treasury to fund her gambling addiction.

Though Alice had confessed to her community, paid the money back and received their forgiveness, she was still troubled. Alice is devout and had taken great comfort in hearing God’s voice when she prayed. However, despite being forgiven by the church, she could no longer hear God. As a self-ascribed penance, Alice worked tirelessly at the church. But nothing changed, and she became suicidal and at-risk for relapse.

3.2. The Meaning of Life and Healing the Outcome of Misdirected Erotic Energy

Claire came to treatment for her alcohol and gambling addictions. As a child, she was sexually abused by strangers, and emotionally neglected by her parents, who also had substance use problems. Through treatment, Claire had been able to reach her goal of abstinence, but could not reconcile a loving God with her suffering.

3.3. Disconnection From the Transcendent (Allah and the Community)

Hakim’s gambling was considered sinful by his Muslim community. He told his clinician that he is “not religious”. Hakim believed that his gambling was so engrained that it was literally in his blood – an inescapable biological reality. He dared not speak to his community about his problem for fear of ostracism. His wife wished for him to atone for his sins by quitting gambling, but this felt impossible to him. His clinician wondered whether Hakim’s declaration of atheism and his alienation from the community was a defense against unbearable shame.

Clients do need to, and often want to, articulate their spiritual struggles (Frame, 2003; Hodge, 2005); this being the first reason for integrating spirituality into addictions treatment. Although referral to a spiritual advisor may be warranted or preferable, this can be problematic if the client has no religious affiliation, has been alienated or has withdrawn from his or her spiritual community, or had a traumatic or dysfunctional religious past. When dealing with addictions, such circumstances are often the case. Nevertheless, a spiritual crisis may be at the heart

of the client's condition, and a skilled and ethical response is required.

The second reason is a *holistic* approach to addiction treatment is effective (Hepworth et al., 2010). Holistic treatment is not only about the addiction itself or one's activities of daily living, but also addresses the psychological, emotional, physical and social aspects of the individual. A completely holistic approach should also include the spiritual. Clients must create and sustain an integrated life if they hope to maintain their goals. Successful relapse prevention is associated with learning how to resist the 'quick fix' of substance use or gambling when confronted with difficult situations or emotions. Following Rolheiser (1999), we argue clinicians must help clients to stay in their angst (their urges, cravings, intense emotions) long enough to allow the painful tensions to be resolved, and for transformative integration to take place. The recent emergence of mindfulness-based therapy (McMain et al., 2007) which helps clients "stay in the moment" reflects a growing awareness of the breadth of holistic care, and an implicit acknowledgment of the role of spirituality in that care.

The third reason for integrating spirituality into addictions treatment is that there is already an implicit mandate to do so. If holistic treatment is most effective and if spirituality is an important dimension of the whole human being, then integrating it into addictions treatment is mandated by the commitment to offer the "total care that could be possible" (Morgan et al., 2008). The holistic approach best expresses the values and practices of many addiction clinicians, and the same rationale that supports holistic treatment will support an expansion to include spirituality (Smith, 1998). In addition, several national bodies implicitly legitimize the need to incorporate the spiritual dimension into addictions treatment, including: the Canadian Association of Social Workers (CASW), the National Association of Social Workers (NASW), the Australian Association of Social Workers (AASW) and the Canadian Centre on Substance Abuse (CCSA). The CASW, with its emphasis on anti-oppressive practices and client self-determination, requires social workers

to serve clients without discrimination – including religious discrimination (Morgan et al., 2008). It recognizes spirituality as an important part of an individual's identity, and, by implication, falls within the domain of care. In the same vein, the NASW requires its members to achieve cultural competence through education and seeking to understand diversity, including spiritual diversity (NASW, 2001). The AASW highlights the need to recognize and honor the religious and spiritual worldviews of clients. The CCSA, which developed a set of Canadian behavioral and technical competencies for all addiction clinicians, states at the intermediate level clinicians should possess "considerable knowledge and understanding" of spiritual issues that affect diverse populations. An increasing awareness of the relevance of spirituality to treatment is therefore emerging in the official statements of many regulatory bodies.

4. Breaking the Silence Ethically

How can spirituality be incorporated into addictions treatment ethically? As noted earlier, clinicians worry that due to inexperience and lack of training they could harm clients in the attempt to offer spiritual guidance. The obvious response to this concern is to integrate appropriate training into clinicians' professional development (Morgan et al., 2008). Our first recommendation, then, is that social work education and professional development must incorporate comparative religion and spirituality into professional training. Hodge (2011) notes courses, professional conferences, and scholarly journals provide opportunities for this purpose, though on an elective basis. A more systematic and routinized approach is required.

A more complex worry is over proselytizing, as previously stated. This worry is both political and clinical. Politically, the right to develop and hold one's own spiritual beliefs is a key pillar of liberal politics and gives rise to the objection that public representatives should exert no pressure on individuals regarding spiritual matters. Clinically, because of the power asymmetry within the therapeutic relationship, there is a risk that clinicians may exert an inappropriate influence on

clients articulating or questioning their spiritual beliefs. It is important on both grounds to ensure a best practice is developed around integrating spirituality into addiction treatment so as to protect the independence of the clients' beliefs.

Ethicists and clinicians are divided about how to address this issue. Both share a concern about harm to clients and undue influence over clients' belief systems. As cited in Sheridan (2011), some would advocate for a rigid separation of the 'private' area of spirituality as a response. The problem with that response though, as we have seen, is it violates the mandate to provide the best possible care. Furthermore, studies show spiritual interventions are indeed taking place and are viewed as important for client health, notwithstanding the absence of clear and consistent ethical direction (Canda et al., 2004; Frame, 2003; Rice & McAuliffe, 2009; Sheridan, 2009). Therefore, professional bodies must develop and integrate guidelines for discussing spirituality and incorporate them into an ethical model.

Following the work of Canda (1990), a number of authors have proposed ethical guidelines for spiritual interventions. Proposed guidelines emphasize prioritizing the care of clients, starting where the client is, aligning interventions with client interests and goals, and protecting clients' dignity and self-determination. Some authors (Frame, 2003; Sherr et al., 2009) explicitly note the importance of being aware of the operation of power within the therapeutic relationship, clarifying roles and setting boundaries, and all emphasize the importance of professional competence. However, as Canda & Furman (1999) state, an ethical model that is context-sensitive yet systematic is still lacking.

A central issue in developing such a model is how power circulates in the therapeutic relationship to promote or to inhibit client wellbeing and self-determination, and to assign responsibility. Here three possible ethical models offer different insights. According to the client-centered model (Cohen et al., 2007), discussion of spirituality can be appropriate and safe as long as only the client's beliefs are engaged. In the client-centered model

the role of the clinician is that of active listener and intelligent respondent. The clinician should engage the client on spiritual issues, if welcomed, and may even request a "spiritual history" (Hodge, 2005). Client-centered clinicians should see their role as that of helping the client to identify her/his ultimate values. If further discussion is therapeutically indicated, the clinician could translate spiritual values into religiously neutral language. Thus, for instance, the religious doctrines of creation can be understood as existing in relation to other humans; sin can be understood as the breakdown of relations and salvation as reconciliation (Guss Jr., 2011). Using such neutral language, clinicians may then proceed to suggest strategies of adaptation or healing, without explicit discussion of religious or spiritual beliefs, and importantly, without disclosing anything about their own spirituality.

Determining to what degree clinicians should disclose their own spiritual beliefs is central to finding an adequate ethical model. Studies show clinicians are often motivated to engage in spiritual discussion or intervention because of their own spiritual beliefs (Sheridan, 2011). An important question will be whether the client-centered model is right to prohibit clinician self-disclosure, and whether client wellbeing and self-determination are compatible with a mutual sharing of personal beliefs and perspectives. In a more liberal spirit, a second model, the transparency model, has been suggested. According to the transparency model, it may sometimes be appropriate for clinicians to engage in a mutual interchange of spiritual beliefs with their clients in contrast to the client-centered model. (Kuczewski, 2007). Although the client-centered model would see this as a boundary violation, the transparency model argues holding oneself apart when discussing momentous issues creates an unhelpful distance from a client and forfeits a therapeutic opportunity as well as a chance to affirm our shared humanity. For instance, a Catholic clinician might talk to Alice about how the clinician himself had experienced God's forgiveness of sin through the sacrament of penance. In such an interaction the priority is still the dilemma of the client; but the clinician

is neither pretending to be spiritually neutral, nor is he disclosing for the sake of being heard. The therapeutic imperative is guiding the discussion, and importantly, the substance of the discussion is the client's spiritual crisis as she understands it.

There is much to commend both models, but each has its own particular shortcomings and naivetés. With the client-centered model, the risk of explicit proselytizing is low; however, it still exists and perhaps is all the more threatening to client self-determination for its overt prohibition. All therapeutic interactions are value-laden (Hodge, 2011), whether this is acknowledged or not, so it is naive to think that prohibiting counselor self-disclosure removes the danger of undue influence over clients' spiritual beliefs. In addition, the distance and spiritual neutrality between client and clinician that is advocated by the client-centered model is therapeutically limiting. The distance and neutrality do not necessarily protect the client from clinician incompetence, since sensitivity and judgment are required in the translation of spiritual or religious beliefs into neutral language, and the neutral language itself may be unsatisfactory as a pathway into the heart of the client's problem.

The transparency model is appealing because it acknowledges the shared humanity of the client and clinician, and because it can allow for richer therapeutic discussion. However, even if a clinician discloses her/his spiritual beliefs and values, as might be permitted under this model, a power asymmetry still exists and may influence client self-determination negatively. Critics point out that a clinician, as a professional, may be inappropriately viewed as a spiritual authority, or that the client may confuse the roles of clinician and companion-traveler (Cohen, 2007; Hodge, 2011). In disclosing her personal stories or beliefs, the clinician thereby risks compromising the client's autonomous moral or spiritual development, especially if, for lack of self-scrutiny or spiritual health, the clinician's disclosure is self-indulgent (Kuczewski, 2007; Skinner & Paterson, 2004).

Recognizing there is no such thing as a value-free intervention, some authors (Frame,

2003; Hodge, 2011) consider the desirability of prescribing a pre-emptive self-disclosure of clinician values, assumptions and beliefs as part of the informed consent process prior to the start of the treatment process. At this point clients could decline further engagement about spirituality, or client or clinician could recommend a change in who provides treatment. However, such pre-emptive self-disclosure seems forced – it may be therapeutically premature, and/or may preclude or disrupt the development of the trusting relationship in which spiritual issues most helpfully emerge. Rather than prescribing the timing and nature of a process to ensure clients' beliefs are protected, a context-sensitive ethical model will rely heavily on clinical judgment about the helpfulness, the timing, and the scope of self-disclosure. Thus, having a prescriptive informed consent procedure is no substitute for clinical judgment about spiritual self-disclosure. Nonetheless, the operation of power within the therapeutic relationship must be acknowledged and addressed.

How might the advantages of transparency be incorporated into an ethical model that provides context-sensitive yet systematic direction? We advocate an empowerment model. The empowerment model integrates the benefits of transparency, but highlights the operation of power in the therapeutic relationship. First, cultivating a robust awareness of the naiveté of the "myth of equals" in this context, a clinician must neither "deny nor avoid the power of his or her position, but see how it affects the helping process" (Skinner & Paterson, 2004, pg. 81). The appropriateness of spiritual disclosure by a clinician must always be judged in light of both its relevance to the helping process and the degree to which the power asymmetries advance rather than limit client recovery. This is where the context sensitivity called for by Canda (1990) and others is vital.

The link between context and empowerment is frequently made in the literature on the ethics of care, whose norms are helpful in the treatment context (Held, 1993 and 2006; Noddings, 2010). A central focus of care ethics is to

identify ethical norms arising in relationships of unequal power, such as relations between parents and children, teachers and students, clinicians and clients. Because each relationship is in some way unique, care ethics accepts ethical conduct must be a response to particulars about the relationship and its stakeholders, must, in fact, be context-sensitive. However, care ethics is not simply relativistic; it proposes norms that are applicable to all relationships and analyzes the fruits and risks of asymmetries of power. Caring relationships requires of the caregiver to give receptive attention to the circumstance and expressed needs of the cared-for, as well as have a motivational displacement such that responding to the needs of the cared-for takes precedence. In a caring relationship cultivating these dispositions is normative, and the norms provide a standard by which to judge the quality of care. Unlike the ethical principles of non-maleficence, beneficence, autonomy, and justice arising out of traditional ethical theory, the norms offered in care ethics build in context sensitivity since it would be impossible to succeed as a good caregiver without being sensitive to and motivated by the particular needs of the person cared-for.

Along with providing norms for caregiving, care ethics revises the concept of power as it applies to relationships of care, such as that between clinician and client. Meeting the needs of a vulnerable other, particularly if that vulnerable other is an autonomous person, is not a matter of wielding power or neutralizing asymmetries so as to become equals. Equal moral worth is assumed. Rather, the caregiver seeks to empower the cared-for in order to achieve the goals of the caregiving relationship. As has been shown, achieving the goal of empowerment may call for a spiritual intervention, and in the context-sensitive judgment of a clinician it may call for the clinician to disclose his or her spiritual beliefs, history or practices. Employing the norms of care ethics should give clinicians confidence such a practice can be ethical.

In the empowerment model, ethical responsibility for the appropriateness of spiritual self-disclosure is not carried by clinicians alone.

The client-clinician interaction is nested within a context of overlapping power relationships. According to Skinner and Paterson (2004), the ethical space in which treatment takes place is co-constructed by a diverse group of parties including clients, clinicians, agencies and professional bodies - each having rights and responsibilities. In that complex space, it is vital to recognize the many ways in which power circulates as support or hindrance to the ethical judgment of clinicians as they aim to empower clients. Clients are supplicants to clinicians, who have the power of knowledge and authority; but as employees, clinicians themselves are subject to the authority of agencies. Agencies are accountable to the communities they serve and both agencies and clinicians must conform to the professional and ethical requirements of professional bodies. There are multiple relationships of power and dependence, of responsibility and entitlement impacting the one-on-one interaction between clinician and client. Although, as we argue, clinical judgment is irreplaceable in determining whether and when a spiritual intervention is appropriate and likely to be helpful, the empowerment model maintains that the clinician shares with others the burden of responsibility for sound judgment. In its recognition of ethical complexity and shared responsibility for empowerment, the empowerment model is an advance on both the client-centered and the transparency models.

According to the empowerment model, what are the specific ethical responsibilities of agencies and professional bodies in supporting sound ethical judgment on matters of counselor spiritual intervention? First, because it recognizes the complex ethical space inhabited by clinicians and clients, the empowerment model demands agencies and professional bodies use their power to provide ongoing education to support ethical conduct. For instance, clinicians may encounter clients whose addiction stems partly from abuse in religious institutions (e.g., Canadian aboriginals in residential schools) and need to know how these scandals are being viewed and dealt with outside their own practice. Such knowledge may help

them understand how their clients' suffering has been shaped, and may limit or enhance treatment options. Regular education sessions with expert speakers or consultants, and comprehensive, accessible, and current resources on spirituality should be provided.

Second, treatment agencies must provide routinized peer/supervisor debriefing and incentives for clinicians to discuss cases touching on spiritual issues. A few authors, including Canda et al. (2004) and Frame (2003) recognize the importance of dialogue with colleagues, seeking consultation and supervision. Clinicians should be invited in a non-punitive atmosphere to share their fears and failures. As Skinner and Paterson (2004) note, cultivating sound ethical behavior in an organization requires "clear policies, guidelines and shifts in practice to encourage and support disclosure?" (p. 78).

Third, and perhaps most importantly, clinicians must be supported in learning and maintaining habits of spiritual self-scrutiny and self-care. Clinicians must strive for spiritual health themselves so as to avoid narcissistic or needy disclosures with clients to reduce the risk to themselves of witnessing client spiritual crisis, and to remain faithful to the primary mandate of client empowerment (Canda and Furman, 1999; Frame, 2003; Krieglstein, 2006; Rice & McAuliffe, 2009; Skinner and Paterson, 2004). Agencies share responsibility for encouraging clinicians to monitor themselves regularly for residual biases and to accept there are limits to their own expertise (Hodge, 2011; Kuczewski, 2007; Morgan et al., 2008). Agencies must offer resources for clinicians' professional and spiritual self-care, and provide incentives for accessing them. Agencies' expectation that clinicians will practice spiritual self-care can be implemented, for instance, in scheduling time with a support group or a spiritual director. Agencies or professional bodies can offer manuals with suggestions for regular self-care, such as those offered by Skinner and Paterson in the context of encouraging ethical practice. The authors suggest that clinicians assess their own ethical 'health' by asking themselves such questions as: Am I

reluctant to pursue consultation? What are my reasons for urging the client to confront or address this issue? Am I just trying to exercise control, or can my power/authority be used to good effect for the client? Would I include details of this conversation in the client record? In a peer group? To my supervisor? If not, why not? This self-assessment template recognizes the operation of power, and can inform a best practice of discussing spirituality. It acknowledges the possibility that spiritual disclosure could empower clients, yet recognizes that disclosure could be wrongly motivated or unhelpful. It emphasizes the importance of transparency to peers, the dangers of secrecy, and the possibility of clinician self-deception. Thus, it highlights the fact that sustainable ethical behavior on the part of clinicians is a function of the structure and ethical ethos of organizations, as well as the individuals themselves (Skinner & Paterson, 2004). To the extent that organizations incorporate resources and supports for enhanced spiritual knowledge and clinician self-care, their openness to fully holistic care will translate into superior clinical interventions.

5. Applying the Empowerment Model to the Cases

5.1. Alice

Alice attended treatment for two years. During this time, she spoke of wanting to die because she felt so abandoned by God. The clinician, who was also a Christian, tried many evidence-based strategies to help Alice stay alive while in this angst, hoping for transformation and healing. He also engaged Alice several times in spiritual discussions in which he shared his own religious experience and conviction that God was willing to forgive her. However, these attempts did not appear to help. Privately, feeling at a loss and wounded by the rejection of his assertions, the clinician prayed for God to make His presence known to Alice. As the months went on and she remained in despair, the clinician began to question his own faith and felt angry with God for not intervening in a situation that was clearly desperate.

In this case, the empowerment model could assist the clinician in several ways. First, he would engage in spiritual self-care to mitigate the effect of Alice's angst on his own spirituality. Second, the clinician would have the routinized support of his employer and peers for problem-solving, stress relief and clinical brainstorming. Third, through training, the clinician would know there is therapeutic value in Alice remaining in her spiritual angst (namely, so that transformation could take place), that her despair was not pointless, and by exercising the norms of attentive listening and motivational displacement he would be confident his clinical judgment about self-disclosure was well-founded. This may decrease his anxiety and help him stay hopeful. The empowerment model, however, would recommend that he seek Alice's consent before praying for her (Frame, 2003).

5.2. Claire

Claire attended treatment for four years. During the first three years, her treatment consisted of evidence-based strategies for relapse prevention and trauma – spirituality was not a focus. In her fourth year of treatment, however, Claire decided that she wanted to examine the impact on her spirituality of the trauma and the addictions. She started attending a church and began to consider how her faith as a child was something that helped her to survive the abuse. This meant Claire's treatment sessions became distinctly more spiritual in focus. The clinician, however, felt limited in her ability to assist Claire in her spiritual healing.

With her clinician's encouragement, Claire began a three-month course of spiritual healing at her Church. The Church asked for the clinician's approval of the content (that is, the clinician endorsed Claire's readiness for the depth of work that was involved) and the clinician was given a copy of the materials discussed.

In this case, under the empowerment model, the clinician exercised spiritual self-scrutiny, acknowledged the importance of the client's spiritual seeking, but recognized her own limitations honestly. She welcomed the engagement of peers – this time experts outside

the agency. In the sharing of materials there was an opportunity for expanded education in cultural and religious practices, as well as a sharing of responsibility for Claire's recovery. Rather than accepting the dichotomy between faith-based and secular recovery approaches, the agency saw the value of diverse perspectives and supported the clinician's judgment.

5.3. Hakim

Hakim's clinician, an atheist, knew that the Islamic faith sees gambling as a sin from which Muslims are expected to abstain. However, lacking any further insight into Islam, she felt hesitant to explore with Hakim why he says he is not religious and what happens in the Muslim community when a member cannot adhere to their rules for living. The clinician attempted to help Hakim by recommending that he seek urge management medication from his family doctor to solve his "biological problem." This, however, was unsuccessful. Hakim still faced two issues: alienation from his community and potential alienation from the faith in which he grew up.

Under the empowerment model, the clinician would be encouraged to do three things: ask her employer for expert resources on Islam and Islamic communities so as to offer Hakim informed support; use supervision/peer support to consider how to ethically probe around the spiritual issues with Hakim and engage in spiritual self-scrutiny to ensure that her atheism was not compromising Hakim's treatment.

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