

## SPIRITUALITY IN FAITH

*As a young social worker in the 1970s, I worked with seriously-ill patients in a hospital setting. I discovered that my religious values and beliefs, "my Jesus thing," opened many avenues of discovery and service. This article recounts some stories of the connections between my spiritual perspective and the relationships and activities with patients.*

by Sarah Sloan Kreutziger

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Sarah Sloan Kreutziger, DSW, ACSW, is Assistant Professor and Director of Continuing Education, School of Social Work Tulane University, New Orleans, LA

Bob was a physician in the state-run university hospital in north central Florida that employed us both during the decade of the 1970's. He asked if his wife Sherry could interview me about a psychology project she was doing on religion in the work place. I was flattered since Bob and I often kidded each other about our respective religious beliefs. On more than one occasion, he told me that I would make a good member of his non-trinitarian denomination if I could just give up "that Jesus thing." I agreed that he was probably right and also agreed with Sherry's request to look at how I used my religious faith in my medical social work practice.

Sherry was a bright and energetic researcher. I answered general questions about my religious background and training. We were doing well, I thought, until I innocently told Sherry that, while I did not actually pray with my clients, there were times when I said silent prayers before and after the sessions, as well as when we seemed to be "stuck." I mentioned a recent case where a woman had dragged her very reluctant husband in for counseling for a rapidly failing marriage because of his new relationship with another woman. He was adamant that

he wanted out of the marital relationship as soon as possible. I admitted that even I was surprised that after I said a silent prayer for guidance, he suddenly made a 180 degree shift and agreed to further counseling. Sherry had no trouble understanding my implication that God had heard my plea for help.

But Sherry was not impressed with my magical thinking. Her facial expression and negative tone of voice reinforced her barely concealed disdain as she grilled me relentlessly until I shrank under her reprobation. I began to feel somewhat desperate and told her about research at Duke Medical Center by Dr. William Wilson (Wilson and Jones, 1978), a psychiatrist, on the efficacy of prayer with psychotherapy patients — all to no avail. In her mind's eye, it seemed, I had eliminated myself from all claims of professionalism by exemplifying the stereotypical version of an evangelical religionist: hopelessly irrational, unredeemed even by my liberal-humanist training. To her, I seemed to be a "True Believer" (Hoffer, 1951) in the sense of fanaticism, doing god-knows-what damage to my helpless clients.

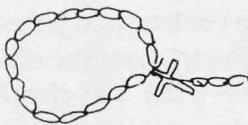
In at least one respect, Sherry had assessed me correctly.

### Author's Note

I am grateful to Dr. Suzanne England for her many kind comments and helpful suggestions in the incipient and final versions of this paper.

I am a "heart" more than a "head" person. I am a member of the United Methodist Church, a religious tradition which has historically been known for its "people of the warmed heart." Like Hillary Rodham Clinton (Woodward, 1994, p. 23), my faith was honed on the legacy of the Social Gospel, or what John Wesley had earlier called, "practical divinity." This is the call to act on behalf of others in response to God's unrelenting love and action in our own lives. I couldn't explain this to Sherry because her own sense of professionalism appeared to be wedded to an empirically-based agnosticism that precluded openness to even gentle metaphysical intervention in therapeutic practice. Nor could I explain this to her husband because it is all connected in my soul with "that Jesus thing."

I had tried for a while to

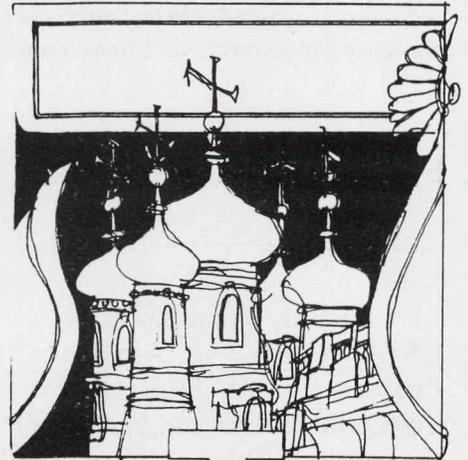


ignore "my Jesus thing." I went into social work because it allowed me "to save the world" as a secular missionary during a long period in early adulthood as I rotated among cycles of agnosticism / atheism / agnosticism. As a young student, I had eagerly embraced the new god, Freud. I embraced the methodism of psychoanalytic

theory as the newer way to human perfection. I believed his prediction in "The Future of an Illusion," i. e., that religion would disappear as humankind relinquishes this harmful illusion in favor of progressive scientific knowledge (Freud, 1961). I worked diligently as my professors urged me to remove all traces of my middle-class morality and to become value-neutral in the fight to save humankind by objective and scientific methods. I spent time in confession with my supervisor repenting of careless remarks to clients that betrayed my misguided beginnings in the morality of my childhood. She duly recorded my misdoings in my evaluations, which served as a kind of absolution by humiliation. And I dutifully filtered my thoughts and words to reflect these new doctrines.

To this day, I'm not sure when my belief in this newfound knowledge began to falter and become hopelessly entangled with my older religious beliefs. I suspect that it occurred when I had children. Having children made it more important for me to forge connections between my past and future. Probably a large part of it occurred, however, because I was a lousy atheist in one significant way: I couldn't quit going to church. Despite my best efforts to disengage, I still loved the feel of church: the rituals, the symbolism, the music, the people, the fellowship, the shared values, "the going onto perfection." In short, I loved the connection with the community, the symphony of good people doing

good works. There the *Hound of Heaven* (Thompson, 1986) found me and howled until its peace made a place within my soul.



This positive connection to church became reinforced in my work. As a beginning social worker, I found myself relieved, for example, when I discovered that my dialysis patients were heavily involved in their churches, especially those patients from rural communities. I knew from experience that support systems would likely be formed to feed the family, to comfort them, and in many cases, to work to raise money for the 20% costs of treatment not covered under Medicare. One of my first cases involved such a person. Dean, an unmarried, white, 19 year old, was the first person in his very supportive family to graduate from high school. His father was a hard working, barely literate farmer who tried diligently to understand his son's medical condition even if he could not understand the psychological pain of being an adolescent hooked three times a week to a dialysis machine. He brought his son regularly and

never gave up hope that somehow Dean would recover and realize his potential.

Unfortunately, the attending doctor had not seen Dean's potential in quite the same way. In fact, Dean was deemed mentally disabled and therefore (this was the early 1970's) unfit for the limited resources of our unit. Because, however, the small community, under the leadership of a determined lay woman from their Pentecostal church, had so rallied around the family with almost monthly fund-raisers and corresponding publicity, I could make the claim that the family had the financial resources and emotional support to go on dialysis. A hospital committee agreed; thus the young man was treated for two years until his death after a failed transplant from an older sister. This interval gave the other medical personnel time to know and care for this family as much as I did.

My recognition of and comfort with the language of religious belief had also enabled me to work with the family and church community before and after Dean's death. I had already discovered that families were often reluctant to talk with professionals about spiritual matters because of their astuteness regarding the invisible barriers signaled by professionals uncomfortable with this area. As a result, I had tried to become an open and friendly oasis in an unexpected place by being sensitive to the signs of subtle forays into this forbidden zone. I found that simple affirmation, merely a

positive nod in agreement with religious claims, created an atmosphere conducive to exploring the benefits of a religious ideology that builds on the strength of positive belief.

Over and over again, I discovered that the patients were openly relieved to find someone to share their very real fears and the existential questions that come in moments of personal crisis. I learned to listen with new ears to the familiar language of the heart as people reached out in hope and prayer for the miracle of healing, or at least for the miracle of understanding and acceptance. And in that familiarity, I was allowed to share the deeper levels of their experiences and to learn from their courage and strength. My clients became my teachers and I, in turn, shared their lessons with the others who would follow me.

Of course, these lessons were forced upon me time and time again. On one occasion I worked with a 32-year-old, married, African-American blacksmith named Mike whose diabetes had, over the past four years, made him blind, impotent, and disabled with the loss of one leg. Although Mike had grown up in a devout Baptist family, his desire to work while he was still able crowded out his previous church-going activities. This caused him to relegate religious concerns to the shadows of his mind. There they stayed, surfacing briefly through his other medical setbacks and emerging full blown when kidney failure forced him into a long hospitalization. He became

understandably depressed, and he and I spent many hours reminiscing about his past in preparation for an uncertain future. In a long session when we were exploring the existential questions of his fate in terms of ultimate justice and mercy, I over-stepped my bounds with a glib apologetic about God's will in relation to his predicament. I explained to Mike that although God's ways were often inscrutable, I was sure that he was not being punished for past sins as he supposed. In retrospect, I realize that in my eagerness to defend God, I had not listened to what Mike was really saying and had brushed aside a major coping mechanism: bargaining with God. In other words, in Mike's world view, if he could seek God's forgiveness, then God might lift the punishment of devastating illness, or at least lessen his suffering.

Fortunately, Mike paid no attention to me until I called in our hospital chaplain who was able to offer realistic comfort (and absolution) through the ascribed power and authority of his sacred position. From that time on, the chaplain and I worked as a team, with mutual consultation and concern about the patients who requested spiritual guidance.

Sometimes, even acceptance and openness to religious language and issues were not helpful in working with patients. Mrs. S., an elderly Jewish woman, had tested the patience of every staff member with her incessant demands, including one that all of us working with her belong to her religious

culture and tradition. When she was referred to me, she objected strenuously because I was outside her faith. However, she softened a bit when the resources I was able to secure on her behalf made her stay more comfortable. Still, she continued to complain until I told her (truthfully) that one of my ancestors *may* have been Jewish. At that moment she relaxed, told me that she suspected this all along, and worked amicably with me from that point on. Had I not had that ancestor, I suspect that she would have still worked with me, but not as quickly or as happily.

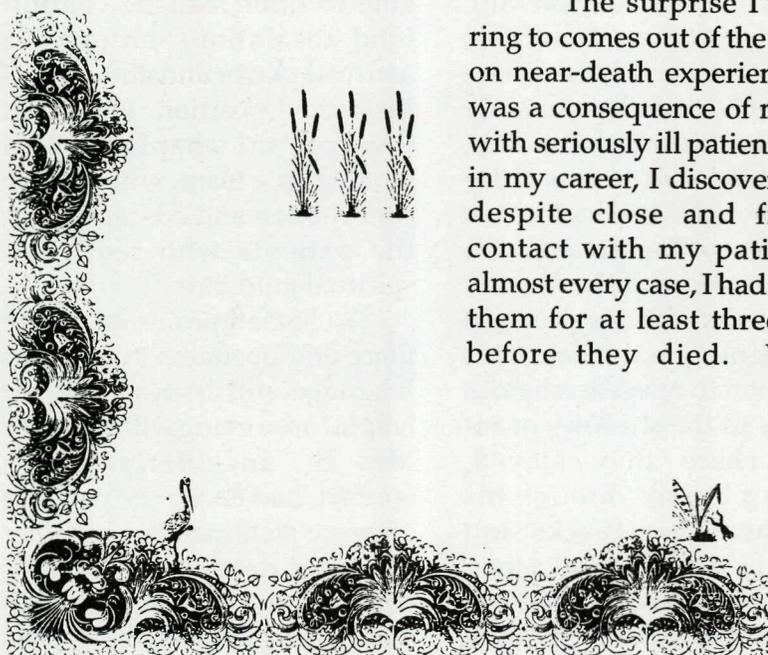
Another man, an elderly writer named Mr. G., at the end stage of a devastating form of cancer, faced his death with a proud atheistic stance despite the incessant pleas of his family to return to the comfort of their Reform Judaism. After I was able to secure his trust by respecting his decision, my work focused on

helping the family accept it as well. Because they knew that I, too, would have been happy for Mr. G. to reverse his decision, we were able to talk candidly about their disappointment and grief balanced with his right to self-determination. Since Mr. G.'s atheism was characteristic of a life-long pattern of self-mastery and control, his behavior was easier for them to accept when we discussed it in the context of Mr. G.'s strength of personality and his integrity. He could apply this strength toward dying as he had lived. In the remaining two weeks of his life, Mr. G., his wife, his two grown children, and I shifted the focus of the discussions into memories of pleasant times together and the beliefs and values that they shared in common. Mrs. G. never fully gave up hope that Mr. G. would change, but he died with his unconquerable soul intact. I prefer to believe, however, that he had a surprise waiting at death.

The surprise I'm referring to comes out of the research on near-death experiences that was a consequence of my work with seriously ill patients. Early in my career, I discovered that, despite close and frequent contact with my patients, in almost every case, I had not seen them for at least three weeks before they died. When I

realized this avoidance, I was forced to face my own fears of death. I still held tremendous guilt, for example, that I had avoided Dean as his health declined, at a time when he needed me and others the most. In an effort to deal with these fears and failures, I attended a workshop given by Dr. Elizabeth Kubler-Ross, author of several books and one of the pioneers in the Death Education Movement. Dr. Kubler-Ross mentioned research done by Dr. Raymond Moody, who at that time had not yet published his best-seller, *Life After Life* (Moody, 1976). I wrote to Dr. Moody and attended one of his workshops. With a fellow-church-member cardiologist, I began some of the very early research in that area, using some of the experiences of my patients who had quietly hidden these episodes from us until we asked (Sabom and Kreutziger, 1977).

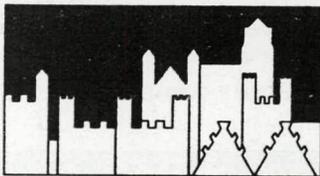
While this work did not prove that there is life after death (for me such a belief is still in the realm of faith) it did show that for many people the experience of death is a peaceful and painless experience. It also fit into my spiritual belief that a Benevolent Power ("that Jesus thing" again) would be there in the bad times as well as the good. This offered a comfort that could be shared with those nearer to death at that time than I. Since there was a tremendous amount of publicity about the study then, patients sought me out for this information, which I offered only at their request and to the extent that they were interested. To some it gave immense relief; to others it was too mysterious and



alien. But for me it offered enough peace about death to calm my fears. From that moment on, I was present with my patients until their ends, and I connected with their families for many months, sometimes years, beyond.

Of course, as the allegorical tale of Lucifer tells us, everything God-given and therefore good, has the potential for misuse and destruction. Opening ourselves up to the spiritual realm of our patients' lives also opens up the dangers this can bring and the pitfall we must watch for. I suspect that this is often the reason social welfare professionals shy away from exploring the transpersonal values of their clients/patients. Several of my cases raised important questions about the misuse of spirituality and the challenge of responding appropriately for healthy reframing and healing.

One of my continuing challenges came from patients or clients who understood enough of my religious tradition to trample upon its good intent in socially dysfunctional ways. The husband of a seriously-ill patient, for instance, enlisted my help in getting churches and other charities to donate money for his wife's care, which he really used to feed his drug habit. In another case, a recovered cardiac patient wanted my help in applying for social security benefits. In such situations, the dilemma for me was how to establish appropriate boundaries with these individuals when my religious values stressed unconditional love and service.



This dilemma actually was the easiest to resolve since Christian belief also stresses accountability for one's actions as part of our covenant with the Creator in response to all empowering grace. I believe that as temporary stewards of the creation, all of us, worker and client together, are obliged to hold all gifts, including the gift of love extended in service, in sacred trust until these gifts are returned to their Source. Speaking this truth from a stance of "tough love" was part of my vocabulary long before I read, "The worker who does not permit the client to exploit him (sic) and who scrupulously makes clear that he (sic) will not settle for the superficial has a good chance of engaging the client in an active identification process" (Zentner, 1984, p. 258). Committed religionists have long known that "cheap grace," i.e., love without cost or fixing limits (Bonhoeffer, 1963), prohibits building strong helping relationships with individuals just as it prohibits building strong societies.

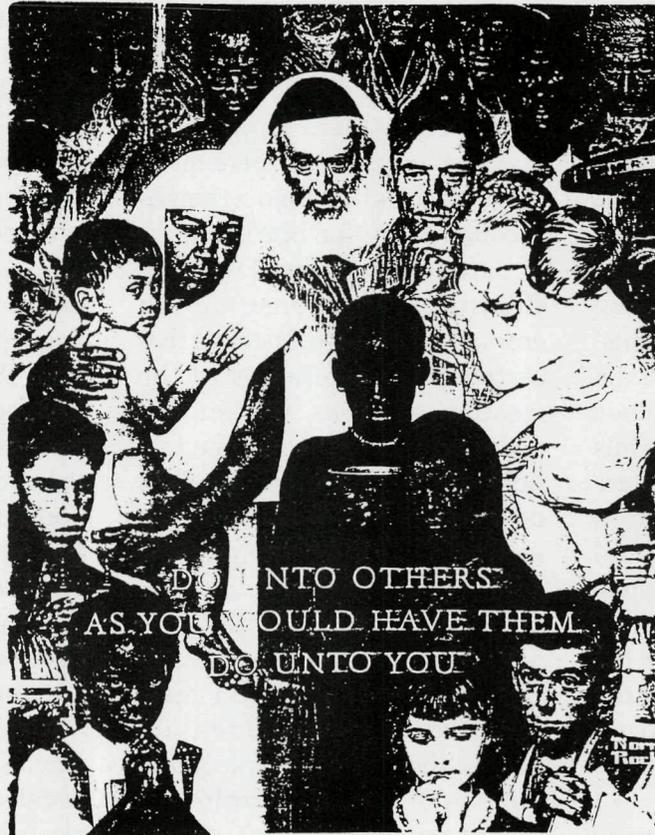
Another challenge I faced in the realm of working within the context of religious commitment arose from the dilemma of helping people to stay connected with religious supports even when they might expose clients to harm. For

example, a mentally disturbed woman, who was connected to her church's supportive network, attempted suicide after misinterpreting a sermon urging sacrifice of one's life so that others (interpreted as her ill daughter) might live. Mrs. M., a white, 39-year-old, married housewife was an active member of a small church whose theology stressed rigid accountability to biblically-based codes of behavior and adherence to reified doctrines about sin and salvation. She was close to members of her congregation. She sought the advice of her minister while she fought off physical exhaustion and depression while she took care of her 17-year-old daughter who had a debilitating illness. He and the other members of her church visited her regularly after her hospitalization for her attempted suicide. The psychiatrist and I decided to make him a part of the treatment effort since he seemed eager to help and was somewhat embarrassed about the unintended consequences of his preaching. He wanted to make sure, as did we, that Mrs. M. didn't attempt suicide again. Since Mrs. M. was far more willing to listen to him than to us, we were able to enlist his help in interpreting and reinforcing beneficial therapeutic interventions in Mrs. M.'s life by a mutual examination of the causes and dynamics of a psychotic depression. After several weeks, Mrs. M. was released after a very successful recovery. The continued follow-up and consultation between us and her minister provided

important monitoring and support for her.

Bill, a 42-year-old, white, married businessman, who was being evaluated as a potential transplant donor for his sister, presented another problem in terms of diagnosis and treatment. He spent over an hour during a very intense initial visit trying to convert me to his evangelical view of Christianity which had saved him, he said, from a life of alcoholism. After I finally told him that I was already in the fold, he relented enough to allow me to continue the interview. In my report, I interpreted his rigid traits as a warning sign of a personality that I felt was loosely integrated and held in precarious balance only by the strong, structured tenets of his religion. However, I was the single person on the medical-psychiatric team to note any concerns. Since Bill turned out to be the only eligible donor, the decision was made to go ahead with the transplant. Right before the operation, Bill had a psychotic break, making my words prophetic. My diagnostic ability had been greatly enhanced, I believe, because Bill had sensed my openness to his religious views. He did not hold them in check as he had with other interviewers, allowing me a glimpse of his character and its vulnerabilities. Fortunately, after several months of psychiatric

treatment, which he was willing to undergo in order to help his sister get well, the transplant was successfully completed.



Perhaps the greatest ethical challenge for me arises from the gap between the psycho-medical environment and possibly misguided religious beliefs. For example, I was challenged by patients or families who refuse life-saving medical care because of their religious values. As a Christian I believe in spontaneous healing and the power to control one's medical destiny in limited ways, but I also believe that healing comes through traditional medical methods as well. Sometimes, reframing the situation in such a way encouraged immediate cooperation. How-

ever, my experience has been that time and process play larger roles in cases where the final decision is made to accept standard medical care. Obviously, patients also have the right to refuse treatment, but they usually do so before they reach the hospital. Sometimes, the patients change of heart occurs when the medical symptoms become too obvious to be denied, and other times it occurs when these individuals are introduced to others who share their experiences and therefore understand their doubts, concerns, and fears.

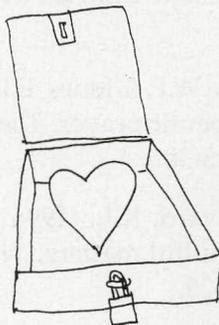
In one such case, an acquaintance named Lynn, who knew of my hospital experience and religious commitment, invited me to her home to share her holistic spiritual beliefs and values as context for her argument for miraculous healing. She gave many examples of how her organic, vegetarian diet and meditative methods made her 15-year-old daughter Susan, who had serious kidney disease, feel better. I listened, explained as much as I could about others' experiences with renal failure (including the dietary need for protein), prayed with her at her request, and then asked her to meet with another friend named Mary who had gone through the same experience with a child suffering from end-stage kidney disease. She did. Some weeks

later, when I checked on the progress of the helping relationship, Mary admitted that she had lost contact, but agreed to call Lynn and see her again. When she did, Lynn's daughter was so critically ill that they both took her to the hospital. When the doctor refused to treat Susan unless it was done in the medically approved manner, Lynn relented and allowed Susan to be dialyzed. Susan did well, eventually received a transplant, and had a very successful recovery. Lynn now attributes Susan's remarkable progress to the power of prayer and the community's support. Lynn, in effect, did her own reframing.

In a sense, Lynn's story is symbolic of what happened to me and others who choose to share the journey of faith of seriously ill patients. We start with our own sense of truth, enter into relationships with others whose difficult situations force us to face with them some of life's most challenging questions, and reframe our beliefs and values based on what we hammer out within those interactions. This process occurs in the context of what theologian Paul Tillich (1963) called "the eternal now." Seriously ill individuals and those who love them often do not have time for abstract philosophical meandering along existential pathways, no matter how alluring. They are confronted with a direct threat to their temporal future. They force those who care about them to confront that threat as well. They need all the resources available

to them, including ones that offer spiritual comfort and solace.

For those who accept the challenge to walk the more narrow path with them, and who do not shun their religious beliefs and values, the rewards are enormous. My patients and clients helped me to refine skills I had learned in Sunday School. They taught me to listen to the silence of thoughts too profound to express. They taught me how to respond carefully to the quiet of these meditations. I learned that words have great power for healing if used wisely and potential for great harm when they are not. I learned that just being with Dean or Mike or Lynn was often as important as anything I could do tangibly. "The evidence of things not seen" is a powerful corollary for any treatment derived from science.



My patients forced me to confront my own existential anxieties in order to help them face theirs. I had to move beyond my youth and inexperience and wobbly religious faith in order to fortify my practice and knowledge for their benefit. I had to leave behind romantic and shallow notions about what it meant to face major disability and the possibility of death as

those with whom I worked allowed me insight into their private struggles and suffering. I had to acknowledge my own reluctance to give up the fight to keep my patients from giving in to the inevitable when they had clearly signaled that they were ready to do so. I had to risk exposure to values and beliefs far different from those I had grown up with and to respect the integrity of their right to coexist with mine. Most of all, I had to learn to support the courage that comes from staying the course minute by minute, day by day, just as the accumulated wisdom of my religion teaches me to do.

The growth process was emotionally and physically exhausting, but it helped me define the limits of my strength in ways that still serve me. I've learned to wait in order to let each situation unfold enough so that I can clearly respond to the realistic needs and desires revealed, rather than to my own compulsion to **do** something. I've learned to appreciate the strength of support systems for recovery, both for the patients and their families and for those of us who work on their behalf. I've learned to prioritize by separating the wheat from the chaff in the context of the gift of each new day that comes without any guarantee of another. I've learned to take time to renew my spirit through worship, music, prayer, and play.

Each renewal of these lessons recaptures the memory of the serendipity of those earlier experiences. I use the memories as part of practice wisdom to pass on to the students whom I

now teach. Whether I consciously realized it at the time or not, the learning that my patients and I forged together, undergirded by my religious faith and values, emphasized the healthy aspects of behavior and belief, long before words such "empowerment" and "working with the client's strengths" became fashionable. I owe my patients much. □

## REFERENCES

- Bonhoeffer, D. (1963). *The cost of discipleship*. New York: MacMillan.
- Freud, S. (1961). *The future of an illusion*. New York: W.W. Norton & Company.
- Hoffer, E., (1951). *The true believer*. New York: Harper & Row Publishers, Inc.
- Moody, A. (1975). *Life after life*. Georgia: Mockingbird Books.
- Sabom, M.B. & Kreutziger, S.S. (1977). Near-death experiences. *Journal of the Florida Medical Association*, 64 (Sept.), 648-650.
- Thompson, F. (1986). The hound of Heaven. In M.H. Abrams (Ed.), *Norton Anthology of English Literature* Vol. II (pp. 709-14). New York: W.W. Norton.
- Tillich, P. (1963). *The eternal now*. New York: Charles Scribner's Sons.
- Wilson, W.P. & Jones, E.D. (1978). Therapeutic prayer. *The Bulletin*, 4 (1), 35-38.
- Woodward, K.L. (1994, October 31). Soulful matters. *Newsweek*, pp. 23-25.
- Zentner, M.: (1984). Antisocial personalities. In Turner, F.J. (Ed.), *Adult Psychopathology* (pp. 345-363). New York: The Free Press.

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