How Social Workers Assess and Treat Clients Undergoing a Spiritually Transformative Experience

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Abstract

This article discusses the findings of a small, exploratory qualitative study of licensed social workers, who work with individuals who have undergone a spiritually transformative experience (STE). These experiences often resulted due to a period of great difficulty for the client, and the experiences themselves can also present as difficult to navigate and integrate. This article will examine what circumstances may lead to an STE, and how clinicians assess and treat individuals who are experiencing STE's.

Key Words: Spiritually transformative experience, spiritual emergence, spiritual emergency

Introduction:

A survey conducted by the Pew Research Center showed that approximately 50% of Americans say that they have had a religious or mystical experience, defined as a moment of religious or spiritual awakening (Pew Research Center, 2009). Despite this evidence, studies have repeatedly found that most social workers report receiving little training in spirituality during their educational careers (Hodge, 2016). The NASW Code of Ethics requires social workers to provide culturally competent services, that include attention to spiritual issues (NASW, 2018, Ethical Responsibilities to Clients), and that social workers should examine and keep current with emerging knowledge relevant to social work (NASW, 2018, Ethical Responsibilities as Professionals). Thus there are ethical concerns if social workers are not properly trained to work with clients experiencing spiritual emergencies.

Psychiatrist Stanislav Grof (1992), coined and distinguished "spiritual emergence" and "spiritual emergency" in the following manner:

> [Spiritual Emergence] The movement of an individual to a more expanded way of being that involves enhanced emotional and psychosomatic health, greater freedom of personal choices, and a sense of deeper connection with other people, nature, and the cosmos. An important part of this development is an increasing awareness of the spiritual dimension in one's life and in the universal scheme of things; when spiritual emergence is very rapid and dramatic, however, the natural process can become a crisis, and spiritual emergence becomes spiritual emergency. People who are in such a crisis are bombarded with inner experiences that abruptly challenge their old ways of existing, and their relationship with reality shifts very rapidly. Suddenly they feel uncomfortable in the formerly

> familiar world and may find it difficult to meet the demands of everyday life. (p. 34-35)

To increase the knowledge regarding spiritual emergence and spiritual emergency, Canda and Furman (2010) define and discuss these topics in their seminal social work text, *Spiritual Diversity in Social Work Practice.* As defined through the social work lens, spiritual emergence facilitates a gradual transpersonal awareness, which allows for a smoother transition into new ways of experiencing the world. Spiritual emergency, however, involves a sudden opening to transpersonal awareness, flooding an individual with mind-blowing insights, visions, sensations, and feelings, which can be a shock to the ego. Examples of spiritual emergence as described by Canda and Furman (2010) include: identifying and merging with other people, plants, animals, and other beings of nature; communicating with ancestral spirits, deceased loved ones, and spirit powers associated with nature; communicating with angels, spirit guides, and God; feeling a oneness with the universe and ultimate reality; remembering of past incarnations; remembering of a past cosmic evolution; distress caused by harmful spirits or psychic attack; out of body travel; near death experience; insight into universal and symbolic meanings; extrasensory perceptions such as telepathy, telekinesis, and precognition; and the awareness of subtle energies in the body. It is important for social workers to have an understanding of these phenomenological categories, in order to conduct culturally competent assessments, when encountering individuals who seek services presenting with these spiritually oriented concerns.

The social work literature has not discussed how social workers assess and intervene, when working with individuals seeking assistance for spiritual emergence or spiritual emergencies. The study described in this article was designed to begin to address this gap.

Materials and Methods:

The findings of this study were derived from a small, exploratory, qualitative study. Due to the underexplored topic of spiritually transformative experiences, an in-depth interview was an ideal method, to provide detailed and descriptive content.

Participants:

The sample for this study consisted of 10 licensed social workers, from various regions in the United States, who identified as working with clients who had experienced an STE.
A non-randomized, purposeful sampling method (Palinkas, 2015) was used to recruit participants.

Eligibility: To be included in this study, participants needed to be licensed social workers who had worked with clients seeking treatment for spiritually related concerns.

*Recruitment***:** All subjects were recruited via a transmitted email, which was dispersed through The American Center for the Integration of Spiritual Experiences (ACISTE). ACISTE is an organization that was created to assist individuals experiencing difficulties during their spiritual emergence process, as well as provide trainings for helping professionals who would like to increase their competence in this area of work.

Respondents: The participants consisted of 7 females and 3 males, ranging in ages from 41 to 76. All the participants were affiliated with ACISTE, with the exception of one participant, Richard, who received a forwarded email from one of his clients. The average years of experience, in the field, of the participants was 22.8 years, with a minimum of 5 years and a maximum of 40 years of experience. All participants were licensed social workers and 7 participants were licensed clinical social workers. Three participants had additionally obtained their PhD's, two in transpersonal psychology and one in philosophy. All but two participants

stated that they had worked with this specific population primarily in a private practice setting; the other two participants stated they practiced privately, but also had experienced working with a spiritually-oriented lens in an agency setting, in the fields of gerontology or with the chronic or terminally ill, respectively.

Data Collection:

Interviews were conducted via telephone. The study instrument was an in-depth, semi-structured interview (Padgett, 2017), which contained approximately 23 questions. Interviews were recorded, via an external recording device.

Data Analysis:

For the purposes of data analysis, the six steps of Thematic Analysis (Braun & Clarke, 2008) were used, to identify codes and themes within the interview data.

(1) Interviews were transcribed, word for word by the author.

(2) The transcripts were read over multiple times so the author could become familiar with the data.

(3) Initial codes were developed, by coding the transcripts line by line.

(4) From these codes, initial themes were developed, reviewed, and finalized.

(5) To increase rigor, memo writing was utilized to document theme development, and peer debriefing was utilized to cross check codes and themes.

Results:

Two overall themes were identified in this study. The first was the experience and perspective of the social worker, which included clinicians personally having experienced STE's, the need for social work competency of spiritual issues in treatment, and social workers being ideally suited to work with spiritual issues. The second overall theme was treatment, which

included assessing the differences between a STE and psychosis, and validation and normalization followed by a mix of traditional and spiritual methods as interventions. Whether it was the clinicians who participated in this study, or the clients that they served, spiritually transformative experiences were often precipitated by some major life challenges or traumatic events. All the clinicians in this study, besides one, experienced their own STE and reported either a sense of loss or disconnect prior to their experience, or a feeling of connection and interconnectedness as a result of their STE. The STE's, of the clinicians, influenced their desire to assist clients experiencing their own STE's.

The Experience and Perceptions of Social Workers: Eric stated:

> I was going through a very difficult time, my wife and myself, trying to adopt our children. We were in the middle of this process and it really began to derail and began to look like it wasn't going to happen. We were very angry at the time, very angry, very hurt, struggling, and I turned to intense supplication, prayer, meditation. Specifically, I found myself just intuitively praying to the divine mother. During one of those intense deep meditations, I experienced what I can only describe as an audible download with a very specific message. I heard it as if the voice of the divine descended and was in the room with me and speaking directly into my ears, with a message which I'll not share because it is so intensely personal, but the essence of it was basically pure love and compassion, and in some sense assurance that all will be well, and when that finished I absolutely just burst into tears, and long story short, the adoption worked out and there seemed to be, quote-unquote, some miracles that took place to actually bring

> our children home. So that touched me in a way like nothing ever has and perhaps never will (Eric).

Eric's STE emerged as a result of a very challenging time for himself and his wife; the possible disconnect between himself and his foster children, leading to intense prayer and a connection to a higher power, who reassured him that things will be ok. Sarah, another clinician, discussed her STE as a way to also find connection to a higher power.

> My spiritual emergence manifested as recovery, from uh, it was alcoholism at the time. (pause) So that crisis of not wanting to drink and not being able to stop myself, was the, you know in the shamanic work we call it the shamanic initiation, or the shamanic crisis. That was the crisis that brought me onto the path of spiritual emergence. In my case, I feel like I was turning to addiction to soothe my emotional pain and to feel connected (pause). Well when I couldn't use the substance to connect, I had to think about what it was that I was trying to connect to, and when I thought about that, I realized I was trying to connect to this greater intelligence of life, that would help me feel secure and safe.

Similarly, Elizabeth revealed that it was her upbringing, in a family struggling with alcoholism, that resulted in feelings of disconnect. She stated:

> I had a spiritual experience in 1987. I was doing breath work training. So I did breathe and this breath breathed in me when I wasn't breathing. Now it seemed to me that this whole process took 15 minutes but it actually took four hours, and then I experienced my physical birth, after the breath stop breathing, and then when it was all over I stood up and there was 21 people in this program, and I thought they were really weird when I started, and this was like four days into it,

> and I just knew that I loved them very much and that we were all connected (crying). It still brings out the feelings of awe and everything. I knew there was a God when I went there. I was raised in an alcoholic family, so I thought God had better things to do than work with us. (Elizabeth)

Susan, a LCSW who has continued her studies to obtain a PhD in transpersonal psychology, stated that her own research and work in this area has resulted from:

> Having my own spiritual experiences and not knowing where to go with seeking clarity about them. One in particular that led me, I believe, to my interest in this area specifically, which was an experiencing of unitive-consciousness. It was an unsolicited experience, of oneness, with a great sense of empathy and heart opening that came out of nowhere, and it was really permeating my whole being, took me out of time and space, and was blissful and beautiful, and came with a sense of knowing and understanding of the interconnectedness of all of us at a heart level in a very real way. All of us people, as a living being, part of a living system of the universe. (Susan)

Susan's case resulted in a feeling of interconnectedness which has informed her work, to help clients who are experiencing STE's of their own. Like Susan, clinicians in this sample who had experienced their own STE's had all continued to explore, investigate, and learn through trainings, about how to work with clients experiencing STE's. These clinicians believed that there was a need, as evidenced by the clients they serve; however, there has historically been low levels of competence among social workers related to issues of spiritualty in treatment. Studies have repeatedly shown that many clients want to have their spirituality integrated into their psychotherapy (Arnold, Avants, Margolin, & Marcotte, 2002; Dermatis, Guschwan, Galanter, &

Bunt, 2004; Hodge & Horvath 2011; Rose, Westefeld, & Ansley, 2008); however, data suggests that clients perceive low levels of spiritual competence among helping professionals (Hodge, 2007). The clinicians interviewed for this study point to a lack of social work education, on spiritual issues, as the culprit.

Lack of social work education on spirituality: Eric stated:

> The level of competency seems to be all over the map, and it seems to accord with people's interest. I think it's critically important (to have competency) because even if you're not practicing, or advertising yourself as somebody open to working with spiritual themes on the whole, it's still bound to show up. So, I think everyone, of course, should have some general basic competency, and for that reason I think it should be a bigger part of social work education and training.

Susan believed that the lack of competence is not only a result of a lack of spiritual topics in social work education, but also the social work field's recent shifting, more and more, towards a medical model, which she stated puts an emphasis on diagnosis and pathology.

> I think until we get (spiritual) programming into the social work schools and the study guides for the licensing exam, I don't think that there is real competence there at all. I mean, what everyone is trained in, is the DSM, diagnosis and pathology, and even though we talk a good game with some perspective, we're so trained to label through the disease model. So I don't know that there is competence, unless somebody has really taken their own journey with their own spiritual experiences.

Sermabeikian (1994) states that "spirituality is a human need; it is too important to be misunderstood; avoided; or viewed as regressive, neurotic, or pathological in nature. Social

workers must recognize that a person's spiritual beliefs, values, perceptions, feelings, and ideals are intrinsically connected to religious, philosophical, cultural, ethnic, and life experiences. It is important that the practitioner acknowledge that spirituality in a person's life can be a constructive way of facing life's difficulties" (p.181). However, Gotterer (2001) states that what clients often see as a strength, their spirituality, is often pathologized, and that clients frequently cannot discuss their beliefs in therapy out of fear of being judged as crazy. Susan believed that increasing spiritual competence is not only a necessity but an ethical mandate:

> I think the main sticking point for me, is that this is not optional. That this is something that needs to be a requirement, because whether or not you personally believe in a world beyond the material, your clients are having these experiences, they're scared to be truthful about them, and it impacts their overall health and well-being, and it's not a matter of negotiation that we're not at least seeking to understand this, in the social work literature and training, because it's leaving a huge portion of people unseen and at risk.

Despite the perceived low levels of spiritual competence among social workers, the clinicians in this study all felt the core values of social work make social workers ideally suited to assist this population.

***Social workers ideally suited to work with people who have experienced STE's*:** Canda (1998) states, "people who wish to explore the transpersonal reaches of their potential could be assisted by social workers who are in an especially appropriate position to help clients reflect on the interplay between their spiritual growth and responsibility to society and nature, given our person-in-environment focus" (p.100). Additionally, Garbe (2019*) states that due to our client-centered, strength-based, and systems theory approach, social workers who utilize a bio-psycho-

social-spiritual assessment, to determine factors that are contributing to client stress, are in an excellent position to assist clients to multi-systemically interpret and integrate their spiritual experiences. Susan agreed and stated:

> I think the benefits of being a social worker is that perhaps we are more open-minded to deal, I don't want to compare to other professionals because I don't know, but I think at least in my training, I was educated to always be thinking about the bigger picture and the strengths perspective, where somebody is coming from, their own experiences and all of their concentric circles of being. So I think that even for a social worker who perhaps is more materialist in their world view, I think there is a way to work with people having those experiences just by normalizing them, and being open to listening, like you would to any other special population, and the needs of any other special population, which I feel that's what social work is meant to address, special populations who are often unseen, misunderstood, marginalized.

Susan discussed the importance of the strength-based perspective of social work practice. Richard, the sole clinician in this study who had not had an STE of his own but who was comfortable working in a spiritually oriented fashion, agreed:

> I think social workers are in a much better position to assess competently and accept, that's the word that's important here, to accept the person coming before them, and are probably better trained to allow for the possibility of this being a very real situation for them, more than the other two professions, and I think there is something in our training about acceptance and meeting the person where they're at, that's very different from psychological training, which really tends to

> focus on intra-psychic problems, and psychiatrists who are typically also looking for the problem and how do I medicate it. I think social workers are trained much more so, in terms of accepting the person where they are now, along with our psychopathology training. I think we're really in the best position of the three disciplines to work with this.

So how do clinicians work with this? The next section of this paper explores how the social workers interviewed work with individuals seeking treatment for spiritually related concerns.

Assessment and Interventions:

Assessment: Spiritual experiences versus psychosis: Seinrich (2013) states that it is important for social workers to learn to accept clients' reported mystical and psychic experiences as valid, rather than quickly attempting to interpret such phenomena from a pathological perspective. The clinicians who participated in this study shared how they distinguished between spiritual experiences and psychopathology. Elizabeth stated:

> That's one thing I teach. In my thesis, I gave a pre and post-test to 140 mental health workers, some of whom were social workers, some of whom were psychologists, and only 37 percent of them knew the difference. Usually somebody who's in psychosis is grandiose and they do not have a good functioning ego, so that they can't go in and out of the situation, and tell, and stop, their story, and then come back to their story. Their story changes and they can't just come in and out, or stop it, they just continue on and on. So they're more grandiose and talk about it, and then somebody who's had a spiritual experience is usually humbled by it, even if they don't understand it. They can tell the story

> over and over again. So you have a good functioning ego about the story. Somebody who has schizophrenia is all over the place.

Susan expounded more, on being able to communicate the STE in a rational manner:

> Well I think somebody in acute psychosis would not be able to talk about it rationally. I think somebody who is in the midst of spiritual emergency would probably be able to give greater context to their experience, even if there is still some pieces that they haven't completely understood intellectually. There's a different felt sense for me, and I don't know whether you would call that energy, or just maybe it's clinical experience at this point, but I think in general someone experiencing psychosis is a lot less boundaried. They're a lot less aware of how I might be assessing them. Whereas somebody in a spiritual emergency may be saying, hey I know you think what I'm saying is crazy, but I'm going to say it anyway. Where someone in psychosis doesn't usually have that level of insight.

William believes that an STE can even be distinguished in an individual who has been diagnosed with schizophrenia:

> The thing about this particular guy was in addition to schizophrenia, he was also, he's what they called a functioning alcoholic. So, in the course of years, I spent some time talking with him about the difference of his alcohol induced psychotic experiences and some of the things that happened when he was clean for several days, a week or two. So what happened is, I moved to the brief therapy crisis team and he wasn't on my caseload. Then about two, or three, years later I got a call from the local hospital that he had drove his car off a cliff, in an apparent suicide attempt, and he was in that process of being treated for that, but they didn't

want to let him go, and so what he did was, he advocated for, and he got a day pass from the hospital. He came into the mental health office, he sought me out, and he sat down and told me this following story, and the story was purely spiritual, straight out of the NDE (near death experience) literature, and the story was what he went through just before he drove the car off the cliff, and what happened while the car was going down the hill, and what he described was an out of body experience, where he was separated from his body and he observed the car going down the hill and coming to rest, and then being flashed, being back inside of his body, and then being separated from it, and then being unconscious, and then he had another out of body experience where he was aware of being put in the back of an ambulance, and then as the ambulance was driving to the hospital he was aware of being outside of the ambulance, and above it and watching the ambulance go to the hospital. I asked, well did you talk about this with the staff at the hospital? And he said, oh no, no, no, they would not understand. He went on about that, and he felt that I was the only person who would thoroughly understand what he had been through and not misdiagnosis it as some aspect of his schizophrenic, or alcoholic delusions, or hallucinatory nature. So from the point of view of the intervention, all I did was listen to all that he had to say, and using what I learned in my explorations, of the research in regards to NDE's and related matter, I sought to mainstream him and most importantly give him as much emotional reassurance as I could that he was "not crazy".

Interventions:

Validation: A major theme for clients seeking assistance was the need for validation; for a client to be able to sit with a helping professional and share their experience, without the fear of being judged or labeled as crazy. All the clinicians interviewed placed a strong emphasis on validation as a key intervention. Jill stated:

> From what I have seen, most people just want to know that their therapist, that human being across from them, listens and doesn't think they're crazy and validates them. Some people have said they see me because they can talk to me about their meditation experiences, and they're not worried that I'm going to judge them or think they're crazy.

Eric discussed how validation gives permission for our clients to share of their experiences:

> I think many people would not be so keen to report spiritual, or psycho-spiritual, or paranormal, or any such kinds of experiences, for fear of being seen as mentally ill, or delusional (pause). I'd maybe add one more element to that, and that would be, perhaps, um, if people would see that more clinicians were openly speaking about and advertising that they have competency in this, that could only help people who would otherwise not feel safe to report, report.

Normalizing. A key aspect discussed in the validation of a client's experience is the use of normalizing. Phyllis stated:

> So, what I tend to do is, I use the psycho-education to normalize their experience for what it is and just empathize and validate with them. Sometimes I share my own experience so that they know that it's okay. I normalize things a lot. People don't need much. People mainly want to talk and get it out, be acknowledged, be

> understood, be validated. I might give them references about what they might read about the subject.

Susan agreed and stated normalization is the first step in her interventions:

> I think the biggest intervention is normalizing the experience, and by normalizing the experience the person begins to feel supported, and it usually alleviates anxiety and allows them to talk about it more extensively and process it for themselves in a different way, than with their own fear and with their fear of me judging them. So I think that's always the first intervention, and then building up from that, depending what the need is at that point, it may be just processing it, allowing them to be heard in a loving and compassionate way.

After using validation and normalization to reduce client anxiety, clinicians used a mix of traditionally and spiritually oriented interventions.

Integrating Traditional and Spiritual Therapeutic Modalities: When Eric was asked how he worked with clients experiencing an STE, he stated:

> I'm trying not to get jargon here, but, it was really rooted in attachment, you know, trying to have a secure holding environment, build a secure attachment with this person. There was a long trauma history, a previous divorce, a pretty horrendous childhood on the whole, and a lot of that unexplored, so I think, you could say that, intervention-wise, a lot of it was psychodynamic, relational, interpersonal, attachment-oriented, all while trying to discern, and differentiate what was going on in terms of, uh, psychosis or symptoms that look like psychosis, as well as the non-ordinary events that were unfolding. As we went towards later portions of our work together, I would be bringing in some more

> energy therapy methods, mind-body stuff. We would do guided meditation together.

The interesting aspect of Sarah's work, were the similarities between what some might see as traditional versus spiritual work. Examples of this were the correlation between the internal family systems model and the shamanic work of "soul loss", and the similarities or differences between group therapy and a drum circle. Using a case to describe her work, she stated of her client:

> She had a lot of issues with people not being able to meet her where she's at, and feeling unseen and unheard. She had a lot of experience of medical trauma, being held down as a child to be administered injections, and treatments, and things like that, and profound anxiety about her own death. So the intervention with her, in the beginning, was intense depth work. She learned to retrieve her soul parts through the depth psychotherapy process.
>
> Most of my clients after reading my website, they really seemed to resonate with the language of "soul loss". So from the shamanic perspective, soul loss occurs when we are faced with a trauma, throughout our current life, our birth, our past life, and so the soul sees the trauma about to happen and the soul fragments. There's a really interesting correlation with the internals family system parts work. Internal family systems is a psychotherapy model, and the general premise is, that we have all these parts of ourselves and then an organizing core, and so internal family system seeks to bring all of the parts into balance and get all of the needs of the various parts addressed.

> The second intervention, and I find this is really, really, important for this population, that they get into a circle, a community of other people who have had similar experiences, other people who are looking for healing, because that is such a way to rewrite those early patterns of disconnection with a primary caregiver. I do a drumming circle once a week, and this particular client is religious about coming to the drumming circle, in fact she calls it her church, and then engaging her in group breath work sessions, and the breath work sessions, you know, in my work the breath is the medicine, so this is how we engage in medicine work.

Whether the modalities were traditional or spiritual ones, the importance was to meet clients where they were at. Christine discussed using any and all types of modalities to work with her clients:

> I will use storytelling. I will use narrative. I will use archetypes. Carl Jung was such a spiritual man, and he talked about the mandala, and the intensity of the mandala, and the spirituality of being in the mandala on different levels, and I have coloring books of mandalas, and I will have people just sit there and color, and talk and color, because I'm using different parts of the brain. I work with the brain, which means I'm working with cognitions, changing cognitions, cognitive behavioral therapy. I work with the body. I work with hypnosis. I do guided imagery. I do past life regression. I'll work with drums. I'll work with rattles. I will sit down on my rug with people and we'll talk, and sometimes just talking and sitting, and not sitting in a chair, and not having them sit on a couch actually affords us greater intimacy, greater conversation, and we're just kind of playing, like two people in a room.

If social workers are not comfortable working in these modalities, as stated in the NASW code of ethics, “social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that other services are required” (NASW, 2008, Ethical Responsibilities to Clients, 1.16 a). Richard, the sole clinician in the sample who had no affiliation with ACISTE and reported not having had a personal STE, but who felt comfortable working with client presenting with spiritually related concerns, utilized validation through normalization and followed ethical guidelines to refer out when necessary. He stated:

> You do the best you can. You listen, and you summarize, and you help people to understand what the issues are for them, and I'm very clear that I'm not an expert in this area and could certainly refer them to somebody who might have more expertise than I do. So for example, I've had people come in who have felt like their house has been haunted, or may have wanted a referral for an exorcism. I obviously don't have any expertise in either of those areas, but I would refer them to people, who I have used in the past, who believe in those kinds of things, and I would follow up with these people afterwards and find out that they were given prayers and things to do, and the problem that they came in for went away. Who am I to argue? So I'm open to the idea that there is a spiritual realm that some people just are more connected to than others, and part of my role as a referral agent is to make sure that I know who those good people are to refer to as opposed to come con artist off the street.

Whether using their preferred modalities, or referring to experts when necessary, a common theme among all clinicians who participated in this study, was the personal trainings they engaged with, to build competence in this area of work. Resources most commonly mentioned among the practitioners included: The American Center for the Integration of Spiritually Transformative Experiences (ACISTE), which is an organization that provides training and a national certificate, for those clinicians who are interested in working in this area. ACISTE also offers a referral directory of certified clinicians, for clients who are seeking assistance for spiritually related concerns. David Lukoff's Spiritual Competency Resource Center, (www.spiritualcompetency.com), is another useful resource. Due to themes of death, loss, and the afterlife, which coincide with spirituality, The International Association for Near Death Studies (https://iands.org/) was an often-mentioned resource to build competence.

DISCUSSION:

There is a need for increased competence, within the social work field, of spiritual issues as they relate to treatment. It is our clients who have requested that their spirituality be integrated into the therapeutic exchange (Arnold, Avants, Margolin, & Marcotte, 2002; Dermatis, Guschwan, Galanter, & Bunt, 2004; Hodge & Horvath 2011; Rose, Westefeld, & Ansley, 2008). In order to do so, all the clinicians who participated in this study emphasized the importance of validation and normalization as interventions, when working with clients experiencing STE's. These findings coincide with literature on this topic. Treatment protocols discussed by Lukoff (2007) include normalizing the (spiritual) experience, through providing a positive context and sufficient information regarding the process which clients are going through. Furthermore, Garbe (2020) stated, clients experiencing spiritual phenomena often have not had an opportunity to discuss their experiences, out of fear of being judged and labeled as

"crazy". Using a client-centered and strength-based approach, it is important to validate and encourage the client's spiritual meaning making, rather than pathologizing it.

So as not to pathologize a spiritual experience, clinicians in this study discussed the importance of differentiating between a STE and psychosis, with an emphasis on assessing ego functioning, including assessing for the ability of the client to coherently discuss their STE. This coincided with literature on how to differentiate between spiritual emergence, or emergency, and psychosis. Grof and Grof (1989) suggested ruling out medical criteria such as physical disease that may impair psychological functioning as well as to assess for serious psychiatric history, including disorganization, incoherence, loosening of associations, hostile delusions of persecution, or acoustic hallucinations of enemies with very unpleasant content. Additionally, the client should have the awareness of the intra-psychic nature of the process and be able to distinguish between inner and outer worlds, in order to internalize the process rather than project, blame, and act out. Furthermore, Lukoff (2007) offered criteria to differentiate between a STE and psychosis. For a spiritual emergency, the criteria should include an absence of a medical illness including drug intoxication. One should look for a phenomenological overlap of a client's presenting symptoms with previously stated categories of spiritual emergence, as discussed by Canda (2010).

Adding to the literature on this topic, clinicians in this study discussed utilizing a mix of traditional and spiritual modalities in treatment. Whether utilizing psychodynamic, cognitive-behavioral, individual, or group therapies, it was important for clinicians to meet the clients where they were at. A salient example was the clinician Sarah, discussing shamanic soul work being similar to internal family systems work and how the use of a drum circle provided the therapeutic benefits of group therapy. Her client, seeking spiritual interventions, benefitted from

these modalities, which could be viewed as traditional interventions packaged spiritually, or vice-versa. Additional spiritual interventions, utilized by the other clinicians, such as mindfulness, meditation, past life regression, or energy therapy methods, were learned through personal interest and continued training. This study suggests that social workers are ideally suited to work with individuals with STE's, if they have this proper training.

Some resources for training and increasing competence, mentioned by respondents, were provided in this paper, however there is also a need for an increase in spiritual topics to be integrated in the social work education curriculum. Further research could explore the possible resistance, or barriers that may be keeping clinicians from partaking in spiritual discussions with their clients.

Limitations and Conclusions:

The limitations of this study include the small sample size, as well as a possible bias in the sample of participants. All participants were acquired through the organization ACISTE, and all but one were members of the organization. The majority of the participants, 9 out of the 10, reported that they had experienced their own STE. It is also important to note, that the author of this article has also experienced an STE and acknowledges his own bias. Clinicians who have experienced an STE may be biased in their treatment approaches, possibly favoring spiritual modalities; however, the clinicians in this study all emphasized meeting their clients where the clients were at, as well as utilized a mixed intervention approach. Furthermore, these clinicians were sought after by clients due to their spiritual orientation. The respondents in this study all were Caucasian and this could also present as a bias. A future study incorporating multi-ethnic respondents could possibly introduce differing spiritual perspectives and intervention strategies.

The research is still important, however, based on the history of literature that does state the need for increased competence on spiritual matters within the social work field. This exploratory study sheds light on a phenomenon that is relatively unexplored within the field of social work, and due to client need and demand, further research in this area is warranted.

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The author has no conflicts of interest to declare.

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