


12-2013

Religious Multicultural Competence Amongst Dance/Movement Therapists

Jaclyn Abramson

Follow this and additional works at: http://digitalcommons.colum.edu/theses_dmt

 Part of the [Dance Commons](#), [Dance Movement Therapy Commons](#), [Performance Studies Commons](#), and the [Religion Commons](#)



This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 4.0 License](#).

Recommended Citation

Abramson, Jaclyn, "Religious Multicultural Competence Amongst Dance/Movement Therapists" (2013). *Creative Arts Therapies Theses*. Paper 50.

RELIGIOUS MULTICULTURAL COMPETENCE AMONGST DANCE/MOVEMENT
THERAPISTS

Jaclyn Abramson

Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy and Counseling Department

December 2013

Committee:

Susan Imus, MA, BC-DMT, LCPC, GL-CMA
Chair, Dance/Movement Therapy and Counseling

Laura Downey, MA, BC-DMT, LPC, GL-CMA
Research Coordinator

Kim Rothwell, MA, BC-DMT, LCPC, CADC, GL-CMA
Thesis Advisor

Nancy Tonsy, MA, BC-DMT, LCPC, ICDVP, GL-CMA
Reader

Abstract

The purpose of this study was to understand how dance/movement therapists, with BC-DMT or R-DMT credentials, acquire, foster, and perceive their own religious multicultural competence. The research question was how do dance/movement therapists develop religious multicultural competence? Through the methodology of a qualitative case study and the data collection method of a focus group, I examined the self-perception of each participant's own religious multicultural competence. After I transcribed and analyzed the data, I uncovered several themes, highlighted in the Results section. Once the analysis was complete, I utilized the data analysis method of intuitive inquiry. Findings included a) a definition of multicultural competence, b) a reciprocal relationship between religious shifts and religious self-exploration c) a lack of religious training in the Columbia College Chicago Dance/Movement Therapy and Counseling program, and d) the shared experience of religious insensitivities. Ultimately, this study demonstrated the need to prioritize religious multicultural counseling training in dance/movement therapy curriculums to help novice counselors become better equipped to manage complex, diverse, and ethically sensitive religious experiences.

Acknowledgements

I would like to thank all my co-researchers who participated in my focus group. Literally, I could not have completed this study without your willingness to participate in a complex, religious research project. Your wisdom, kindness, openness, and love inspired me throughout the entire writing process.

Additionally, I would like to thank my thesis advisor, Kim Rothwell, and reader, Nancy Tonsy, for providing me with wonderful feedback. I look up to both of you and could not have asked for better mentors during this experience.

I absolutely need to thank the wonderful Bethany Brownholtz. Bethany—thank you for meeting with me every week for the past several months and editing my thesis. Without your writing expertise, I would have apostrophes and commas in all of the wrong places.

Lastly, to my friends and family—thank you for supporting me during my research journey. I know it has been a huge source of stress and the topic of conversation for a very long time. I choose to surround myself with the people that I love because you provide me with support, balance, and my favorite thing in life ... laughter.

TABLE OF CONTENTS

Abstract	i
Acknowledgements	ii
Table of Contents	iii
Chapter 1: Introduction	5
Chapter 2: Literature Review	10
Chapter 3: Methods	31
Chapter 4: Results	37
Chapter 5: Discussion	55
References	72
Appendix A	78
Appendix B	82
Appendix C	84
Appendix D	85
Appendix E	86
Appendix F	87

Chapter 1: Introduction

During my studies in Columbia College Chicago's Dance/Movement Therapy and Counseling MA program, I observed that multicultural competencies regarding ethnicity, sexual orientation, and gender were insufficiently addressed in the curriculum. Specifically, I felt that the topic of religion was not fully discussed or explored. Based on my personal experience as a Jewish religious minority amongst my peers, I quickly realized that limited opportunities existed inside the classroom to discuss, explore, and experiment with a variety of belief systems. I wanted more time to explore the role of religion amongst dance/movement therapists in order to prepare me for work as a well-rounded and culturally competent dance/movement therapist.

During the Social and Cultural Foundations course in the beginning of the DMT program, we were given a cultural dance assignment where we would perform and teach our classmates a dance that represented our culture. The intention behind the assignment was to help the students develop an embodied awareness of other cultures and develop multicultural competence. However, I found this activity to be unhelpful. I felt uncomfortable because in my life religion and culture are synonymous, so my cultural dance had an explicitly religious component. Being raised in a Jewish family, I learned to identify my culture from my religious background instead of a geographic one. We were raised to identify with Judaism because my great great grandparents were evacuated from their homeland, unable to identify with a particular geographic region or culture. I remember feeling different from my classmates because I feel deeply connected to my religion. Also, I experienced these cultural dances as oversimplified and/or stereotypical,

and embodying these dances did not provide insight into the cultures they were supposed to represent.

After the dances were complete, the class did not adequately process the experience of culture, religion, or stereotypes. Additionally, I felt intimidated because developing an understanding of everyone's cultures based on this brief opportunity to learn their dance seemed inadequate. As a result, we did not address the important concepts/values of multicultural counseling, and I felt unprepared for diversity in my clinical placements. In order to fully understand multicultural competence, including explorations of religion, I needed more time to explore the counseling concepts throughout the counseling curriculum.

Furthermore, when I experienced religious stereotyping, jokes, and ignorance from my classmates, I began to fear that those prejudices would manifest in their internships—which contained a variety of religious populations—and even in my own internship. For example, I felt more comfortable performing therapy in a setting where my belief system aligned with the religion of the organization. In contrast, I felt a lack of self-confidence when I needed to facilitate religious conversations at an organization where the participants had different religious beliefs than me. Overall, after self-exploration, I learned that regardless of the organization or religious affiliation, I felt unprepared in a clinical setting to deal with religious topics such as prayer, God, and prejudices. I wanted to discover if other dance/movement therapists experienced such fears. I became curious about the role that religion plays as a part of multicultural competencies, which later developed into my research question: How do dance/movement therapists develop personal religious multicultural competence?

My personal theoretical framework, and how I approached working with my clients, derived from Carl Rogers's person-centered framework. Rogers's theory emphasized the client as an individual and further illuminated that clients are responsible for improving their own lives because they get to make the choices regarding their treatment (Ivey and Ivey, 2012; Rogers, 1951). Roger also believed that the therapists' assumptions and values were important components in the therapeutic process, and the contrasting cultures of the therapists' and clients' should be acknowledged. My personality aligns with this theory because I believe that every client and therapeutic experience is unique. Moreover, I recognize, just as Rogers did, how my culture and assumptions affect the therapeutic relationship. As I learned about the person-centered approach in my graduate coursework, I began to notice similarities between the person-centered framework and what is known as multicultural competencies.

Multicultural competencies equip therapists to approach their clients ethically, ensuring that their cultural values and biases do not override those of their clients (ACA, 2005). The American Counseling Association (2005) defined multicultural competence as “a capacity whereby counselors possess cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge is applied effectively in practice with clients and client groups” (p. 20). The multicultural framework was created to help therapists deal with complex situations, such as when they work with clients of different, “ethnographic, demographic, gender, socioeconomic, religious/spiritual, and cultural/racial identities” than themselves (Ivey& Ivey, 2012, p.521). Multicultural competence is crucial because the therapeutic relationship can be damaged if the clients' religious identity is neglected or negated. Multicultural counseling

focuses on the individual, like Roger's framework, as well as individuals' entire perspective in order to ensure best clinical practice (Ivey and Ivey, 2012). Therapists must pay attention to the client as an individual, including their religious perspective.

As a novice clinician, I placed value on both the person-centered framework and the multicultural competencies because both theories believe that every person is culturally unique and those cultural perspectives should be respected. However, even though I was taught both of these frameworks in the classroom from a textbook, I did not feel ready to utilize them at my internship sites. I personally felt limited in my understanding of the material, and I felt like I was not reaching my fullest potential as a dance/movement therapist, which correlates to Roger's theory of self-actualization (Rogers, 1951). I needed more time to understand and to practice the multicultural competencies, so I could practice ethically and responsibly.

Once I started researching the topic of multicultural competencies and religion in the counseling field, I realized that the lack of integration of religion in the counseling education system is systemic (Berkel, Constantine, & Olson, 2007; Hage, Hopson, Siegel, Payton, & DeFanti, 2006; Kelly, 1994; Plante, 2007). In fact, current research demonstrated that students enrolled in psychology/counseling programs do not obtain efficient training in how to deal with religious issues that may arise during the counseling process. If the students lack religious multicultural competence, which helps a therapist practice effectively and respectfully during religious situations, and the students' education does not focus on religious multicultural competence as a key element for growth and development, then clients may suffer as a result (Berkel, Constantine, Olson, 2007). In particular, the existing literature regarding dance/movement therapy (DMT)

and religion is sparse. After reading and reflecting on all of the research, I realized that the lack of religious awareness in counseling education poses an ethical problem. In choosing to focus on this as my research topic, I intended to highlight this problem while simultaneously learning from the wisdom and experience of other therapists. Through their stories, I hoped to learn how to become a more culturally competent therapist—particularly as it relates to religion.

The purpose of this study was to understand how dance/movement therapists perceive, acquire, and foster religious multicultural competence. After examining the focus group members' responses, I was able to better answer the research question and understand how religious cultural competence has developed for a group of dance/movement therapists. My hope is to lay the foundation for future research related to religious multicultural competence.

Chapter II: Literature Review

Introduction

Barnett and Johnson (2011) asserted that religion can enter the therapeutic process in various forms: many clients believe that religion is a crucial part of their identity, worldview, and sense of self. In contrast, clients also seek therapy when their religion is a source of stress and causing conflict in their lives (Yarhouse and Fischer, 2012). Regardless of how religion impacts clients, the authors believed that religious issues could play an essential role in the process and outcome of therapy, reiterating the importance of acknowledging a persons' religious identity.

Historically, Freud wanted psychoanalysis to be considered a science, resulting in the field utilizing the medical model (Freud, 1989). McLeod (2008) demonstrated that using the medical model required abnormal behavior to be diagnosed from a physical cause and should be treated medically. Because the field of psychology was adhering to the medical model, the mental health profession held antipathy towards religion—seeing it, at best, as weakness or, at worse, as delusional and/or a product of neurosis (Freud, 1989). On a fundamental level, this secular prejudice has restrained therapists from exploring the religion in their clinical work (Freud, 1989; Plante, 2007). Thankfully, there has been a shift, and now mental health professionals recognize the need to address issues of religion as part of cultural identity rather than dismissing them as delusions or neurosis (Freud, 1989; Plante, 2007). Due to this shift, religion has become incorporated into the counseling process, and a large number of professional publications, conferences, books, and specific journal issues in major professional journals on religion, psychology, and integration have been created (Plante, 2007).

As religious incorporation into the therapy room increased, the DSM-IV included “religious or spiritual problems” as a condition that therapists may identify when working with their clients (American Psychiatric Association, 1994, p. 685). The DSM-V included religious or spiritual problems such as, “distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution” (American Psychiatric Association, 2013, p. 725). This inclusion of religious or spiritual problems demonstrated the need for mental health practitioners to be properly trained in religion as a specific part of multicultural competence. However, it is unclear if clinicians currently have adequate training in religion and spirituality practices (Berkel, Constantine, & Olson, 2007).

Few pieces of literature address the integration of religion into counseling and/or DMT. Due to the lack of literature on religion and these topics, the bulk of the literature review addresses religion as a subset of multicultural competency. The Literature Review is organized into three main categories: religion and multicultural competencies, religion and education, and religion and DMT.

Religion and Multicultural Counseling

Historical context of multicultural counseling. Historically, counseling techniques were applied without consideration of clients’ different worldviews (Carmichael, 2012). However, in 1972, the Association of Multicultural Counseling and Development (AMCD) was established. The organization was developed in order to help include people from different ethnic, racial, and national heritage in counseling services (Arredondo, 2003). Despite this development, during the early 1980’s, counseling texts,

research studies, and clinical training approached ethnic/racial minorities as inferior; the counseling field engaged in scientific racism, especially targeting the African American people (Arredondo et al., 1996). The AMCD began to realize that in order to avoid causing harm to clients, mental health professionals needed to recognize and respect the importance of culture, ethnicity, and race. The desire to ensure ethical practice led to the creation of multicultural counseling competencies in 1992. D'andrea and Daniels (1991) shared that the multicultural counseling movement allowed mental health professionals to

- a) rise above institutionalized racism that many counselors were hesitant to address and
- b) to recognize racism as inherently a part of their mental health training experiences.

D'andrea and Daniels stated,

A combination of an increasing awareness of the implications of the rapidly changing demography in the United States, the underrepresentation of minority group perspective in counselor education, and the ethical crisis that these two factors create has led to a variety of modifications in many professional training programs. Most notably the emergence of cross-cultural counseling courses over the past two decades (p.79).

The emergence of the multicultural counseling movement has allowed progress in this area and helped counselors move past a professional entrenchment that prevented them from working effectively, appropriately, and ethically with diverse clients. Additionally, though the multicultural counseling movement focused on cultural competency, it paved the way for religious awareness in therapy, as religion constitutes part of a client's cultural identity.

Defining multicultural counseling. Because religion can be a part of a person's culture, I consider it a subset of multicultural counseling. Religion also brings complexity into the therapeutic relationship: according to Ivey and Ivey (2012), the counseling process becomes more complex when therapists work with clients with different, "ethnographic, demographic, gender, socioeconomic, religious/spiritual, and cultural/racial identities" than themselves (p. 521). Therefore, therapists trained in multicultural counseling may be equipped to address religion in therapy. Ivey and Ivey (2012) stated, "Multicultural counseling therapy may be described as a metatheoretical approach to helping that recognizes that all helping methods ultimately exist within a cultural context" (p. 497). Multicultural counseling stresses and acknowledges cultural context by bringing awareness to the differences amongst clients.

Before the creation of multicultural counseling, there was a significant power imbalance between client and therapist. However, due to the development of multicultural counseling, therapists and clients can have a therapeutic relationship based on equality—a shared relationship of cooperation, learning, discovery, growth, and healing (Arredondo et al., 1996; D'andrea and Daniels, 1991). Carmichael (2011) supported this, stating, "Multicultural counseling competencies have been pivotal in the movement towards a more inclusive psychology" (p. 101). Multicultural competencies help therapists work from an ethical place, ensuring that the cultural values and biases of the therapist do not override those of the client (ACA, 2005).

Defining multicultural competence. There are several definitions of multicultural competence. Sue, Arredondo and McDavis (1992) defined multicultural competencies as an approach to the counseling process from the context of the personal

culture of the client. The American Counseling Association (2005) defined multicultural competence as “a capacity whereby counselors possess cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge is applied effectively in practice with clients and client groups” (p. 20). Overall, the multicultural competencies framework highlighted beliefs and attitudes, knowledge, and skills as the identified competencies that can help culturally competence therapists develop cross-cultural counseling skills.

At the time of this Literature Review, Arredondo (1999) and Sue and Sue (2003) were leaders in identifying multicultural counseling competencies. These authors highlighted the need for the multicultural competencies because these explicit guidelines help create culturally competent mental health professionals who practice ethically and appreciate individuality. Sue (1992) established a competencies framework that described how a culturally competent mental health professional should behave. The framework consisted of three dimensions a) belief and attitudes, b) knowledge, c) and skill. Sue and Sue continued to elaborate by demonstrating skills that each professional should adhere to such as: a) professional is aware of his/her own cultural assumptions, b) professional contains knowledge about the worldviews of their different clients, c) and professional uses culturally appropriate interventions. Arredondo (1999) expanded on Sue’s (1992) ideas by elaborating on each dimension and highlighting evaluative guidelines. See table 1 below for further explanation of multicultural competencies.

Table 1. Multicultural Competencies Framework

Multicultural Competencies Framework		
<u>Three dimensions</u> (Sue et al., 1992)	<u>Characteristics of the dimensions</u> (Sue et al., 1992)	<u>Evaluative guidelines</u> (Arredondo, 1999)
1) Belief and attitudes	a) The counselor's awareness of personal beliefs and attitudes, knowledge and skills for effective practice	<ul style="list-style-type: none"> - Emphasis on therapist own cultural heritage - Self-awareness is relevant, (Know how oppression, racism, discrimination, and stereotyping affect the therapist personally) - Pay attention to sensitivity, comfort, and other indicators of affect that can lead a therapists to work effectively in interpersonal situations
2) Knowledge	b) The counselor's understanding of beliefs/ attitudes and knowledge he or she holds about the worldview of the client	<ul style="list-style-type: none"> - Responsibility is placed on the counselor to be educated about other cultural groups - Engage in active self-awareness - Become aware of stereotypes and preconceived notions of other ethnic minority groups - Acquire awareness about how cultural socialization through family and different institutions and professions, the media, and political machinery shape our thinking and disrespect toward certain people.
3) Skills	c) The counselor's ability to provide ethical and culturally relevant counseling through appropriate intervention strategies and techniques	<ul style="list-style-type: none"> - Must have a comprehensive understanding of the field of counseling, sociopolitical realities, culture-specific values, and behavioral tendencies - Respect clients' historical and cultural experiences - Exercise institutional intervention skills on behalf of the client - Develop strategies ethically while remaining culturally sensitive.
<p><i>Table 1. Outlined the multicultural dimensions, and highlighted how Arredondo (1999) expanded upon the original work (Sue, 1992) by creating the evaluative guidelines.</i></p>		

Overall, the multicultural competencies provide explicit statements that will help therapists identify racism, oppression, and discrimination. Arredondo believed that counselors should look at these dimensions as guidelines that will make them better

equipped for their profession and help them practice ethically when working with clients of diverse backgrounds (Sue & Sue, 2003).

Furthermore, when a mental health professional becomes a part of a professional organization, like the American Mental Health Counselors Association or the American Counseling Association, they will agree to abide by that organizations code of ethics. One can then assume that they will act in accordance with that acknowledged set of standards, such as the document that addresses multicultural competence. This document “helps professions achieve greater sophistication in preparation and practice” (Arredondo & Toporek, 2004, p. 46).

Advantages of multicultural counseling. D’andrea and Daniels (1991) discussed several different advantages that have developed from the creation of multicultural counseling. The authors first broadly mentioned that the United States’ educational and mental health systems have inherently neglected the needs of the diverse American people throughout history. D’andrea and Daniels highlighted the creation of multicultural counseling as an advantage because it can help professionals address some of the cultural insensitivities that are involved in the counseling process and help the professional be more effective in such situations (Ivey & Ivey, 2012). Aforementioned, a benefit of the multiculturalism movement is that it allowed therapists to develop techniques that helped guide them to look beyond institutionalized racism that counselors were typically scared to address or could not identify as being inherently a part of their counseling training. D’andrea and Daniels affirmed, “This sort of training is often designed to stretch counselors’ awareness, extend their knowledge base, and expand their repertoire of counseling competencies” (p. 79). The hope is that after multicultural training, counselors

will be better able to work within their clients' worldview, to honor their client's own identified cultural needs and to make appropriate and effective interventions.

Disadvantages of multicultural counseling. Current research highlighted the limitations of multicultural counseling (Das, 1995; Ivey & Ivey, 2012). First, Ivey and Ivey (2012) found that the research that validates the effectiveness of multicultural counseling is quite limited. In addition, Ivey and Ivey mentioned that multicultural counseling therapy is extremely time-consuming and difficult to master due to myriad cultural facets. Das (1995) found that although 90% of the counselors' educating programs currently utilize multicultural counseling in their curriculum, these programs do not train students to meet the consistently expanding mental health needs of evolving diverse populations. In addition, the author demonstrated that multicultural counseling techniques stem from the view that the world is static and that groups are insular, suggesting that Americans remain in isolated groups and only are socialized within their own culture. Das argued that cultures constantly influence one another. When cultures impact one another through the exchange of beliefs and/or technology, acculturation begins to take place. Furthermore, due to the power differences in America, people from racial minorities tend to acculturate to the dominant or privileged race, and such assimilation inherently creates even more complexity.

Das (1995) proposed that in order to make cross-cultural counseling more effective, the counselor education curriculum must be altered to better serve the needs of the students (Carlson, Tarell, & Bartlett, 2006; Ivey & Ivey, 2012). Das pointed out that the majority of counseling programs only offer one class in multicultural counseling, and this one class typically only focuses on the social trends in society. Das preferred to see a

more sophisticated curriculum that analyzes relationships between all different cultures and made recommendations to utilize cultural perspective as a layer of depth throughout all clinical coursework exploring theories and practices.

Religion and Education

The current research described a lack of religious integration in counseling education courses (Berkel, Constantine, & Olson, 2007; Hage, Hopson, Siegel, Payton & DeFanti, 2006; Kelly, 1994; Plante, 2007). Berkel, Constantine, and Olson (2007) found that students enrolled in psychology/counseling programs did not receive efficient training in religious issues that may arise during the counseling process. The authors' findings correlate to my research question: if students are not provided opportunities to explore religion within their psychology courses then where and/ or how do they develop religious multicultural competence? In addition, Kelly (1994) conducted a national survey on religion in counseling programs. Kelly found that 93% of the academic programs did not offer a specific course on how to deal with religion in counseling. Similarly, Plante (2007) illuminated the lack of integration of religion in graduate and postgraduate training programs. Plante's main concern was that mental health professionals may not know how to provide proper services to their clients who might need religion integrated into the therapy sessions. Hage, Hopson, Siegel, Payton and DeFanti (2006) concluded that psychotherapy courses had innate opportunities for religion to be discussed, but these opportunities were underused. The abundant amount of research that discussed the lack of religion in the counseling education system illustrates that mental health professional are not adequately prepared in their educational programs to manage religious situations during the therapeutic process.

This lack of education causes professionals to be unprepared when dealing with religion in therapy, which results in therapists doubting each others' abilities. Berkel, Constantine, and Olson (2007) found that the majority of psychologists doubt their peers' capabilities in assisting clients with issues regarding religion or spirituality. Shranfranske and Malony (1990) found only 28% of psychology based faculty members perceived their colleagues as prepared to integrate religion or spirituality into the counseling process. Shransfranske and Malony believed that lack of preparation might have stemmed from the lack of competence and/or from the lack of education training regarding these issues in psychology.

Blurred boundaries and dual relationships can occur when psychologists provide psychological services while they are also members' of the clergy or religious organizations. Joyce and Symons (2009) advise that psychologists who are providing religious guidance should not also provide psychological services because the clients can confuse the two different roles, which can result in a dual relationship. Additionally, they argue that if the client is aware of the psychologist's religious affiliation, then the therapist should clearly communicate which role he or she is facilitating. For example, the obligation to report certain behaviors would differ depending on whether the therapist was acting as a clergy member or a counselor. Therefore, the clergy member would have to disclose his/her intended role and the legal obligations of that role.

Walker, Gorusch, and Tan (2004) argued that due to the lack of training in integration of religion into counseling courses, inappropriate integration is occurring within therapy sessions. For example, as a result of students not exploring these complex topics in their training processes, students are self-disclosing their personal beliefs inside

therapy sessions. The authors stated suggestions for additional training to benefit these students, such as how to appropriately include religious interventions with their religiously diverse clients. Myers and Willard (2003) added that regardless of the clients' stage of religion, therapists must not impose their personal religious beliefs onto their clients' in order to lead them in a particular direction; rather, therapists must facilitate clients as they integrate their own personal religious beliefs.

If integration of religion and counseling do not take place in counseling education, several different results may occur (Berkel, Constantine, & Olson, 2007; Curtis & Davis, 1999). Curtis and Davis (1999) believed that if students do not get the opportunity to explore their personal biases and control their self-disclosure, then the students might impose their beliefs onto their clients. In addition, Curtis and Davis suggested that it is important for therapists to learn about their clients' religious and spiritual beliefs, similar to how therapists learn about their clients' cultural norms and values. If clients' religious beliefs are ignored, they may terminate therapy and miss the opportunity for psychological growth. Berkel, Constantine, and Olson (2007) stated that failure to discuss religious issues in the academic training level might result in an environment that feels unsafe for the students. Furthermore, the lack of integrated training opportunities can make students who put value on their religious identities feel invalidated or disrespected because their belief systems are not being acknowledged. To develop more opportunities for students to increase their cultural awareness, several suggestions on how religion can become more integrated into counseling education were provided. Hage, Hopson, Siegel, Payton and DeFanti (2006) wanted to see future education programs providing more opportunities for students to improve their self-

awareness and therapeutic skills when dealing with religion. Curtis and Davis (1999) wanted to see entry-level classes providing more opportunities for students to explore their personal perspectives with religion before providing therapy. They added that additional time for religious self-exploration in the classroom would allow more time for students to become aware of their own religious biases.

Further research provided suggestions for how religion could become more integrated in the counseling field (Curtis & Davis, 1999; Hage, Hopson, Siegel, Payton & DeFanti, 2006; Plante, 2007). Plante (2007) discussed that if therapists decide to integrate religion into their work, then it is necessary that they: engage in religious training and supervision, seek the essential publications, and attend workshops and seminars regarding the clients' religious traditions. Das (1995) noted that counselors need to pay attention to several variables that can influence the interaction between a counselor and a therapists such as, "social stereotyping; different linguistic, non-verbal, and semantic patterns used by the client; and interaction rules that govern the moment-to-moment interaction between two people belonging to different cultural backgrounds" (p.46). These techniques provided insight on how to integrate religion into the counseling field.

In addition to these techniques, several researchers encouraged therapists to seek consultation when working with religious clients (Yarhouse & Fisher; 2002, Walker Gorusch, & Tan; 2004, Barnett & Johnson; 2011). Yarhouse and Fisher (2002) suggested when a therapist is unfamiliar with his/her client's religion, seeking consultation or supervision leads to greater awareness of the client's needs. They also highlighted that therapists need to be aware of their clients' religious involvement because some clients perceive their religious identity as the core of who they are, and others may not view it as

an important factor. Walker, Gorusch, and Tan (2004) concluded that future psychotherapists should seek further assistance from other explicitly religious therapists if they are struggling to understand their clients' who, "practice their spirituality within the context of an organized religion," (p.76). If therapists pursued guidance from an expert in their clients' specific religion, then the therapists would benefit from the gained understanding and awareness, and in doing so, further the therapeutic relationship. Barnett and Johnson (2011) believed that therapists should also educate themselves on helpful community resources such as community centers, health care organizations, and religious and cultural organizations (when collaboration is needed with other therapists). Therefore, they have a comprehensive list to refer their clients to for extra assistance.

In order to address complexities that can arise when dealing with religious diversity, an alternative model was developed by the American Psychological Association (APA), known as the RRICC model. The respect, responsibility, integrity, competence, and concern (RRIICC) model is a way to integrate all the aforementioned suggestions, and help integrate psychotherapy and religion (Plante, 2007). The values that were displayed in the RRIICC model are not only for psychologists. The RRIICC model can apply to other social sciences, such as social work and marriage and family counseling, thus demonstrating that the RRIICC model is relevant to most mental health workers.

Plante (2007) highlighted the key components of the RRIICC model. The word respect in this model references the need for mental health workers to respect clients' religious beliefs and to avoid diagnosing clients simply because they pursue explicit help in the area of spirituality. The therapist's responsibility is to have an awareness of

religion and spirituality and learn how those views/values can impact the clients with whom he/she works. Furthermore, therapists have a responsibility to collaborate with clergy and religious figures when dealing with religious clients if this is wanted from the client. Integrity is essential when dealing with clients because the professional must be honest at all times. It is important for the therapist to remember that they are a licensed mental health professional and not a religious official. Even extremely religious therapists are not deemed experts of that religion. Competence refers to professionals receiving adequate training and supervision if they decide to use religion and spirituality in their work with their clients. Concern is utilized because concern for the client's well being is the essence of the therapeutic relationship. Overall, the RRICC model has the potential to create learning opportunities related to diversity in the educational setting for counseling students as well as facilitate multicultural competence for current professional psychologists, (Plante, 2007) particularly regarding religious issues in therapy.

Religious Techniques Utilized in Therapy

In addition to the RRICC model, therapists can utilize several universal spiritual activities, albeit cautiously. Walker, Gorush, and Tan (2004) found that scripture and prayer were spiritual techniques that were utilized in therapy. Therefore, the authors discussed the need for specific training on how to use scripture and prayer as appropriate therapeutic religious interventions. Gubi (2009) conducted a qualitative study on counselors who used prayer in their practice and also provided insight on how to utilize prayer appropriately. The study revealed that the counselors who included prayer within their therapy were more aware of the ethical problems that could arise and discussed preventative actions. For example, in order to help reduce the power imbalance between

counselor and client, it was suggested the client lead the prayer instead of the counselor. Also, it was recommended that the counselor be mindful of the wording of the included prayers: counselors should not let their values and beliefs be conveyed through the prayer because this can offend the client. Moreover, the counselors should be aware of how they introduce prayer in the session because initiating the session with prayer can interrupt the client's process and negatively affect the relationship. According to some, if done correctly, prayer can help the therapeutic process by creating mutuality and intimacy between therapists and clients.

Sollod (1993) also discussed prayer as an important factor in therapy if done correctly. Furthermore, the author explained a few other important religious techniques such as therapeutic touch, meditation, and intuition. Hands-on religious healing, also known as therapeutic touch, is a touch technique or a near-touch technique where healing energy can be moved from the healer to the client (Brennan, 1987). Therapists who are trained in therapeutic touch, reiki, or other related healing modalities could employ these techniques for both physical and psychological problems during psychotherapy. This hands-on technique can help the client feel more relaxed, increase energy, and solve issues that have a somatic experience and/or representation. Additionally, Sollod (1993) suggested religious meditation as a way to facilitate therapeutic change. Meditation can help the clients achieve relaxation, alertness, awareness, empathy, sensitivity, and openness. Another technique discussed was the role of intuition and religion to help guide the therapeutic experience. Sollod defined intuition as, "The ability to attain a relaxed, meditative state, to focus on a question for which an intuitive answer is desired, and to wait for relevant thoughts, feelings, or images to arise in answer constitute the intuitive

process” (p. 10). The information gained by the therapist through the intuitive process should be examined rationally and utilized to help the client move forward. Sollod believed that religious integration in any technique discussed could help the client achieve deeper levels of healing. It is important to note that touch, mindfulness meditation, and intuition are secular techniques utilized by DMT curriculums, (Goodin, 2010; Sanchez, 2012), and these secular techniques can be employed with religious/spiritual significance.

Religion and DMT

It was imperative to discover literature that correlated DMT and religious multicultural competence. However, the research revealed a gap in the literature with regards to DMT and religious multicultural competence. Therefore, the majority of the literature relevant to this topic examined DMT and culture. Treewater (2008) spoke at an American Dance Therapy Association (ADTA) conference about her personal experience working in a setting that was culture specific. She mentioned that through her personal experience, she learned that it was necessary for dance/movement therapists to expand their awareness of their personal culture, co-workers’ culture, and their clients’ culture in order to create movement experiences that honored and respected everyone included in the spectrum of cultural diversity. The author believed that if dance/movement therapists learned how to understand and respect their clients’ culture as well as their co-workers’ culture, then the overall environment would be more inviting, comfortable, and open.

Chang (2008) also spoke about culture and DMT at an ADTA conference; however, her discussion focused on cultural competence. Chang had similar opinions as Treewater (2008) in regards to dance/movement therapists working with diverse

populations. When dance/movement therapists are working with ethnically diverse inner-city populations, the dance/movement therapists must learn how to be culturally competent. Chang discussed how to become culturally competent through the framework adopted by the American Association of Counseling through the aforementioned dimensions that Arredondo (1999) and Sue and Sue (2003) highlighted. Chang believed that through the dimensions, dance/movement therapists could begin self-exploration to enhance their cultural competence and have a better understanding of a wider range of clients. Just as dance/movement therapists deeply expand and explore their personal movement repertoire, they also have to explore culture, so they are better able to understand themselves and others.

Carmichael (2012) highlighted several steps that the DMT community has taken to increase awareness surrounding multicultural competency. For example, the ADTA developed a multicultural and diversity committee, and Carmichael noted the increase of outreach committees, professional development courses, and workshops to help promote growth in this area. However, even though there have been steps to improve the DMT community in regards to cultural competency, this study highlighted the lack of research on non-verbal communication, which is a benefit of DMT and cultural competence. This qualitative research study was created to learn how dance/movement therapists approach multicultural competency, and how the therapists, who contained an extensive and advanced therapy career working with diverse populations, utilize their non-verbal skills. Four unique dance/movement therapists were interviewed. Carmichael concluded that the current literature on cultural competence mainly focused on the powerful and privileged. In order to advance in the understanding of therapists and their diverse clients, she

suggested that the training curriculum in the education system needs improvement. However, course work requirements will not be enough to fix the problem. The author mentioned additional outlets for change such as “mentorship, continuous experiential study, and personal courage” (p. 110). This feedback will hopefully demonstrate the need for institutions to promote appropriate and ethical practice when working with clients, and highlight the need for students’ to learn, foster, and adhere to the multicultural competencies code of ethics.

Hervey and Stuart (2012) researched “the state of cultural competency education in the ADTA approved DMT training programs in the United States” (p.85). The ADTA approves graduates from the DMT programs based on several factors, which include, students’ competencies and their understanding of the material in the curriculum. Furthermore, the ADTA requires students to demonstrate, “The capacity to engage in therapeutic relationships informed by self-awareness, an understanding of cultural context, recognition and respect for diversity, and a commitment to social justice” (ADTA, 2009, p.2). The ADTA requirements were important to mention because the authors wanted to research if the curriculum in the DMT programs were meeting the ADTA requirements. Hervey and Stuart completed 10 different phone interviews with educators and administrative staff from a variety of the DMT graduate programs. They concluded that five out of the six approved programs had a discrete multicultural competence course, and the majority of the programs included a multicultural competence class during the first year of school. The instructors agreed that the multicultural competence courses were, “best at awakening the student’s awareness of the journey toward cultural competence” (p. 91). However, the study demonstrated that due

to the homogenous nature of the graduate students enrolled in the programs, it was a challenge for them to contain knowledge of others' worldviews. Additionally, the educators expressed that the courses being taught were not at the desired sophisticated level of competence. Two different programs proposed a similar non-verbal activity to increase multicultural competence: "learning dances from other cultures, and thereby expanding movement repertoire and empathic reflection skills" (p. 92). It is also important to note that half of the programs identified that when students actively learned from others at their field placements, they increased their cultural competence. Developing cultural competence from interacting with diverse populations supports the claims of Chang (2008) and Treewater (2008). However, aforementioned, the instructors believed that the students lacked knowledge of their personal culture and lacked knowledge of others' worldviews before they entered their field placements. These findings correlate to the purpose of my research, which was previously mentioned in the introduction section. If there are limitations in the multicultural training in DMT classrooms, then how does that lack of knowledge of other peoples' worldviews manifest when the students are at their diverse field placements and internships? Lastly, several recommendations were made to further enhance the cultural competence among dance/movement therapists, such as:

- a) Provide further multicultural and diversity training for all faculty, not just training for the instructors of the identified courses,
- b) seek an ongoing balance of free-standing courses and milieu support,
- c) actively increase diversity of faculty and student body,
- d) assess faculty and student cultural competence,
- e) embrace, develop, and teach to the cultural competencies that are unique to DMT. (p. 96)

These suggestions will help the future counselors and dance/movement therapists to increase their awareness, knowledge, and skills when working with diverse clients, which are the main guidelines for multicultural competence (Arredondo, 1999; Sue, 1992). However, again, it is important to remember how the DMT literature on multicultural competence mainly addressed culture—not religion specifically—as an overarching and all encompassing problem that needs to be further researched.

Several DMT studies examined the importance of religious and spiritual self-exploration (Rezai, 2013; Rothwell, 2006; Starrett, 2010). Starrett (2010) explored the religious chakra system as a DMT clinical self-care technique. The purpose of her study was to learn if the chakra system, based in Buddhist/Hindu tradition, was an effective self-care technique. Ultimately, she found that the chakra system helped her find a deeper awareness of her DMT presence. Rezai (2013) explored the interrelation between her profession as a dance/movement therapist and her Bahá'í faith. She investigated how her professional role, as she worked on an adolescent behavioral unit, influenced her religious role. Her goal was to help faith based dance/movement therapists find ways of religious integration and so they could bring those components into their work more consciously.

Rothwell (2006) used organic inquiry to examine how a group of dance/movement therapists described spirituality emerging within DMT sessions. The co-researchers described spirituality emerging in five areas: in the space created for the session, in the therapeutic relationship, in the actual process of therapy, in the spiritual self of the therapist and finally in the cosmological understandings, such as religious content or values, in a DMT session. Rothwell described the cosmological realm as a

component of spirituality within D/MT sessions. She stated, “the cosmological perspective informs and is informed by the religious, spiritual, cultural, or philosophical framework or context of a person” (p.62). Therefore, the cosmological realm shapes the values, beliefs, spirituality, and overall worldview of both therapist and client. She concluded, “this fact reiterates the importance of addressing multicultural diversity issues within the context of therapy and of furthering education in religious perspectives for therapists” (p.62). Furthermore, the co-researchers in Rothwell’s study recognized their own spiritual self as a crucial part of therapy because, “the spirit self is an experience and an embodied way of being” (p. 64). Although Rothwell identified ways in which spirituality emerges in a therapy session, she emphasized the need for further research into religious multicultural sensitivity and ethical responsibility within the DMT literature. These studies highlight religion and spirituality as important factors in the therapeutic process of DMT, but further research is needed to articulate the intersection of DMT and religious multicultural competence.

Conclusion

Overall, there was limited research discussing the role of religion and psychotherapy, especially the role of religion and DMT. Therefore, my research question—How do dance/movement therapists develop their own religious multicultural competence?—was not explicitly answered through any of the previously mentioned literature. Although cultural competency and DMT was minimally addressed in the existing literature, further research needs to highlight religion as inherently a part of cultural competence to improve the field of DMT and help prepare students to ethically incorporate religious practices into their clinical work.

Chapter III: Methods

The purpose of this study was to understand how dance/movement therapists perceive, acquire, and foster their own religious multicultural competence. As a novice clinician, I knew it was imperative to examine clinicians who already obtained their BC-DMT (Board Certified-Dance Movement Therapist) and R-DMT (Registered-Dance Movement Therapist) credentials so I could learn from their clinical experiences. I facilitated a focus group with six participants, and we engaged in a dialogue regarding their personal experiences with religion and multicultural competence. Based on my results and correlating data analysis, I hope to create an understanding of how dance/movement therapists develop their religious multicultural competence. Additionally, I wish to contribute to future research related to this topic and suggest ways in which the conversation of religion can be fully integrated into the educational experience.

Methodology

The methodology for the study was a qualitative case study. Mertens (2005) stated that a case study, “involves intensive and detailed study of one individual or a group as an entity, through observation, self-reports, and any other means” (p. 237). Discussing the role of religion with several participants with a variety of different belief systems was predicted to be intense and detail oriented; therefore, the case study methodology aligned with the complexity of the topic.

Participants

When I began preparing for the recruitment process, I intended to include a variety of diverse populations and religions in order to have a better understanding of

cultural diversity. I wanted to include as many people as I could to ensure a large sample size. The proposed sample size for my focus group was five to seven people, which was the standard size.

The recruitment process included a post to the ADTA website. In addition, I sent recruitment emails to participants through the Illinois Chapter of the American Dance Therapy Association. My study was also announced during an Illinois Chapter meeting of the American Dance Therapy association during spring 2013. Lastly, I personally sent out emails based on recommendations from my professors and peers. The recruitment post and the recruitment email (see Appendix B) as well as the announcement at the chapter meeting explained the purpose of the research and required participants who identified themselves as dance/movement therapists, with R-DMT or BC-DMT credentials, who have developed religious multicultural competence. The first five to seven people to respond were included in the study. During the recruitment phase, I discussed how technology would be utilized to allow for people out of the state of Illinois to participate to also ensure a variety in the group.

When the study took place I was able to meet my goal and had a total of six participants. The focus group included six dance/movement therapists from a variety of religions such as: Judaism, Catholicism, Neo-Paganism, Unitarian Universalism, and Christianity. Five of the participants were currently living in the Chicago land area, and one participant lived outside the United States; she participated in the discussion through Skype, a video conference tool. Additionally, four of the participants were board-certified dance/movement therapists and two participants were registered dance/movement therapists. All the participants were women. Ethnicities included one African American,

one Puerto Rican, and the remaining participants were Caucasian. All six participants graduated from Columbia College Chicago.

Procedure

During the recruitment process, I received confirmation from the first few participants. I responded to their emails, and I asked for their preferred dates in the month of June. I learned, from their separate emails, that June 28th, 2013 worked for the first few participants. Therefore, the next recruitment emails went out stating the date of the focus group would take place June 28th, 2013 from 5:30 pm to 7:30 pm and asked for interest of participation. Once people agreed to attend, they were required to complete the informed consent (see Appendix A) that I emailed them, and then they were given the choice of emailing it back to me, sending it through the postal service, or picking it up from me in person. Once all seven people agreed to that date, two reminder emails went out a week before on June 12th, 2013 (see Appendix D) and the night before June 27th, 2013 (see Appendix E). At the last minute one of the participants had to cancel, which resulted in six participants total.

The data was collected at a private reserved room Columbia College Chicago for two hours. When the focus group members arrived, they were asked to sign in on a sheet that asked for their name, credentials, pseudonym, religious affiliation, and where and when they graduated from DMT graduate school. They were reminded that the pseudonym would be used if they wished to be anonymous. Five out of the six focus group members included a pseudonym. After the sign in sheet was completed, I began the focus group with an introduction and explained the agenda, including five questions to be answered. I facilitated the questions in the order that I prepared them. However, I allowed

the conversation to occur organically in an unstructured interview form. I encouraged each participant to answer each question. A couple of times participants asked permission to go off topic, and I had to decline their requests for the sake of time. If participants were confused about a question, I did provide them with additional feedback so that they understood what was being asked of them. Being mindful of the time, I was able to obtain answers for all five questions.

Data Analysis

After the focus group was complete, I started transcribing the data on July 20th, 2013. It took me one week to finish the transcription of the data. The data analysis method was intuitive inquiry. Anderson (2004) stated the five intuitive inquiry cycles as “clarifying the research topic, identifying preliminary lenses, collecting original data and preparing summary reports, transforming and refining lenses, and integration of findings and Literature Review” (p. 307). For cycle one of my intuitive inquiry cycles, I engaged in different types of art making where I mainly focused on coloring different religious symbols. I observed several different religious symbols continuously showing up in my personal life, and spent much time exploring why they had a profound effect on my life every time I encountered them. In addition, I wrote in a journal every time religion came up in my personal and professional life, and I tried to emphasize my journal entries on how my day-to-day experiences with religious topics related to my findings for my Literature Review. Both the art making and the journal writing were ways that I engaged in my creative process to keep me motivated and clarify the research topic. For cycle two, I developed the focus group questions to help create my preliminary lenses before I collected any data. The focus group questions were developed from components that I

was personally curious about as well questions that arose after I read the current literature on the topic. After I transcribed the data, I began cycle three, collecting original data. First I printed the transcription and highlighted poignant quotes. I highlighted quotes that resonated with me, were articulated well, and information that I thought was insightful and beneficial for the field. From there, I looked at each question separately and hand wrote all the themes that I saw emerging. Highlighting the themes helped me create summaries of all the data, and those were included in my results section. During cycle four, titled transforming and refining lenses, I ensured validity by using the interpretative validity. I completed this by emailing my interpretative lenses to the focus group members, and I asked them to interpret what I discovered in order to deepen and clarify my interpretations of the material. After I received their input, I completed the cycles by integrating my new understandings from the participants' reactions as well as integrated the information with my Literature Review. The additional relevant information was added to the discussion section of my thesis.

Ethical Considerations

The main ethical concern was confidentiality risks. Focus group research can be difficult to ensure confidentiality because the researcher cannot guarantee that all of the participants will abide by the confidentiality agreement. However, I encouraged confidentiality before the focus group began, and I highlighted the importance of it. To further help the participants remain anonymous, pseudonyms were created and they were utilized throughout the research process. The audio recording, transcription of the data, and validity emails were seen only by the primary investigator (i.e., myself) as well as my

thesis advisor. Additionally, the audio recording and transcription will be deleted upon my thesis submission and completion of my master's degree.

A potential risk was the possibility of discomfort because the topic of religion is complex. Not only did I facilitate a focus group where everyone contained different religious values, but I also asked them personal information that could have triggered traumatic memories. However, each of the participants volunteered their time and read the informed consent before participation. Therefore, it can be assumed that they had some level of comfort discussing the topic because they volunteered their participation.

Chapter IV: Results

I set out to investigate how religion plays a role in multicultural competence. My research question was how do dance/movement therapists develop their personal religious multicultural competence? To obtain this answer I asked the focus group members five specific questions (see Appendix C). During the discussion of these questions, each person shared their journey of how their personal religion developed and how their experiences correlated to their own multicultural competence during their course work and clinical work. From their answers to the questions, several themes emerged, such as, definition of religious multicultural competence, shifts and non-shifts in religion, lack of training, religious insensitivity, and additional components added to the definition of multicultural competencies.

Question 1: Definition of Religious Multicultural Competence

The first question that I asked was for each focus group member to define religious multicultural competence. Each participant contributed to the conversation and explained how they viewed religious multicultural competence, including the most important factors that needed to be included in the working definition. Specifically, focus group member S stated that she viewed religious multicultural competence as follows,

Just like any other kind of multicultural competence, [it] is being aware of where you come from and your own place and your possible biases, and how your religion affects your worldview and therefore how it might affect how you are taking in your clients, your coworkers, and your supervisors, and whoever else is in your clinical environment.

Focus group member L added to the conversation the concept of neutrality. L stated that dance/movement therapists need to “recognize [their] biases and also when [they] are actually applying [them]. Because whatever else shows up in the room [they] still have to stay neutral.” Focus group member F further developed the concept of neutrality by suggesting that dance/movement therapists should approach the therapeutic process from a place of curiosity. F stated, “Coming from a place of curiosity and asking questions helps me remain neutral and not impose.” In addition, focus group member A added the role of openness and respect to the definition. A stated,

Life or existence can be challenging, and there’s many different ways to approach those challenges, and religions attempt to make sense of those challenges.

Understand or know that there are lots of different ways to approach the challenges of existence, in that you may have your own preferences. Be aware of your preferences, but understand that somebody else’s preferences are just as valid [as] them too. Be able to be respectful towards other peoples’ preferences.

Related to the concept of openness, Focus group member GA discussed the importance of remaining open in order to achieve receptivity. GA stated,

As therapists, we need to receive that person in that sense of openness. Just being with whatever they bring into the room is what we do as therapists all the time.

But yet, taking in that worldview [briefly], and just receiving [it]. But, being mindful of how hit it hits you, [and] let it wash through.

Focus group member Clair highlighted the importance of awareness to the discussion.

Clair answered the first question by stating,

The first word that comes to my mind is awareness of yourself and awareness of others. But I think the questioning is the key because we all have stereotypes of “this religion means this,” and actuality it is just about what the person personally believes, and we have to educate ourselves.

After each of the participants shared what they believed should be included in the definition of religious multicultural competence, I integrated all of their answers into a working definition: Engaging in religious multicultural competence includes having an awareness of yourself, your worldview, biases, and religious stereotypes so that you can remain neutral, respectful, and open in order to receive your clients, co-workers, and supervisors when encountering religious situations in the clinical setting. After the working definition was developed, I emailed it to the participants and asked for their input on my interpretation of the data.

Question Two: Where Does Your Religious Multicultural Competence Stem From?

The second question of the focus group asked participants where their religious multicultural competence stemmed from by requesting they reflect on their religious upbringing. As all of the focus group members reflected on their religion and how it developed over time, I was able to identify several themes that had emerged from their responses: a religious shift in the participants’ parents, a shift in the participants’ religion of origin, and no shift. In addition, several factors were identified that contributed to the religious shifts or non-shifts such as openness and a sense of connection to their religious community.

Religious shifts. The first theme that I identified for question two was the presence of a religious shift that had occurred during the participants’ lives. The type of

shifts happened in different forms; however, I was able to identify similarities between their stories and group the participants under each similarity. In this particular group, the majority of the participants had a significant religious shift that took place in two different identifiable forms that they discussed: (a) a shift in the participants' parents' personal lives and (b) a religious shift from their religion of origin. There was one participant who did not describe a religious shift in her journey of how she developed her religious multicultural competence.

A religious shift in the participants' parents' personal lives. Three of the focus group members discussed how their parents had a religious shift in their lives that contributed to the participants' current personal religious beliefs. Focus group member A stated that her parents grew up in a Christian environment, but then they rebelled against it. Her parents gravitated towards the United Church of Christ. At the time of the focus group, focus group member A identified herself as a Unitarian Universalist, which aligned with her parents' religious views. Additionally, focus group member F discussed her mother's religion of origin as Catholic. However, focus group member F's mother watched her father question the Catholic Church, and she eventually converted to Judaism. Both of focus group member F's parents were Jewish, and she stated that because of her mother converting there was an, "extra commitment there." During the focus group, F identified her religious affiliation as Jewish, which aligned with her parents' religious views. Similarly, focus group member S discussed her fathers' religious shift. Her father was ordained as a minister in the covenant church but eventually, "rejected conservative Christianity and got re-ordained in the United Church of Christ (UCC)." Focus group member S explained that even though both her parents

were apart of the UCC, she eventually had her own personal religious shift from her family of origin and identified as Neo-Pagan. Therefore, S had both identifiable shift forms in her personal journey because her parents changed their religious affiliation as well as focus group member S.

A religious shift from their religion of origin. Two focus group members had their own personal religious shift from the religion of origin. Focus group member L talked about growing up Catholic in Puerto Rico. Focus group member L explained, “Catholicism is quite big there.” However, L eventually stopped going to Catholic Church and now identifies herself as Christian. In addition, focus group member Clair shared that she grew up southern Baptist and both her parents, to this day, work for a southern Baptist church. However, after high school Clair told her parents, “ I am never going to southern Baptist church again.” After the religious shift, Clair identified herself as Christian.

Non-religious shift. The remaining focus group member did not discuss any shift in her parents’ religion of origin or her personal religion of origin. Focus group member GA shared how she grew up in a Catholic household. Focus group member GA identified as Catholic her entire life. GA stated, “ So my Catholic faith is what I know, my Christian Catholic faith.”

Factors contributing to the shifts or the non-shift. All of the participants shared factors that impacted why their parents shifted, why they shifted, or why they did not shift their religious belief system that they identified with. These factors included: openness and connection to community.

Openness. A majority of the group discussed how openness played a role in their development of religious multicultural competence. Focus group member L shared that both her parents were open when she stopped going to the Catholic Church. L stated, “My mom was very open. My parents [both] were.” Similarly, focus group member S shared that because her father rejected the faith that he grew up with, he and her mother were open and supportive when she made the shift because they had done something similar. Additionally, F expressed that her mother was always “very very open” and remained open as she went on her spiritual journey. Lastly, even though GA did not make a religious shift, she shared how she and her mother were open to different religions. GA described religious workshops that GA and her mother attended, and they both went on spiritual journeys with people of all different faiths. This demonstrated that even though they never changed their religious views, they were open to being surrounded by a variety of different religious beliefs.

Sense of community. Another theme that emerged during question two was the sense of community and how it affected their religious multicultural competence. Focus group member A talked about going to a private African American school and how that community made her feel. When she described her experience at the school, she emphasized, “It was really nice and kind of protected.” Focus group member GA discussed growing up in a Catholic community. GA stated, “My whole life I went to Catholic grammar school, Catholic high school, all women’s Catholic college. So my Catholic faith is what I know.” As she continued to share her journey, she also mentioned, like focus group member A, a sense of safety from her Catholic community. GA stated, “My world was being Catholic—that’s what it was for me. And I loved that.

There was a beauty in that there was a safety. It felt good that everyone thought similarly.” Additionally, focus group member F described her sense of community, even though she did not grow up in a Jewish community. She mentioned that there were few Jewish families that went to school with her, and she described herself as “the token Jew.” Focus group member F shared memories of going to temple where she felt connected to Judaism and was with people who shared similar religious beliefs. However, she described painful memories of going to temple because she came from a lower socioeconomic class than her peers. Due to the difference in socioeconomic class, there were times when she did not want to continue going to temple. Focus group member F stated,

I am telling you that was one of the best life experiences I got throughout my childhood because as much as there was a place for me to feel comfortable and connected to people and yet feel different, there was a place in my life where I felt left out. And I felt different not in a good way. And that was a really good education.

In addition, focus group member F discussed how she gained a sense of community now that she is a parent who is Caucasian to her child who is an African American. She shared how she feels accepted by her Jewish community when her and her daughter go to their temple. F shared that she is a member of a temple that is, “very progressive and all inclusive, and my African American daughter is not very different there.” This demonstrated how she was able to re-find a sense of community as her roles have changed throughout her life. Another example of being connected with a community of faith was shared through focus group member Clair’s experiences. Clair shared how she

was able to find a group of people she felt religiously connected to even though she was living outside of the United States and living in a Hindu community. Clair explained,

I guess I would have friends that had the same religious beliefs, but I never necessarily connected with a community of faith at a church. And to this day, I am married and have kids, and we have what we call a community of faith. We don't actually go to a church. But, we have friends, three families, and we meet with them. So, it's four families all together, and we just sort of read the bible, pray, share, do life together, and that's our community of faith.

Question Three: Multicultural Counseling Training

Question three of the focus group asked the participants if their multicultural counseling training prepared them when working with religious clients. Additionally, I asked them to provide specific examples of interventions during which religion was discussed, and their management of those situations. A couple of themes emerged from this question. One theme was the lack of training in the DMT program at Columbia College Chicago, specifically with regards to religion and the therapeutic process. Another theme was internal and external sources that helped the participants work effectively when the topic of religion entered the room. Therefore, I concluded that regardless of the lack of training in the graduate program, the participants found ways to progress forward.

Lack of Training

The majority of the focus group members agreed that there was a lack of education in their multicultural counseling courses in regards to religion. Focus group member F responded immediately by saying, "I do not feel like I was properly trained."

Focus group member L agreed, stating, “I feel the same way. I think that what I learned in school just kind of tapped into different belief systems. But it wasn’t very directly like ‘this is about spirituality, or this is what to expect.’ But no great training.” Similarly, focus group member GA stated, “I did not get specific training on that.” Furthermore, focus group member S highlighted her role, in the focus group, as the most recent graduate of the program and revealed how her recent lack of training has affected her.

Focus group member S stated,

I didn’t receive training in religious competencies. I feel like we read articles and book chapters on counseling people with someone of another racial background or someone of another ethnic background, gender, and sexuality. But, there was zero about religion and spirituality. So I did not feel prepared at all when [religion] came up in my internship. Really even today I feel like I have a hard time with it. I’m a young clinician, and I am just getting started out. Sometimes I really don’t know what I am doing at all.

Focus group member A replied to focus group member S’s response. It is important to note that focus group member A was in the first graduating class of the DMT program, so she provided a historical perspective to the question. Focus group member A explained that religion was never discussed in the classroom. She emphasized, “What you are talking about didn’t exist 30, 40, 50 years ago. So whatever training I had really wasn’t formal, and I don’t think it would be considered training.” Overall, everyone’s responses showed that whether a student graduated from the program when it originally began or from the most recent years, the consensus was clear: there was a lack of training in the classroom with regards to religion and the therapeutic process.

When I asked participants to provide examples of how they dealt with religious situations, two themes arose. I realized that the focus group members managed the situations from either internal sources or external sources. Both the external and internal resources helped the participants keep moving forward with their clients regardless of their lack of training.

Internal resources. The participants discussed several different internal sources that they utilized to manage religious situations for which they felt unprepared. Focus group member F discussed the importance of her breath. She shared an example of a client who was tough for her, as he was working through a sexual and religious crisis. Focus group member F stated

[As I was being flooded with] judgment and countertransference, I pulled from my breathing. Just breathing myself down. To ground myself to stay present and to connect with my core qualities that I prefer to function from obviously non-judgment and calm were the biggest ones I had to connect with.

Focus group member GA also shared the importance of breath and prayer during these complex situations. She shared how she utilized her own personal religion to help her get through situations where she did not necessarily know what to do. For example GA said,

I pray before a session, and I ask God to give me wisdom. How can I be with this client? I pray before, I pray after, I pray during. I would breath and ask God to be with me. So, I would use my own spirituality often in the session. So, I connect with spirituality constantly, and its through breath, my posture, and grounding for me. It's tied into my spirituality and being Christ. I embody Christ.

Similarly focus group L utilized her own spiritual beliefs and prayer as a technique for self-care during complex religious situations. Focus group member L said,

...Literally we go into the dark all the time when we work with people who are hurting. So, I ask for protection, for Jesus to protect me. I invite the Holy Spirit into the room. When working with a Christian client there is the opportunity to pray together. But also knowing and having that boundary of what's going to benefit them, and that's when prayer comes in a lot. It informs me of what they need and of course the clinical skills and keeping that boundary and safety.

Additionally, focus group member GA shared another internal source was her responsibility as a therapist to continually engage in self-evaluation and therapy. GA stated,

I do think that it is our responsibility as therapists to continue to do that self-evaluation. So that's where I think your own psychotherapy comes in, supervision, exploring your own self and your own spirituality. I think if you don't explore what goes on within yourself it's going to get carried over into your therapy. It's our responsibility as a therapist to continue to re-evaluate, explore, to work on us. So, I think it's easier then to be with your clients when you can go there.

Focus group member A utilized the technique that she learned from being in the program several years ago to help her manage religious encounters. She emphasized that during her classroom experience, she was taught to "meet the client where they were at." Focus group member A explained her techniques by saying,

If you are meeting the client where the client is at, then you will try to get an understanding. If they are bringing something new to you, or something that you are unfamiliar with, or something that you have a really shallow background in, then the clients can be invited to share to teach.

As focus group member A provided a couple of specific examples from her clinical experience, it became clear that when she was unfamiliar with the religion of her client, she allowed them to teach her about their faith. After she learned about their faith, she would spend time bridging what she learned from them and how it could help the therapeutic process from a psycho-educational framework. For example focus group member A stated,

Well she told me about hers, and then I told her about what we were doing. So I thought it was a sharing of equals. Among equals. And it helped to kind of decrease her defensiveness and her resistance [to therapy].”

The education of the religion from the client as well as the education of what therapy entailed ultimately helped the client feel seen and validated, which are standard therapy goals.

In addition, focus group member A discussed the link of mindfulness and spirituality as helpful techniques. She stated,

As dance/movement therapists, we are taught to be mindful, and we learn how to be more mindful over time. And mindfulness is strongly connected to spirituality. So whatever dance therapists may have called it in the past, they called it positive energy. It's hard doing dance movement therapy without being spiritual.

Focus group member A tried to illicit that even though religion was not explicitly stated in the classroom, the concept of mindfulness was welcomed, and she believed that mindfulness is directly correlated with spirituality. Therefore, technically, spirituality, if not religion, is inherently a part of the therapeutic process.

External resources. Although the majority of the sources mentioned were internal ways of dealing with religious situations in the therapeutic process, a few external sources were highlighted. Focus group member F shared how she sought out additional training on religion since she graduated the Columbia DMT program. She attended continuing education workshops because she wanted to increase her knowledge. Additionally, she demonstrated that being a professor in the DMT program and learning from others had been another external source that helped her gain more knowledge regarding religion. Focus group member F stated,

I have been so fortunate with getting to teach, and all those years being exposed to all of our students coming with such diverse cultures and religions. Learning along the way as you teach people who are becoming therapists. Learning what's important to them with all the different religions and cultures as developing therapists, and how to use it to be a better therapist. That's been an education for me. As well as my work with all my patients and clients over the years and learning from them.

Focus group member F also shared her education through the Internal Family Systems (IFS) framework as a helpful resource during complex religious situations. She attended IFS conferences and completed her own personal research to help her handle her responses to her clients when they were in spiritual crisis. Aforementioned, focus group

member F preferred to facilitate therapy sessions from her core qualities, which is an IFS concept. In addition, a couple other focus group members spoke similarly about leading therapy sessions from their core religious selves. The connection of religious multicultural competence and the IFS model will be further explored during the discussion section of this thesis.

Upon researching the curriculum over time, I found that multicultural counseling training did not take place in Columbia College Chicago training during the first class of 1982, the cohort that focus group member A was a part of. Since then, multicultural counseling theory has been incorporated into the program, but the majority of participants still felt a lack of training in religious multicultural competence. Despite the lack of religious training in the graduate program, participants learned underlying therapeutic principles in the program that guided them in developing multicultural competence.

Question Four: Religious Insensitivity

Question four of the focus group asked participants to discuss any religious insensitivity they experienced as a student in the DMT program and as a practicing clinician. Several of their responses demonstrated the religious insensitivity as not only a past problem, but also an issue that is still occurring in various forms.

Insensitivity as a DMT student. Focus group member GA shared her experience as a student in the DMT program as a practicing Catholic. GA shared,

In school there were times where I felt like maybe I am not as open minded as other people because I am connecting to Christian[ity]. Coming into the program as a Christian, I did feel that at times I was the only one who came from an organized religion. I don't want to say it was negative. It was a self-exploration.

They were trying to figure out me, and I was trying to figure out them, and how my faith fit in this. So in terms of dance therapy for me, I was this kind of Catholic woman. I felt kind of shamed when I started dance therapy because I was Catholic. I felt very shamed that I had a religion. I felt like that for a while within my class. So if I was going to church I kind of felt odd.

Focus group member Clair experienced similar questioning to her openness as a Christian during her time as a DMT student. Clair stated,

I feel like everyone was pretty open. I have gotten 'you're a Christian you are going to be judgmental.' But I have never felt like it was a personal attack on me or who I was. That was just people's perceived stereotype. But, I think that in school there were times where I felt like maybe I am not as open minded as other people because I am connecting to Christian[ity]. Like am I as open minded as other people? But that was a personal thing I was going through. So, I don't think anyone was putting that on me. But, being around other people with different backgrounds it made me question.

Focus group member S shared, that to this day, the majority of her classmates do not know her religious affiliation. Therefore, she explained how she received insensitivity in a different form because they did not know her religious values. Focus group member S stated,

I feel like I am on the receiving end of insensitivity where people don't know that they are being insensitive because they did know my religious affiliation. They might use different terminology or language or that kind of thing because they don't know ...[to] be careful.

Focus group member L discussed how she believed that a lot of the DMT theories taught in class could be inherently attached to certain religious beliefs, and she viewed this as insensitive. Focus group member L stated,

I feel like a lot of theories or the material that we learn in school, specifically for DMT, a lot of the background for when we talk about mindfulness can kind of be attached to certain specific religions or organization. For example, Buddhism in the sense that people are open and in the same sense still has some sort of roots in something else that could also be considered a religion.

Focus group member F also shared her views on the DMT program and the insensitivity she had experienced regarding scheduling on Jewish high holidays, which she viewed as insensitive. Focus group member F said, “I have had insensitivity with the scheduling with Columbia on Jewish high holidays, specifically during GL-CMA (Graduate Laban Certificate Movement Analysis) there have been scheduling issues.”

Religious insensitivity in the clinical environment. Focus group member L shared her working experience with stereotypical jokes related to her being a Christian from clients and co-workers. She shared that people feel like she is judgmental because she is Christian, and she views this assumption as insensitive. Focus group member L stated, “the judgment that may come from denominations of Christianity. People may judge and people make jokes in front of you. So, I can find that to be insensitive.” Focus group member F shared her experience in the clinical environment, working in the late 1990’s at a teen parenting center that was Catholic. She spoke about experiencing stereotypical and hateful comments surrounding Judaism. She mentioned that she

handled the situation poorly and minimized it because it caught her off guard, but in fact, she was dealing with “profound racism.”

Lastly, focus group member A discussed her lack of experience of insensitivity in regards to religion, rather she encountered more cultural insensitivity. Focus group member A stated,

I don't think I have felt any insensitivity to religion. There has been more insensitivity towards my cultural racial background. But, on religion, maybe because my religion is so broad based I can flip to anyone's religion for a little bit. But it's a non-issue for me at this time. Maybe it will change. But, right now I feel like it is a non-issue

Question 5: Revising the Definition of Religious Multicultural Competence

The last question of the focus group gave the participants an opportunity to reflect on all their previous responses to the focus group questions, and see if they wanted to revise the definition of multicultural competence that they previously answered for question one. Focus group member Clair stated,

... [As therapists] we should talk about spirituality and religion because it brings up a lot of things for me personally and the clients. It brings up a lot of things that you need to process and you can see your biases, and if you can get through those then you can become a stronger person, and you can work through a lot of those issues. So I just think a part of being a multicultural therapist is that you have to be comfortable with that being in the room, and being able to talk through those things and being able to deal with your stuff. But, also, being comfortable with

other people's stuff because I think there's power in that, and there is deeper healing once you get through that.

Focus group member F replied to Clair's response by highlighting the need to appreciate peoples' differences. She stated,

You know it's not everything, but for a lot of patients and clients a large part of the work is assisting people to get to the point where there is an appreciation of differences. When we are seeing the differences, [and] embracing [them] amongst groups of human beings with love. Seeing and embracing the difference so that we can exist intra-personally from peace, acceptance, non-judgment, non-criticism, and from love. The more we are doing that with ourselves the more we can teach that to the client or help the clients get there.

Focus group member L completed the focus group by simply stating, "It goes back to regular ethics, doing whatever it is we do as clinicians. Is it going to harm them or be beneficial?" After I analyzed the participants' responses to question five, I combined the new information to the previous working definition of multicultural competence that was created in question one: Engaging in religious multicultural competence includes having an awareness of yourself, your worldview, biases, and religious stereotypes so that you can remain neutral, respectful, and open in order to receive and appreciate the differences amongst your clients, co-workers, and supervisors when encountering religious situations in the clinical setting in order to practice ethically.

Discussion

Purpose

The purpose of this study is to understand how dance/movement therapists, with BC-DMT or R-DMT credentials, acquire, foster, and perceive their own religious multicultural competence as it relates to DMT. The research question is how do dance/movement therapists develop religious multicultural competence? Through the methodology of a qualitative case study, and the data collections method of a focus group, examination took place regarding the self-perception of each participant's own religious multicultural competence. Through the analysis of the focus group questions, several themes were discovered and provided in the Results section. The Discussion section will begin by reviewing each question that was asked during the focus group, and then connect themes that emerged from those questions to the existing literature in psychology and DMT. Additionally, implications and results for the DMT field will be discussed, and will recommend new research questions to help guide future research.

Questions 1 and 5: Definition of Religious Multicultural Competence

One reason the participants were recruited was to discuss religious multicultural competence because of the lack of literature on this particular topic; the majority of the literature focused on cultural competence in a general sense, rather than on religion specifically. Consequently, I wanted to discover how religion played a role in the overarching concept of cultural competence, and I wanted to examine how cultural competence could impact the counseling field and DMT. After listening to participants' answers, I combined their responses into a more group-defined definition to illuminate the importance of integrating religion in the counseling field. The following was the final definition created for religious multicultural competence, which includes the revisions

suggested during question five: Engaging in religious multicultural competence includes having an awareness of yourself, your worldview, biases, and religious stereotypes so that you can remain neutral, respectful, and open in order to receive and appreciate the differences amongst your clients, co-workers, and supervisors when encountering religious situations in the clinical setting in order to practice ethically.

There are several important factors to note about this definition. First, the participants' definition could be considered a universal meta-theory or guiding principle that encompasses and ensures multicultural competence. The religious multicultural competence definition could help dance/movement therapists develop an understanding of the importance of the competencies because it was created from several different viewpoints. The variety of religious viewpoints makes it more easily relatable and applicable. Second, many similarities exist between the co-researchers' definition of religious multicultural competence and the respect, responsibility, integrity, competence, and concern (RRICC) model, discussed in the Literature Review. For example, several participants discussed the need to respect their clients' religious worldviews, and they also shared experiences when respect was not received from clients/co-workers while working in the clinical field. Additionally, several participants shared how it was their own responsibility to continue in religious self-awareness to help them practice more respectfully. These examples demonstrated the overlap between the participants' definition of religious multicultural competence and the RRICC model and highlighted that in order to be an effective therapist, one must recognize that understanding the religious background of both therapist and client is a key to successful therapy.

Therefore, one may propose that if separate religious training courses do not fit into graduate program curriculums, the RRICC model should be taught at minimum. As noted in the Results section, several of the co-researchers discussed a number of the RRICC values as internal and external resources they utilized when encountering difficult religious situations at their clinical work. If this model was taught in the DMT classroom, it would create religious learning opportunities in the educational setting and prepare students to be more effective and ethical counselors by explicitly examining how religion plays a role in DMT and counseling. Again, Plante (2007) highlighted the RRICC model as a way to address religious complexities that can arise during therapy and help therapists achieve respectful religious interactions. If the RRICC framework was integrated into the DMT program, it could act as a meta-theory that could be addressed/utilized in all the courses as a guide to ethical multicultural practice.

Third, this definition of religious multicultural competence speaks to aforementioned statements regarding the disadvantages of multicultural counseling. As noted in the Literature Review, Das (1995) demonstrated that cultures and religions do not develop and socialize in a vacuum, but the multicultural counseling theories are taught in this manner. It was suggested that future multicultural counseling training should be altered to better fit the needs of the diverse populations (Carlson, Tarell, & Bartlett, 2006; Ivey & Ivey, 2012). Therefore, in order to develop a definition for religious multicultural competence, it needed to evolve from a multifaceted perspective to ensure an all-encompassing definition that could be applied by anyone. This was achieved in the focus group in that, despite an array of diverse and distinct religious perspectives, there was a shared value system that guided our discussions about religion.

This evidence suggested that regardless of what the participants' religious perspectives were/are, they identified key factors that needed to be included in the definition of religious multicultural competence, and the majority shared common ideas for this definition, regardless of their personal belief system. The co-researchers confirmed that dance/movement therapists needed to be respectful of all religious beliefs (Barnett and Johnson, 2011) and demonstrated that with each other throughout the focus group and in developing their definition.

Question Two: Where Does Your Religious Multicultural Competence Stem From?

The opportunity was provided for every participant to share her religious journey. During their responses several different emotions were expressed, such as joy, sadness, shame, guilt, excitement, and laughter. However, what I found the most interesting was that the participants discussed the concept of openness several times during the answer of this question, and generally throughout the entire focus group. This surprised me because before the focus group took place, I automatically prepared myself for stereotypes of organized religions and assumed the participants were going to be narrow-minded, intolerant, and argumentative. Surprisingly, the exact opposite took place. Everyone appeared polite, calm, and open, regardless of the different worldviews. The focus group demonstrated that a part of the co-researchers' multicultural competence stemmed from their own spiritual/religious journeys, and multicultural competence itself was demonstrated as the group participants discussed their spiritual/religious journeys with openness, self-exploration, and a sense of community. These common characteristics shared between the participants reflect the literature that highlighted the values of multicultural competence, such as beliefs and attitudes, knowledge, and skill (Arredondo,

1999; Sue, 1992) and respect, responsibility, integrity, competence, and concern (Plante, 2007). The participants self-identified as having religious multicultural competence, and evidence of this competence was clearly displayed during the focus group.

Religious shifts, openness and self-exploration. Through the focus group, each person had a chance to share her religious journey. Many, but not all, of the participants described some kind of a shift in their religious affiliation. The religious shifts identified were a) a religious shift in the participants' parents, b) a shift in the participants' religion of origin, and c) a non-religious shift, such as remaining the same religion as her parents. For many of the participants, this shift facilitated more investment and connection with their religion. It also initiated the multicultural competencies of openness and self-exploration. For example, several participants shared their parents were open in nature because they had experiences in their lives that had resulted in a conversion from their religion of origin, something they had communicated with their children. Did the parents' religious shift affect the participants, and how did this manifest in their clinical skills? I speculated that because the participants were able to observe their parents being open-minded in regards to other religions, then this therapeutic principle of being open to others became inherent in their daily and clinical lives. Religious shifts seemed to relate in a positive way with developing openness to other people's religion and religious journey and developing a capacity for religious self-exploration.

In addition, the participants shared that in order for them to remain open to other religious values, they consistently needed time for religious self-exploration, while both a student and working mental health professional, in order to remain aware of how their religion played a role in the therapeutic process. Practicing broad-mindedness and taking

time for introspection were evaluative guidelines that Arredondo (1999) highlighted as inherently a part of the multicultural competencies. This was reflected in many of the participants' experiences in the focus group. Focus group member GA believed it was the therapist's responsibility to consistently engage in religious self-evaluation in order to continue, "exploring your own self and your own spirituality." Due to the participants' having a relationship to the idea of openness, this could have helped them practice religious self-exploration in their daily lives. From the informed consent form, the participants knew they were going to be introduced to several different religious belief systems into the room and explicitly delve into uncomfortable situations and/or memories. Even though they came from different religious backgrounds, the participants were willing to take the time to explore their own religious upbringings, share their personal stories, and listen to others' viewpoints, worldviews, and feedback. Their interactions within this sensitive discussion demonstrated the openness, self-exploration, and respect included in the multicultural/religious competencies. The current literature also supported the result that broad-mindedness and self-exploration are essential factors in multicultural training (Arredondo, 1999; Berkel, Constantine, & Olson, 2007; Curtis & Davis, 1999, Sue, 1992). Students needed time to explore themselves, specifically their own religion and others, so they could be better equipped to practice ethically and responsibly when working with religion in the therapy room (Curtis & Davis, 1999; Hage, Hopson, Siegel, Payton and DeFanti, 2006).

Sense of community. Even though the participants were not explicitly asked to discuss the role of their religious communities, the concept surfaced several times. Some participants mentioned how their personal beliefs did not align with their religious

community, and this ultimately led them to shift from their religion of origin. Others highlighted how their religious community provided them with a sense of safety and comfort. Therefore, it can be speculated that religious communities could be a positive, negative, or neutral resource for people—whether therapist or client. Either way, the influence of the religious community needs to be addressed in therapy. If therapists can recognize the influence of one's religious community, then they can more appropriately and effectively understand how the religious affiliation affects the client, and intervene more knowledgeably.

Question Three: Multicultural Counseling Training

Multicultural counseling literature consistently reinforced that counselors received insufficient training in multicultural counseling and felt unprepared to counsel diverse populations (Berkel, Constantine, & Olson, 2007; Curtis & Davis, 1999; Hage, Hopson, Siegel, Payton & DeFanti, 2006; Kelly, 1994; Plante, 2007; Shranfranske & Malony, 1990). This was consistent with the focus group, which echoed the participants feeling unprepared due to the lack of religious specific multicultural counseling education. When asked about their multicultural training experience as DMT students, the majority of the participants felt there was a lack of training in their graduate coursework; specifically a lack of religious training in the curriculum left them feeling unprepared to manage religious topics and interventions. Participants mentioned that they felt unprepared for field placements and internships, consistent with my observations in the program and my eagerness to develop and improve my personal multicultural competence.

Interestingly, this phenomenon of learning during field placement/internship was presented in DMT literature. Professors interviewed in Hervey and Stuart's (2012) study mentioned that even though DMT multicultural courses were lacking in sophistication, students were able to develop their multicultural competence when they entered into their field placements. However, there are many problems with this, the most important being that it can be unethical to clients due to religious insensitivity or prejudice. As noted in the Literature Review, an unethical experience can also occur when a therapist imposes his/her religious values onto their clients' (Walker, Gorusch, and Tan, 2004). As articulated by Berkel, Constantine and Olson (2007), failure to discuss religious issues during academic training might result in an environment that feels unsafe for the students. As noted in the focus group (question four), several participants faced incidents of religious insensitivity while in the program due to a lack of religious multicultural training.

Internal resources. Even though the participants felt they did not receive sufficient religious training during graduate school, a positive theme to emerge was their ability to seek internal and external resources to help acquire religious sensitivity and manage complex religious situations. To offset the multicultural/religious training deficit, participants sought religious multicultural competence through internal sources. Internal spiritual resources included the therapists engaging in the following: breath work (in the vein of meditation), prayer during therapy to help them discover solutions for their clients, prayer as a self-care practice, spiritual self-evaluation, and mindfulness (also in the vein of meditation). All of the mentioned internal resources related to Arredondo's (1999) belief and attitudes evaluative guidelines for the multicultural competent

counselor. The participants discovered internal mechanisms to help them expand their religious beliefs and attitudes and develop their religious selves.

External resources. Several of the participants discussed external religious resourcing, such as participating in religious workshops and continuing education seminars, engaging in religious communities, learning from the diverse students as a professor, interacting with religious clients, and using the Internal Family Systems (IFS) model. IFS therapists believe that helping clients accept their many parts will lead to healing (Schwartz, 2013). One participant utilized the IFS method as an external technique that she resourced when religion was discussed in therapy. This technique enabled her to view the religious self of the client as a part, which she was able to approach with compassion. These external resources that the participants discussed related to Arredondo's (1999) knowledge component included in the evaluative guidelines for the multicultural competent counselor: the participants sought ways to acquire information concerning other religious facets in order to practice with the necessary knowledge.

Spiritual self. One participant highlighted the IFS method as a technique she utilized when she felt unprepared to facilitate religious interventions/conversations during therapy sessions. She utilized this method during religious encounters because she was able to connect to a core Self (Schwartz, 2013). Furthermore, several participants mentioned that when religion was brought into the therapeutic relationship, several of them utilized a spiritual self to help them appropriately manage the situation. The participants' discussion of the spiritual self also related to Arredondo's evaluative guidelines for multicultural competence in regards to the belief/attitude section as well as

Rothwell's (2006) discussion of the spiritual self. These findings support the concept that exploration of the spiritual self can help dance/movement therapists acquire religious multicultural competence.

Other external resources. A final external influence mentioned by participants was a counseling technique known as “meeting the client where they are at.” Focus group member A emphasized that this technique was taught to her in the classroom and helped her develop religious multicultural competence. Accepting the client for who they are and where they are—including their religious beliefs—allows the therapist to remain neutral and empathize with the client regardless of their own religious affiliations. One can also view this technique as a person-centered approach because both approaches share similar values: they allow therapists to learn from their clients, which focus group member A highlighted as her intention behind employing this strategy (Ivey and Ivey, 2012; Rogers, 1951). But, like IFS, this technique was an adaptation of a general counseling concept, resourced when participants felt unprepared for religious topics in therapy.

One could venture that even though the participants did not obtain ample religion-specific multicultural training at Columbia College Chicago, the DMT program did, however, teach the students basic core counseling principles based in person-centered therapy that allowed them to succeed when working with their clients. The internal and external resources mentioned also encouraged best practice and reflected Arredondo's (1999) evaluative guidelines in regards to the skills area. The participants developed strategies in order to manage religious situations ethically while remaining culturally sensitive, upholding the standards of religious multicultural competence.

Inclusion of multicultural counseling. After spending time exploring the Literature Review and the transcription from the focus group, I discovered a parallel relationship between the multicultural movement in the counseling field and the multicultural coursework in the DMT program at Columbia College Chicago. In 2004 Columbia College Chicago contained a one-credit course titled Community Cultural Seminar. In 2005 there was a shift in the curriculum, and the course changed to a three-credit course titled Social and Cultural Foundations. The implementation of Social and Cultural Foundations demonstrated that Columbia College Chicago recognized the importance of learning about diversity. Though the inclusion of this course represented a step in the right direction, greater depth, sophistication, and integration of multicultural competence into the rest of the program should be prioritized. If religious multicultural competence does not become integrated into the entire curriculum, students may continue to experience religious insensitivity or fail to practice ethical religious multicultural competence through religious stereotyping or insensitivity.

As mentioned earlier, instead of competence being achieved through one designated course, multicultural competence should be incorporated into all courses. For example, Dance/Movement Therapy Theory I could explore religious movement techniques, and students could explore, observe, and discuss the implications for religious multicultural competence. Additionally, Arredondo's (1999) evaluative guidelines could be further explored in Counseling Theories. The students could utilize this framework before, during, and after their diverse internships. Hence, they would feel more prepared to manage diverse religious encounters and practice ethically and responsibly, which are the main objectives of multicultural competence (Arredondo, 1999).

Multicultural competence as a meta-theory. As noted in the Literature Review, one of the disadvantages of multicultural counseling is that it is hard to achieve a level of expertise because of all the existing cultures, or all the particular religious denominations (Ivey & Ivey, 2012). Therefore, learning about multicultural competence in the MA program could be taught from a meta-theory perspective. Hence, students would learn about the key values of multicultural competence, such as openness, self-exploration, non-judgment, and acceptance. If the students were given the opportunity to learn about multicultural competence from a meta-theory practice, they might develop their own spiritual awareness and spiritual selves. Then they might be more prepared to ethically, appropriately, and responsibly hold the therapeutic space for the clients. Future researchers could investigate if the meta-theory practice helps dance/movement therapists better engage their spiritual selves and develop multicultural competence. Perhaps the use of a multicultural overarching theory will be transferrable between religion, race, and culture and would benefit the DMT community in a variety of environments, educational to clinical.

Religious techniques. Another way to introduce students to religion in counseling might be to teach religious therapeutic techniques, while highlighting ethical boundaries. As articulated in the literature, there were several religious techniques that could be utilized appropriately in the counseling field, such as prayer, meditation, therapeutic touch, and intuition (Gubi, 2009; Sollod, 1993; Walker, Gorush & Tan, 2004). From personal experience in the program, as well as from the DMT literature, I noticed that practices such as mindfulness, touch, and intuition were already generally explored in the DMT program curriculum (Goodin, 2012; Sanchez, 2012). However, one

could suggest that these concepts be further explored during the entire MA program, especially in relation to explicitly religious practices that are similar in nature.

Question Four: Religious Insensitivity

DMT religious insensitivity. A majority of the participants recounted several instances of religious insensitivity both when they were enrolled in the DMT program and while working in the clinical field, including assumptions, stereotypes, and inappropriate jokes. Participants shared feelings of shame and intimidation, which resulted from experiencing religious prejudice, and insensitivity towards their being part of a religious minority. Despite these incidences, participants said they advanced as clinicians because they developed assertiveness and self-advocacy regarding their religions. Although unpleasant experiences are to be expected when students grow as clinicians—and even as professional clinicians develop—how can counselors learn, process, and grow from those experiences? By helping students process insensitive religious situations, students could learn how to negotiate difference and acquire appropriate multicultural competence among peers' conflicting viewpoints. As noted in the RRICC model, respect is an essential component for a multicultural counselor (Plante, 2007).

Research Limitations

The focus group included six different co-researchers, which resulted in six religious perspectives. Several other religious denominations were not represented in this study, and the few religions represented may have limited the variety of viewpoints. Therefore, one can speculate that the data collection method of a focus group inherently is a research limitation because it limits how many participants and perspectives are

included. In addition, all the participants in this study were female, and this restricted their responses to a female perspective. Participants also attended Columbia College Chicago, even though it was my intention to recruit participants from any of the six nationally accredited DMT programs. This could have skewed the data for several reasons. First, it created a narrow perspective because it only represented one of the DMT schools. Second, the participants may not have been as forthcoming due to peer pressure amongst an intimate setting. Thirdly, more in depth questions could have been asked regarding internal or external resources used to acquire religious multicultural sensitivity, boundaries around religious techniques, and experiences of religious insensitivity. For example, several of the co-researchers spoke about insensitive religious encounters they had endured but described them on a surface level. Therefore, more in-depth questions regarding the insensitive experiences may help the co-researchers explore this on a deeper level and provide more clinical insight. This could have been achieved by asking the participants to provide specific examples of how they dealt with religious prejudices to help understand several ways on how to handle the situations more appropriately, affectively, and responsibly.

Future Research

Opportunities for future research include further investigation of the definition that developed through the focus group, the boundaries of how the spiritual self of the therapist relates to the spiritual self of the client, how students can explore their spiritual selves in a classroom context, and how a meta-theory of multicultural competence may support development of religious multicultural competence.

Internal resources. Based on focus group responses and Rothwell's (2006) findings regarding the spiritual self, I became curious about how dance/movement therapists' spiritual and religious self relate. How does spiritual self-exploration relate to the development of religious multicultural competence? Future research could further examine the emergence of spirituality in DMT sessions in order to help DMT students become conscious of their own spiritual process, acquire sensitivity to spirituality as it emerges, and be better prepared to discuss spirituality with clients.

External resources. Based on the focus group responses regarding external resources, future researchers could also investigate DMT specific training on religious multicultural competence. Additionally, future researchers could investigate the IFS model and the meta-theory of the RRICC model specifically as ways to help students learn about their religious self, converse with clients ethically, and engage in multicultural competence appropriately (Plante, 2007; Schwartz, 2013). Also, further research could investigate cosmological concepts, such as religious content, ritual, and practices, so dance/movement therapists could manage the religious content in sessions, and identify ethical boundaries when therapists utilize religious practices in therapy. When is religious content appropriate in therapy sessions? What are the ethical boundaries to consider when engaging in religious techniques, such as prayer or scripture, during dance/movement therapy and counseling? Lastly, understanding how religious content may or may not serve the client is also an important question for further exploration. Future researchers could ask when is religious content blocking a client from personal growth? When is it appropriate for dance/movement therapists to question their clients' religious beliefs? The study of religious/spiritual ethical boundaries may help

clarify how religion/cosmology may be integrated into a session in an ethical manner, which again highlights the need for further research on religion and DMT in order to help developing counselors be better equipped to manage this complex subject matter.

Conclusion

My research question for this study was how do dance/movement therapists develop religious multicultural competence? The purpose of this study was to understand how dance/movement therapists, with BC-DMT or R-DMT credentials, acquire, foster, and perceive their own religious multicultural competence. Ultimately, I learned that several different ways facilitate development of these competencies such as: religious upbringings, multicultural counseling education (in the DMT classroom and/or through other education modalities), religious self-exploration, and internal and external religious resources. Significant findings included a) a definition of multicultural competence, b) a reciprocal relationship between religious shifts, openness, and religious self-exploration c) a lack of explicitly religious training in the Columbia College Chicago Dance/Movement Therapy and Counseling program, and d) the shared experience of religious insensitivities. In general, I learned that there is not a single universal answer to my research question because this focus group demonstrated that every participant had a different religious upbringing and those personal experiences manifested themselves differently throughout their lives and in their approaches to therapy. These findings also related to my personal theoretical framework, which is Roger's person-centered approach. As previously mentioned, Rogers viewed every client's worldviews as unique (Rogers, 1951). Therefore, when I am interacting with a client, it is important for me, and I believe for all dance/movement therapists, to remember how each person's religious

upbringing is different. This includes providing an opportunity for the client to share how religious experiences have affected his/her life journey and to allow him/her to make the decisions on how religious experiences will play a role in the therapeutic process.

The focus group demonstrated that even though people may identify with the same religion or have similar upbringings, they may not share the same outlook or methodology. Because religious experiences are not universal, students need time to explore their personal relationships to their own religious values, so they will become more well-rounded dance/movement therapists. Students' deepening their religious/spiritual self-awareness could be the key to formatting an approach and a new perspective for the MA program to implement. Hopefully, this would result in DMT students expanding their religious journeys and in turn help their clients do the same.

Given my conclusions, I was able to bridge my findings with the existing literature. Several common themes emerged, which I was able to translate into recommendations to improve Columbia College Chicago's multicultural counseling training—specifically how to integrate religion in the curriculum. Additionally, research limitations were discussed and future research areas were addressed. Ultimately, my hope is that this study demonstrated the need to improve the religious multicultural counseling training in DMT curriculums to help novice counselors become better equipped to manage complex, diverse, and insensitive religious experiences.

References

- American Counseling Association. (2005). ACA code of ethics. Retrieved from <http://www.counseling.org/Resources/aca-code-of-ethics.pdf>
- American Dance Therapy Association. (n. d.). Multicultural and diversity committee information sheet. Retrieved from www.adta.org/Resources/Documents/MDC%20Info20Sheet.doc
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed). Arlington, VA: American Psychiatric Publishing.
- Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling and Development, 77*(1), 102-108.
- Arredondo, P., Toporek R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*, 42-78.
- Arredondo, P., Toporek, R. (2004). Multicultural counseling competencies=ethical practice. *Journal of Mental Health Counseling, 26*. Retrieved from <http://www.questia.com/library/1G1-113300343/multicultural-counseling-competencies-ethical-practice>
- Arredondo, P. (2003). Resistance to multiculturalism in organizations. In J. S. Mio & G. Y. Iwamasa (Eds.), *Multicultural mental health research and resistance* (pp. 83-104). NY: Brunner-Routledge.
- Barnett, E. J., & Johnson, B. (2011). Integrating spirituality and religion into

- psychotherapy: Persistent dilemmas, ethical issues, and a proposed decision making process. *Ethics and Behavior*, 21(2), 147-164. doi: 10.1080/10508422.2011.551471
- Berkel, L., Constantine, M., & Olson, E. (2007). Supervisor multicultural competence: Addressing religious and spiritual issues with counseling students in supervision. *The Clinical Supervisor*, 26(1/2). doi: 10.1300/J001v26n01_2
- Brennan, B. A. (1987). *Hands of light: A guide to healing through the human energy field*. New York: Bantam.
- Carlson, L., Tarrell, P., & Bartlett, J. (2006). Self-management of career development: Intentionality for counselor educators in training. *Journal of Humanistic Counseling, Education and Development*, 45(2), 126-137.
- Carmichael, G. N. (2012). Turning towards multicultural diversity competence in dance/movement therapy. *American Journal of Dance Therapy*, 34(2), 99-113. doi:10.1007/s10465-012-9140-z
- Chang, M. (2008, October). *How does cultural competence matter to the 21st century dance/ movement therapist?* Paper presented at the 43rd annual conference of the American Dance Therapy Association, Austin, TX.
- Curtis, R., & Davis, K. (1999). Spirituality and multimodal therapy: A practical approach to incorporating spirituality in counseling. *Counseling and Values*, 43(3), 199-209.
- D'Andrea, M., & Daniels, J. (1991). Exploring the different levels of multicultural counseling training in counselor education. *Journal of Counseling and Development*, 70, 78-85.

- Das, K. (1995). Rethinking multicultural counseling: Implication for counselor education. *Journal of Counseling and Development, 74*(1), 45- 54.
- Goodin, J. M. (2010). *A heuristic investigation of intuition in dance/movement therapy practice* (Unpublished master's thesis). Columbia College Chicago, Chicago, IL.
- Gubi, M. P. (2009). A qualitative exploration into how the use of prayer in counseling and psychotherapy might be ethically problematic. *Counseling and Psychotherapy Research, 9*(2), 115-121.
- Hage, S., Hopson, A., Siegel, M., Payton, G., & DeFanti, E. (2006). Multicultural training in spirituality: An interdisciplinary review. *Counseling and Values, 50*(3), 217- 234.
- Harvey, L., & Stuart, L. (2012). Cultural competency education in approved dance/movement therapy graduate programs. *American Journal of Dance Therapy 34*, 85-98. doi: 10.1007/s10465-012-9135-9
- Hill, P. C., & Pargament, K. I., Hood, R. W., Jr., McCullough, M. E., Swyers, J. P., Larson, D. B., & Zinnabauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social behaviour, 30*, 51- 77.
- Freud, S. (1989). *The future of an illusion*. New York, NY: W. W. Norton & Company.
- Hoge, D. R. (1996). Religion in America: The demographics of belief and affiliation. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 21-24). Washington, DC: American Psychological Association. doi: 10.1037/10199-001.

- Ivey, A., & Ivey, S. (2012). *Theories of counseling and psychotherapy* (7th ed). Boston, MA: Allyn and Bacon.
- Joyce, M., & Symons, M. (August, 2009). Psychology, religion, and spirituality: Ethical issues to consider. *InPsych*. Retrieved from https://www.psychology.org.au/inpsych/spirituality_ethics/
- Kelly, E. W., Jr. (1994). The role of religion and spirituality in counselor education: A national survey. *Counselor Education and Supervision*, 33, 227-237.
- McGoldrick, M., & Giordano, J., & Pearce, J. K. (1996). *Ethnicity & family therapy* (2nd Ed.) New York, NY: The Guilford Press.
- McLeod, S. (2008). The medical model. Retrieved from <http://www.simplypsychology.org/medical-model.html>
- Meyers, J. E., & Willard, K. (2003). Integrating spirituality into counselor preparation: A developmental wellness approach. *Counseling and Values*, 47, 142-155.
- Plante, T. (2007). Integrating spirituality and psychotherapy: Ethical issues and principles to consider. *Journal of Clinical Psychology*, 63(9), 891-902.
- Rezai, E. M. (2013). *Explorations into continuity: An heuristic, artistic inquiry into the interplay between works as a dance/movement therapist and service within the Bahá'í community*. (Unpublished master's thesis). Columbia College Chicago, Chicago, IL.
- Rogers, C. R. (1951). *Client centered therapy: Its current practice, implications and theory*. Cambridge, MA: Riverside.
- Richards, P. S., & Bergin, A. E. (1997). *A spiritual strategy for counseling and psychotherapy*. Washington, DC: American Psychological Association.

- Rothwell, K. (2006). *The spiritual awareness of the dance/movement therapist: An organic research study*. (Unpublished master's thesis). Columbia College Chicago, Chicago, IL.
- Sanchez, M. (2012). *Mindful bodies: The use of guided meditation with dance/movement therapy in addiction treatment*. (Unpublished master's thesis). Columbia College Chicago, Chicago, IL.
- Schwartz, C. (2013). Moving from acceptance toward transformation with internal family systems (IFS). *Journal of Clinical Psychology*, 69(8), 805-816.
- Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy*, 27, 72-78.
- Sollod, N. R. (1993). Integrating spiritual healing approaches and techniques into psychotherapy. *Comprehensive handbook of psychotherapy and integration*. New York, NY: Plenum Press.
- Starrett, L. A. (2010). *Charka self-care: A heuristic exploration*. (Unpublished master's thesis). Columbia College Chicago, Chicago, IL.
- Sue, D.W., Arredondo, P., McDavis, R. J. (1995). Multicultural counseling competencies and standards: A call to the profession. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.). *Handbook of multicultural counseling* (pp. 624-644). Thousand Oaks, CA: Sage.
- Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice*. Retrieved from http://books.google.com/books?hl=en&lr=&id=SUrWYYpX2ScC&oi=fnd&pg=PR19&dq=sue+and+sue+2003+counseling+the+culturally+diverse&ots=3_sntb9w

3i&sig=xfu4ED6h_UwueeR7as8OtvQisI#v=onepage&q=sue%20and%20sue%202003%20counseling%20the%20culturally%20diverse&f=false

- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling Development, 20*(2), 64-88.
- Treewater, L. (2008, October). *Dance therapy with a Jewish twist: Working in a culture-specific setting*. Paper presented at the 43rd Annual Conference of the American Dance Therapy Association, Austin, TX.
- Walker, D., Gorsuch, R., & Tan, S. (2004). Therapists' integration of religion and spirituality in counseling: A meta-analysis. *Counseling and Values, 49*, 69-79.
- Yarhouse, M. A., Fischer, W. (2002). Levels of training to address religion in clinical practice. *Psychotherapy: Theory, Research, Practice, Training, 39*(2), 171-176.
doi:10.1037/0033-3204.39.2.171

Appendix A

Columbia

C O L L E G E C H I C A G O

Informed Consent Form

Consent Form for Participation in a Research Study

Title of research Project: Dance/movement therapy and religious multicultural competence

Principal Investigator: Jaclyn Abramson, Jaclyn.abramson@loop.colum.edu, 847-209-6627

Faculty Advisor: Laura Downey, ldowney@colum.edu, 312-369-8548

Chair of Thesis Committee: Laura Downey, ldowney@colum.edu, 312-369-8548

INTRODUCTION

You are invited to participate in a research study to look at, if, and/or how you developed religious multicultural competence. This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. You are encouraged to take some time to think this over. You are also encouraged to ask questions now and at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. This process is called 'informed consent.' You will receive a copy of this form for your records.

You are being asked to participate because you either are a board certified dance/movement therapist or a registered dance/movement therapist who responded to the recruitment email expressing interest in participating in the project.

PURPOSE OF THE STUDY

The purpose of this study is to examine dance/movement therapists who have BC-DMT and R-DMT credentials to better understand how they develop religious multicultural competence. The purpose of the research is to initiate a dialogue about religious multicultural competence among dance/movement therapists.

PROCEDURES

- Board certified dance/movement therapists and registered dance/movement therapists that expressed interest in being a part of this project will be asked to participate in the study.

- If you choose to participate, you will attend a two-hour focus group either by being physically present or through the use of technology. The focus group will be audio recorded.
- You will then be asked to reply to my email containing my interpretations of the data I collected. Your responses will help deepen and clarify my understanding of the material.
- The types of questions that will be asked during the focus group will regard how you develop religious multicultural competence?
- The research will be conducted in a private reserved room on Columbia College Chicago property.
- I will transcribe the audio, and two years after the focus group is complete I will destroy the data.

If you agree to participate in this study, you will be asked to do the following:

- Attend either physically or with the use of technology and participate in the two-hour focus group.
- Reply to a follow-up email.

POSSIBLE RISKS OR DISCOMFORTS

- There are no expected discomforts except for those relating to the emotional and social self-disclosures in participating in the focus group amongst your colleagues.

POSSIBLE BENEFITS

- The benefit of this study for you as an individual is the potential of professional development through reflection on personal practice.
- The possible benefits of being in this study include benefiting the future of the dance/movement therapy community by bringing awareness of the need to initiate religious multicultural competencies

CONFIDENTIALITY

Confidentiality means that the investigator will keep the names and other identifying information of the research participants private. The investigator will change the names and identifying information of research participants when writing about them or when talking about them with others, such as the investigator's supervisors.

- A confidentiality statement will be made at the beginning of the group asking the participants to keep everything that is said in the focus group confidential. There is a confidentiality risk, as confidentiality cannot be completely protected in a focus group setting, however it is firmly requested of each of you and of course required on the part of the principal investigator.
- The researcher will keep all study records in a locked location.
- The audio recording and any documents from the focus group and reply emails will be destroyed no longer than 2 years after you participate in the study.

- Information about you that will be shared with others will be unnamed to help protect your identity. When presenting the findings in my written thesis and presentation, if it seems necessary to present the data of a particular participant in a more in depth manner, I would use a pseudonym to further protect you. Each participant will be given the chance to choose his or her own pseudonym. The principal investigator will be the only one to know the participants pseudonyms. Drawn from the content of the focus group, I request your permission to anonymously quote you under your pseudonym.
- The thesis advisor and the principal investigator will be the only individuals who have access to the focus group audio recordings and follow up email.
- At the end of this study, the researcher may present her findings. You will not be identified in any presentation.
- No real names will be mentioned in the final written thesis.

The following procedures will be used to protect the confidentiality of your information

1. The researcher will keep all study records locked in a secure location.
2. Any audio and videotapes will be destroyed after the thesis is approved.
3. All electronic files containing personal information (i.e., follow up email) will be password protected.
4. Information about you that will be shared with others will be unnamed to help protect your identity.
5. No one else besides the investigator and thesis advisor will have access to the original data.
6. At the end of this study, the researchers may present their findings. You will not be identified in any presentations.

RIGHTS

Being a research participant in this study is voluntary. You may choose to withdraw from the study at any time without penalty. You may also refuse to participate at any time without penalty.

You will have two weeks to make a decision. I will be happy to answer any question(s) you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator Jaclyn Abramson 847-209-6627 or the faculty advisor Kim Rothwell 312-968-3154. If you have any questions concerning your rights as a research subject, you may contact the Columbia College Chicago Institutional Review Board staff (IRB) at 312-369-7384.

PARTICIPANT STATEMENT

This study has been explained to me. I volunteer to take part in this research. I have had opportunity to ask questions. If I have questions later about the research or my rights as a research participant, I can ask one of the contacts listed above. I understand that I

may withdraw from the study or refuse to participate at any time without penalty. I will receive a copy of this consent form.

Participant

Print Name:

Date:

Principal Investigator's

Print Name:

Date

Appendix B
Recruitment Email

Subject: CCC Dance/Movement Therapy research participants wanted- Registered and Board Certified Dance/Movement Therapist only please

You are invited to participate in a Columbia College Chicago graduate research study to be used as a part of a dance/movement therapy Masters' thesis. The purpose of this study is to examine dance/movement therapists who have BC-DMT and R-DMT credentials to better understand how they develop religious multicultural competence. The purpose of the research is to initiate a religious multicultural competence among dance/movement therapists.

I am looking for 5 to 7 Registered or Board- Certified Dance/Movement Therapists who believe they have developed religious multicultural competence. The two-hour focus group will take place in a private reserved room on Columbia College Chicago property in the month of June. Based on the group member's availability a date and time will be later notified via email. If you are interested in participating please contact me for further details. If you do not live in the state of Illinois and you are still interested in participating, please note that you will still be able to partake through the use of technology. Several different types of technology will be implemented to better meet the needs of the potential participants. After I interpret the data, you will receive an email of my findings. I will ask you to reply to my interpretations to help deepen and clarify my understanding of the material.

My contact information has been provided below. Please do not hesitate to email or call me with any questions you might have regarding the focus group or the study in general. In addition, I have provided the contact information of my thesis advisor, Kim Rothwell. If you have any questions concerning your rights as a research participant, you may contact the Columbia College Chicago Institutional Review Board staff (IRB) at 312- 360- 7384

Thank you for your time and consideration, and I look forward to hearing from those who are interested in participating in this research study.

Sincerely,

Jaclyn Abramson

Jaclyn Abramson (Principal investigator)
Email: Jaclyn.Abramson@loop.colum.edu
Phone Number: 847-209-6627

Kim Rothwell (Thesis advisor)
Email: Kimbrozia@gmail.com
Phone Number: 312- 968-3154

Appendix C

Focus Group Questions

Research Question: How do dance/movement therapists develop religious multicultural competence?

Questions

1. What is your definition of religious multicultural competence? (**Definition**)
 - a. What are the most important principles of RMM in your experience?
2. Where does your religious multicultural competencies stem from? (**Source – internal**)
 - a. What resources do you engage, in order to develop religious multicultural competency? (**resource- external**)
3. Has multicultural counseling training prepared you for working with religious clients? If so how? Please provide specific examples and/ or interventions
4. How have you experienced multicultural insensitivity (specifically religious insensitivity) in your experience as a dance/movement therapy **student**? If so, how has this influenced the development of your religious multicultural competence as a dance/movement therapist?
 - a. How have you experienced multicultural insensitivity (specifically religious insensitivity) in your experience as a dance/movement **therapist**?
5. Does anybody want to add/ revise to their previous definition of religious multicultural competence?

Appendix D
Week Reminder Email

Dear (name)

I am looking forward to the focus group, which is rapidly approaching. I wanted to remind you that the focus group is taking place June 28th from 5:30- 7:30pm (624 S. Michigan Ave, floor 11, room # **1108**).

A DMT class will be finishing a course at 5:00 pm in room 1105. Therefore, if you wish to remain anonymous, you may want to enter the room before 5:00pm.

Food will be served from 5:00 - 5:30pm, and we will begin at 5:30 pm.

Thank you, and if you have any question feel free to call me at (847) 209-6627

Jackie Abramson

Appendix E
Final Reminder Email

Dear (name)

This is the final reminder that the focus group is taking place tomorrow June 28th from 5:30- 7:30pm (624 S. Michigan Ave, floor 11, room # **1108**).

A DMT class will be finishing a course at 5:00 pm in room 1105. Therefore, if you wish to remain anonymous, you may want to enter the room before 5:00pm.

Food will be served from 5:00 - 5:30pm, and we will begin at 5:30 pm.

Thank you, and if you have any question feel free to call me at (847) 209-6627

Jackie Abramson

Appendix F

Summary of Results

Dear participants,

Listed below is a summary of the Results section of my thesis. Each question is discussed, and I highlighted the main themes that I found after I transcribed and analyzed the data. If you are interested in reading the entire results section, which includes several of your quotes, please let me know and I will be happy to provide it to you. After you have read the summary provided, please read and respond back with any feedback that you have. I plan on having the entire thesis completed by November 1st. Therefore, I am requesting that you read and send back your comments within a two week period (Due by October 4th, 2013). Again, thank you for your time. I really appreciate it.

I look forward to hearing from you.

Jackie

Question 1: Definition of Religious Multicultural Competence

The first question that I asked was for each focus group member to define religious multicultural competence. Each participant contributed to the conversation and explained how they view religious multicultural competence and what were the most important factors that needed to be included in the working definition. After I included several quote responses, I combined all the answers and created a working definition.

Definition of religious multicultural competence: Engaging in religious multicultural competence includes having an awareness of yourself, your worldview, biases, and religious stereotypes so that you can remain neutral, respectful, and open in order to receive your clients, co-workers, and supervisors when encountering religious situations in the clinical setting.

Question Two: Where Does Your Religious Multicultural Competence Stem From?

The second question of the focus group asked the participants where their religious multicultural competence stemmed from by reflecting on their religious upbringing. As all of the focus group members reflected on their religion and how it developed over time, I was able to identify several themes that had emerged from their responses such as, a religious shift in the participants' parents, a shift in the participants' religion of origin, and non-religious shift such as: remaining the same religion as her parents. In addition, several factors were identified that contributed to the religious shifts or non-shifts such as: openness from their parents, openness to people with different religious belief systems, and personal openness to exploring other religions. Additionally, a sense of connection from their religious community helped the participants develop their own religious multicultural competence.

Question Three: Multicultural Counseling Training

Question three of the focus group asked the participants if their multicultural counseling training prepared them when working with religious clients. Additionally, I asked them to provide specific examples, of interventions, when religion was discussed in their clinical environment and how they managed the situation when the topic arose. A couple of themes emerged from this question. 1) Multicultural counseling training was not apart of Columbia College Chicago training several years ago. (The Social and Cultural Foundations class that incorporated multicultural counseling was implemented into the program in 2005, and it was a three-credit course. Before 2005, the class was called Community Cultural Seminar, and it was a one credit course) 2) Now that multicultural counseling is apart of the program, the participants felt a lack of training in

regards to religion specifically and the therapeutic process. 3) Regardless of the lack of religious training, the participants self-selected to seek internal and external therapeutic sources of guidance. In acquiring religious multicultural competence, the participants' are/were aware of their religious/spiritual orientation as present in the therapeutic relationship/therapy room, and that lead them to investigate the nature of religious multicultural competence.

Internal sources mentioned: breath work, use of prayer during therapy, use of prayer as a self-care practice, process of self-evaluation, using the “meet the client where they are at” technique, and mindfulness.

External sources mentioned: continuing education seminars, workshops, being a dance/movement therapy professor, and IFS training. The use of IFS was a way that several participants identified connecting with a core spiritual self.

Overall, I found that multicultural counseling training did not take place in Columbia College Chicago several years ago. However, now that multicultural counseling has been incorporated into the program, the majority of the participants felt a lack of training on religious multicultural competence. Regardless of the lack of religious training in the graduate program, the participants used underlying ethical and therapeutic principles that helped guided them in achieving multicultural competence.

Question Four: Religious Insensitivity

Question four of the focus group asked the participants to discuss any religious insensitivity they experienced as a student in the DMT program and as a practicing clinician. Several of the participants' responses demonstrated the religious insensitivity in

the classroom and in the clinical environment were not only a past problem, but also an issue that is still occurring in various forms.

Religious insensitivity as a student: DMT theories inherently attached to certain belief systems, scheduling classes on religious holidays, classmates being insensitive due to lack of awareness of religious affiliation, feelings of shame for connecting to an organized religion.

Religious insensitivity in the clinical environment: stereotypical jokes, inappropriate assumptions, and racism.

Question 5: Revising the Definition of Religious Multicultural Competence

The last question of the focus group gave the participants an opportunity to reflect on all their previous responses to the focus group questions, and see if they wanted to revise the definition of multicultural competence that they previously answered for question one.

New definition of religious multicultural competence: Engaging in religious multicultural competence includes having an awareness of yourself, your worldview, biases, and religious stereotypes so that you can remain neutral, respectful, and open in order to receive and appreciate the differences amongst your clients, co-workers, and supervisors when encountering religious situations in the clinical setting in order to practice ethically.