k

by B N

Submission date: 20-Jun-2021 12:45PM (UTC-0500)
Submission ID: 1609504799
File name: good_and_evil.edited.docx (22.54K)
Word count: 3138
Character count: 17744

Good and evil in a religious/clinical view

Name:

Institution:

Course:

Instructor:

Date:

Good and evil in a religious/clinical view

Part 1

Good versus evil is a prevalent duality in theology, philosophy, literature, and science. In most cases, evil is viewed as the dualistic adversarial opponent of virtue, with good prevailing and evil vanquished. The term "good" refers to the absence of self-centeredness. It entails empathizing with others and prioritizing their interests over personal wishes. In addition to that, Foley (1988) argues that it entails compromising personal well-being if needed to save others. Good also means seeing past differences in ethnicity, sexuality, or culture to connect with a typical emotional spirit underlying differences.

On the contrary, Rosenbaum (1995) suggests that society views evil as a lack of empathy towards others. Individuals lacking empathy prioritize their personal needs at the expense of others. They are arrogant, self-absorbed, and egotistical. Others are only valuable to them if they can assist them in realizing their interests or be misused by them.

Spiritual or religious activities are among the most prevalent ways people deal with traumas (Moschelle et al., 1997). Religious therapists have conducted numerous research to assess the benefits and disadvantages of this coping technique. Religious coping has been divided into two categories: constructive and destructive religious coping. In a distressing event, people who utilize positive religious response methods are more likely to seek spiritual guidance and significance. Moschelle (1997) also argues that negative religious coping (also known as spirituality conflicts) reflects struggle, uncertainty, and skepticism about Christ and belief.

In a hypothetical scenario, assuming I am working with a patient who has lost a limb in an accident. This patient is not ready to accept that he will live with a disability for the rest of his life, is crying, and wants to die. In such a case, I will ask the patient whether he believes in God,

and as a Christian, they will agree, but after their experience, they will start to question the existence of God. I will remind the client about spiritual teaching, suggesting that before God created man, he had already conceived of his plans for him. Plans of prosperity and not despair. I will remind the patient that God knows the reason for everything, and in the end, the patient will leave the hospital after accepting his condition.

References

Moschelle, V.D., Pressman, K.R., & Weissman, D.E. (1997). The Problem of Theodicy and the Religious Response to Cancer. Journal of Religion and Health, 36 (1), 17-20.

Rosenbaum, R. (1995, June 4). Staring Into the Heart of the Heart of Darkness. The New York Times Magazine, 36-72.

Part 2

Religion and spirituality have gotten minimal prominence in conventional professional social work in the past. This is not very pleasant considering the religious origins of the trade. Until lately, when specific religious problems arose, physicians preferred to adopt one of three common mechanisms: Retreat, fumble, or feign as alternatives. However, there is a considerable rise in focus on this topic in social work practice over the past two decades. The majority of research has been philosophical and abstract. The main focus of this area of work was on determining whether or how to approach a patient's religious doctrine in primary care. Presently, spirituality is regarded as a significant element of civilization in theory. While there are many values and beliefs, they all stress that culture is shaped by collective knowledge, norms, ideals, and behaviors among communities (Canda et al., 2019). Professional social work does have a lengthy history of paying attention to tradition, as a set of shared values, and as an integrated element of an individual's selfhood. According to research, clients like being able to discuss this subject during treatment. Canda et al. (2019) argue that the method in which doctors approach religious doctrine can have a beneficial or detrimental impact, depending on the clinician's tolerance.

Religious belief and spirituality are defined differently in different places. Religion is defined as an outward expression of faith; consisting of doctrines, divine commandments, and devotional activities. Likewise, it is a belief, devotion, rites, and tradition-organizing framework. These meanings may vary for clients throughout their therapy and after it has been completed, in contemporary form. The answer is to accept that these meanings are fluid. As a practitioner, I can induce the patient to express his or her understanding of the problem when using positivism by quoting religious teachings. Asking for the client's explanations of issues and talking when

these terms are discussed with patients, a definition evolves that is co-created by the patient and the physician.

Again, clients consider faith as a source of strength when experiencing troubles. In this regard, clients should be supported using faith-based tactics because it is an asset they bring up during social engagements to solve a problem (Al-Krenawi, 2017). However, in some settings, clients consider faith as a source of pain. In social work, professionals must consider the ethical considerations bordering on supervision and self-awareness in practice and containing their personal beliefs to impose specific values on patients to help them become better. In this perspective, the professional must allow the patients to exercise their religious, ethnic, and cultural freedoms. In this case, the word "allow" captures a crucial element of the profession: the boundary concerning patients and professionals in the field. Also, religious institutions are included in the NASW description of culture: The concept of culture is employed since it refers to a unified model of human behavior that incorporates a race, cultural, spiritual, or socioeconomic group's thinking, interactions, behaviors, rituals, values, attitudes, and power structures (Barsky, 2017). Culture, and whatever the interpretation, has gained much coverage in recent years. Social work is a place where social services should exhibit their abilities to deal with culture conclusively. Based on the NASW code of ethics, Social workers must be aware of culture's role in human conduct and civilization and the advantages that exist across societies. Welfare workers must embrace a comprehensive understanding of patients' ethnicities and exhibit proficiency in offering services responsive to their clients' ethnicities and variations between cultures and different groupings. They must learn about and try to comprehend the problem. Social diversity and discrimination regarding race, culture, nationality, ethnicity, color,

gender, sexual preference, age, relationship status, political beliefs, and religion are all factors to consider.

The field of social work has significant religious roots. The Charity Organization Society (COS) and settlement house groups, for instance, were centered on spiritual virtue ideals and significantly contributed to the establishment of the social work practice (Berg-Weger, 2016). All governmental and non - governmental social welfare services were established by mainline Protestantism values, and cultural and religious prosperity were blended. Several social welfare entities, including Jewish Family Service and Catholic Charities, have religious origins. Presently, religion, spirituality, and culture have gained prominence in the clinical practice of social work. Health professionals are becoming more receptive to the introduction of religious doctrine in clinical discussions. This could be perceived as a good trend, as religious belief has been highlighted as a symbol of motivation for the patient and advantageous to the therapeutic relationship (Al-Krenawi, 2017).

Additionally, the inability to incorporate religious doctrine into social work practice has serious consequences. As with any area of inefficiency, there are potentially harmful consequences for patients. The clinician's ideas on religion impact the patient prevails in a contemporary interactional therapeutic environment. Before engaging the patient's religious belief, the practitioner must consider her underlying belief system. Al-Krenawi, (2017) argues that the clinician's inherent religious convictions can influence their willingness to engage religious doctrine in treatment. The more often social workers engage in religious and spiritual practices during their careers, the more inclined they are to consider it appropriate to mention the subject of religion and faith during sessions. Intrinsic religiosity promotes utilization, leading to a corresponding rise in the adoption of religious doctrine. Even though few sources explain how

religious belief emerges in clinical settings, professionals must learn to deal with it. For instance, as a Christian social worker, it is essential to be sensitive when working with Hindus and Muslims (Chow et al., 2021). Religious doctrine can emerge in treatment as a dominant element or as an accidental one. In whichever case, it appears to serve as a complement to treatment practice frequently. In this regard, the healthcare professional can use a belief system to strengthen the rapport with the patient and further the treatment process.

A social worker works in a helping relationship model. It means that the profession entails working with individuals who hold different views from those of the professional. In this regard, the profession has changed to the extent that social workers are no longer just professionals but entities of a new class involved in producing and disseminating knowledge. Furthermore, social workers must strive to embrace divergent values from those they believe. Based on research, many patients believe spirituality should be a mandatory component in treatment. Whereas with many social workers, religious beliefs are undesirable in their practice, most patients feel that spiritual belief plays a crucial role in their lives, especially during therapeutic engagements.

Based on my philosophy of helping, I am an aid. I seek to assist others in achieving psychological and emotional stability from past, painful experiences. I am also a believer in religious teachings and faith. There is numerous intervention when dealing with clients, but the role of religion cannot be underscored. Religion teaches individuals to believe and assist others when they are in need. The profession demands that I assist others, devoid of personal biases and convictions, as pronounced in the NASW tenets. In addition to that, Religious freedom is not directly cited in the NASW ethical codes. Regardless, the standards suggest that welfare workers must act towards their coworkers with dignity and not disparage their beliefs (National

Association of Social Workers (NASW), n.d.). Besides, social workers shall not discriminate based on faith. Based on these suggestions, when a client has an issue that I am called upon to address as a professional, I must consider their religious beliefs, cultural aspects, and ethnic considerations. For instance, if I am a Christian and a patient is a Muslim or Buddhist, I will address their issues without considering their religiosity or ethnic background.

Furthermore, the career demands that I maintain professionalism. One way of achieving professionalism as a social worker entails being impartial to all those who need my services while adhering to the social work values and principles. Appreciation and valuing of patients are both advantageous to the patient and a professional. In this regard, the profession demands that I withhold my biased or personal feelings and attitudes towards other entities' personal feelings, attitudes, and religious beliefs. Within this discussion lies the perspective of ethical integration. Whereas personal resolve on ethical integration of religious belief establishes an environment that limits the professional's expression of religion during practice, the NASW code of ethics states that I cannot impose on a client my feelings and attitudes towards a certain resolve.

Moreover, clients prefer working with someone sensitive to spirituality and open to discussing the issue objectively. While this inclination may not be evident for all patients, the fact that it exists for such a significant proportion of people necessitates practitioners' awareness of it in the context of treatment. In addition to that, sometimes patients fail to address religion and personal convictions during sessions. In such instances, people can be uncomfortable because they fear the clinician or are afraid of being judged negatively. As a social worker, this scenario is not helpful, especially when a patient feels that I am imposing judgment or personal convictions on them. As suggested earlier, as a social worker, I also have personal religious convictions. However, I must be aware that a patient's confidence in the therapy interaction is

influenced by harmful spiritual disparities between patients and practitioners. The possible distress for the patient can rule out professional self-disclosure of religious faith. In addition to that, as a helper, I am cognizant of the fact that religious faith affects the effectiveness of treatments in three areas. The first is about moral decision-making, which is at the core of patients' difficulties. The second involves assisting clients in becoming anchored or taking charge of their internal ideas and reasons to solve their concerns. The third step entails supplementing people's resources with spiritually enriching materials. As a helper, I can detect whether I am treading on the preferable ground for a patient by looking closely at the answers offered by the patient. Both verbal and non-verbal cues are important in determining whether I am on the right path to continue working with the client towards a common goal. Put differently, Glasser (1984) argues that by abiding by the fundamentals of the profession, a practitioner can meet a client's expectations for resolving aspects of treatment via religion and faith in patient interactions.

On the same note, it is essential to point out that social workers are part of society. They are citizens of a nation who enjoy their constitutional right to freedom of choice like other citizens, especially on moral issues that affect society. Also, they are free to adopt a position regarding some contentious topics like sanctioned reproductive rights based on their religious convictions. Regardless, in my professional capacity as a social worker, I do not have the liberty to handicap the views and inclinations of a patient whose perceptions do not mirror my personal beliefs. Provided that the patient's views and opinions about a contentious topic do not encroach upon the mission and goals of social work, I must exercise some level of restraining towards the person as a social worker. It is one argument for a caseworker to suggest that patient groups that are sexually assaulting females, killing someone, and distributing narcotics are all bad; these are

all unlawful behaviors that the rest of the population has rejected via laws approved via a legally guaranteed process. As a social worker, it is another thing to tell patients that their intrinsic religious convictions and choices about homosexual behavior and procreation are entirely mistaken, whether they are right-wing or left-wing, and also quite another to actively intrude in their beliefs and decisions that do not contradict social work's objective or principles. In this perspective, as a private citizen, I can express my reservations regarding the societal issues that are important to me. Whereas I am allowed to challenge certain convictions and beliefs, for instance, challenging the laws that discriminate against religion, race, or gender, I must not impose my personal opinions and biases on clients because it violates the NASW policies and guideline that were ratified via a legally sanctioned democratic process (Barsky, 2017). This argument aligns with the NASW code stating that social workers must not let their private engagements affect their ability to fulfill their mandate (National Association of Social Workers (NASW), n.d.). In simple terms, as a social worker, I must endeavor to separate their remarks and acts and their words and actions as representatives of the social work practice, a critical social work body, or the social worker's sponsoring agency.

For instance, in a typical work environment, I will interact and devote a significant amount of my work time to assisting people convicted of heinous crimes and are completing long prison sentences. Drug trafficking, child molestation, theft, rapes, assault, abduction, fraud, vandalism, racial violence, and homicide are among their crimes. Many of the convicts' ideas, morals, and practices are not ones I agree with, approve, or desire to promote. However, there is a significant difference between my open admission that my ideas, values, and attitude may contrast from that of the individuals with whom I interact and my willingness to serve them in addressing the complex and demanding situations in their lives. As a social worker, I have the

responsibility, regardless of whether I am working with an individual who is more conservative or liberal, spiritual or politically inclined, to express my opinions provided that it is in the best interest of a patient that I express my reservations with their beliefs and convictions. However, social work does not allow me to discriminate. The religious autonomy of clients is paramount in this profession, and I must endeavor to protect it while practicing my profession. In other words, religious and social workers must treat patients with respect since clients are free to make decisions. In the future, social workers must be exposed to different scenarios and perspectives to encourage them to make their conclusions regarding some of the contentious issues presently affecting society. Spiritual relativists, naturalists, bisexuals, and feminists must be introduced to the ideas of Christian Conservatives, Orthodox Catholicism, Mormonism, Islam, Hindus, and Jewish People. Similarly, the latter demographic must be educated in faith-based discourses because social work is increasingly becoming multifaceted in a dynamic society that ought to give voice to divergent views. Regrettably, the viewpoints of Religious Conservatives and other religious persons are mostly missing from the industry's debate.

To sum it up, when freedom of religion ideals clashes with health professionals' commitments to patients, including the moral purpose of providing assistance and treating all persons with dignity, problems can occur. Everyone must be permitted to choose their religious convictions and live their lives in line with beliefs, free from intervention or pressure from the authorities and other agents. Social workers' professionalism does not prevent them from expressing their beliefs in their private life. Still, they should not push their religious convictions on patients when operating in their professional capacities, nor should they manipulate people to develop their spiritual goals. Social workers must examine what they are doing to improve their

understanding and skills to deal with various groups to display tolerance and ensure clients have prompt access to necessary assistance.

References

Al-Krenawi, A. (2017). Religious and Spiritual Perspectives of Social Work among the Palestinians. *The Routledge Handbook of Religion, Spirituality, and Social Work, Routledge, London*, 128-35.

Barsky, A. (2017). Ethics Alive! The 2017 NASW Code of Ethics: What is New? *New Social Worker. Retrieved From http: //Www. Social worker. Com/Feature-Articles/Ethics-Articles/The-2017-Nasw-Code-Of-Ethics-Whats-New*.

Berg-Weger, M. (2016). *Social Work and Social Welfare: An Invitation*. Routledge.

Canda, E. R., Furman, L. D., & Canda, H. J. (2019). *Spiritual Diversity in Social Work Practice: The Heart of Helping*. Oxford University Press, USA.

Chow, H. H. E., Chew, Q. H., & Sim, K. (2021). Spirituality and Religion in Residents and Inter-Relationships with Clinical Practice and Residency Training: A Scoping Review. *BMJ Open*, *11*(5), E044321.

Foley, D.P. (1988). Eleven Interpretations of Personal Suffering. Journal of Religion and Health, 27 (4), 321-328.

Glasser, P. (1984). Being Honest With Ourselves: What Happens When Our Values Conflict With Those of Our Clients? Practice Digest, 6 (4), 6-10.

National Association of Social Workers (NASW). (n.d.). *National Association of Social Workers (NASW)*. NASW - National Association of Social Workers. Https://Www.Socialworkers.Org/About/Ethics

k

ORIGINALITY REPORT

1%	1%	0%	0%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	www.tandfonline.com Internet Source	1%

Exclude quotes	Off	Exclude matches	Off
Exclude bibliography	On		