Handouts for Association for Conflict Resolution (ACR) 2012 Annual Conference, "God in the Process: Learning How to Engage Faith Safely," Saturday, October 15, 10:15 AM - 11:45 AM, New Orleans.

Ethics

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APPENDIX 2.1:

PRELIMINARY PRACTICE GUIDELINES FOR WORKING WITH RELIGIOUS AND SPIRITUAL ISSUES

RELIGIOUS/SPIRITUAL ASSESSMENT GUIDELINES

A-1. Psychologists are mindful that religion/spirituality is a vital and important aspect of many clients' lives.

A-2. Psychologists are attentive to indications that clients have religious/spiritual concerns and take steps to convey to the client that expressing such concerns is appropriate if present.

A-3. Psychologists are encouraged to routinely incorporate brief screening questions to assess for the presence of clinically salient religious/spiritual client concerns.

A-4. The need for more extensive spiritual assessments is suggested when clients indicate that religious/spiritual factors are personally and clinically salient to their presenting concern.

A-5. Spiritual assessment is most helpful when aimed at gaining an understanding of the clinically relevant dimensions of the client's religious/spiritual life. Such assessment should be directed toward the following goals:
   (a) determining how normative the client's religious/spiritual life is for the client's religious reference group,
   (b) exploring whether clinical problems are adversely impacting religious/spiritual functioning, and
   (c) evaluating how aspects of the client's religion/spirituality might constitute either constraints on treatment or productive resources for coping.

A-6. Psychologists are sensitive to biases that arise from religious/spiritual factors in the way in which clients complete psychological tests.

A-7. Psychologists are cautious to avoid interpreting client reports of attitudes or behaviors that are normative for a client's religious community as indicative of pathology.

A-8. Psychologists strive to be attentive to individual differences in religion/spirituality and avoid stereotypic inferences based the client's identification with a spiritual tradition.

RELIGIOUS/SPIRITUAL INTERVENTION GUIDELINES

I-1. Psychologists obtain appropriate informed consent from clients before incorporating religious/spiritual techniques

and/or addressing religious/spiritual treatment goals in counseling.

I-2. Psychologists accurately represent to clients the nature, purposes, and known level of effectiveness for any religious/spiritual techniques or approaches they may propose using in treatment.

I-3. Psychologists do not use religious/spiritual treatment approaches/techniques of unknown effectiveness in lieu of other approaches/techniques with demonstrated effectiveness in treating specific disorders or clinical problems.

I-4. Psychologists attempt to accommodate a client's spiritual/religious tradition in congruent and helpful ways when working with clients for whom spirituality/religion is personally and clinically salient.

I-5. Religious/spiritual accommodations of standard treatment approaches/protocols are done in a manner that
  (a) does not compromise the effectiveness of the standard approach or produce iatrogenic effects,
  (b) is respectful of the client's religious/spiritual background,
  (c) proceeds only with the informed consent of the client, and
  (d) can be competently carried out by the therapist.

I-6. Psychologists are mindful of contraindications for the use of spiritually/religiously oriented treatment approaches.
  (a) Generally, psychologists are discouraged from using explicit religious/spiritual treatment approaches with clients presenting with psychotic disorders, substantial personality pathology, or bizarre and idiosyncratic expressions of religion/spirituality.
  (b) Psychologists should discontinue such approaches if iatrogenic effects become evident.

I-7. When psychologists use religious/spiritual techniques in treatment, such as prayer or devotional meditation, they
  (a) clearly explain the proposed technique to the client and obtain informed consent,
  (b) do so in a competent manner that is respectful of the intended religious/spiritual function of the technique in the client's faith tradition, and
  (c) adopt such techniques only if they are believed to facilitate a treatment goal.

I-8. Psychologists appreciate the substantial role faith communities may play in the lives of their clients and consider appropriate ways to harness the resources of these communities to improve clients' well-being.

I-9. Psychologists avoid conflictual dual relationships that might arise in religious/spiritually oriented treatment or in adjunctive collaborations with faith communities.

I-10. Psychologists set explicitly religious/spiritual treatment goals only if
  (a) they are functionally relevant to the clinical concern,
  (b) can be competently addressed within the treatment,
  (c) can be appropriately pursued within the particular context and setting in which treatment is occurring, and
  (d) are consented to by the client.

I-11. Psychologists commit to a collaborative and respectful demeanor when addressing client aspects of a client's religion/spirituality the psychologist deems maladaptive or unhealthy. The preferred clinical goal in such cases is to promote more adaptive forms of the client's own faith rather than to undermine that faith.

RELIGIOUS/SPIRITUAL MULTICULTURAL PRACTICE AND DIVERSITY GUIDELINES

M-1. Psychologists make reasonable efforts to become familiar with the varieties of spirituality and religion present in their client population.

M-2. Psychologists strive to be self-aware of their own perspectives, attitudes, history, and self-understandings of religion and spirituality. Psychologists should be mindful of how their own background on religious/spiritual matters might bias their response and approach to clients of differing background.

M-3. Psychologists do not seek to proselytize or otherwise impose their worldview on the client.

M-4. Psychologists are mindful of factors that influence the appropriateness of their own religious/spiritual self-disclosure to a client. These include but are not limited to disclosures that are
  (a) congruent with the treatment orientation or approach used,
  (b) consistent with other general background self-disclosures offered to a client at the outset of treatment,
  (c) facilitative of the treatment, and
  (d) necessary to address a potential value conflict that might impede treatment.

M-5. Psychologists are encouraged to gain competence in working with clients of diverse religious/spiritual backgrounds through continuing education, consultation, and supervision.

M-6. The need for clinical referral based on religious/spiritual factors is suggested when
   (a) the client expresses a strong preference for a therapist with a different religious/spiritual background and this preference persists after reasonable attempts are made to establish rapport with the client,
   (b) the presenting problem requires an understanding of the client's religious/spiritual background that exceeds the psychologist's competence regardless of relevant consultation or supervision, and
   (c) a religious/spiritual difference between the client and the psychologist impedes treatment.

M-7. Psychologists respect religion/spirituality as an important diversity domain and are mindful of the complex ways this domain relates to other areas of diversity such as ethnicity, race, age, gender, or sexual orientation.

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Curtis, Russell C. & J. Scott Glass
"Spirituality and Counseling Class: A Teaching Model"

(B)

Second, the class members suggested that spirituality does imply a belief in a force greater than they are, but this force should be left to individual interpretation. Third, spirituality is a powerful concept that is very personal in nature and can represent different things to different people, without losing its importance. Fourth, the group acknowledged that spirituality and religion are two separate concepts that do not always mesh into one.

Porter (1995) argued that some people have difficulty imagining spirituality outside of organized religion, whereas others cannot fathom spirituality within the confines of a religious setting. Some students expressed feeling uneasiness at the thought of participating in formal religion, whereas the vast majority of the class expressed more difficulty with trying to separate their spirituality from their religion, explaining that the two of them were intertwined.

Increasing Awareness of Students' Own Spiritual Development

The main activity used to increase students' awareness of how they developed their own spiritual identities was the assignment of writing a "spiritual autobiography." In this assignment, we asked each student to identify significant events that contributed to their current spiritual perspective. We also asked them to discuss how their spiritual perspective might facilitate or hinder their work with clients. After completing their autobiographies, students were asked to discuss them in class. This assignment presented students with an opportunity to reflect on and discuss areas of their lives that had an impact on their views of spirituality.

During this exercise, one student commented,

> This activity gave me the opportunity as an adult to examine events that occurred when I was [a] child. The experiences were not all pleasant, but it did give me a chance to better understand the lasting impact they had on me.

The spiritual autobiographies allowed participants to view childhood messages about religion and spirituality through adult lenses, helping them to gain additional insight into the power of their previous experiences.

A second activity used in the class was a presentation to their classmates on a topic dealing with spirituality. Students were allowed to present on a topic of their choice that dealt directly with spirituality. Presentations ranged from progressive relaxation and guided imagery to the power of labyrinths. These presentations aided in broadening the scope of what students initially believed spirituality to mean. After listening to one presentation, a student commented, "It helped me realize how closed-minded I have been about what spirituality means to other people." Although causing some initial confusion, the activities and reading materials provided the students an opportunity to discuss these issues with peers who were having similar difficulties.

TABLE 11.1. Evaluative Framework for the Clinician to Guide the Spiritual Assessment

1. Locating the client in the search for the sacred
   a. Is the client in a conservational mode?
   b. Is the client going through a spiritual struggle?
   c. Is the client experiencing a spiritual transformation?
   d. Is the client spiritually disengaged?
   e. Is the client rediscovering the sacred?

2. Spiritual integration in the destinations
   a. How does the client envision the sacred?
      i. Is the client's representation of the sacred large enough to encompass the full range of life experiences, or is it constricted?
      ii. Is the client's representation of the sacred benevolent or malevolent?
      iii. Does the client recognize the limits in his or her understanding of the divine, or does the client confuse representations of the divine with the divine itself (i.e., idolatry)?
      iv. Does the client accept his or her darker side or project these qualities onto demonic forces in others?
      v. Do the client's various understandings of the sacred blend together or do they clash with each other?
      vi. Is the client aware or unaware of the place of the sacred in his or her life?
   b. Where does the sacred fit into the client's strivings?
      i. Is the client engaged or disengaged in the search for the sacred?
      ii. Is the sacred central or peripheral to the client's strivings?
      iii. Is the client's spiritual motivation internally based or externally based (e.g., guilt, social pressure)?

3. Spiritual integration in the pathways
   a. How broad and deep are the client's spiritual pathways?
      i. Does the client integrate the spiritual pathways into his or her life or does he or she compartmentalize them?
      ii. Does the client take a number of spiritual paths or follow one spiritual pathway to the exclusion of others?
      iii. Does the client have a long or a short history of spiritual involvement?
      iv. Is the client disciplined or undisciplined in following the spiritual pathways?
      v. Is the client's relationship with the sacred secure or insecure (e.g., anxious, hostile, self-degrading)?
      vi. Is the client aware or unaware of the spiritual pathways he or she is taking?
      vii. Is the client familiar or unfamiliar with the variety of spiritual pathways that are available to him or her?
   b. How flexible are the client's spiritual pathways?
      i. Is the client flexible or inflexible in selecting and following the spiritual pathways?
      ii. Is the client working through or stuck in his or her spiritual struggles?
   c. How well do the client's spiritual pathways fit with the problem, destination, and social context?
      i. Are the client's spiritual pathways appropriate to the destination or too extreme?
      ii. Is the client spiritually authentic or hypocritical?

TABLE 11.1. *(continued)*

      iii. Are the client's spiritual pathways appropriate or inappropriate to the problem?
      iv. Is the client embedded in a spiritually benevolent or malevolent context?
      v. Does the client experience spiritual support or spiritual conflict with others?

4. Spiritual efficacy
   a. How comfortable is the client with his or her spirituality?
      i. Does the client experience spiritual comfort or spiritual distress?
      ii. Does the client feel he or she is growing or declining spiritually?
      iii. Does the client feel that spirituality is a part of the solution to his or her problems or a part of the problem?
   b. How does the client's spirituality affect his or her life?
      i. Does the client's spirituality lead to connection with or disconnection from the sacred?
      ii. Does the client's spirituality increase or decrease his or her health and well-being?
      iii. Does the client's spirituality enhance or detract from the well-being of others?
      iv. Does the client's spirituality lead to benefits in many areas of life or are some of the benefits accompanied by costs for the client or those in his or her life?

5. The place of spirituality in treatment
   a. Is spirituality a part of the solution or a part of the problem?
   b. What spiritual resources can the client draw on in therapy?
   c. What spiritual problems should the client address in therapy?
   d. What spiritual obstacles are likely to arise in treatment?

particular spiritual story into the larger spiritual framework. these evaluative questions are complex, but it is important t they are not questions to be asked directly of the client. Rather, they are designed to orient and guide the clinician's own thinking through the process of explicit spiritual assessment.

Let me briefly review these guiding sets of questions. First, the clinician should locate where the client is in the search for the sacred. For example, some clients come to therapy in the midst of a spiritual struggle and potential transformation. Others enter therapy with a spirituality that has been stable and sustaining to them for much of their lives. Still others come to therapy spiritually disengaged, but in the process of rediscovery. Second, the clinician assesses the degree to which the client's spirituality is well integrated. To that end, it is important to consider several aspects of the client's spiritual destination and pathways: the client's vision of the sacred; the place of the sacred in the client's strivings; the breadth, depth, and flexibility of the client's pathways; and the fit between the client's pathways with his or her destinations, problem, and social context. Third, the clinician should be able to evaluate the efficacy of the client's spirituality, including

EXHIBIT 5.1
Comprehensive Framework of Spiritual Assessment

1. Relation of clients to spirituality
   (a) Is spirituality central or peripheral to clients' lives and strivings?
   (b) Are clients aware or unaware of the place of spirituality in their lives?
   (c) Are clients' spiritual motivations internally based or externally based (e.g., guilt, social pressure)?
2. Location of clients in their spiritual journeys
   (a) Do clients have a long or short history of spiritual involvement?
   (b) Are clients spiritually engaged or disengaged?
   (c) Are clients in the midst of discovering their spirituality?
   (d) Are clients primarily focused on conserving their present spirituality?
   (e) Are clients in the midst of transforming their spirituality?
   (f) Are clients going through spiritual struggles?
   (g) Are clients working through or stuck in their spiritual struggles?
3. Content of clients' spirituality
   (a) What do clients hold sacred?
      (i) Are clients' representations of the sacred large enough to encompass the full range of life experiences, or are they constricted?
      (ii) Are clients' representations of the sacred benevolent or malevolent?
      (iii) Do clients recognize the limits in their understanding of the sacred?
      (iv) Do clients' various understandings of the sacred blend together, or do they clash with each other?
   (b) How do clients express their spirituality?
      (i) Are clients aware or unaware of how they experience and express spirituality?
      (ii) Which spiritual pathways do clients take? Do clients take some pathways to the exclusion of others?
      (iii) Do clients integrate their spirituality into their lives or do they compartmentalize it?
      (iv) Are clients flexible or inflexible in selecting and following ways of expressing spirituality?
      (v) Are clients familiar with the variety of ways of expressing spirituality that are available to them?
      (vi) Are clients disciplined or undisciplined in pursuing spirituality?
      (vii) Are clients' relationships with the sacred secure or insecure (e.g., anxious, hostile, self-degrading)?
4. Context of clients' spirituality
   (a) How well do clients' spirituality fit with their social context?
   (b) Are clients' environments spiritually benevolent or malevolent?
   (c) Do clients experience spiritual support from or spiritual conflict with others?
   (d) Does clients' spirituality enhance or detract from the well-being of others?
5. Impact of spirituality on clients' lives
   (a) What kinds of emotions/affect are elicited by clients' spirituality?
      (i) Are clients satisfied with their spirituality?
      (ii) Do clients experience spiritual comfort or spiritual distress?
   (b) Does clients' spirituality lead to benefits and/or costs for them or those in their lives?
   (c) Does clients' spirituality increase or decrease their health and well-being?
6. Place of spirituality in treatment
   (a) In what ways are clients' spirituality well integrated or disintegrated?
   (b) Is spirituality a part of the solution or a part of the problem?
   (c) What spiritual resources can clients draw on in therapy?
   (d) What spiritual problems should clients address in therapy?
   (e) What spiritual obstacles are likely to arise in therapy?

INITIAL SPIRITUAL ASSESSMENT

The first session in therapy is generally the busiest. The therapist has to answer a host of questions in a short period of time. Why is the client seeking help? Why now? Are there any crises that require immediate attention? How has the client tried to deal with his or her problem in the past? What has worked before and what hasn't worked? What is the client's medical status? Does he or she use drugs or alcohol? What about family, friends, and work? Who provides the client with support and who makes matters worse? The idea of adding questions about spirituality to the already lengthy list of questions in the first session may sound anything but inviting.

From the outset, let me stress that the first session is not the time to do extensive interviewing or testing about spirituality. Think of spirituality as simply one more dimension that deserves some attention in the process of assessment. The therapist cannot afford to focus in too great detail on any single facet of the client's life in the first session, be it psychological, social, physical, or spiritual. But neither should any of these dimensions be overlooked. Every clinical intake, I believe, should include an initial spiritual assessment.

Initial spiritual assessment takes the form of a few basic questions that address four important areas: the salience of spirituality to the client, the salience of a religious affiliation or community to the client, the salience of spirituality to the problem, and the salience of spirituality to the solution (see Table 10.1). The first set of questions is: Do you see yourself as a religious or spiritual person? If so, in what way? Clients' responses will provide some inkling of whether they see their lives through a sacred lens and whether they will be comfortable addressing sacred matters in treatment. In addition, their responses may shed some light on clients' preferred spiritual pathways and spiritual destinations—that is, whether spirituality is primar-

TABLE 10.1. Questions in the Initial Spiritual Assessment

- The salience of spirituality to the client
  Do you see yourself as a religious or spiritual person? If so, in what way?
- The salience of a religious affiliation to the client
  Are you affiliated with a religious or spiritual denomination or community? If so, which one?
- The salience of spirituality to the problem
  Has your problem affected you religiously or spiritually? If so, in what way?
- The salience of spirituality to the solution
  Has your religion or spirituality been involved in the way you have coped with your problems? If so, in what way?

TABLE 10.4. Questions for the Implicit Spiritual Assessment

Resources and pathways

- *From what sources do you draw the strength and courage to go on?*[a]
- *Where do you find peace?*[a]
- *Who truly understands your situation?*[a]
- *When you are afraid or in pain, how do you find comfort and solace?*[a]
- *For what are you deeply grateful?*[a]
- *What sustains you in the midst of your troubles?*

Destinations

- *What are you striving for in your life?*
- *Why is it important that you are here in this world?*[a]
- *What legacy would you like to leave behind in your life?*
- *How would you like people to remember you when you are gone?*
- *To what or whom are you most devoted?*[a]
- *Who is your true self?*
- *Who or what do you put your faith and hope in?*
- *To whom, or what, do you most freely express love?*[a]
- *When have you felt most deeply and fully alive?*

Struggles and transformation

- *What are the deepest questions your situation has raised for you?*
- *What causes you the greatest despair and suffering?*
- *How has this experience changed you at your deepest levels?*
- *What have you discovered about yourself that you find most disturbing?*
- *How has this situation shaken your faith?*
- *What has this experience taught you that you wish you had never known?*
- *What are your deepest regrets?*
- *What would you like to be able to let go of in your life?*
- *When in your life have you experienced forgiveness?*

[a]Drawn or adapted from Griffith and Griffith (2002).

psychospiritual questions are words that contain sacred qual- "peace," "courage," "solace," "sustenance," "devotion," "faith," "hope," "love," "letting go," "forgiveness," "regrets," "despair," and "suffering." Even though none of these terms is explicitly religious, some clinicians may find these kinds of inquiries unscientific and merely sentimental. It is true that the questions depart from the traditional, clinical, linear, no-nonsense language of practitioners. It is also true that some clients will not respond to these questions. But the language does resonate for other clients, like Joe, whose search for the sacred may be taking place beneath the surface of their own awareness. And they may respond to these psychospiritual questions with spiritual language of their own.

Clinicians should be sensitive to spiritual responses from their clients. In essence, practitioners must turn on their "spiritual radars." This is the

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TABLE 5.1
Instruments for Assessing Spirituality in Psychotherapy

Dimension	Scale and author	Scale description	Sample item
Spiritual pathways	NIA/Fetzer Short Form for the Measurement of Religiousness and Spirituality (Idler et al., 2003)	33 items assessing 10 spiritual pathways: public and private activity, congregation support, coping, intensity, forgiveness, daily spiritual experience, spiritual beliefs and values, commitment, and religious history.	"Because of my religious or spiritual beliefs, I have forgiven those who hurt me" (forgiveness).
	Spiritual History Scale (Hays et al., 2001)	23 items assessing degree to which religion has been source of support and conflict over the life span.	"For most of my life, my social life has revolved around the church/synagogue."
	Spiritual Assessment Inventory (Hall & Edwards, 1996)	36 items measuring 4 dimensions of individual's quality of relationship with God: instability, grandiosity, defensiveness/ disappointment, realistic acceptance.	"God recognizes that I am more spiritual than most people" (grandiosity).
	Hindu Spiritual Pathways Scale (Tarakeshwar et al., 2003)	27 items assessing degree of involvement in 4 Hindu pathways: devotion, ethical action, knowledge, and restrain.	"How often do you perform *puja* in honor of your deity?" (path of devotion).
Spiritual strivings	Spiritual Strivings (Emmons et al., 1998)	Coded spiritual responses to list of 15 personal strivings ("An objective you are typically trying to obtain").	Sample spiritual strivings: "To approach life with mystery and awe," "To deepen my relation with God," "To achieve union with the totality of existence."
	Spiritual Strivings (Mahoney et al., 2005)	Ratings of degree to which each of 10 personal strivings is perceived as a manifestation of God or holding sacred qualities.	"This striving reflects what I think God wants for me" (manifestation of God).

(*continues*)

TABLE 7.1
Spiritual Strengths and Problems as a Function of Level of Analysis

Level	Potential problem	Potential strength
Individual	Irrational faith or beliefs.	Adaptive sacred beliefs.
	Incoherent or contradictory belief system.	Integrated spiritual worldview.
	Sacred prescriptions or goals mismatched to current problems.	Flexible sacred rituals or adaptive guidelines for living.
	Spiritually driven emotional distress (e.g., excessive guilt).	Spiritually inspired perseverance.
	Barrier to integrated personal identity or growth (e.g., spiritually justified self-hatred).	Sacred source of integrated identity or growth.
Social	Conflict with faith community.	Harmony with faith community.
	Conflict with family over faith.	Faith as unifying force in family.
	Promotes religious intolerance.	Promotes tolerance as virtue.
Cultural	Creates cultural/national violence.	Promotes peace.
	Culture oppresses certain faiths.	Culture respects/promotes spiritual diversity.
Global	World events cause loss of faith.	World events prompt renewal of faith and opportunities to display virtue.
	Divisive faiths can promote global competition or enmity.	Common virtues across faiths can promote global community.

The critical issue for treatment planning is that a therapist must accurately assess the various dimensions of spirituality in and across therapeutic encounters and determine their salience to mental health treatment (see chap. 5, this volume). This process clearly requires a great deal of interpretation and judgment. The dangers of imposing personal or cultural beliefs are very real for the therapist who is ignorant or inexperienced with spiritual concepts and beliefs (Arthur & Stewart, 2001). In addition, research has demonstrated that mental health professionals commonly make cognitive errors in clinical judgment because of mental shortcuts such as the *availability heuristic*, *representativeness heuristic*, and *confirmatory bias* (Dunning, 2005; Falvey, 2001; Falvey, Bray, & Hebert, 2005; Westin & Weinberger, 2004). When this judgment process is extended to complex areas such as spirituality or culture, the opportunities for errors increase.

To avoid these pitfalls, therapists are advised to take cognitive precautions (see Dunning, 2005; Falvey, 2001; Falvey et al., 2005; Westin & Weinberger, 2004; see also chap. 3, this volume). Therapists should actively consider alternative case conceptualizations and treatment plans during the course of clinical work (see chap. 6, this volume) and take into account both contextual and intrapsychic explanations for client behaviors. Also, reliance on memory and experience alone to guide decision making should be supplemented with for-

EXHIBIT 4.2
Informed Consent for Using Spiritual or Religious Components in Therapy

Our therapists are trained to provide mental health counseling services. Many are also capable of integrating specific spiritual or religious practices with typical counseling practice. Your therapist may ask if you would like to integrate specific spiritual or religious practices into your treatment. These include, but are not limited to, praying with or for you, teaching and guiding you in meditation, assigning readings from scripture or sacred writings, encouraging you to practice specific religious or spiritual rituals, and helping you to access the resources of your spiritual or religious community. In all cases, the therapist will strive to provide you with interventions that are congruent with your spiritual or religious perspective and that fit within your faith tradition. You are free to decline these interventions at any time and request that your therapist refrain from including the spiritual or religious in therapy, if it makes you feel uncomfortable.

Intake forms from smaller agencies and private practitioners are often shorter, are more flexible, and allow for more therapist–client time during intake. Some range from including virtually no information about spirituality to including multiple questions, with the intent being follow-up. Intake forms at high-volume agencies may include a question or two in reference to clients' spiritual or religious preferences and influences, such as "Do you have any spiritual or cultural beliefs that may influence your treatment?" This important question may attempt to set the tone that it is appropriate to discuss religious beliefs, although the question itself is inadequate. Clients often arrive unaware that their spiritual and religious beliefs can actually influence their treatment.

EXHIBIT 4.3
Professional Self-Disclosure of View on Spirituality

I specialize in helping individuals, couples, and families cope with the impact of illness, accidents, or other medical issues on their lives. My therapy work is characterized by holism and focuses on the ways people make meaning of their life circumstances. Holism means that I assess health and wellness in mental, emotional, social, physical, and spiritual facets of experience. People seem to benefit from therapy the most when thinking, feelings, behavior, and action are all included in the work. It is my belief that many individuals approach life with moral beliefs or spiritual practices that inform their decisions and perspectives of life. Few people examine how these beliefs and practices are related to emotional issues or life circumstances. Such transcendent beliefs can provide tremendous support and meaning for the issues clients face or may even be associated with unpleasant emotions or exchanges. I typically invite my clients to discuss their religious beliefs and faith practices as a way to think through the challenges they face and to acquaint me with their worldview. Such discussions are for the purpose of enriching our understanding of the issues at hand and are not for the purpose of proselytizing or debating the correctness of our ideas. I am comfortable including religious practices in therapy, such as prayer, meditation, or discussion about guiding religious documents, if these things are valuable to you. It is your prerogative to include or exclude these, or any aspects of your personal thoughts or feelings.

Principle 5: Use a Less Judgmental Approach

The more rigid clients are in terms of their spiritual or religious perspective, the less judgmental therapists need to be. It should be well-known to therapists that individuals who hold strong beliefs will also have a significant emotional investment in maintaining the belief that compels them to protect and defend their belief structures. If, while in counseling, clients who are highly charged around spirituality feel threatened about these beliefs, they will almost certainly defend their position, develop heightened resistance, or experience increased emotional distress. Subsequently, direct confrontation of clients' beliefs or even their perception of a subtle attempt to undermine or change beliefs is generally a therapeutic blunder and will strain the therapeutic relationship. Needless to say, dealing with therapeutic issues that are related to clients' religious orientation can present challenging clinical situations for therapists. During the development of a working alliance with religious clients, Kelly (1995) suggested therapists should strive to (a) foster a relational space that respects the clients' spiritual or religious dimension and that allows them to explore spiritual themes, both positive and negative, as they relate to therapeutic issues; (b) help clients to integrate personally beneficial spiritual or religious material so they can expand and transform their perspective on the issues and problems as well as clarify or eliminate negative spiritual or religious elements; and (c) use positive religious resources as appropriate.

Each therapist we interviewed in some way addressed the fact that clients who are highly spiritual or religious may also be more rigid in their thinking about religious precepts and ideals, though obviously this is not always the case. As Fowler (1991) and others have shown, people who are actually more developed spiritually become more at peace with their beliefs as the beliefs become internalized. In other words, as people's beliefs are lived from within as well as without, they provide a deep sense of purpose that does not depend on the approval of others. Nevertheless, in clinical environments one challenge therapists sometimes face is highly religious clients who are also rigid about their beliefs. Such individuals may either be hyper-religious, filtering nearly all of their experiences through a religious frame of reference, or have compartmentalized thinking, referencing religious rules to make decisions. These are the types of individuals that we, as well as all the therapists interviewed, found most challenging to work with, not because of the spiritual aspects per se but rather because of the black-and-white thinking patterns that sometimes occur. The following list outlines characteristics of rigidly religious individuals that make them challenging to work with clinically:

1. They tend to be convinced they are right.
2. They feel the need to convince others that they hold the truth.
3. They are closed to contrasting viewpoints.
4. They become easily threatened when their views are questioned.

5. They tend to surround themselves with like-minded people.
6. They use religious doctrine as a means to avoid considering new information or perspectives.
7. They are judgmental toward views differing from their own.

The question then becomes how to work with such individuals, particularly if there are clinical issues that need to be addressed that may challenge religious perspectives. As with any other problematic pattern of thinking, therapists must provide both challenge and support. This means the therapists must offer appropriate alternative reframing of the clients' thinking while at the same time provide deep support for the clients and their personhood. What this entails is the ability to feel and communicate heartfelt compassion for rigidly religious clients while at the same time asking them to consider alternative interpretations of their beliefs or perspectives that do not require them to reject their faith.

In clinical practice, I (J. Scott Young) have found this to entail working from within the clients' current frame of reference to bring forth a transformed perspective of their beliefs. This can only happen, however, if the clients first truly believe that I respect and care for them. For example, I once worked with a young man who was highly religious and depressed. As I moved further into the counseling, it was clear that the young man's movement into more religious behaviors and involvement was an attempt to deal with his depression. I sensed he very much needed his religion and that it was helpful to him, but he had such perfectionistic standards of himself and others that he was frequently disappointed. He was also very angry and judgmental. Through a careful process of validation of his perspectives and allowing him to project and blame others for not being what they should be, we were able to form a secure therapeutic alliance. He would criticize and vilify his former girlfriend, friends, people at church, and even himself. Slowly, however, I was able to introduce the idea that his thinking was distorted and that he was actually using religious idealism as a weapon to separate himself from others. We talked about grace, love, acceptance, and God's sovereignty as ways to help him relax his righteous anger about people he perceived as hypocritical or who had hurt him. I remember vividly one day when he came into counseling and said, "You know I have realized that when I work to change my thinking, I feel better. There are still things happening that could upset me but I am working to not let them." He indicated that it was like the whole world looked different. We talked in detail about the idea that his showing more forgiveness and compassion with himself was making his relationship with others different. He was learning that his sense of "rightness" actually made him angry and pushed others away. Essentially in this case I was using religiously based cognitive–behavioral therapy. Similar to any other problematic thinking pattern, religiously based cognitive distortions can be addressed clinically, but because of the sensitive nature of such patterns this

can only occur if the client is first wrapped in a blanket of nonjudgmental acceptance from the therapist that cannot be faked.

Therapists must decide for themselves if and how they can find a therapeutic stance whereby they can work with rigidly religious clients and still maintain deep compassion for the individual. As authors, it is our position that clients require high levels of patient acceptance because they are so highly rigid. Yet, similar to any other form of rigidity, clients can only move to a more cognitively complex stance gradually and in an environment that is not threatening. It may be helpful for therapists to frame clients' religion as not only a strength but also to gently offer possible reinterpretations. However one frames this, it benefits the therapeutic relationship for therapists to find a place of nonjudgmental acceptance toward clients' beliefs, including the cognitive distortions and inconsistencies, or to refer clients elsewhere.

We realize that readers of this book might personally ascribe to a strong spiritual faith themselves or might just as well be personally nonspiritual. Similarly, readers might view themselves as highly spiritual or have no real need to think in terms of spirituality. Nevertheless, it is imperative that therapists observe their own motives and intentions closely when working with clients who are highly committed to a spiritual perspective. We offer the following statement that therapists might make to clients or to themselves that would reassure the clients and would require the therapists to adopt an open stance in terms of clients' belief systems:

> You do not have to argue or defend your religious positions with me. You are free to believe whatever you wish, as I have no interest in undermining your spiritual life. I view faith commitment that is based in love as a positive factor for a person's overall mental health. So, let us agree to openly explore together how you think about spiritual ideas, adopting a joint attitude of relaxed curiosity, so we might learn how your beliefs affect your psychological life. If I offer any interpretations about your thinking in this area, it is only to expand your options in understanding your faith.

Perhaps one of the most difficult situations therapists might encounter is one in which clients' specific religious rigidity strikes the therapist as dysfunctional to the point that it warrants intervention, even though the client may not view it as such (see chap. 10, this volume). As in any clinical situation, we cannot take clients places they do not wish to go, yet we can make gentle attempts to assist clients in enlarging their scope of thinking if the narrowness of their thinking is hurtful to themselves or to others. If therapists wish to do such work, the following is offered as a possible place to begin:

1. Spend a great deal of time exploring how clients conceptualize their beliefs.
2. Think in terms of expanding clients' options (e.g., more freedom, more flexibility, more love) versus fixing the dysfunctional beliefs.

3. Use gentle confrontation followed by support.
4. Offer new conceptualizations from within the clients' religious frames of reference (e.g., religious stories, language, concepts).
5. Work at clients' cognitive levels of complexity or slightly beyond.
6. Work with religiously based cognitive distortions such as other rigid psychological structures (e.g., beliefs, thoughts, and schemas).

(See chap. 2, Appendix 2.1, this volume: A-6, A-7, A-8, I-8, I-11, M-2, M-6, and M-7.)

Therapist Reflections

Therapist A

When asked about using a less judgmental approach with clients, Therapist A responded, "I use their language. I tune into their words. That helps the client. I have to work to get them out of their heads, but I have to honor their need to have something concrete. They often want an A-B-C, 1-2-3 change." She has noticed these individuals lack an "openness of language about sin," which creates a challenge in helping them not judge themselves too harshly.

Therapist B

Therapist B stated, "I ask them, what about the words *forgiveness* and *grace*, how do you see those concepts in your life? I use this when they (the highly religious clients) have trouble accepting sin in their lives. Yet I have also had people with PhDs who are very concrete. I have had atheists who were rigid."

Therapist C

Therapist C replied, "I try to honor and not make judgments about my clients' religion and spirituality."

Therapist D

Therapist D responded, "The counselor does not have to buy into the client's belief system to work effectively, but instead can operate from within the counselor's own perspective on spirituality without letting on to the client that the counselor is at a different place. For Christians who believe the Bible is divinely inspired and literally true, if they keep studying they will see different viewpoints in the Bible and work to reconcile them in any way possible or

TABLE 9.1
Examples of Spiritual Interventions and Techniques

Intervention	Sample readings
Prayer (therapist or client guided)	Frame (2003), McCullough and Larson (1999), Tan (1996)
Teach spiritual concepts	Eck (2002), Fukuyama and Sevig (1999)
Forgiveness	Enright (2001), Worthington (2005)
Reference sacred writings	Frame (2003), Richards and Bergin (2005)
Meditation	Marlatt and Kristeller (1999), McMinn and McRay (1997)
Spiritual self-disclosure	Richards and Bergin (2005), Richards and Potts (1995)
Encourage altruism and service	McMinn and McRay (1997); Schwartz, Meisenhelder, and Ma (2003)
Spiritual confrontation	Richards and Bergin (2005), Richards and Potts (1995)
Spiritual assessment	Gorsuch and Miller (1999), Hodge (2005)
Spiritual history	Chirban (2001), D'Souza (2003)
Spiritual relaxation and imagery	Frame (2003), Richards and Bergin (2005)
Clarify spiritual values	Fukuyama and Sevig (1999)
Use spiritual community and spiritual programs	Oman and Thoresen (2003), Tan (1996)
Spiritual journaling	Frame (2003)
Experiential focusing method	Frame (2003), Hinterkopf (1994, 1998)
Encourage solitude and silence	Long, Seburn, and Averill (2003); McMinn and McRay (1997)
Use spiritual language and metaphors	Fukuyama and Sevig (1999), Prest and Keller (1993)
Explore spiritual elements of dreams	Bullis (1996), Fukuyama and Sevig (1999)
Spiritual genogram	Frame (2003), Hodge (2001)

inclusion of spirituality into their lives. Similarly, others may prefer to engage in artistic expression, such as drawing, writing poetry, or sculpting; films related to meaning could also be useful.

Next we briefly review how spirituality can be incorporated into a number of traditional theories of therapy followed by spiritually oriented and spiritually accommodative treatments. We then present a clinical case study, followed by a discussion of how to implement spirituality into the treatment of these cases from several different theoretical approaches.

IMPLEMENTATION OF SPIRITUALITY INTO TRADITIONAL THEORIES OF THERAPY

Several traditional therapy theories naturally lend themselves to the implementation of spirituality; for example, existential psychotherapy and spirituality have much in common. However, professionals have failed to

helped to realize her motive more constructively. Therapy co fo-
cused on articulating and affirming Thelma's sacred yearning, lg-
ing what she perceived to be the divine character of her relationship with Matthew, helping her to grieve the loss of the sacred, and assisting her in the search for new and more viable ways to experience sacredness in her life.

Let me reiterate: any therapeutic approach can look good when it is applied to difficult cases retrospectively. My goal here was not to critique a powerful approach to psychotherapy and a gifted therapist, but to suggest that spiritually integrated psychotherapy can offer another valuable perspective on human problems, one that may prompt change in new and unexpected ways.

Adding Spiritual Resources to Change in Psychotherapy

Spiritually integrated psychotherapy also points to spiritual resources that could be drawn upon more fully within various models of psychotherapy. Let's take one example. Rebecca Propst (1988), one of the early leaders in the development of spiritually integrated psychotherapy, discusses a number of ways in which spiritual resources add an important and distinctive dimension to cognitive-behavioral psychotherapy. Particularly rich are her examples of the therapeutic use of spiritual imagery and visualization to foster a sense of spiritual support among her clients. One case involved a severely depressed Christian woman, Ann, who had been physically abused by her mother as a child and later sexually abused by her foster father. Although Ann had been in treatment sporadically with a number of therapists, she had never been able to overcome her shame and share her abusive history. She was certain that she was worthless, no good, and unlovable. With time, Ann was able to reveal her history in treatment. Her therapist responded by encouraging Ann to develop an "image of the healing Christ" (p. 137) and then to reexperience the pain of her abuse within the context of this larger supportive vision. Together they practiced the following visualization:

> THERAPIST: Imagine [Jesus Christ] after his crucifixion. As you see his brown eyes and hair, can you see his wounds? What do they look like?
>
> CLIENT: He has deep cuts in his hands and feet and scars on his back and legs.
>
> THERAPIST: What kind of facial expression does he have?
>
> CLIENT: He is in pain.
>
> THERAPIST: Is there any other expression?
>
> CLIENT: His eyes still look warm.
>
> THERAPIST: What lets you know he is in pain?
>
> CLIENT: His eyes have some tears in them, and his mouth is tense.
>
> THERAPIST: Now, Ann, I want you to switch to the image of you with your mother. Tell me what you see.
>
> CLIENT: I see myself sitting on the floor as a young child crying.
>
> THERAPIST: As you are crying, what else is happening?
>
> CLIENT: My mother is angry at me, and tells me to be quiet.
>
> THERAPIST: What happened then?
>
> CLIENT: She turned on the kitchen stove and held me down on the stove. (*She started sobbing at this point.*)
>
> THERAPIST: Ann, imagine now that Christ, whom you saw earlier, comes into the kitchen now. What would he do?
>
> CLIENT: He walks over to the stove and takes me off the stove.
>
> THERAPIST: Then what happened?
>
> CLIENT: He is telling me that he understands what I feel, he has lots of scars too.
>
> THERAPIST: Ann, imagine what Jesus's eyes look like as he tells you that he understands.
>
> CLIENT: He has tears in his eyes, and they are very warm.
>
> THERAPIST: Ann, just allow yourself to look at Jesus's eyes. (pp. 137–138)

In some ways, this form of visualization is nothing new. Changing the images and meanings of traumatic events by reexperiencing them in a more benevolent context is a central part of cognitive-behavioral therapy. But the use of spiritual resources to support and assist this process of change is new for many psychotherapists. Even though other positive images (e.g., supportive figures in Ann's life other than Jesus Christ) could have been used in this visualization, the image of the crucified Jesus had extraordinary power for a woman steeped in this narrative. Through this visualization Ann was likely able to experience a sense of reassurance that she is not truly alone, that someone else has shared her pain. She was also able to witness a model of hope and resilience in the face of suffering. And she could gain a sense of support that, in spite of her pain and guilt, she was still worthy of someone's love. In this way, Propst was bringing a distinctive resource to the process of psychotherapy.

Spiritually integrated psychotherapy is multimodal. It draws on many mechanisms of change from many traditions and can be integrated into a wide range of therapies, not only cognitive-behavioral, but psychodynamic, existential, marital/family, interpersonal, humanistic, experiential, rational-emotive, and acceptance and commitment therapies as well (see Shafranske, 1996). I will consider other examples shortly. But it is important to stress here that spiritually integrated therapy is not simply one more set of

CONTENTS

TABLE 14.1
Comparative Analysis of 10 Spirituality Oriented Psychotherapy Approaches

Approach	Historical and theoretical bases	Relationship between spirituality and psychotherapy	Therapist's skills and attributes	Therapeutic indications and contraindications; culture and gender considerations	Strengths and weaknesses; future trends
Spiritually oriented cognitive–behavioral therapy (SO-CBT) (Tan & Johnson)	*Historical roots*: Roots in CT, BT, REBT and dominance of CBT in psychotherapy today; biblical support of CBT and the rise of SO-CBT *Theoretical premises*: SO-CBT's belief-orientation, teaching emphasis, and therapeutic focus on modifying beliefs is compatible with religious clients; theistic realism; research and outcomes based; interventions include	SO-CBT involves an explicit, rather than implicit, integration of spirituality and therapy because it is a structured, directive, and explicit approach; spirituality parallels psychological growth, but it does not depend on it; primacy of the spiritual is emphasized (Model 4)	*Professional:* capacity for a collaborative relationship, to conceptualize the case, and to select and apply appropriate CBT technique *Therapist attributes:* interpersonal warmth, lack of personal psychopathology, tolerance of negative client affective states, abstract conceptual abilities, respect religious beliefs and experiences; theistic realism	*Indications:* applicable and effective for most disorders except for some psychoses; spiritual disciplines useful for many clients *Culture:* SO-CBT has been used with Christian, Hindu, Muslim, Jewish, and Buddhist clients; religious Asian Americans may have a preference for SO-CBT *Gender:* guidelines available for	*Strengths:* strong research support for efficacy of CBT and SO-CBT; high appeal among clients and therapists *Limitations*: few empirical studies; few training and supervision opportunities *Trends:* more research on the efficacy of SO-CBT with specific clinical disorders and religious groups; integration of *spiritual direction* in SO-

continues

	scriptural disputation, use of religious imagery				
Spiritually oriented psychoanalysis (Shafranske)	*Historical roots:* Freud's critique of religious experience; God-representations expressing internal objects derived from human interaction and fantasy; self psychology; Spero's critique; current focus is on the relational perspective	Psychological and spiritual growth is divergent, parallel, and ultimately integrative; development occurs within each domain and may lead to an emergent reorganization of one's psychology and spirituality in a hierarchical fashion, resulting in increased complexity	*Personal:* therapist's personal faith perspective can influence the effectiveness of SO-CBT	effective use of CBT with female clients	CBT; use of CBT/SO-CBT for chronic health problems
	Theoretical premises: Alterations in psychological state can serve a transcendent purpose in spiritual practices; religion provides culturally given motifs for representing self-experience in relationship to the	(Model 3)	*Professional:* technical skills from analytic training; attitude of respect and commitment; be nonjudgmental, open-ended, and open-minded, and affirm the collaborative nature of the psychoanalytic process	*Indications:* client must possess sufficient ego strength and psychological mindedness	*Strengths:* allows for a comprehensive analysis of unconscious processes and unfolding of awareness
			Personal: an openness to the nuances of religious experience and its impact on the totality of psychic life is more readily accomplished by therapists for whom spirituality is a meaningful dimension	*Contraindications:* impulse disorders, psychopathic character structures, or severe borderline personality organizations	*Limitations:* commitment of time and resources; may be less relevant to those seeking solution-focused direction and advice
				Culture: the focus on individual psychodynamics; delimits the role of culture	*Trends:* continuing research on intersubjectivity; attachment; relationship of brain–unconscious processes; psychological processes involved in spirituality
				Gender: the relational approach is sensitive to the feminist perspective	

continues

TABLE 14.1
(Continued)

Approach	Historical and theoretical bases	Relationship between spirituality and psychotherapy	Therapist's skills and attributes	Therapeutic indications and contraindications; culture and gender considerations	Strengths and weaknesses; future trends
	sacred; spirituality encourages a transcendent relationality				
Existential–humanistic (Elkins)	*Historical roots*: Kierkegaard, Maslow, May, Allport, Rogers, Jung, as well as James, Tillich, Otto, Frankl, Buber, and Hillman; tension of humanistic vs. transpersonal advocates *Theoretical premises*: key constructs: soul, sacred and spirituality; when the soul is nourished through regular contact with the sacred dimension	Psychology encompasses the spiritual dimensions; psychotherapy should be conceived of in sufficiently broad terms to include the soul, the sacred, and the spiritual dimensions; the psychological has primacy, however (Model 3)	*Professional*: need basic therapeutic skills and appreciation of the psychospiritual realm *Personal:* without a developed spiritual life, therapists tend to deal with soul-level issues on an I–It vs. I–Thou basis; the deeper therapists have gone on their own spiritual journey, the greater the chance of engaging clients on a soul-to-	*Indications:* useful to most with well-developed capacity for self-reflection *Contraindications:* psychotic, defensive, or fundamenalistic; not for those with limited self-reflective capacity; not for those who have been deeply wounded by spiritual systems *Culture:* widely applicable but may need to adapt clinical ap-	*Strengths:* applicable to most clients interested in developing their spiritual lives *Limitations*: theoretical difficulty of defining the constructs of *spirituality, soul,* and *sacred* *Trends:* continue fostering spirituality in the practice of psychotherapy; incorporate Eastern and other spiritual systems into human-

continues

	lished through regular contact with the sacred dimension		chance of engaging clients on a soul-to-	cable but they need to adapt clinical ap-	tems into human-
					continues
	the result is spiritual growth or spirituality; the client suffers at the level of the soul, and psychotherapy is the process by which the soul is nurtured and healed		soul basis and helping them	proach to those with non-Western values *Gender:* equally applicable	ism; strive to broaden the view of science and research methods to better value subjectivity and phenomenological realities
Interpersonal psychotherapy (IPT) (Miller)	*Historical roots*: developed by Klerman as treatment of depression with the goal of symptom reduction and better social functioning; spiritually oriented ITP (ITP-S) was articulated by Miller *Theoretical premises*: Interpersonal Relationships are: (a) divine; (b) vehicles for spiritual evolution; and (c) transform us	Spiritual growth underlines psychological health; primacy of the spiritual; basic conviction that suffering serves spiritual growth; beliefs in the primacy of spiritual growth and the spiritual significance of all interpersonal relationships propels therapy forward (Model 4)	*Professional:* beyond proficiency with techniques of IPT, the therapist must be comfortable with the belief in a purposeful loving universe, which guides individuals through relationships *Personal:* ideally, therapists personally subscribe to underlying IPT-S beliefs about spiritual growth, suffering, and the spiritual significance of all IPRs	*Indications:* most appropriate for clients who operate a priori from within a spiritual perspective; useful for most Axis I and II presentations *Contraindications:* may not be useful for clients having a crisis of faith or with a nontheistic or agnostic stance on the universe *Culture:* sensitivity to differing cultural views of clients *Gender:* equally applicable	*Strengths:* IPT-S is a spiritually structured, concrete therapy that can meet the needs of nontraditional therapy clients *Limitations*: clients having a crisis of faith or who are agnostic or atheistic *Trends:* increasing need among nontraditional clients for structured, concretely focused therapies such aslike IPT-S; no formal training programs or research project planned
					continues

TABLE 14.1
(Continued)

Approach	Historical and theoretical bases	Relationship between spirituality and psychotherapy	Therapist's skills and attributes	Therapeutic indications and contraindications; culture and gender considerations	Strengths and weaknesses; future trends
Transpersonal (TP)–integrative (Lukoff & Lu)	*Historical roots*: founded by Maslow and Sutich; expanded by Grof, Wilbur and Vaughan because other approaches omitted the spiritual or transpersonal (T) dimension, consciousness (C); evolving transpersonal psychotherapy (TP); *DSM-IV* Religious Spiritual Issues category *Theoretical premises*: key constructs: C is infinite; "T Context" for therapy (attitude regarding healing suffering, growth); aim is to expand C; spiritual emergencies; integrative approach	Individuals are spiritual and psychological beings, with spiritual primacy; spiritual beliefs and experiences are explored from a psychological perspective in TP (Model 4)	*Professional*: openness to T and ability to assess it; foster T context for therapy while using techniques from other approaches *Personal:* TP therapists are expected to work on their own development and to develop qualities of attention, clarity, compassion, nonattachment; should have firsthand experience of transpersonal states and engage in spiritual practices	*Indications:* spiritual crises, psychotic disorders, substance abuse issues, death and grief issues, help in differential diagnosis of depression and OCD *Contraindications:* meditation not for acute psychotic or dissociative states *Culture:* TP facilitates collaboration with traditional healers of non-Western traditions *Gender:* accepting of feminine values	*Strengths:* provides for genuine dialogue with traditional healers *Limitations*: no consensus on T self or how T self-identity is achieved; not a complete approach in itself *Trends:* contribute to interreligious dialogue regarding political conflict; TP clinical approaches will expand without using TP constructs; research on spiritual healing in complementary and alternative medicine

continues

Experiential-focusing (EF) (Hinterkopf)	*Historical roots:* Gendlin's EF approach; expanded by Hinterkopf to spirituality issues; research validates its role in increasing positive outcomes in psychotherapy *Theoretical premises:* basic constructs: felt sense, felt shift, spiritual experience; focusing is a gentle, powerful way of spending time with a felt sense to foster psychological and spiritual growth; a felt shift signals such growth	Distinguishes process and content; although content (spiritual and psychological) are distinct, process is not (Model 5)	*Professional:* requires specific training in EF as it applies to therapy; ability to provide exact, empathic listening responses to felt sense material; congruence, empathy and positive regard *Personal:* effective EF therapists are spiritually oriented and practice the EF method themselves; EF may be the deepest spiritual practice they use	*Indications:* useful in all settings to facilitate process in talk therapies; continue using method with client ease *Contraindications:* discontinue with client tension or discomfort *Culture:* appropriate in diverse multicultural settings because focus is process oriented *Gender:* equally applicable	*Strengths:* wide applicability; useful adjunct to any therapy approach *Limitations:* A content-less method; limited training *Trends:* continued, coordinated clinical outcomes research throughout the world; international focus on training therapists, scholarly research, and public dissemination
Forgiveness in psychotherapy (Worthington, Mazzeo, & Canter)	*Historical roots:* focus on forgiveness in couples counseling leads to empirical research and development of the REACH model	Religion and spirituality are moderators of forgiveness (Model 1)	*Professional:* formal training in manualized forgiveness groups; although not as yet empirically verified, therapist's agreeableness, empathy, sympathy, compas-	*Indications:* anxiety, anger, and depression rooted in relationship problems; use as an adjunct or as part of therapy *Contraindications:* personality disorders	*Strengths:* appeals is greater for Christian therapists who value their Christianity *Limitations:* less appeal for therapists for whom forgive-

continues

TABLE 14.1
(Continued)

Approach	Historical and theoretical bases	Relationship between spirituality and psychotherapy	Therapist's skills and attributes	Therapeutic indications and contraindications; culture and gender considerations	Strengths and weaknesses; future trends
	Theoretical premises: operationally defined core constructs: unforgiveness, forgiveness, and "injustice gap"; forgiveness can be an effective intervention when consistent with client's values, religious beliefs and when forgiveness is desired		sion, and love are likely to have a positive impact on those in forgiveness groups *Personal:* the therapist's religious conviction should match those of the client for maximum success of the approach	with empathic deficit, (e.g., narcissism) *Culture:* African Americans seem amenable to approach *Gender:* female clients appear more willing to engage in forgiveness groups	ness is not highly valued; this intervention must be integrated in ongoing therapy *Trends:* model is being lengthened and empirically tested in new contexts (e.g., parenting, Christian, and international settings)
Theistic psychotherapy (Richards)	*Historical roots*: a wide variety of theistic sources that coalesced *Theoretical premises*: God exists;	Primacy of the spiritual is posited; although change and healing are facilitated through many dimensions, healing and change is pri-	*Professional:* capacity to adopt a multicultural and denominational stance, assess spiritual dimension, ethically implement spiritual	*Indications:* theistic clients with less severe disorders who wish to discuss or have concomitant spiritual issues	*Trends:* further philosophical and empirical development, including clinical outcomes research

continues

	spiritual processes link us to God; those with faith can draw on spiritual resources in therapy; the approach is integrative, empirical, ecumenical (multicultural), and denominational, with regard to tailoring treatment to specific religious denominations	marily a spiritual process (Model 4)	interventions, and help clients access useful spiritual resources	*Contraindications:* severe psychological disorders *Culture:* sensitive to multicultural and ecumenical concerns *Gender:* equally applicable	Americans have theistic beliefs, the approach has wide applicability *Limitations:* May not be as applicable for those with nontheistic beliefs *Trends:* further philosophical and empirical development, including clinical outcomes research
Intensive soul care (ICS) (Benner)	*Historical roots:* personal experience; psychoanalytic, theory, analytical, archetypal and existential psychology; Christian spiritual direction and Ignatian spiritual *Theoretical premise:* the soul and spirit are intimately linked, and journeys of both are essential for full growth;	The psychological and spiritual form two faces of the coin of the inner self; no real distinction between soul (psyche) and spirit; both are intimately linked, and the journeys of both are essential for full growth (Model 5)	*Professional:* expertise in psychodynamics theory and practice; working knowledge of existential, analytic, and transpersonal approaches to spirituality *Personal:* commitment to personal psychospiritual well-being within a Christian perspective; involvement	*Indications:* healthy individuals with high ego strength, honesty, and psychospiritual issues *Contraindications:* not for adolescents, children, psychotics, borderline clients or lower functioning narcissistic clients; requires availability to spend 2–3 weeks in intensive treatment	*Strengths:* the intensity of the approach can lead to significant change in a short time *Limitations:* suitable for only a small percent of therapists and clients *Trends:* increased training of practitioners; research focused on clinical outcomes

continues

TABLE 14.1
(Continued)

Approach	Historical and theoretical bases	Relationship between spirituality and psychotherapy	Therapist's skills and attributes	Therapeutic indications and contraindications; culture and gender considerations	Strengths and weaknesses; future trends
	psychopathology always represents some combination of soul suffering and spiritual longing; ICS is an intensive experience of psychotherapy and spiritual direction in a retreat context to foster focused growth		client in spiritual directional and ignatian exercises	*Culture:* applicable across compatible cultural and religious groups *Gender:* equally applicable	
Integrative spiritually oriented psychotherapy (Sperry)	*Historical roots*: bio-psychosocio-spiritual model and biopsychosocial therapy; spiritual direction; attachment theory–God image; positive psychology and virtue and strengths research	The psychological and spiritual dimensions differ yet are interdependent; spiritual aspect has primacy; spirituality is distinct from, but may parallel, psychological growth, yet both spiritual disciplines	*Professional*: able to conceptualize and provide tailored, integrative therapy with a spiritual component; skilled in interpretation and schema change *Personal*: experience	*Indications*: wide ranging, from severe disorders to high functioning clients with spiritual issues *Culture:* high cultural competency required because therapist–client mu-	*Strengths:* applicable to most presentations; holistic and comprehensive *Limitations*: requires extensive knowledge, experience, and high personal commitment

continues

Theoretical premises: primacy of spiritual dimension; developmental-growth perspective; goal is transformation; integrative, outcomes based, and tailored treatment	and psychotherapeutic work are necessary to achieve wholeness (Model 4)	in spiritual direction and with spiritual disciplines; commitment to ongoing spiritual development	tuality is a key factor *Gender:* equally applicable	*Trends:* approach will develop and expand with research findings and client expectations of holistic approach

BT = behavioral therapy; CBT = cognitive–behavioral therapy; CT = cognitive therapy; IPR = interpersonal relationship; REBT = rational emotive behavior therapy.

A, D, G, H, J, K

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