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Deanna Wilcoxson Dodd
Exploring Spirituality/Religion
Related Interventions Used by
Mental Health Workers in
Psychotherapy and Counseling

ABSTRACT

This qualitative, exploratory and descriptive study is designed to gain understanding about the question: In what ways do mental health professionals incorporate spiritual and/or religious interventions during psychotherapy? It builds on existing research, focusing on specific interventions that have been carried out in a variety of mental health disciplines. The study is an attempt to further identify and document such interventions. It also explores factors that contribute to the successful use of the interventions within therapy sessions.

Twelve highly experienced mental health workers in the eastern United States were interviewed, including clinical social workers, licensed professional counselors, pastoral counselors, clinical psychologists, and a marriage and family counselor. Analysis of their recorded responses to a structured interview with open-ended questions resulted in thick descriptions of their accounts of cases, interventions, and their perceived success factors.

The most significant and dramatic finding of this research project is support for the assertion that: When appropriate, a willingness and ability to include spirituality and/or religion in the psychotherapeutic process is *essential* to optimal psychotherapy.

EXPLORING SPIRITUALITY/RELIGION RELATED INTERVENTIONS USED BY
MENTAL HEALTH WORKERS IN PSYCHOTHERAPY AND COUNSELING

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Deanna Wilcoxson Dodd

Smith College School for Social Work
Northampton, Massachusetts 01063

2007

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CHAPTER I

INTRODUCTION

The purpose of this study is to answer the following question: In what ways do mental health professionals incorporate spiritual and/or religious traditions in the interventions they use during psychotherapy? Currently there is extensive literature describing the trend toward greater acceptance of the belief that spirituality and religion have a significant role to play in strengthening psychotherapy practice. This study builds on existing research by collecting data on specific interventions that have been carried out successfully in a variety of mental health disciplines. The study is an attempt to further identify and document such interventions. It also explores factors that contribute to the successful use of spirituality/religion based interventions within psychotherapy sessions.

There are numerous references in the literature about the use of religion and/or spirituality in psychotherapy (e.g., Northcut, 2000; Yarhouse, 1999), but the area of inquiry is still relatively new and existing literature calls for further research into this subject. Few resources were found that provided a listing and detailed description of common types of therapeutic interventions that incorporate the client's spiritual or religious tradition. There is value in surveying cases where spirituality/religion based interventions were used and providing detail on how to execute each identified intervention, both for adaptation by the readers and to stimulate new ideas for practice. Specific factors found to promote the successful use of such interventions are important to document, since inappropriately used interventions have caused damage to clients (Yarhouse, 2002). In addition, some previous studies (Hodge, 2004) emphasize the need

to conduct an accurate assessment of the client with whom such interventions might be used. There is therefore a need for guidelines for adapting, creating, and using interventions.

The sample for this study included twelve mental health professionals who agreed to participate. They met the criteria stipulated for participants: each had used spiritual/religious based interventions in their practice, were licensed, and had practiced at least three years. In fact, participants' average number of years in practice was 24.7. In telephone or person to person interviews, participants responded to open-ended questions from a structured interview guide to describe their use of spirituality/religion related interventions. The recorded interviews were professionally transcribed and then analyzed using theme identification and coding (Anastas, 1999).

The analysis resulted in eleven thematic areas that were explored and refined into six themes and five sub-themes with sub-sub themes that were then used to organize the findings and discussion. These were: participants' approach to therapy/counseling; practitioners' views and beliefs (definitions of spirituality and religion, the practitioner's own spiritual and/or religious beliefs, and views regarding the use of spirituality and religion in psychotherapy, including how some moved from not using such interventions to using them); interventions as described in cases (including presenting problems, descriptions of the interventions, and non-spirituality/religion based interventions, which was coded as "techniques" to distinguish the two types during coding); success factors for interventions (therapist, client, environment, other); further training; comments on study.

With regard to their general approach to therapy, most participants use a holistic or systems approach and most are eclectic, some using a wide range of theories and techniques. A major theme in each participants' approach is their commitment to understanding the client's background and culture and responding in ways that respect and honor client individuality and uniqueness.

While all the participants seriously pursue some spiritual and/or religious path of their own, they stress the importance of not imposing one's own beliefs or practices on the client. However, most believe that it is critical to culturally sensitive therapy for all therapists, regardless of their own beliefs, to legitimate the possible consideration of the client's spiritual or religious concerns and strengths in the therapy process. Several describe the conditions under which this can be done in a manner that is comfortable for both the therapist and the client.

The findings of this study can be critiqued for use by other therapists, particularly clinical social workers. Thick descriptions are provided by participants of exactly what interventions they used and how they went about selecting and implementing these interventions. Responses to questions about success factors and lessons learned provides more detail on specific types of interventions used, and the success factors described can help in the development of guidelines for adapting, creating and using spirituality/religion based interventions.

In addition, this study contributes to the field of social work by supporting more culturally competent forms of interventions in therapy (Saari, 1991), since users of the study can become more familiar with ways to incorporate the spiritual and/or religious traditions of their clients who value bringing their traditions into the therapeutic setting.

The findings may foster respectful treatment of spirituality and religion in therapy sessions for people of faith, or for those who have been damaged by destructive uses of religion or spiritual practices. In reading the results of this study and pursuing readings from the references, practitioners may deepen their understanding of various faith traditions and thereby become more sensitive to the values of their clients. The information gathered may also contribute to respect for cultural and racial diversity, since spiritual and religious traditions are woven deeply into the culture of different ethnic groups and races. Culturally competent care acknowledges and incorporates, at all levels, the importance of culture, language, strengths of people, their communities, and in many cases their religious and spiritual beliefs (Abernethy et. al., 2006). This study can serve as a resource to clinical social workers who seek to provide such care.

CHAPTER II

LITERATURE REVIEW

The literature review for this study focuses first on the broad context and issues in psychotherapy as related to religion and spirituality, and it then summarizes and critiques major themes that emerge from the literature reviewed. Next reviewed is the empirical and theoretical literature more directly focused on spirituality/religion related interventions, such as prayer, meditation, and mindful attention, which have been used by various mental health professionals who seek to incorporate religious or spiritual traditions of their clients into psychotherapy. Specific categories of interventions as well as documentation of the actual process of the interventions are provided, as well as the therapeutic context and circumstances surrounding the use of these interventions. In addition, the factors that make the use of the intervention effective in the course of the particular case(s) in which it was used are identified and described. The purpose of the literature review was to inform and guide my own research into the question: In what ways do mental health professionals incorporate spiritual and/or religious interventions during psychotherapy?

The first section of this chapter presents the words *religion*, *spirituality*, and *intervention* as they have been defined in the literature and as they will be defined for the purposes of this study. The second section describes the historic controversy and changing theories regarding religion and spirituality in psychotherapy, and thus provides a context for understanding how various therapists have approached the subject of religion and spirituality in their work with clients. The third section provides an overview

of key developmental stage theories of the spiritual and moral dimensions of human development. In so doing, the second and third sections provide references to sources for the reader to use for further understanding of the various psychoanalytic and developmental theories in which spirituality/religion based interventions may be grounded. The fourth section describes some of the values that religion and spirituality are reported to provide to the process of psychotherapy, noting the rationale for including spiritual/religious considerations in the therapeutic process. The fifth section explores the relationship of cultural/racial diversity to religion and spirituality in psychotherapy. This section is important for understanding the need for cultural awareness and sensitivity in selecting and applying particular interventions. The sixth section describes examples of spirituality/religion related interventions from the literature. The seventh section reviews literature and draws conclusions that show the need for increased understanding of the valuable role spirituality/religion related assessment tools and interventions can play in the healing process, and the need for further resources in this area. This final section also points out the need to understand what is required for the successful use of spiritual and/or religious interventions in the therapeutic process.

Definitions of Spirituality, Religion and Intervention

Agreement on the exact definitions of the terms spirituality and religion does not exist (Fukuyama & Sevig, 1999; Richards & Bergin, 1997). Although the terms are not entirely interchangeable, they have overlapping meanings and are most often used together. Spirituality is often described as the broader of the two terms. The word *spirituality* is derived from the Latin *spiritus*, meaning breath or life force. Spirituality generally refers to the meaning or purpose in one's life, a search for wholeness, and a

relationship with a transcendent being or transcendent reality. One's spirituality may be expressed through *religion* or religious involvement, which generally refers to participation in an organized system of beliefs, rituals, and cumulative traditions (Fukuyama & Sevig, 1999).

To paraphrase Hayes & Cowie (2005), spirituality is defined as a dimension of being that gives life meaning and that can be expressed as a relationship with a higher being, sometimes called God. In contrast, religion is defined as a particular framework that includes a belief structure, a moral code, an authority structure and a form of worship. Joseph (1988) defines religion as "the external expression of faith...comprised of beliefs, ethical codes, and worship practices" (p.445). Spirituality on the other hand can be defined as "the human quest for personal meaning and mutually fulfilling relationships among people, the nonhuman environment, and for some, God" (Canda, 1988, p. 240).

For the purposes of this study the term spirituality/religion will include all the above definitions. The meaning will be refined in the context where it is used. When used separately, religion will refer to a particular framework that includes a belief structure, a moral code, an authority structure and a form of worship, and will not exclude the internal spiritual process as suggested by Joseph (1988) above. When used separately, spirituality will refer to the human quest for personal meaning in whatever form the individual takes it. The ambivalence of the words was kept in mind when constructing the research instrument and in preparing participants.

In the field of medicine an *intervention* is the act of interfering or interceding with the intent of modifying the outcome. An intervention is usually undertaken to help treat

or cure a condition (Medicinenet.com). In this study, intervention will refer to a specific, structured activity employed to contribute to the therapy goals. Examples of spirituality/religion related interventions are: prayer, meditation, fasting, and mindful attention, to name a few.

*Historic Controversy and Changing Views Regarding Spirituality/religion and
Psychotherapy*

In the beginning of psychoanalysis as developed by Sigmund Freud and most early theorists and practitioners, religion and spirituality were not only considered inappropriate for psychoanalytic practice, such beliefs and systems of religion were considered aspects of illness or dysfunction (Simmonds, 2006). Psychoanalysis was considered by Freud (1961/1967, p. 27) to be “a method of research” and an “impartial instrument” that used scientific techniques to arrive at demonstrable, objective truth. Religion was equated with superstition and seen as a cause of social repression and intolerance.

At first there was no room for the use of any interventions that might rely on or benefit from a positive consideration of spirituality or religion. There was even some fear of confusion between the young discipline of psychoanalysis and existing spiritualism. There began a growing reductionist attitude, which equated all spirituality/religion with its most destructive forms (Simmonds, 2006). As these views and the theories that ground therapeutic practice changed over time, however, openness to spirituality/religion based interventions increased.

Over the years, Freud and his disciples (to use a religious term) debated the role of spirituality/religion in psychotherapy among themselves and with intellectual peers.

Simmonds (2006) described three periods during which some psychoanalysts articulated views opposing those stated by Freud and held that there was value in spirituality/religion for the healing work of the therapist. The first period was during Freud's life. His peers pointed out that the universal "religious feeling" or impulse is different from religion itself, which often destroys the life-giving quality of spiritual awareness, one's sense of connectedness with the transcendent. However, Freud explained away this "oceanic feeling" as pathology (Simmonds, 2006).

During the second period, around the time of Erikson (1962) a growing number of critics discredited Freud's view. Erikson's stages of psychological development supported later developmental stage theory summarized in the following section.

During the period beginning in the 1990's, a third wave of psychoanalysts have built on the work of Erikson (1962) and others to do empirical studies on "the god concept" and define "primitive" and "mature" religion (Kurtz, 1992; Meissner, 1996; Rizzuto, 1981/1979; Symington, 1993). The "reductionistic attitude was ...disputed by some of the British psychoanalysts...and by some notable European immigrants to America. This influenced "the current wave, whose momentum is swelling the sea change" (Simmonds, 2006, p.138). These three periods contributed to the current mental health provider environment in which we see that while the anti-spirituality/religious view is not widely held now, there is still some skeptical distancing, particularly among psychoanalysts. Other factors also contributed to the increasingly affirmative attitudes toward inclusion of spirituality and religion in psychotherapy. Due to broadening theories that inform practice, there is no longer only *one* way to do therapy.

One such theory was the rise of constructivism. In contrast to the psychoanalytic roots of dynamic theory, constructivism is a conceptual framework that can inform practice approaches. “Constructivist theories posit that humans cannot know (perceive) objective reality absolutely” (Franklin & Nurius, 1998, p. vii). This accounts for the shift in psychotherapy from “finding insights or answers to helping clients find meaning” (Saari, 1991, 1999). Constructivism underlies therapeutic approaches such as narrative based therapy, which is flexible and open and can use religious and spiritual material (Saari, 1991, 1999). Both the maturing of spirituality/religion and the maturing of psychotherapy open the way to awareness of the values of religion and spirituality in psychological assessment and intervention.

One American historian who detailed the maturing of the spirituality/religion relationship to psychotherapy is Ernest Kurtz (Miller, 1999). He traces the common antecedents of spirituality/religion and psychotherapy in ancient Greece and the many complex forces that first separated, then began the integration of the two. His account of the post World War II scene in the world of psychology describes the “third psychiatric revolution” in which there was a revolt against the medical model and issuing in a new emphasis on “a full life” and the integration of sociological insights into the therapy process. Some used this phrase to mean a restoration of religious insight into psychotherapy, while others used it to account for the increasing numbers of spirituality-based group therapy (Miller, 1999).

Meanwhile, expressions of religion and spirituality were diversifying, moving in the 1950’s from the neo-orthodox theology into the “peace of mind, heart, and soul popularizers” such as Norman Vincent Peale, Fulton J. Sheen, and Joshua Loth

Lieberman” (Miller, 1999, p 36) and on into the decade of the sixties with anti-Vietnam demonstrations by flower children. At this point there was a confluence between psychology and spirituality. During this time pastoral psychology and counseling grew into an institutionalized practice (Miller, 1999).

Covering part of the same periods, Canda and Furman (1999) provide an overview of the history of connections between spirituality/religion and social work. They identify three broad historical phases in the shifting trends in the relationship between spirituality/religion and the social work profession. The first period highlights the sectarian origins of social work and it covers the time from the colonial period to the early twentieth century. Next is the period of professionalization and secularization from the 1920s through the 1970s, and finally the period of resurgence of interest in spirituality from the 1980s through the present.

In the first phase, voluntary services and governmental social welfare related policies were largely influenced by Christian and Jewish conceptions of charity and community responsibility. These involved competing application of theological ideas to social life. For example, individual moral blame or merit was emphasized by one faction. They distinguished between serving the *worthy* poor rather than the *unworthy* poor. The other faction stressed service philosophies based on social justice and communal responsibility. These social workers were part of such movements as the Jewish communal service and Christian social gospel. During this time there were also social work pioneers who had strong spiritual motivations for service, but they did not focus on religious terminology or institutions to express them. For example, in 1888, Jane Addams, who won the Nobel Prize for her pioneering work with the settlement house

movement and peace movement, used the metaphor of a “cathedral of humanity which should be capacious enough to house a fellowship of common purpose, and which should be beautiful enough to persuade men to hold fast to the vision of human solidarity” (Canda and Furman, 1999, p. 88). While she found motivation for her work in her religious faith, she did not emphasize it in her work, and thus avoided any sectarianism. This period was before social workers began functioning in the role of psychotherapists, but it appears to have created an environment that was more or less neutral toward spirituality and religion.

During the second phase, social work professionalized in competition with and along models of medicine and law, secular humanistic and scientific perspectives, such as socialism, social functionalism, Freudianism, and behavioralism. These forces became more influential than theology. Professional social work leaders hoped that these scientific views would provide a more reliable base for practice. Also, increased involvement of federal and state government in social work and social welfare brought greater concerns about separation of church and state within the arena of social services. Many people were concerned about the tendency of some religious social service providers to make moralistic judgments, blame the victim, proselytize and exclude those who did not conform to their religious views. It was during this period that clinical practice among social workers began to grow, and the cautious attitude toward religion present in the social work field, along with the influence of Freud’s theories of psychoanalysis, shaped clinical social work theories. It was also during this period that the National Association of Social Work (NASW) and the Counsel of Social Work Education (CSWE) formed as inclusive, secular, professional organizations, in contrast to

earlier sectarian social work organizations. CSWE curriculum policy guidelines in the 1950s and 1960s referred to the spiritual needs of people in non-sectarian terms. However, the guidelines of the 1970s and 1980s eliminated even these non-sectarian references to spirituality. Still, religious and non-religious spiritual perspectives influenced social workers throughout the second phase. (Canda & Furman, 1999)

In the third phase, the resurgence of interest in spirituality, there was an expansion of the ecumenical, inter-religious, and non-sectarian spiritual undercurrent that existed in the profession from its beginning. In the 1970s, there were some early calls for new spiritual approaches to social work, such as Zen Buddhism and existentialism. During the 1980s many publications called for a return to the profession's historic commitment to spirituality, but in ways more inclusive and respectful of diversity. During the 1990s this trend continued to expand rapidly as evidenced by the growing amount of literature published on the subject. The 1995 version of CSWE curriculum guidelines returned attention to belief systems, religion, and spirituality, especially with regard to client diversity. In the area of clinical social work's biopsychosocial assessment instruments, they increasingly include spiritual and religious dimensions. (Canda & Furman, 1999)

Beyond the field of social work, this increasingly holistic approach to human well-being can be seen in the growing body of recent literature that views psychotherapy as integrally connected with all of five dimensions of human experience: psychological, social, moral, somatic, and spiritual. Psychiatrist Len Sperry (2001) posits that the spiritual dimension is central to and integrally related to the other four dimensions. He describes seven perspectives on spiritual development distilled from the professional

literature. They are “Object-Relations, Transpersonal, Self-transformation, Self-Transcendence, Character, Conversion, and the Ethical perspective” (Sperry, 2001, p. 21). This description of how each perspective relates to the process of spiritual development can provide a theoretical grounding for the use of spiritual/religious assessment and interventions in psychotherapy.

Developmental Models of Spiritual Dimension

Further theoretical grounding for selecting spiritual/religious assessment tools and identifying appropriate spirituality/religion-based interventions can be found in the various stage models of human development. Such models are “rooted in four traditions: 1) psychodynamic theory-Freud, Erikson and Jung; 2) structural-developmental theory- Piaget, Kohlberg, Fowler, Kegan, and Helminiak; 3) transpersonal theory- Wilber; and 4) spiritual traditions- Keating (Sperry, 2001, p.51). Stage models in all four of these traditions have relevance for spiritual/religion-based interventions, but three appear to have very important insights to guide such practice. They are Kohlberg’s (1984) Stages of Moral Development, Fowler’s (1981) Stages of Faith Development, and Helminiak’s (1987) Stages of Spiritual Development.

Kohlberg’s (1984) model of moral reasoning was based on Piaget’s structural-developmental paradigm. He describes three levels of moral reasoning, each with two stages. There has been considerable criticism of the basis of Kohlberg’s research and those who followed him. However, the stages and the follow-up studies are valuable theoretical background. The stages are as follows:

1. Pre-conventional Levels. Here morality is externally based and there is a strong emphasis on external control.

2. Conventional Levels. Here the emphasis is on pleasing others or achieving set standards.

3. Post-conventional level: Here abstract moral principles must be seen to guide concrete rules and laws. Otherwise there is a conflict between one's understanding of the principle and the apparently conflicting rule.

James Fowler (1981) posits that one's faith is directed toward their object(s) of ultimate concern. A person's faith is the result of the way that person develops both cognitively and spiritually in dealing with ultimate reality or the transcendent. By becoming familiar with this stage construct the therapist may help the client who is stuck at an early stage to examine and transform literal and symbolic formulations into more mature concepts that foster a healthy life. Fowler describes faith development in six stages that follow a pre-faith stage in which a fund of trust and mutuality is built up during the first two years of life. The six stages are as follows:

1. Intuitive-projective faith. During ages 3-5 the child is in a fantasy filled imitative stage from which he/she is highly influenced by the visible faith of primary care-givers. The child imagines concrete images consistent with the faith portrayed in the environment.

2. Mythic-literal faith. During ages 7 to puberty children take into themselves the observances, stories, and beliefs present in the community of which they are a part. They take literally the stories told in the context of the faith of their family and community.

3. Synthetic-conventional faith. During adolescence and early adulthood authority is important and faith is structured through conforming to beliefs found in

interpersonal relationships. Values shaped here are deeply held but are largely unexamined.

4. Individuative-reflective faith. In adulthood one becomes committed to a set of personalized beliefs. While there is still much unconscious material, symbols are critically examined and translated into one's own conceptualizations.

5. Conjunctive faith. Here much that was suppressed or unrecognized in stage four is integrated into the self. In this stage one strives to synthesize apparent opposites. Inclusiveness is stressed and faith is acted out with conviction.

6. Universalizing faith. Here one is concerned with relating justly and lovingly to others. There is a vision of universal community and strong commitment to living it out in daily life, transcending concern for one's own well-being.

In his interdisciplinary study Helminiak (1987) describes what he calls Stages of Spiritual Development. Rather than seeing spiritual development as a separate line of development alongside the physical, emotional, intellectual, moral, ego, or faith development, he sees spiritual development embracing all these dimensions. Four factors must be present to make human development spiritual development: 1) integrity or wholeness, 2) openness, 3) self-responsibility, 4) authentic self-transcendence. The process of human development that leads to the fully authentic person is presented in five stages. They are:

1. Conformist stage. Emphasizes a deeply felt and highly rationalized worldview which is accepted on the basis of external authority and is supported by the approval of valued others.

2. The Conscientious Conformist stage. One realizes that the conformist stage abdicates responsibility and one begins to assume responsibility to make life what one wishes to make it.

3. The Conscientious stage. Commitments become more realistic, more nuanced, and more supported by one's deeply felt and complex emotions.

4. The Cosmic stage. One becomes more fully authentic, more open and willing to change and adjust to what circumstances demand. There is a profound merging between the spirit and the self.

A study of these and other models of spiritual development may provide a firm foundation for therapists who wish to integrate spirituality/religion into their practice.

Value of Spirituality/religion to Psychotherapy

In recent years, healthy spiritual or religious functioning has been consistently associated with positive mental health outcomes (Plante & Sherman, 2001). For example, certain types of religious involvement, such as frequency of church attendance, have consistently been found to be related to greater subjective well-being and life-satisfaction, whereas other factors, such as difficulty forgiving God and "negative" religious coping styles have been shown to be related to negative mental health outcomes such as depression, stress, and suicidal behavior (McCullough, Larson, and Worthington, 1998).

Len Sperry (2001) reports that "Based on the number of magazine articles and trade books addressing the topic, it appears that many individuals are searching for ways of incorporating spirituality in their daily lives (p.3)." "Survey research indicates that 94% of Americans believe in God, nine out of ten pray, 97% believe their prayers are

answered, and two of five report having life-changing experiences (Steere, 1997, pp.43 & 54).” Since these statistics are consistent across recent literature (Baker, 1997; Wallis, 1996; *The Harvard Mental Health Letter*, 2001) it would appear that a high percentage of clients might wish to have effective spirituality/religion based interventions as part of their therapeutic process. This study attempts to add resources to assess and address that desire.

In their descriptive study of clients’ beliefs and preferences, Rose, Westefeld, and Ansley (2001) found that “although no research has specifically examined clients’ beliefs about the appropriateness of discussing spiritual issues in therapy, there is indirect evidence regarding client preferences (p. 61).” The focus of their study was on clients’ attitudes about discussing religion and/or spirituality, however, and it did not include inquiry about the use of spirituality/religion related interventions. Psychologists report that 60% of their clients often use religious language to describe their personal experiences (Shafranske & Malony, 1990). In a study of 64 participants from seven counseling sites, descriptive analyses were performed to derive instrument means and standard deviations, which are provided in their “Results” (Rose, Westefeld, and Ansley, 2001, p.65). Findings indicated that many clients, particularly those who are highly religious or spiritual, believe that these issues are important therapeutic factors. They are considered to be central to the formation of worldview and personality and to human behavior. The researchers conclude that “psychologists who provide psychotherapeutic services need to be sensitive to clients’ needs to address spiritual and religious issues” (Rose, et. al., 2001, p. 69). It seems logical that if individuals value

discussing their spiritual and religious beliefs, they may also value having their therapist use spirituality/religion related interventions.

Cultural and Racial Diversity

There is also literature indicating that increasing numbers of therapists do feel comfortable drawing on religious/spirituality resources in developing and executing their treatment plans. However, none of the literature found to date provides a conclusive assessment as to what percentage of mental health professionals do use spirituality and/or religion as part of the practice. As mentioned above, according to Northcut (2000), both constructivism and psychodynamic theories consider it important for clinicians to understand their own religious/spiritual beliefs and practices before taking on these issues with clients. In fact, the NASW Code of Ethics (NASW, 1999, Section 1.05) stipulates that social workers should work toward competence in the area of religious diversity.

Incorporating religion and spirituality in therapy contributes to respect for cultural and racial diversity. Culturally competent care acknowledges and incorporates at all levels the importance of culture, language, strengths of people, their communities, and in many cases their religious and spiritual beliefs. Having basic knowledge of the tenets of other religions such as the House of Islam (Muslim), Judaism, Christianity, Hinduism, and Buddhism, to name a few, can have a direct and positive impact on the dynamics in the therapy setting (Abernathy et al., 2006).

For many Americans spirituality and/or religion is also an integral part of their racial and cultural identity, essentially shaping their worldview and sense of self. Some have argued that spiritual and religious affiliation is “more potent social glue than the color of one’s skin, cultural heritage, or gender” (Shafranske & Malony, 1990). For

some marginalized groups (e.g., African Americans) spirituality and religion have long been identified as a major source of strength and survival (Boyd-Franklin & Lockwood, 1999).

Despite the growing awareness of the importance of spirituality and religion to many of America's ethnically and culturally diverse psychotherapy clients, we are only beginning to accumulate examples of how to address and integrate these concerns and values into the therapeutic process.

Examples of Spirituality/religion-related Interventions Described in the Literature

The literature has frequently shown examples of both prayer and meditation being used as actual interventions in therapy. William Miller (1999/2003), in his book *Integrating Spirituality into Treatment* put out by the American Psychological Association, has compiled the works of therapists in the field who use these interventions in their therapy. The following are examples taken from his research. Descriptions included here are supplemented from other literature as cited.

Prayer as an intervention. According to McCullough & Larson (1999), prayer can be a vehicle for creating cognitive change. The therapist can encourage clients to use prayer for coping, if appropriate, and praying in session “might help to incorporate therapy into their worldview” (p.100). When praying with a client in session, clients and therapist should probably pray together only when three circumstances converge: (a) The client requests in-session prayer; (b) a thorough spiritual and religious assessment and psychological assessment have convinced the therapist that engaging in such explicitly spiritual and religious activities would not lead to the confusion of therapeutic role boundaries; and (c) competent psychological care is being delivered (Richards & Bergin,

1997). Although praying with clients is probably wise only in limited cases, it is not unethical, inappropriate, or therapeutically counterproductive (Richards & Bergin, 1997). It might be beneficial for practitioners to take advantage of clinical opportunities to use clients' prayer lives as a potential window into their spiritual and psychosocial functioning. Also, prayer might be used as a vehicle for creating cognitive behavioral changes.

Meditation in Clinical Practice. Meditation had been used as a global method of stress management, relaxation, and personal centering. According to Marlatt (1985), meditation can be used as a method to attain a balanced lifestyle, and the topic of lifestyle balance can be introduced early in the clinical process. In the session, after discussion and questions about meditation are completed with the client, the client should be given instructions for a practice session in the office. The client should then be asked to practice the techniques on a daily basis between clinical sessions. Meditating with the client in the first session provides a model for the client, and it creates less self-consciousness for him or her (Marlatt & Kristeller, 1999).

Understanding the mechanisms related to the clinical application of meditation first began to draw considerable attention in the 1970s. At that point it was associated with an increasing interest in applying contemporary psychological research methods to understand the relationship between mind and body (Shapiro & Walsh, 1984). This interest continued to grow.

Meditation has also been described as a treatment for alcohol and drug problems. The implications of Buddhist psychology and mindfulness meditation for addiction treatment have been discussed by Groves and Farmer (1994). The effectiveness of this

approach along with a description of various clinical applications of mindfulness and acceptance in addiction treatment has been discussed by Marlatt (1985). Meditation has also been found to be an effective intervention for reducing excessive drinking and alcohol problems in young adult drinkers (Marlatt, 1984).

Sacred Writings. Known as religious bibliotherapy (West, 2000), sacred writings can be used when it is determined to be a value to the client, and the particular writings can be examined at least cursively in advance by the therapist. Geri Miller (2003) identifies three uses for such materials: self help/educational, psychosocial support, and interactive. She describes how each use is approached and lists other resources to assist with this technique.

Focusing. Described also by Miller (2003) as well as other researchers, this technique is defined as “the vague, bodily, holistic sense of the situation such as a problem, creative project, or spiritual experience” (Hinterkopf, 1998, p. 19). Through this intervention the clients may learn to listen to themselves without judgment. The openness can result in new awareness and growth.

Journal Writing. A great deal of literature as well as training sessions and other resources are available to teach therapists and others how to use this technique. The journal may take many forms including chronology, recollections, focused analysis, etc. The intent is to help the client feel free and safe. Clients often learn to trust themselves and to learn their inner thoughts and feelings as well as to find inspiration. (Miller, 2003; Sperry, 2001)

Rituals. While rituals can be of either a religious or secular nature, they are formalized behavior patterns that draw out certain feelings (Denzin, 1974). They help

people move from what is known to what is unknown. They include creating a sacred space, the expectation of a change in insight, attitude, affect, or the receipt of guidance, and the expectation of awareness of the transcendent. Many diverse rituals can be identified, either from literature valued by the client or from knowledge of the therapist, but always used in consultation with the client.

Need for Client-appropriate Religious/spiritual Interventions

While there are numerous references in the literature to the use of religion and/or spirituality in psychotherapy, limited literature was found in which a practitioner could find a detailed description of common types of interventions. The most recent literature calls for additional research into this area (Miller, G., 2003; Miller, W., 1999; Sperry, 2001). Many documented cases often include thick descriptions of specific interventions, as in Abernethy's (2006) report on the use of prayer as a culturally competent intervention with an African American family. There would be value in generalizing such cases and providing detail on how to execute each generic intervention. The result would provide a range of interventions that could be modified for specific client situations. They could also stimulate creativity for the therapist to design other specific interventions.

The intervention alone, however, is useless unless the therapist knows how to adapt and use it with her/his particular client. There is therefore a need for guidelines for adapting, creating, and using interventions. Specific factors found to promote the successful use of spirituality/religion oriented interventions are therefore important to identify and document.

Finally, it is necessary to conduct an accurate assessment of the client with whom such interventions might be used. According to Hodge (2003), there are several

assessment tools to help a client bring his or her spirituality and or religion into the therapy setting. This includes such tools as a spiritual lifemap, which is a pictorial delineation of the client's spiritual journey. The pictorial lifemap affords practitioners the opportunity to learn more about the client's worldview, while focusing on building therapeutic rapport. Another tool is the spiritual genogram that provides social workers with a tangible representation of spirituality across at least three generations. Both clients and practitioners see the flow of historically rooted patterns through time. Such tools for assessment can accompany the interventions to provide a tool kit for the practitioner.

Summary

In response to the request of many clients, a diminishing positivistic understanding of psychotherapy, and the growth of a less dogmatic understanding of spirituality and religion, many mental health professionals now recognize the value in considering the spiritual and religious concerns of their clients in the therapeutic process. While there are many indications in the literature that spirituality/religion based interventions are being successfully used, few single works were found that collect and describe some of the major interventions in use, analyze why they are effective, and elaborate on the factors that make for success in their use. The purpose of this study is to respond to the call in professional literature to add to such a work.

CHAPTER III

METHODOLOGY

This qualitative, exploratory and descriptive study is designed to answer the question: In what ways do mental health professionals incorporate spiritual and/or religious interventions during psychotherapy? The qualitative exploratory approach was used, since I am “studying things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them” (Denzin & Lincoln, 1994, p.2). The study is also descriptive in that I am attempting to “increase the accuracy and scope with which ... facts ... are known” (Kuhn, 1970, p.25). A flexible method of data collection and analysis was initially planned through which the researcher could return to participants for additional data or clarification, but time did not permit following through on this method. The design of this study was approved by the Human Subjects Review Board of the Smith College School for Social Work (see Appendix A).

Sample

The method used for sample selection was a non-random, purposive method using the snowball sample technique through which I first identified professional acquaintances in the mental health field. They recommended potential participants known to them as people who have used spirituality/religion related interventions and who met my sample criteria. The criteria for participants included licensed clinical social workers, clinical psychologists, licensed professional counselors, and pastoral counselors who were or had been licensed and who had degrees from accredited colleges/universities. They were required to have been practicing for at least three years after graduation.

This snowball method of sample selection was utilized in order to assure that participants were identified within the time available for the study. I secured recommendations from three sources: a retired, former licensed counselor and management consultant who had provided consulting services to various therapists around the country, primarily in the eastern United States; a former pastoral counselor now in the field of education; and by networking at professional gatherings in the mid-eastern city where I served as a clinical social work intern. I began the screening process by providing these contacts with the Informed Consent Form (See Appendix B) and the introductory letter (See Appendix C) describing the criteria for participants and asking them to recommend therapists who met these criteria. I then called or emailed the introductory letter to each person recommended and explained the study, the criteria for participating, and the time involved as well as the risks and benefits and the privacy provisions. I then asked if the individual would be willing to participate in the study. I contacted a total of 20 candidates. Five of the candidates did not fit all the criteria. Three others wanted to participate but they were unable to fit their schedules with times possible for me. One of these initially indicated that she would participate, but upon examination of her calendar, she called to say she would not be able to do so. Of the 20 candidates, 12 participated in this study. All twelve who agreed and signed the Informed Consent Form followed through, and none dropped out during the data collection process. Four of the twelve interviews were conducted by phone and eight were carried out in face-to-face meetings in the participants' offices or homes.

Sample Description/Demographics

Of the twelve mental health workers who participated, eight were female and four were male. One (1) stated that he was African American while eleven (11) appeared to be Caucasian, though this question was not asked in the interviews. Ages of participants ranged from approximately 35 to 65, though this data was not formally gathered.

The education of participants included the following. Two (2) participants held the Ph.D. in Clinical Psychology, 3 held Doctorates in Counseling Psychology, and 1 held a Ph.D. in Early Childhood Education and the equivalent of a Ph D. in clinical psychology. Several cited Post Doctoral work including Child Psychology, Psychoanalysis, School Psychology, and Rational Emotive Psychotherapy. At the master's level, two held Master's in Social Work, one held a Master's in Counselor Education, one held a Master's in School Psychology, one held a Master's in Psychology, and two held Master's of Divinity. All participants had post graduate work and many (n=8) had formal education in spirituality and religion, primarily Christianity and Buddhism, while others cited informal readings and workshops (n=4) in that field.

Participants held licenses as follows: Licensed Clinical Psychologist (n=2), State Licensed Psychoanalyst (n=1), Licensed Psychologist (n=1), Licensed Professional Counselor (n=3), Pastoral Counselor (n=2), Licensed Clinical Social Worker (n=2), Licensed Marriage and Family Counselor (n=1). Six (6) participants were licensed in the state of Virginia while others had held licenses to practice in Georgia, Mississippi, Alabama, Texas, Michigan, and the District of Columbia. Years in practice ranged from 15 to 37 with an average of 24.7 years.

Ethics and Safeguards

All participants signed an Informed Consent Form, and hard copies of these signed forms are locked in a secure area and will be so maintained for the amount of time required by federal law. To protect the confidentiality of the study participants I used a number code on interview transcriptions. I developed a separate key associating the participant by first name with the transcribed interview. The first name can be used only by authorized persons to identify its link with the Informed Consent Form, should this ever be needed. The transcriber generalized any institutions and geographic locations that might make identification of the participant possible. I asked the participants to avoid any identifying information about their clients, and in collaboration with my transcriber, I further disguised any information that might be used to identify the cases or clients discussed. All data collection materials, including consent forms, were secured. In reporting findings, I have used pseudonyms and have not reported any demographic details that might allow readers to recognize participating therapists or their clients.

The audio recordings were transcribed by a professional who has been trained and practiced in verbatim interviewing and transcription. I have secured a signed “Transcriber’s Assurance of Research Confidentiality Form” from her (See Appendix D), and it is secured with the Informed Consent Forms along with the tapes.

There were two identified risks to participating in this study. I discussed these with the participants, and all were satisfied and willing to participate. One had to do with the use of the participant’s time. My hope is that I made their time worthwhile by faithfully recording and diligently using participant contributions. The second risk to participants had to do with privacy. As described above, strict confidentiality has been

and will continue to be maintained, as consistent with federal regulations and the mandates of the social work profession. While the data may be used in other education activities, this will be done in ways that protect the privacy of the participants.

Benefits anticipated for participants include knowing that they have contributed to the effective use of spirituality/religion-related interventions in the psychotherapy, and they have received the findings of the study. Most participants expressed appreciation for the study and for being asked to take part in it. Many expressed pleasure at being able to tell their story and having their perspective heard. This was particularly true for two therapists who have recently retired from their practice. For two participants it was difficult to recall and recap specific cases, and they seemed to feel a bit of dissatisfaction with themselves as a result.

Data Collection

Once the sample was identified, subjects who agreed to participate returned the signed Informed Consent Form. The four participants who were interviewed by phone returned the signed forms by mail before the interview. I collected the signed forms from the others at the time of the face-to-face interviews.

The Structured Interview Guide, which was provided in advance for subjects to use in preparing their responses, included requests for the following demographic information: gender, education, and licensure information; coursework/training related to spirituality and religion; and the number of years in practice. There were specific questions regarding the subject's approach to therapy, views regarding the use of spirituality/religion in the therapy process, and the therapist's own spiritual and/or religious beliefs and practices, including their definition of spirituality and of religion.

Subjects were then asked to describe one or more cases in which they used a spirituality/religion related intervention. Each case was to include an overview of the case, a description of the intervention(s) used in the case, the therapy goal(s) addressed by the intervention, the therapeutic function performed by the intervention (e.g. strengthening ego functions, improved object relations), and factors seen as contributing to success of intervention. Finally, the subjects were asked to comment on lessons learned, additional training they might seek, and comments they had about the study. (See Appendix E for a copy of the Structured Interview Guide.)

Before the Structured Interview Guide was sent to participants I had it reviewed and tested by two professionals experienced in instrument design, one counselor trained in survey design and one pastoral counselor with educational research experience. I did this in order to strengthen the validity of the study. It also helped to ensure that the instrument would be easily understood across mental health professions. In order to avoid undesirable interviewer bias/influence, while structuring the interview enough to focus data that responded to the purpose of the study, I asked specific questions in an open-ended manner. Even with the core concepts of spirituality and religion, I asked each participant to define what they meant by each word. I also asked the question about interventions in such a manner as to allow the subject to identify what they considered an intervention. Similarly, when I asked about factors that made the intervention successful (in the eyes of the subject), I focused on four types of factors: those related to the therapist, the client, the environment, and other. In addition, I asked this question in a different way by asking what lessons the subject had learned about using

spirituality/religion-based interventions. I also ended the interview with an open-ended question asking for any comments the subject had about the study.

Participants valued having the guide in advance, and those who had prepared by using it provided much more thoughtful, clear, detailed and focused information. Two participants who did not show a familiarity with the guide during the interview were less responsive to my questions during the interview and were disorganized in their responses and unsure of the details they attempted to provide. One subject had typed out the demographic information and shortened the interview time by handing me a hard copy, which I noted in the transcription.

During the interviews I followed the Structured Interview Guide and recorded the responses, both in my notes and on the recording machine. I had planned to use a digital voice recorder, but that process required additional time from the subjects to program their voices into the instrument, and my aim was to minimize effort of the subjects. Instead, I used a Radio Shack Tele-recorder, voice-activated, using micro-tape and having telephone recording capability. The voice activation feature was not useful, however, and in fact it occasionally cut off parts of words, and thus made the transcription much more labor intensive for interviews in which subjects had long pauses between thoughts.

I used a separate 90 minute tape for each interview and labeled it with the first name of the subject. I turned on the tape recorder after the subject was seated and settled (or indicated they were ready during phone conversations). Before the interview, I tested the pick-up on face-to-face interviews, and prior to any telephone interviews I tested the pick-up from the phone to the machine. After each day of interviews I hand delivered the

completed tapes to my transcriber who created a number key to the subjects (a separate document associating each first name with a number). The transcriber kept the tapes in a secure area. The transcriber created a document for each interview, titled only by number. The subject's name was not on any of the tapes or transcriptions. The transcriber left out or disguised any identifying data in the recordings. She then emailed me the documents and handed me the transcribed tapes. Within 48 hours of each interview, I reviewed each document and compared it to the tapes and to my notes. During transcription of two of the documents, the transcriber met with me to verify or fill in gaps of words she could not discern.

Data Analysis

Since the data were recorded in the participants' own words and transcribed, I have verbatim data. I analyzed the data using theme identification and coding (Anastas, 1999) except for the first section on demographics. Data provided on demographic questions were summarized above under *Sample Description/Demographics*.

After all data had been transcribed and cleaned, I began analysis. I used phrases rather than numbers for my codes, and maintained memos documenting the titles, definitions, and where useful, an example of what was not meant by the title. From this I was able to see the categories that I used in describing my findings. I began coding by examining one question at a time across the interviews. On the computer, with a separate document for each interview, I created a two column table with the data as transcribed under each question in the right column. I then coded it in the left column of the table. This allowed me to open up the narrative data contained in each question. Beginning with Interview #1 and the first question after the demographic data, I identified all the themes

in that section that seemed discrete and relevant to the question and the objective of the study. Any data that seemed irrelevant was not coded but left in the text in case codes were added and it might be needed later if additional codes were identified. In the first cut, I was intentionally very inclusive, coding almost everything that appeared in the text. I then moved to the same question in Interview #2 and continued this process until I had completed all twelve interviews. I then repeated this process for each remaining question. I used “constant comparison” (Anastas, 1999, p. 423; Padgett, 1998, p. 77) to refine my themes and sub-themes. This means that I approached each new piece of interview text and compared it with previously created sub-themes to see if it fit or needed a new sub-theme. The result was the identification of eleven themes and their related sub-themes. Some of the-sub themes later broke into sub-sub themes for reporting.

Once I had created the two column table for each interview and populated it with each code (theme or sub-theme) in the left column parallel to the text that illustrated it in the right column, I reviewed the themes and sub-themes one by one and copied relevant and illustrative text passages into a new document, one document for each theme or sub-theme. For each unit of text copied, I noted the number of the interview and the page from which it was taken in the coded interview document. I have retained these documents for review by any researcher who wishes to know more detail about the research process.

This process of data analysis resulted in a thematic analysis producing eleven documents called “Code Examples”, each including units of text from all the interviews that referred to the theme or sub-theme being documented. The original analysis included less than four additional sub-themes, but the sub-themes they represented did not turn out

to be related to the themes identified, and were considered miscellaneous and not included in the analysis. The eleven themes and sub-themes identified were:

- **Therapy Approach:** This refers to the participants' descriptions of how they approach therapy or counseling.
- **Moving to Spirituality/Religion:** This refers to information about how the participants moved from being therapists who did not address spirituality or religion during therapy to being therapists who do so.
- **Spirituality/Religion definition:** This refers to the way each participant defines spirituality and religion.
- **Participant's spiritual/religious (SR) beliefs:** These were described by the participants in their words.
- **Use of SR in therapy:** This refers to what the participants think about using spirituality or religion in therapy.
- **Intervention:** This referred only to therapeutic interventions that were deemed spiritual or religious by the participant who reported them.
- **Technique:** This code was used to tag interventions or approaches the participant used that are not spiritual or religious, e.g. active listening, CBT. The code was later named non-spirituality/religion related intervention, which more accurately described its meaning.
- **Presenting problem:** This refers to information participants included about the problems presented in the cases they describe.
- **Success factors:** This referred to any factors that the participants believed contributed to the effectiveness of the spiritual/religious intervention.

- Further training: This referred to participants' desires for more training in spirituality or religion.
- Study Comments: This refers to any comments the participants made about the study.

These documents were then studied to organize sub-themes and sub-sub themes and to identify patterns and frequencies of data. To accomplish this step, I developed a worksheet (Structured Guide Tally Sheet) to record and tally various incidents of sub-themes. In addition, the original interviews were further reviewed and compared to these documents to ensure findings were complete. These tally worksheets and associated thematic documents are the analytic support for the research findings. Using these worksheets and the documents, I was able to draft Chapter IV moving from one theme to the next. The detailed discussion of themes in this chapter was then written drawing on the work sheets, the Code Examples, and the Coded Interview documents. Finally, I generalized the themes into overall findings which were used to conclude Chapter IV.

CHAPTER IV

FINDINGS

This chapter describes the findings from interviews with twelve mental health workers who use what they define as spirituality/religion related interventions in their practice of therapy or counseling. Interview questions followed a Structured Interview Guide, provided in advance, in order to secure organized responses to specific, open-ended questions focused on answering the overall study question: In what ways do mental health professionals incorporate spiritual and/or religious interventions during psychotherapy?

Since the study purpose was to glean all possible information about what the practitioners considered to be useful spirituality/religion based interventions and what they thought contributed to the successful use of such interventions, the interviews approached this information from several different perspectives. In addition to asking directly what interventions each practitioner used and specifically what they thought contributed to success, the participants were also asked about their approach to psychotherapy, their own views regarding spirituality and religion in psychotherapy, their own spiritual/religious beliefs, and their approach to psychotherapy/counseling. They were asked to describe the interventions in the context of one or more cases. In addition, they were asked what, if any, further training they would like to have related to spirituality or religion. Finally, they were invited to comment on the study itself.

In reporting the findings of this study, I present six categories of detailed findings: Participants' Approach to Therapy/Counseling; Practitioners' Views and Beliefs

(definitions of spirituality and religion, the practitioner's own spiritual and/or religious beliefs, and views regarding the use of spirituality and religion in psychotherapy, including how some moved from not using such interventions to using them); Interventions as Described in Cases (including presenting problems, descriptions of the interventions, and non-spirituality/religion based interventions, which was coded as "techniques" to distinguish the two types during coding); Success Factors for Interventions (therapist, client, environment, other); Further Training; Comments on Study. These categories organize the eleven themes, sub-themes and sub-sub-themes resulting from the data analysis. Demographic information about the participants was also presented in Chapter III. Taken together these categories and the demographic information in Chapter III cover all information derived from the interviews.

Participants' Approach to Therapy/Counseling

Participants were asked to briefly describe their approach to therapy or counseling. The following summary of data identifies the types of descriptions provided and the frequency of their occurrence. This is followed by four excerpts of participant responses.

While a majority (n=8) used the words holistic or systems to describe their approach, others (n=2) used language that made it clear that their approach was holistic. One participant describes what he means by holistic as follows, "...I take a holistic view and use the complete range of resources as much as possible, the panoply of resources the person has." The remaining participants (n=2) did not use any language that indicated that they did or did not consider their approach holistic.

The remaining descriptions of participants' approach to therapy/counseling often included more than one of the following approaches. Five (n=5) participants reported using Cognitive Behavioral Therapy (CBT). Others (n=2) describe cases in which CBT is clearly being used. Five (n=5) participants reported using a psychodynamic approach to therapy. Several others (n= 4) clearly use this approach as demonstrated by the cases they reported later in the interview. Others may view their approach as psychodynamic but the responses did not indicate this one way or the other. Three (n=3) subjects report doing psychoanalysis. Two (n=2) report using Gestalt therapy techniques. Two (n=2) report being pastoral counselors. Each of the following approaches was cited by one (n=1) participant only: narrative therapy, crisis intervention, Jungian archetypes, neuropsychology, and interpersonal process.

One participant who is both a licensed professional counselor and a pastoral counselor, and is trained in both fields states:

Of course it depends on the setting. In the church setting I do short term counseling and then refer people out for long term counseling. In general, in therapy I describe my counseling as eclectic, primarily cognitive behavioral, though I did some extensive training in gestalt and in Jungian archetypes and so on.

A psychoanalyst responded:

Therapy is a way, probably the only way, of directing the nature of the relationship that one bears to one's self. It is because of the distorted nature of the relationship to one's self that you get symptoms generated. The distortions I am talking about are created during infant, child, and adolescence, and they occur by way of unconscious processes. The aim of therapy is to bring the distortions into consciousness so our real selves can form. In psychotherapy that is my aim...from the beginning to the end...to make the, as Freud said, to make the unconscious conscious. And to reconnect someone to his real self, which people lose very quickly.

A clinical social worker responded:

My training was in casework... and I got training in family therapy, but I have not used it very much. It's hard to get whole families to come in, but most of my post masters work has been insight-oriented, psychodynamics, object relations, pretty classical psychoanalytic psychotherapy, and that's what I've done for years and for years.

A clinical psychologist responded:

If I had to choose I'd say psychodynamic, but I do a complete holistic approach. I always do a religious and spiritual assessment, and I include financial, how finances have shaped the person's views.

As we see from the data described above, the therapeutic approaches of these participants include a wide range of theory and practice. Most use a variety of approaches and techniques they deem to be optimal in the particular case. A study of the relationship of their training or particular discipline is beyond the scope of this study, and the number of participants is not adequate to make any generalizations here.

Participants' Views and Beliefs

Interviews asked the same questions of each participant regarding his/her definition of spirituality and religion; his/her own spiritual and/or religious beliefs, and participant's views regarding the use of spirituality and religion in psychotherapy.

Findings are addressed in the following subsections.

Definitions of Spirituality and Religion

Each participant was asked to define spirituality and religion as they conceived of it. This question was asked in the context of the question regarding her/his own spiritual and/or religious beliefs. All but one participant made a specific response. Some used many words and metaphors while others made very short, precise definitions. Below I have presented direct quotes of all the responses, since I think this thick description read

as a whole provides a better gestalt of participants' responses than any generalizations I could make.

Interview #1 did not provide his definitions, though he usually referred to religion based interventions as he described the five cases reported. He did not refer specifically to spirituality at all.

Interview #2 reported having an active Quaker background and training in theology in an Episcopal program for laity:

My fundamental belief is that there is that of God in everyone, and that leads to a lot of very important things. Like, you can't kill anyone because there is that of God in them, and you have to respect every individual because you are respecting something holy and something divine. So that's the fundamental core belief in my own spirituality. Oh, and that also then implies that access to God is in everyone's reach, so if people want to talk about their experiences of God, I can believe that they do have experiences of God, and they don't have to go through some intermediary, so I think of it more as a mystical notion that God is everywhere and available to everyone...and is benevolent.

Interview #3 spoke only about spirituality and did not define religion:

...the connection to the spirit or the divine, that still voice within. That is what the spiritual is; who we are is the essence that we are: finding our connection to love and peace. What the peace is about is connection.

Interview #4 who has both Quaker and Buddhist training made only one simple statement:

I prefer to view morality as a way of life rather than a religion.

Interview #5 comes from a pastoral counselor, formally trained in protestant Christian theology, who defined both religion and spirituality:

I see religion as being an organized system of beliefs and dogmas related to the eternal, and as such religion is not as important to me, though I know it helps us organize our thoughts about our relationship to the eternal, the things that go beyond the obvious mortal structure in which we exist. Spirituality to me is less defined, more fluid. It depends on the individual. One can be religious without being spiritual and vice versa.

Interview #6 comes from a person formally trained in protestant theology who addressed spirituality but not religion.

My definition of spirituality is the conscious pursuit of a healthier, happier, more productive, more fulfilling life, at the ultimate level, and that being meaning in life, answers questions like why am I here, what is it I am supposed to do? How can I fulfill a role as a member of the group that subscribes to these particular set of beliefs or religious practices. I guess I want to broaden the definition of spirituality, because I think a therapist has to be receptive to any description and viewpoint that the client has of spirituality, and then the therapist role is to assist the client to go deeply into that spirituality looking for ways that they can become healthier and happier and at peace within themselves.

Interview #7 compares spirituality and religion and speaks of them in relation to clients:

I think there are two different definitions. I think I tend to see spirituality as one's relationship with the universe, and people, who are not religious, often can relate to my definition of spirituality...where we're not alone. So, often people who don't want to go the organized religion route, but who quest for a higher understanding or want a relationship with a higher being, it is important to them how I see spirituality. With religion, I see as more of an organized set of beliefs and practices, rituals, not necessarily Christian, but a sort of standard way of worshipping. Yeah...I'd say that. And they definitely can go together.

Interview #8 is formally trained in protestant Christian theology and other religions and comments on the origin of the words as well as on how both spirituality and religion are often regarded in the culture:

The word religion comes from the Latin word *religare*, which means to hold things together. So, the purpose of religion is to create a container or a way of tying together the parts of the person in a way that they have integrity, and that they hold together. Religion that is healthy and helpful integrates people and keeps them strong. I guess a lot of people think of religion as a bad word and spirituality as a good word, but that doesn't make any sense to me. I think that healthy religion should lead toward integration and wholeness and spirituality is part of that.

Interview #9 who has a background in Jewish, Christian, and Buddhist religions addresses both spirituality and religion.

Well, you have to differentiate religion from spirituality. Religion is an organized system of beliefs, whatever they may be, Catholic, Jewish, it doesn't matter, to connect with the spiritual. The spiritual is an attempt to become intimate with an un-nameable presence, I would call it. You could call it God. But that doesn't do justice to it. It's un-nameable, but it's there. It's right in front of you all the time.

Interview #10 who also has a Methodist, Episcopal, and Quaker background addressed the root of the word religion and provided a metaphor for understanding spirituality:

I don't know if this is accurate or not, but I like it so much I never did check it out. *Re-ligio*, what someone once told me, is *re* and *ligio*, and *ligio* is a tie, it's like a ligament, and so it is a tie back in. The persistent image for me during the last couple of years is that of a web, like a spider web. It came to me a couple of years ago when I was watching a spider in the nighttime outside my door. The spider was knitting it and it was huge; it was bigger than the door. It looked like all of life to me, and it kind of came to me as the holy or God, that we are all in this little net, part of where the net connects, so that I can't see the other side of the web. Now this image doesn't include the spider; that messes it up. But in it I am sinking down and the web pulls me up, and what I do with the web affects the other end, even though I can't see it. So I think of God as the glue that holds that web together, or maybe the Spirit holds it together, and I think of God as the one who can see the whole web and cares about the whole web.

Interview #11 brings up the social and structure aspects of religion as compared to spirituality:

I see religion as related to organized spirituality. I think Christian, I think Presbyterian, I think Baptist, I think Catholic, I think Jewish, whether it is orthodox or reformed or conservative, whatever. I think Buddhist, Hindu. I'm thinking of structure. Spirituality with structure. It's a social organization. Whereas, spirituality is what is inside the person spiritually. They also have overlap. If you think of a Venn diagram, how much the overlap is probably varies from person to person, and I doubt that it is ever a 100 percent overlap.

Interview #12 emphasizes the comparative scope of spirituality in contrast to religion:

I look at spirituality as being broader than religion. I think religion does not have to be narrow and pointed, but I think it often times is. I think that if one has a particular religion that can be helpful as a place where one can belong. One can connect with other people that way as well. It can be larger than one's self. It can

be a group, a movement, causes, etc. Spirituality in general, when I think of it as a term, I've always thought of it as all encompassing and including looking at the similarities and differences of the various religions of the world. As well as enabling a person to find out how one might connect with the universe or God, as one sees it.

In summary we see that with regard to their definitions of spirituality and religion, one participant believes that one can have religion without spirituality, but most think religion is a formalized, organized approach to the spiritual. Most see spirituality as referring to one having a relationship with something greater than one's self. The relationship is described as being with a variety of entities including "the unnamable, God, the universe, spirit, the divine, that still voice within, love, peace, the eternal, a higher being." Several speak of a function of spirituality as making a connection, showing "we're not alone." One person described a metaphor that had come to her, "So I think of God as the glue that holds that web [of all reality] together, or maybe the Spirit holds it together, and I think of God as the one who can see the whole web and cares about the whole web." Another participant simply said, "I prefer to view morality as a way of life rather than a religion." Yet another described spirituality as "the conscious pursuit of a healthier, happier, more productive, more fulfilling life, at the ultimate level, and that being meaning in life, answers questions like why am I here, what is it I am supposed to do." Two people refer to the Latin root of the word religion, holding things together. One of them describes it as holding the parts of the person together, and the other describes it as holding people in relation to others or to that which is beyond them.

Participant's Own Spiritual and/or Religious Beliefs

The religious traditions represented among the participants included: Buddhist, Jewish, Religious Society of Friends (Quaker), Methodist, Baptist, Roman Catholic,

Lutheran, Presbyterian, and Episcopal. While all participants valued their own spiritual perspectives and were serious about their faith, none of them made comments that seemed dogmatic or exclusive. These views may be seen in the following excerpts from interviews.

From a participant who was originally from the Quaker tradition:

Since I was born a Quaker my fundamental belief is that there is that of God in everyone, and that leads to a lot of very important things. Like, you can't kill anyone because there is that of God in them, and you have to respect every individual because you are respecting something holy and something divine. So that's the fundamental core belief in my own spirituality. Oh, and that also then implies that access to God is in everyone's reach, so if people want to talk about their experiences of God, I can believe that they do have experiences of God, and they don't have to go through some intermediary, so I think of it more as a mystical notion that God is everywhere and available to everyone...and is benevolent.

From a participant who was originally from the Southern Baptist tradition:

Well, my own beliefs are that there is a spiritual force or presence that is available to people for a variety of means of support and ...basically that is what we do. We call upon our beliefs in times of celebration and joy, but usually more in times of crisis and trauma and pain. Another view I have is that if people believe that they can go to their religious denomination and spirituality for help, for comfort, for direction, that to me is a very positive aspect of the human motivation, and it tells me a lot about the person.

From a participant who was originally from the Roman Catholic tradition:

I grew up Roman Catholic and had a kind of falling away from the church during college years, so I shied away from organized religion, and that's why I was drawn to Buddhist meditation some 20 years ago. I prefer to view morality as a way of life rather than a religion. I practice Quaker teachings and participate actively in a Quaker Meeting.

From a participant who was originally from the Jewish tradition:

I was raised in a Jewish family. I bar mitzvahed and all that, and then I lost interest. I just thought it didn't make sense and I didn't have any interest in it at all. At one point I was going to be married to a Christian woman. When I met her I converted, actually. And then I lost faith in that too. And now my view is that organized religion is not where it's at for me. It doesn't address the issues in a

way that would make me interested. Or, it's too dry, it's too stale. And that goes for all of them. I think what does make sense is the attempt to become intimate with the unknowable. And you could say that is the basis of all of them, but in the organized branches of these religions that tends to get lost, and there tends to be a focus on the rules, the regulations, the "thou shalt's" and all that business. I could go on like this forever, but that seems to be the essence of it.

None of the participants provided detailed descriptions of their own affiliation with a religious organization, though they all expressed serious pursuit of greater spiritual understanding. One had moved from Judaism to Christianity and on to dedicated Buddhist practice, but not to an active affiliation with a specific religious group. Of the three with seminary training, one was serving a congregation, and two were not. The high percentage who were active with Quakers (n=4) was influenced by the sampling approach. In addition, over half (n=8) specifically referred to their own practice of meditation of some type.

Views Regarding the Use of Spirituality and Religion in Psychotherapy

In the interviews participants were asked to describe their views about using spirituality and/or religion in the therapeutic helping process. Their responses are described below. Most frequently cited (n=6) is the view that spirituality must be considered if one has a holistic approach to therapy. As one participant described it:

I believe that when trying to do therapy we are trying to help the person, and I take a holistic view and use the complete range of resources as much as possible, the panoply of resources the person has, so I am very interested in various aspects of their identity and the resources they bring to bear in trying to achieve mental health. So, as a cognitive therapist, I see spirituality as a part of that. I see cognition as affecting emotions and emotions affecting behavior, and so what one believes can affect their current problems and can be used in helping them deal with them.

As we saw above in *Participants' Approach to Therapy/Counseling*, almost everyone (n=10) considers their therapeutic approach to be holistic. This means that the

majority considered spirituality as an important part of assessment and that it can be an important type of intervention.

Several participants (n= 6), four (4) psychotherapists and two (2) pastoral counselors, report using spirituality or religion in their approach to therapy at the onset of their professional practice. Several others (n=3) described their avoidance of using it in the beginning of their professional practice, but they had incorporated it in recent years. This shift was attributed by participants to both personal changes and to changes within the mental health professional regarding spirituality. Two excerpts below describe this transition.

One participant said:

I used to say it didn't belong in a therapy room at all. I don't think I ever mentioned the word God, because it was sort of like the separation of church and state, so if you wanted to talk about God, you'd go to a priest or pastor, but as I started working on my own therapy and spiritual journey, I don't know if I was listening more, or if people thought I was more receptive, or I started asking, but I'd say about ten years ago, people started talking more about God or spiritual concerns, and I was like, "Have I not heard this before or are they sensing something receptive in me, or is this a sign of the times, or what?" But now I make it a standard practice to ask every single person who walks in the door and most people are usually surprised, and they say, "I've been in therapy for 15 years" or "I've seen five therapists", and "no one has ever asked me about my spiritual concerns", and 100 percent of them are appreciative of it.

Another described her move:

I wouldn't have touched spirituality or religion with a 10 foot pole...for years, the first 10 years. I would have been talking about family of origin... talking about trauma... talking about psychodynamics, that sort of thing. So I've changed. I've evolved.

Later in the interview she said:

I think it's very important. I think the paradigm of therapy is changing in your generation.

Many participants (n=5) cited the importance of examining their understanding of their own spirituality and values. As one therapist said:

I think that its very important for... it used to be years ago, they wanted a therapist to have their own therapy or psychoanalysis or whatever, and I do think that that is very important, not necessarily formally, but whether it's with your professors or with other psychiatrists or psychologists or social workers or counselors... it's really important to understand yourself. I think that in and of itself is a spiritual quest: to be able to understand yourself and your place in time and space...

Three participants (n=3) referred to being open to the possibility that people want to talk about their spiritual life. One participant said, "... for the last ten years, I would say that what I was doing was that I was being open to the possibility that people want to talk about their spiritual life, and it was amazing what happened when I was ready to do it."

Two participants (n=2) specifically said it is essential to effectiveness as a therapist. This view is described by the participant who said, "I think to not attend to that [spirituality] is like lopping off a part of someone." While this view was only expressed by two people in this section, it was expressed by several more (n=10) in other parts of the interviews.

Some (n=2) see spirituality and religion as closely tied to identity. As one person said, "My views are that for many, many people their beliefs about religion and spirituality are very important to them and are closely tied to their identity, and so it is very important to acknowledge and affirm those beliefs and practices."

One person (n=1) sees their own spirituality as a factor in how they value their clients, describing it as follows: "In terms of my views about using spirituality or religion in the therapeutic process, I think it determines my sense of the value of the person, that

the persons have inherent value in themselves. That belief comes from my spiritual background.”

One person, in responding to this question, describes spirituality as a critical part of finding meaning:

I am very interested in how people find meaning in their experience because when one talks about cognition one is very interested in knowing what are the things one thinks about their experiences, what do they say to themselves about their problems about their behavior and how does that in turn affect their emotions and how does that in turn affect their functioning, so I am very interested not only in the specific self statements that are made that may come out of religious tradition or spiritual experience, but I am also interested in knowing how that person attempts to find meaning through the use of the resources.

However, many other instances (n=12) of the importance of finding meaning are cited in participants’ responses to other questions during the interview. One (n=1) views spirituality as “making room for self compassion, therefore self acceptance, awareness of feelings and deeper levels of emotional processes.” Another (n=1) sees “spirituality and religion as a resource that helps them in whatever struggles they have.” Another points out that, “Spirituality must be suited to the particular client.”

In summary, we note that when practitioners discussed the importance of spirituality in their practice, they mentioned the need to understand their own spiritual beliefs as well as how spirituality may be used as both a resource and a means of understanding how clients construct meaning.

Interventions as Described in Cases

Participants were asked to describe one or more cases in which they used a spiritual or religious related intervention. For each intervention used, they were asked to provide an overview of the case, a detailed description of the intervention(s) used in the

case, and the therapeutic functions performed by the intervention, such as ego strengthening, and improved object relations. All (n=12) participants described at least one case and at least one intervention. They varied widely in the amount of detail they provided. Very few clearly described the therapeutic function performed by the intervention they identified. In this section I first describe the cases that were provided in the interviews and then discuss the interventions identified in the cases. For each spiritual/religious intervention cited I include one or more examples from the interviews.

Thirty-one (n=31) cases were described in more or less detail. The case study clients included both female (n=21) and male (n=10). Of the total cases (n=31) a few (n=3) were families rather than individuals. The spiritual/religious traditions of clients are as follows:

- Christian (n=19): Roman Catholic (n=6); Presbyterian (n=3); Episcopalian (n=2); Southern Baptist (n=1); conservative Christian of unknown denomination (n=1); denomination unknown (n=6)
- Spiritual with religion unknown (n=7)
- Hindu (n=2)
- Buddhist (n=2)
- Muslim (n=1)

Not all subjects reported the presenting problems of the cases. Of those who did report presenting problems the problems were diverse and did not seem limited to any particular issue. Following is a list of the problems cited and the frequency of their occurrence.

- Depression (n=10)

- Anxiety and panic attacks (n=8)
- Grief and bereavement related to loss of others (n=4)
- Self esteem (n=4)
- Identity struggles (n=4)
- Intimate relationships problems (n=4)
- Death and dying issues of the client (n=3)
- Religious confusion (n=2)
- Sexual Abuse (n=2)
- Psychological evaluation (n=2)
- Psychosis (n=1)
- Marital problems related to sex (n=1)
- Adjustment disorder with OCD (n=1)
- Bipolar Disorder (n=1)

Although the focus of this study was examining spirituality/religion based interventions, practitioners also mentioned a wide variety of non-spiritual/religious interventions used concurrently. Non-spiritual/religious interventions (n=17) were frequently noted in the case descriptions and included : Readings in psychology (n=4); CBT cognitive exercises (n=3); Family systems therapy (n=2); Deep breathing (n=1); Identifying cognitive dissonance (n=1); Letter writing (n=1); Stress reduction exercises (n=1); Referral for couples counseling (n=1); Social skills counseling (n=1); Advocacy (n=1); Hypnotism (n=1).

Fifty-one (n=51) spiritual/religious related interventions were reported. They break down as follows in the order of frequency reported: Prayer suggested (n=8);

Reflection on spiritual/religious framework of client (n=6); Mindfulness (n=5); Clergy collaboration (n=5); Recommending community resources (n=5); Discussion of sacred story (n=5); Spirituality/religion study (n=4); Ritual/ceremony (n=3); Deconstruction of spiritual/religious beliefs of client (n=3); Buddhist meditation (n=2); Affirming client strengths based on faith (n=2); Absolution (n=2); Prayer with client in session (n=2); Spiritual direction (n=1); Using sacred writing psychodynamically (n=1); Marriage counseling (n=1); Guided imagery (n=1); Open-ended questions regarding spirituality/religion of client (n=1). Following are examples of each of the intervention categories. Those with common characteristics are arranged together, rather than in order of their frequency, which is noted above.

Prayer suggested by the therapist for use outside of the session was mentioned eight times. Prayer was used with clients who were from both Christian and Hindu backgrounds. The following quotes are examples of how prayer outside of session was used by two Hindus and one Christian.

My Hindu client was able to use the Sanskrit prayer to stay in the present: “Look to this day for it is life, the very life of life. In its brief course lie all the varieties of existence, the bliss of growth, the glory of action, the splendor of beauty. Yesterday is already a dream, tomorrow only a vision, but today well lived makes every yesterday a dream of happiness and every tomorrow a vision of hope. Look well therefore to this day.” She found that very helpful.

As a matter of fact, I am seeing a Hindu client now. He isn’t particularly religious, but one of his problems is he is so worried about his wife that she has been with other men before him, and so he is always thinking, “Am I good enough for her?” But she said to him, “Stop thinking about the past. Why can’t you be in the present?” So that Sanskrit prayer, when he heard it, he wanted a copy and he took it home with him, and it helped him change his focus.

He wrote back to me one day and said that one thing that had helped him was that when he was feeling his most despair I did not try to deny the difficulty of what he was going through but sort of helped him to face it. He said there was a prayer

I gave him by Cardinal John Henry Newman. He often said it to himself when he felt that times were dark for him. That was the verse that said, "Lead kindly light amidst the encircling gloom. Lead thou me on. The night is dark and I am far from home, lead thou me on." He found that helpful. So there again you see how spirituality was enclosed in a larger treatment package.

Prayer with client in session was cited by two participants, one a clergy person and the other a licensed professional counselor. Following is an example from the pastoral counselor.

With regard to interventions: With Mark I did religious things. We prayed together; we did Bible study together. I preached sermons that interpreted the value of all persons and provided biblical and theological basis for this concept.

Ritual/ceremony (n=3) and absolution (n=2) were names given specific interventions by the participants who reported on them. Of course, absolution is a type of ritual. Spiritual direction (n=1) is a broad activity cited by one participant who did not intend to be providing that service, but whose client felt with great appreciation that she was receiving spiritual direction during therapy. Similarly marriage counseling (n=1) is part of the ceremony of marriage. In each of these interventions the participants were either themselves clergy or they enlisted the assistance of a clergyperson to carry out the ritual or ceremony. Following are examples of each.

It was very important to her, and I've seen this in other cases, that it is very important to her that she feels cleansed of the past, so a ritual, prayers, the hand on her head. I pronounced the words that she had heard a thousand times, but in this context has a very direct connection, of God's offering her a different future.

One of the things that helped me to work with him was his spirituality, because he was a devout Roman Catholic, so we talked about why it is that religions use rituals and how ritual practices can actually help people as they attempt to cope with anxiety. And we talked about the rituals in his religion that help cope with anxiety.

OK, let me say that the intervention included in part, since she knew I was clergy, included an absolution, which she needed, so we included that. In fact, as I was going through my seminary training, when I was in my last meeting to be

approved as a pastor, one of the questions that was asked of me was, “What can you do as a pastor that you cannot do as a psychologist?” And the answer was that you can offer someone absolution. And for someone raised with a religious or spiritual background, those words that free someone from the past with a voice that they recognize as one with authority, carries some weight. So, in terms of the intervention, it was strengthening the ego function.

But a year or so later, she came back to me and asked me to be her spiritual director, and I said, “But I don’t do that sort of thing”, and she said, “Yes you do, that was what you were doing.” But because we had this common language, she was a therapist, I was a therapist, she really wanted to do this. So over the next four years that’s what we did. I was her spiritual director.

So, over time they became engaged, and I was the person who performed their wedding. One of my rules I have in performing weddings is that I would not perform a wedding unless the couple had at least six one-hour counseling sessions with me. There were a number of issues we dealt with in these sessions including the families of origin, how their parents related to one another, what it means in their families to be married, and what they believe about issues that often create difficulty in marriage, such as sex, money, raising children, and those kinds of things.

Reflection on spiritual/religious framework of client (n=6) was used in some cases to reinforce the clients’ use of spirituality or religion when their faith was a resource for positive therapeutic work. In other cases the reflection was used to help the client gain relief from some harmful effects of his or her belief system or tradition. An example of confronting the detrimental beliefs follows.

I can contrast that to several other foster parents that I have talked with whose religion to me seemed to be very rejecting and exclusive and judgmental. And I found it very difficult to intervene with those people, except that generally if you look at the historical perspective on a lot of sexual issues, the racial issues, oppression, psychosexual issues...it can help understanding. Sometimes you realize you are dealing with a closed minded person who is clinging to their religious doctrine or to their spirituality in a way that may be detrimental to them or to the foster children that they have. I try to intervene in that by giving them this little book called *The Bible Tells Me So*, which basically outlines the way the Bible has been used for horrible things like racism and all of that. So then one of my tasks as a therapist is to deal with that client’s beliefs and thinking around religious practice because their attitudes and beliefs are, I feel like, blocking them from being able to effectively parent that child. But you can’t, and have no right, and cannot anyway, say you know, it’s not what I believe and you’re wrong,

you're causing harm to the child. You can't approach it that way. You have to give that client an opportunity to investigate and do some research and thinking for themselves, because with a lot of the harmful religious beliefs, the person really doesn't think about them much. They don't see that their religion's perspective on some issues, how damaging they can be for other people. So I try to make the connection, help them make the connection, in terms of the cause and effect of certain rejecting and exclusive religious practices and beliefs, how they are so detrimental in a broad sense of the word. But you have to help them come to that determination themselves, especially with regard to their religious practices and their spirituality.

Deconstruction of spiritual/religious beliefs of client (n=3) is a more specific aspect of reflection on one's spiritual or religious framework. A participant describes how he does this:

So many people, southerners especially, speak that fundamentalist language about their lives, about God, and all the fundamentalist kinds of attitudes and beliefs are there. I feel that in terms of my own religious practice I have a responsibility and mission as a psychologist and therapist to be able to address these issues in a way that helps the client be more healthy and maybe they can give more in terms of resolving justice issues and economic issues, and all the other things. It is up to the therapist to be accepting of the client in such a way that they can lead the client to see other options, other ways of thinking about this. The accepted religious beliefs from their past, their family, their rural community, neighborhood or whatever it is, just taking that and parroting them back is not authentic. It is very superficial, but sometimes when you deconstruct all that, the person has the opportunity to reclaim themselves and their spirituality in a way that is very authentic. When they are more authentic, it makes them more honest and open, more tolerant...

Open-ended questions regarding spirituality/religion of client (n=1) was described as an important intervention by one of the participants, but it can be seen used by many participants in their case reporting. It is a very important tool in leading the client in reflection and deconstruction. In the following except a participant describes the use of open-ended questions as part of his approach to assessing the area of spirituality and religion in the client.

So in introducing it I could simply ask an open ended question, "What, if any, way does your religious background, or your sense of God, or your spiritual sense

of the Being behind life, play in what you are today or what you want to become?" Then pretty often they would initiate a discussion of religious or spiritual issues.

Mindfulness (n=5) and Buddhist meditation (n=2) were named separately as interventions, but their meaning as used by the practitioners overlap. The first quote following is described as mindfulness in a body scan, and the second as Zen Buddhist meditation used to relieve anxiety enough for the client to focus on the work.

We are looking in the body, trying to bring attention to it rather than avoiding it, giving attention to it rather than trying to push it away. And that is what medications do; it's kind of an avoidance of the actual presentation, but to bring our attention directly to it, like directly into the mouth of the dragon, where there is more opportunity for things to shift and change and for the person to be present to that. So that approach I have used many, many times with patients and I found it to be very helpful.

He had panic because he is conflicted between feeling the duty to help his mother to stay there and hating being there every minute. He's Catholic; he was raised Catholic, so I gave him a meditation exercise, at the beginning, in order to reduce the anxiety. I gave him this meditation exercise. It was a meditation exercise used in Zen meditation. And it simply involves focusing on the syllable *mu* on the outward breath. I had him practice this two times a day, twenty minutes a day. And this has gone on for at least two months. Now his anxiety is significantly reduced and he is able to talk about his problem with his mother more easily, because he doesn't have to constantly be trying to get his head above water in relation to the anxiety. When a patient can do that they are more open to going into more exactly what is bothering them. And we are trying to get him to narrow the conflict he feels between having to please his mother and hating doing it, so I guess you could say indirectly the ego functions are being strengthened by this. I have also encouraged him...he hasn't been going to church very regularly, and even though I myself I do not feel it is useful to me, I do feel it is useful for some people. He has gone back to the church, and he tells me that he feels a very calming effect when he walks in there and he just sits silently. And I think that's it.

Guided imagery (n=1) was cited as a spiritual intervention and it is closely related to mindfulness as seen in the following quote.

You know, I have helped a woman with cancer and used color and light and guided imagery and different things to get rid of cysts and tumors and all kinds of things like that. And it's not something *I* have done, but *they* have done it out of

faith and being able to put their energy in a certain spot, so I call it energy medicine.

Clergy collaboration (n=5) and recommending community resources (n=5) are closely related interventions. Each is here illustrated by a quote.

I called around, and said I need a priest, but it can't be a Catholic priest unless it is one who is pro-choice. My friend said I would recommend Carla X who is now retired, but she was at the Episcopal Church, or William X who was also at that church. So I called up Carla, and I didn't know her from Adam, but I called her and talked to her and said, "So and so said I should call you. I have this client who has had three abortions and feels she is doomed to hell." And I hoped that Carla was pro-choice, and I assumed she was because my friend was also radically pro-choice like me, so I took that leap of faith like, "Carla, don't screw up this client", so I asked her and she said, "Certainly, I'd be more than happy to talk with her." And I had no idea who this priest was. I said, "female, good; pro-choice, probably, good; Episcopal, probably good." So I talked to the client about it, and she was very intrigued and scared to death. I would have been too. She decided to go and made an appointment with Carla. She signed a release so I could talk with Carla, and I did. She was much older than I had thought. She was in her sixties. So the client goes to see Carla and comes back, and it was like a different person coming into my office. She was transformed. Absolutely!

He was sort of in transition in regard to his spirituality. For him, though he respected his Islamic tradition, he was very interested in becoming a Unitarian. So I encouraged him to meet people at the Unitarian Church. He needed to have a support group here. So one of his therapy assignments was to try it, explore it.

Discussion of sacred story (n=5), spirituality/religion study (n=4) and sacred writings (n=3) are used in similar ways, often to help the client move toward greater self acceptance. First we have an example of the use of the sacred story, then two examples of study of writings about spirituality or religion. No specific examples of sacred writings were provided, such as reading Koran or Bible, though the Sanskrit prayer is described above. First is the sacred story.

Yeah, we talked about the feeling of the concept of betrayal and love, and that one story that we used came from the gospels in which St. Peter who has denied Christ in his trial which led to Christ's crucifixion, and Peter later becomes the first among the apostles, where he is the leader of the early church. That story was so powerful for the early Christians; it was told and retold by them. Of course it

appears in the four gospels and is alluded to elsewhere. We talked about the resurrection appearance. We talked about during the denial three times he is accused of being one of the disciples and he says, "I don't know the man." And this is the very same guy who said that if all people forsake you I will never abandon you, and yet here he was in this critical hour, and he denied knowing Jesus, but he was in this dangerous situation and couldn't risk being crucified with him, but his courage failed him. Later on, after Christ was crucified Peter feels very guilty about that, but the resurrected Christ confronts him and says to him, "Peter, lovest thou me more than these?", and Christ uses a word that in the Greek text when Christ asks he uses the word *agape*, and Peter says I love you, but uses the word *phileo* which means brotherly love as opposed to this self expending love. And Christ asks him, almost corresponding to his three betrayals, asks him three times. Do you love me, and of course Peter breaks down and cries, and Peter says you know I love you. And Christ says the third time this time Christ uses the word brotherly love. My client found that very powerful because he related it to an experienced he had had when he felt a need for love and yet he felt that his love had fallen short, and that story was a source of comfort and it came out of his religious tradition.

One of the things that helped is talking about what it means to be saved, what her own definition is. And I gave her a couple of books that are more user friendly than the Baptists gave her. But when she is under a lot of stress it comes up again.

And so what I did was refer him to a book called *Addiction and Grace* by Gerald May, which is a wonderful book, by the way. It talks about how everyone has an addiction, and links it up, he's a wonderful writer, and links it up with grace; grace is what will heal. He read the book.

Success Factors for Spiritual/Religion Based Interventions

Participants were asked to comment on factors they saw as contributing to the success of the interventions. They were asked to consider factors related to the therapist, the client, the environment, and other. Most instances of success factors cited (n=35) were related to the therapist, while the next most frequently cited instances of success factors (n=14) related to the client, and the least number cited (n=10) related to the environment. No other factors were cited.

Success Related to Therapist

The most frequently mentioned factor was cultural competence with regard to spirituality or religion of the client (n=13). One therapist demonstrated his cultural competence when he talked about using resources from the client's tradition, saying, "I was able to help him use some of his resources from his religious tradition, so that was one thing that related to me as the therapist." He then added, "It is very important not to impose your own spirituality, not to impose your own religious view on the client, but to help the client see things in his or her tradition that might be useful to him or her."

Another said, "You have to utilize what the person presents to you. If you get a practicing Catholic, one who is involved there, you might get them to say the rosary or the Jesus prayer. The effects are the same, but you want to find something that fits."

One participant described this factor as follows, emphasizing the importance of using the client's language:

And the fact that I am conversant in religious and spiritual issues, all of it is part of who I am, means I do not have to leave that out when I work with somebody. Now that doesn't mean I have to put my own particular spin on it. I would not...I would have the same kind of discussion in many cases with someone who is Jewish, or Baha'i, they would not have to be Christian. I would be able to comprehend what it meant for them to have religious beliefs as part of the dogmas and the system of thought they grew up with. So very often if I did not understand the system they grew up in, I would have to ask them to help me know how their particular spiritual upbringing shaped their current thinking. And of course the benefit for the two of us, therapist and client, was that we could have that common language.

As with this participant, several others talked about the importance of learning about their clients' religious or spiritual tradition in cases where they did not already have an adequate awareness. For example, one participant said, "If I don't know anything

about the spiritual and religious practices that the client participates in, then I try to educate myself about it, and I try to use the client to help me do some of that.”

Another aspect of cultural competence expressed was the importance of expanding the client’s world view as part of this work:

It is up to the therapist to be accepting of the client in such a way that they can lead the client to see other options, other ways of thinking about this. The accepted religious beliefs from their past, their family, their rural community, neighborhood or whatever it is, just taking that and parroting them back is not authentic, it is very superficial, but sometimes when you deconstruct all that, the person has the opportunity to reclaim themselves and their spirituality in a way that is very authentic.

A related point has to do with confronting the client’s dysfunctional beliefs while honoring their culture and religious traditions. This takes a high level of cultural and therapeutic competence. One participant describes it this way:

I try to make the connection, help them make the connection, in terms of the cause and effect of certain rejecting and exclusive religious practices and beliefs, how they are so detrimental in a broad sense of the word. But you have to help them come to that determination themselves, especially with regard to their religious practices and their spirituality. So I have to face a more uninformed, unexamined set of beliefs and religious practices, and I want the client to be able to... I think any powerful, meaningful spirituality or religious practice is thought through, that you know what it means, why you do what you do, and all that, and if the person has such a closed, narrow concept about what is sin and evil, then the therapist’s task is to deal with all that goes into those attitudes, which is the way you were raised, parented, where you grew up, what influenced you when you were in school, how all that influenced who you are.

In the following excerpt another participant stresses the importance that the therapist not impose his or her beliefs upon the client.

I think it very important that the client not know my spiritual beliefs. I am not there to change their beliefs or in any way to influence their beliefs. What I want to do is help them recognize what’s important to them and figure out for themselves how that fits in. I try to use the strengths that come from their spiritual and religious beliefs to help them with whatever issue they are having. For college students a lot of that is figuring out what is important to them. This is their first time away from home, and they are making decisions for the first time. And they

are thinking in a more complex way. And they are thinking in a different ways. And they often need help in being consistent.

Another success factor related to the therapist has to do with the therapist remaining open. While this might be seen as an aspect of cultural competence, it was cited (n=3) as a separate success factor. One practitioner described it as follows:

There are always surprises! It's just...lessons I have learned... I have to keep in mind that whatever happens happens, and what I have to keep in mind is everyone needs forgiveness. It comes up all the time. I'm glad I do what I do, I'm glad I incorporate spirituality into my therapy.

A different type of success factor that depends upon the therapist is including spirituality and religion in the assessment at the beginning of the therapy sessions. Most of the participants specifically spoke of doing an assessment and several (n=4) stressed the importance of including the spiritual and religious dimension in the process. Excerpts from three participants illustrate this factor.

If I had to choose I'd say psychodynamic, but I do a complete holistic approach. I always do a religious and spiritual assessment...and financial, how finances have shaped the person's views

Well, it is very important first to do a kind of assessment of the client's resources, to assess the client's personal, familial, cultural resources and it is very important if the client can use those resources, and to see how and to what extent the client can use those resources and how much meaning they can give the client in his or her experiences.

You know the last person I talked about in her own practice has added to her intake interview spirituality and religion. In my last year of practice I didn't take on any new clients, but I think if I had kept going I would have added that kind of assessment. You know I added money. We had to talk about money. And what is your spiritual life like? And religion. I think those are two different topics. I think those are both difficult to talk about.

One success factor difficult to describe is the bonding of therapist and client through grace, as they understood it. In their understanding a transcendent presence which they called grace created a bond between the client and therapist that facilitated a

greater degree of psychological healing than would have been possible without it. The participant described it: “And the only other thing I thought about with this case is that we both believe, she and I believe, and we have this bonding between us, we both believed that grace was what was transforming her, and that was very therapeutic.”

Another success factor is described (n=3) as joining with the clients and meeting them where they are. An example of this is:

With certain people these kinds of interventions work. One type the meditation exercises wouldn't work with is certain people who, if you get them too calm, they get frightened by that. They are used to the anxiety. If you get them too calm, it represents a major change, an ominous thing. You wouldn't use it with someone like that. You have to pick and choose. You have to utilize what the person presents to you.

Another success factor is being able to understand when a client wants to discuss spirituality or religion but is not comfortable doing it. One participant describes helping bring out the concern in this way:

In polite society you generally don't talk about religion and politics because it generally causes a lot of conflict. People get very upset by discussing those subjects, so the lesson I have learned is that sometimes the client is communicating with you in a tangential way, when they may say one thing but, if you investigate it, you may find it to be based in their spiritual or religious beliefs, so how you go about it has to be very, very careful, because generally you cannot go directly to asking questions or making comments about religious beliefs or spirituality, and you have to do it indirectly and let the client do it, I think. So the challenge is to think, “How do I as a therapist respond to this; how do I feel about their beliefs and their perceptions?” Then, “How does the client's beliefs and orientation limit their own personality development and mental health?” Because I believe many times religion can do that. It can be a stopping place, really. Most of the people I see in here who talk about their religious faith, as they call it, are talking about the things they learned when they were six years old. They have really not done any more investigation to increase the depth of their understandings

There were three remaining success factors, each cited by one (n=1) participant. One stressed the importance of providing a holistic context that supports and augments

the intervention. Another mentioned using spiritual/religious countertransference constructively. And another discussed the importance of the therapist being aware of his or her own blind spots.

Success Related to Client

Related to the client, several (n=14) instances of success factors were identified. From those instances three (n=3) distinct client related factors were cited. One factor is that of client knowledge and expertise on the client's own needs (n=5). An example is:

I asked him about the medicines, medicating himself to manage the bipolar problems as well as psychosis. He thought he did need medicine. But then we talked in detail about how meditation worked for him, how he had learned to do it, how he maintained his practice, what he experienced physically and what he could be open to when he was keeping up his meditation practice, who in his life supported his spiritual practice, what kind of life situations or relationships would pull him away from his spiritual practice. So that's an example of what I would do to provide positive support for one's spiritual practice. And in the midst of these questions, he started taking this risperidone. He said, "When I take two milligrams, I can be calm enough to meditate, but when they want me to take four like they do now, I can't; I can sit there and be still but my mind is dull. I can't think." And I thought that's really close to the knowledge we have about the drugs. So I thought about how to talk to his doctors about this, because I thought they would take a bit of a dim view of adjusting the medicine to his meditation, but they might take a sharper view to negotiating, a positive view, toward negotiating the medicine so that he would take the dosage that he would maintain. I don't remember what they ended up doing. I remember how glad I was that I thought when I walked into the room and did not interrupt his meditation and that I became an ally in it. And being so interested in his knowledge of how exactly he knew how much he needed to integrate the antipsychotic with his practice. And that was just stunning.

Another example from a different practitioner is:

A success factor related to the client is that what I believe is not relevant in therapy. That what is important is figuring out how to use what the client believes in a way that is therapeutic, whether that is helping them connect socially with other people who share their beliefs, or using a particular part of their belief system to help them make change, or examining if their life is consistent with their belief system. It seems when there is inconsistency it seems to cause distress and either causes depression or anxiety.

A second success factor related to the client is that of client motivation (n=5). One practitioner describes the importance of client motivation as follows:

So at that point she did not have the motivation to do the work. And at that point she went off other modalities, such as acupuncture. But later she came back and agreed she needed to work on the trauma. So, that kept happening over a course of four years when she kept coming back, but only on her time table. So about a year an a half ago she came back, and the kids had both left for college, the empty nest syndrome, she was in this sort of crisis then.

Another practitioner pointed out that all clients are not motivated or even interested in interventions related to spirituality or religion. He said, "...this is not to say that there were not other cases where clients were not interested at all."

A third success factor related to the client is that of client insight (n=4). This refers to the fact that an important factor in the success of a spiritual/religion based intervention is the extent to which the client has the capacity for insight. As one therapist described it:

As he focused more on living in the moment, which he just absorbed like a sponge... the next session one week later, when he came back he looked like a different person. He had really freed himself up from all that anxiety and worry. Now he is able to focus on his course work; he is enjoying time with his friends. He is taking this living in the moment... He could have taken it in a bad way. He could have taken it to mean that he gets to play all the time. But he took it as a need for balance, the balance of life. And he realized that his life was out of balance, that he needs to live more in the present and less in the future. So a very small intervention turned into something big because of what he did with it. A very interesting young man.

Another therapist described this client insight in a family therapy session.

And her father, who had been sitting there so rigidly, leaning back, leaned forward in his chair and said, "That's not God; that's me. God doesn't say you can't come in prayer because you've chosen wrong. That's me. That's my belief. I'm wrong." So he spoke a little more about that, like "If I couldn't have approached God when I was doing wrong, I never would have approached God. And, you know God is graceful." I don't even think he was saying what God is. He was talking in a very personal way and asking her forgiveness for having taught her that by the way he was. And he spoke a while about his alcoholism,

how hard a year it had been for her, and he asked her forgiveness. And she was weeping and indicating that she forgave him. We had some more meetings and they were good. At that point, I don't know what she did later, but at that point she was able to turn things around. I called them about a year later and they were doing well, and he came every couple of weeks to college and she and her friends went out to lunch with him.

Success Related to Environment

The religious community and its availability to provide resources for the clients was reported to be a factor contributing to success by most (n=10) of the participants. In describing the interventions used by a participant whose major approach was CBT, the client's existing religious community is cited.

And then, related to the external environment, he was able to make use of his religious community. He had a role in society. He told me a very striking story about going to the hospital. He said, "The people love me there when I go there to take communion. They are so grateful. And one man actually started going back to church when he got out of the hospital." The guy came up to him at church and said, "You know why I am here today, it is because of you." And he said that his fellowship there in the Catholic student community that gave him support.

In describing the use of the ritual of absolution one participant emphasizes the importance of the physical space in which it takes place and the associated clothing and paraphernalia of the clergy person.

...and it can be done anywhere, but in this case he took her to the chapel, a small chapel, and he was at the kneeling rail, and he put on his robe, and he was really a priest with his stole and all, and there is a formal confession where she confessed to the priest, anything she felt she needed to confess, and then the priest performs the absolution, saying, "I absolve you of your sins, by the power...by the authority invested in me..." whatever...I'll show it to you in the book, and he said, "Your sins are forgiven. Go in peace."

In reporting on interventions a pastoral counselor describes the environment of the congregation in which she and her client are members. The external environment to her is not just people and organizations outside the therapy setting, but the broad

environment in which her ministry is carried out and which is important to and valued by the client.

I think in all these situations the external environment was a holistic, healing community in which the individual was seen as spiritual, emotional, physical, all of that together, and the actual counseling was just a portion of what the person was experiencing that led to greater health.

Several participants referred to the contribution of spiritual resources in the community. These were critical to augment the work of the therapist in the course of using the particular interventions within the therapy sessions. The following three excerpts from different participants illustrate a few of these community resources.

My accepting God, in her way of understanding God, as her ally in whatever that meant to her, gave her the strength to do it. She was another one that... She went to a very long spiritual formation process and worked with a priest here in town.

He continued to do the relaxation exercises and is using some of the cognitive exercises. He has a book called *Stress and Adrenalin*, which was given to him by his priest. He plans to read it, so he was continuing to use these resources.

I feel I am really lucky that I have so many resources in the community. I have called on a lot...I know a lot of clergy. Very often I consult with clergy and not necessarily send a client to the clergy person, but get some ideas of what to do with certain clients.

In summary, the most critical success factor seems to be that the therapist finds ways to be understand and respond to the client's spiritual/religious belief system in a way that honors the client's culture and tradition while helping the client modify their beliefs as they need to and draw on existing beliefs and practices to achieve greater health and growth. Therapists can do this regardless of their own belief system if they put in the required effort or are willing to refer the client when necessary to get the resources he or she needs.

Further Training

To the question asking what further training participants saw as being needed, some (n=2) responded that they did not need further training in this area. Two participants (n=2) did not answer the question directly but began describing a spirituality oriented conference they were on the way to attend upon completion of the interview. (Whether or not it was the same conference is unknown, since the participants lived in different geographic locations.) Four (n=4) addressed their own needs as recorded in the section below. Three (n=3) addressed what they consider to be the training needs for people studying to become therapists/counselors. Some of these last comments were from the same person.

One participant simply said, “I would like to deepen my own practice of meditation.” A pastoral counselor who was also a licensed professional counselor with a doctoral degree described his further study plans as follows:

I might have a lot [of training], but I am considering doing some more training in imagery. Such as...I have used guided imagery in the past. I haven't in a long time, but I am thinking of using it more. I think religious and spiritual imagery can play a profound role, whether you are thinking about Jungian archetypal imagery, or Hindu imagery, or Christian imagery. Those images have played a part in my own therapy, and they have also played a part in my role in the therapy I have done with other people where I am the therapist. So I think the role of spiritual and religious imagery in therapy is something I want to do something with. And the other is contemplative prayer, centering prayer, the role of quiet, centeredness and what that does in helping people manage anxiety.

One clinical psychologist who had taken a course for laity at a seminary responded as follows:

I would love to get more training in Spiritual Direction. ...one thing I liked about being in a seminary context and dealing with issues of pastoral care and counseling and all that is that you were surrounded by people who were doing it all the time and were studying it. I think that all counseling and psych programs should have courses in dealing with these religious and spiritual issues. For me

personally, I think about it a lot, but I'm not sure I would do it. I think what I need is to be in collaboration with a group of people who are further along than I am. Regarding courses, I think courses should be taught, because that is a way to do reading and reflecting, and have your ideas confronted. I would like to see more courses on it and more acknowledgment by the professions of the importance of these issues to clients. But what I am seeing is a reluctance of colleges and universities to talk about these topics, because it is like a gasoline can and it is like striking a match to it. But we are in such crisis internationally because, well anything dealt with basically with a language that refers to religion will be a problem. All the religions involved, Christianity, Islam, Judaism. That's where people get their education, from TV, and well, that's terrible, because it's about the warring and the killing that's going on.

One participant who spoke only of how others should be trained said:

I think it would be useful for a therapy student in their coursework to have part of how you think about people be their spirituality and religion. How does that play a role in the client's life and how can you use that to help make change for that individual. I think when religion is brought into counseling, it is often brought in as religious counseling, and I don't think it has to be that way at all. It is more like this is an important part of this person's life, just as is where they came from. It is where they came from. So, just as there's an emphasis on multiculturalism and the client is Asian American, we are trained to have an awareness that that has an influence on the person's life. And how to be aware of interventions we use with them. I think that we should be trained in how to look at a person's spirituality and religion in terms of how that affects them and how to use that in a way that is therapeutic for them. I see that more as part of a conceptualization class. How do you think about people and this part of a person's life, and what role that plays and how you can use that in therapy? So that's what I would like to see happen.

Despite the fact that the participants were highly trained and most had some spiritual or religious training already, the majority (n=9) cited ongoing participation in training or a desire for more training. In addition, several participants outlined the necessity for all therapists to engage in spiritual training.

Comments on Study

A few people only expressed personal best wishes to me. Others as quoted below expressed a range of reactions to the study. One participant expressed great interest in the outcome of the study, but it came after the tape was turned off. One participant said,

“I think it’s very important. I think the paradigm of therapy is changing in your generation.” Another commented, “I was just wondering what other aspects of religion or spirituality you are learning about.” Another said, “I am curious as to what you find out and I’d like to find out that.” Another said, “I think it’s wonderful. I am so delighted you are doing this and I want to see what you come out with.” And another said, “I think it’s really neat. I think that it is definitely needed and it should have been done a long time ago, and I can’t wait to see what you have to say.

Another participant reflected on the impact the interview had on her:

What this has brought up for me in participating in your study is that if I had it to do over again, I feel I am at a point in my life, I am in the luxury of deciding who I want to be there for, and can now be protective of my own needs... I want to work with people with anxiety using this approach [mindfulness]. I would steer more toward the body centered therapy. We are in an exciting time.

Another participant with formal theological training commented:

I think it is really worthwhile, and I am glad you are doing this. It’s not an unfamiliar topic to me because it is something that has been set in front of me, and it is part of my training in my entire career, from both sides [as an LPC and clergy]. In both Christian circles and in psychotherapeutic circles there is a tendency to be dismissive of the other. But there are those who see the value in the other, and so I think when used respectfully, they are sets of tools that can be used like any other. I think that any therapist who doesn’t recognize that people are deeply affected by spiritual or religious training is really missing the boat.

Another participant points out the lack of information about spirituality and religion among therapists and the possible dangers of that absence of knowledge.

I think it’s a wonderful study. We need to do more and more in this area because I think it is the therapist professions that have the problems with these issues, and not the general public and people themselves. I think it is because of the lack of information and knowledge the therapist has about different practices and what issues can be addressed. Many don’t have experience examining these issues in depth. I don’t think one’s spirituality can be very authentic if they do not have such depth study.

CHAPTER V

DISCUSSION

The purpose of this study was to answer the question: In what ways do mental health professionals incorporate spiritual and/or religious interventions during psychotherapy? The study began with a literature review which was continued throughout the course of the study. Using a structured interview guide, data were collected from twelve mental health workers with respect to their use of spirituality and religion in their practices. Interviews were tape recorded, transcribed and analyzed using thematic analysis and constant comparison. Following is discussion of these findings, including observations regarding the trustworthiness of the study, the limitations of the study, a discussion of the findings from these interviews in light of the literature review, the implications of the study for the field of social work, and recommendations regarding future research.

Trustworthiness of the Study

Related to Researcher

As the researcher I attempted to reduce bias or inappropriate influence on the findings of the study in several ways. With regard to the literature review, I attempted to identify and read as many opposing views as possible, particularly taking care to read views of those who oppose the inclusion of spirituality or religion in psychotherapy, since I am positively inclined to its inclusion. In constructing an interview guide I focused the questions on the objectives of the study while using open-ended questions to elicit and organize participant's responses without influencing their content. I had the guide critiqued by two professional instrument designers who screened it for bias. I used only

verbatim data transcribed from recordings by a professional transcriber. In coding I used an open approach organized by the Structured Interview Guide, and then analyzing the data I consolidated all examples of each code and then reviewed them repeatedly, constantly comparing codes with definitions and other examples I collected. Overall, I maintained an attitude of skepticism toward my expected findings and documented all support I found for views opposing my own.

Related to Participants

There was no attempt to verify the reliability of the statements made by subjects. Their responses were taken as true. In order to increase the probability of their trustworthiness, I established criteria designed to assure the professionalism of those who made up the sample. While the educational institutions they attended were removed from the demographics in order to protect anonymity, all were highly reputable, as were the associations that subjects represented. The 24.7 average years in practice assures a high level of experience among the sample.

Limitations of the Study

The primary limitation of the study was the time available since it was done during full time study and internship responsibilities of the researcher. This affected the number of subjects who could be identified and interviewed within the very limited window of time. Other candidates promised rich data, but they were unable to fit into the researcher's schedule. In addition, full advantage was not taken of the flexible data collection method. Further exploration of comments made in the first interview of several clients could have provided more depth and detail.

A substantive limitation of the study had to do with the definition of the word *spirituality*. While most participants and most literature had a fairly common definition of *religion*, *spirituality* was defined very differently among participants, even more widely than within the literature. Several subjects equated the spiritual with human and environmental health and well being. Others defined it as one's relationship with nature. People frequently defined it with the search for meaning. Others, of course, defined it more narrowly and related to some understanding of relating to a deity. When defined broadly, healthy spirituality seems to be the same thing as sound mental health. Such a commonality of definition between spirituality and mental health makes the notion of using spirituality in psychotherapy a given, and thus makes the study question irrelevant.

For this reason, the findings in this study can best be understood when *spirituality* is defined as a separate domain from other aspects of the human being. For example, as in the work of Sperry (2001), he breaks out the dimensions in which human experience has been described historically as: "the spiritual or religious, the moral, the social, the biological or somatic, and the psychological dimensions" (p. 12). He then refers to Wilber (1999) who developed a model of the centrality of the spiritual dimension among the dimensions of the human experience. In Wilber's model the spiritual is in the center influencing and being influenced by the other dimensions: moral, psychological, social, and somatic. It is this kind of definition that sees spirituality as related to but distinct from all other dimensions that must apply in order to find the concepts of this study to be useful.

Finally, the study is limited geographically in that most of the participants were trained and carried out their practices in the mid-Atlantic and southern United States with

two trained and/or practicing in the northeastern United States. As a result, the findings cannot be generalized across the United States or beyond. However, as noted above, the sample is not large enough to afford reliable generalization, even if there were a more balanced geographic representation.

Discussion of Findings

This section begins with a discussion of the detailed findings presented in the categories found in Chapter IV: Participants' Approach to Therapy/Counseling; Participants' Views and Beliefs (definitions of spirituality and religion, the participant's own spiritual and/or religious beliefs, and participant's views regarding the use of spirituality and religion in psychotherapy); Interventions as Described in Cases; Success Factors for Interventions (therapist, client, environment, other); Further Training. To conclude this discussion of findings, I present the overall study results, a discussion of what can be learned from this study. These learnings are broader than the specific study results, and in my view, they are the most significant implications of the study. First, however, we turn to discussion of the detailed findings.

Participants' Approach to Therapy/Counseling

In discussing their general approach to therapy, most participants reflected a philosophy of practice that is basically holistic or systemic in nature. In their stated commitment to treat the whole person, they laid a foundation for their views and beliefs about using spirituality/religion in their practice. Despite the wide range of psychotherapeutic and counseling approaches cited, all had decided for various reasons to bring (or allow) some spiritual/religious elements into their sessions. Participants were of course selected because they did so. The findings document *how* practitioners from a

wide range of approaches and theories are comfortable bringing spirituality/religion into sessions when it is appropriate for their clients.

The finding that the approach taken by the practitioner is equally dependent upon what is useful to the particular client is consistent with Hodge (2003) who reports on tools for assessment. Repeatedly participants speaking of their therapeutic approach talk about how “it depends on the setting” and what is “optimal in the particular case”“so our real selves can form.” The findings in this study also add to existing literature regarding how to make these decisions regarding what approach to take with each client.

Participants' Views and Beliefs

As mentioned above, it is the view of most participants that the holistic or systems approach to therapy is basic to their work. This view provides a philosophical foundation for their views and beliefs about spirituality/religion and its place in the practice of therapy/counseling. In addition, some reported how their own spiritual/religious views and beliefs affect their general therapeutic approach. While their own personal spirituality or religion varied greatly, as illustrated in their quotes in Chapter IV, several participants describe how their own faith leads them to their sense of respect for the uniqueness and value of their clients and some cite their own faith as a motivating factor for being persons who seeks to bring health and well being to others through their practice.

With regard to definitions of spirituality and religion, we find a variety of definitions among the participants. Only six participants defined them separately. Of those, five defined spirituality as broader than religion and viewed religion as being more organized and social. This view concurs with definitions given in literature review on Chapter II. The interesting finding is that this distinction is only emphasized by about

half of participants. Another contrast is that about half the participants responded to this question with the intent of giving what they considered a commonly understood definition, while others focused responses on their own beliefs about the words, or they did not address the differences at all. There was not a consensus on the definition of the spiritual and despite the fact that some saw it as a belief in and relationship to God, others defined it so broadly as to make it difficult to differentiate from a state of well being. This seems to indicate that some sort of consensus on defining spirituality may be important for the mental health field and further research on this area.

With regard to their own spiritual/religious views and beliefs, it is notable that none of the participants report being atheistic or agnostic or having any antipathy toward all religion or spirituality. While the study sought participants who use spirituality/religion based interventions in their practice, no criteria were stated about participants' own beliefs. As noted below, a study with a sample drawn from practitioners who include spirituality/religion in their therapy approach, but who consider themselves non-spiritual or religious would be enlightening.

With regard to participants' views regarding the use of spirituality and religion in psychotherapy, again as mentioned above, all participants were selected because they did include it. Most described spirituality/religion as being part of the whole person and therefore necessary to be entertained as a subject for discussion in therapy/counseling. One implication of this view is that it promises to provide ways for the practitioner to be more culturally competent with regard to the client's spiritual or religious views. Since a higher percentage of the general population than of the therapist population report being religious (Steele, 1997), the findings of this study may make it more comfortable for non-

religious/spiritual therapists to meet the needs of their more religious or spiritual clients.

This possibility is supported by the fact that even though most of the participants reported having some kind of spiritual/religious conviction, they consider it very important not to impose their own views on their clients. Chapter IV provides insight from these participants about how to do this.

An unexpected finding was that none of the participants, including the pastoral counselors, referred to any of the stage models of faith, religious, or moral development (Fowler, 1981; Kohlberg, 1984; Helminiak, 1987) described in Chapter II, though it is a requirement of clinical pastoral education in mainline seminaries. It is also true that none of the participants referred to any stage development theories in describing their approach to psychotherapy, but this of course does not mean that such models do not influence their assessments. Several participants did describe including the spiritual/religious dimension in their biopsychosocial assessments and others were considering doing so. One implication of this study is that there may be value in further research that can inform efforts to do this.

An interesting finding that presents an opportunity for further study is that some of the participants began their practice believing that spirituality and religion are off limits in psychotherapy and non-pastoral counseling, and in recent years have moved to including it. In a few cases, the participants made the transition when their clients raised the subject and helped them see the importance and value of including it. In other cases, as participants' own faith grew they began to think their clients may have a need for them to become more competent in dealing with spiritual and religious issues and practices. Another factor in this transition may, as two participants pointed out, be influenced by the

general increase in openness across various disciplines including the mental health field. Increasingly the literature (Miller, W., 1999; Sperry, 2001; Miller, G., 2003) documents this openness and speculates on forces driving it.

Interventions as Described in Cases

The findings focus on spirituality/religion based interventions as found in cases of the participants. The cases included Christian, Hindu, Buddhist, and Muslim clients with the majority being either protestant or Roman Catholic Christian. Since the reporting was not done in a strict case study reporting format, not all participants addressed all the same aspects of their cases. For example, the religious backgrounds of some were not reported. Some provided a detailed, structured approach to presenting the case while others simply referred to the client, the issue addressed by the intervention, and the intervention itself. Some described or referred to only one case while others provided a number of cases. In future studies, it might be useful to provide more detailed instruction for participants on what information to include. This would provide a more comprehensive basis for comparisons and generalizations.

However, the open-ended approach in this study generated an interesting variety of responses. Two participants provided five cases each, one choosing cases that illustrated different spiritual or religious traditions of the clients with whom he used religion based interventions. Some participants used only interventions from the client's tradition while others used interventions from more than one tradition. For example, one participant used both a Buddhist meditation derived technique as well as Roman Catholic mass for a person with a Roman Catholic background, even though the client was not a regular church attender. Another recommended that a Muslim client explore a Unitarian

worship service, since the client was uncomfortable as a religious minority in his social setting. These data imply that a fluency in a variety of spiritual/religious traditions may be of benefit to mental health practitioners. Future studies that allow more time could build on this variety by having follow-up interviews in order to augment information from some participants through questions stimulated by the first interviews with others. Such an approach would take fuller advantage of the flexible method than was possible in the time frame of this study.

While not all participants reported presenting problems, most did, and several described multiple presenting problems. From the 31 cases 42 presenting problems were reported. The problems were very diverse, ranging from intimate relationship problems to psychosis. This finding seems to suggest that spiritual/religious related interventions are not limited to a particular set of presenting problems.

It is interesting to note that though questions were about spirituality/religion based interventions, only two presenting problems were overtly about spirituality or religion. However, several cases led to the disclosure that dysfunctional spiritual or religious beliefs contributed to, if not caused, the client's problem. Despite the fact that the interview question specifically asked participants to describe the therapeutic goal of the intervention, only two actually reported on it. Again, there was no opportunity to probe further into this issue.

Learning about spirituality/religion related interventions was the primary goal of this study. Chapter IV provides great detail about how interventions are described by the participants. They are reported in the participants' language, but it is clear in reading the excerpts that the same phenomenon is called by different names by the different

participants. For this reason, clear cut, generic interventions were not possible to derive from the study, despite the fact that a goal of the study was to generalize about such cases and provide detail on exactly how to execute each generic intervention. It was hoped that the resulting document, this document, would provide a range of structured interventions that could be modified to suit specific client situations. It is now clear that the participants did not use common language to describe the same type event, and the sample is not large enough to generalize generic names for the interventions reported. It was also hoped that this document would stimulate creativity for other therapists to design other specific interventions. I believe this aim has been realized in that the interviews provide thick descriptions of just how each participant carried out the intervention.

As an example of how categories merged and overlapped, the category of prayer included both Hindu as well as Christian prayers but the same phenomenon could be described as ritual or ceremony. In addition, some of both the Christian and Hindu prayers reported appeared similar in their function to the Buddhist meditation that was used to facilitate mindfulness.

Prayer can be analyzed into two types, one which involves listening for a message or guidance and another in which prayer involves speaking to or asking for something from the object of the prayer. Most of the prayers reported were those in which the prayer was listening rather than asking. They were most often used to assist the client in coming to a state of mind in which he or she could focus more deeply on the issues being dealt with in the therapy process. This is similar to McCullough & Larson (1999) when they point out that prayer can be a vehicle for creating cognitive change. The therapist can

encourage clients to use prayer for coping, if appropriate, and praying in session “might help to incorporate therapy into their worldview” (p.100).

Two of the participants, one pastoral counselor and one licensed professional counselor, reported praying with clients in session. The pastoral counselor was working with someone from her congregation and thus could be seen as moving from counselor into another legitimate role, pastor. The licensed professional counselor commented on how important it was to be certain that this is appropriate with the particular client. Both these instances seem to be consistent with Richards & Bergin (1997) who posit that when praying with a client in session, clients and therapist should probably pray together only when three circumstances converge: (a) The client requests in-session prayer; (b) a thorough spiritual and religious assessment and psychological assessment have convinced the therapist that engaging in such explicitly spiritual and religious activities would not lead to the confusion of therapeutic role boundaries; and (c) competent psychological care is being delivered. They go on to suggest that although praying with clients is probably wise only in limited cases, it is not unethical, inappropriate, or therapeutically counterproductive.

One category of intervention I identified was used several times by participants, but it is difficult to name and describe. I call it reflection on spiritual/religious framework of clients. In this intervention the therapist/counselor guides the client through the process of thinking about, reflecting on, and analyzing his or her spiritual or religious belief system. Part of it is deconstructing a particular practice or belief so that the client can make more conscious choices about it and choose to restructure it if he or she finds that of value. The therapist role is to help identify patterns, contradictions, or

dysfunctional beliefs or practices. Included in it is the intervention referred to as open-ended questions about client spirituality/religion. Such questions were illustrated in Chapter IV by one of the pastoral counselors. This process of reflection seems to move the client from one stage of faith development to another, as defined by Fowler (1981). While none of the participants referred to any of the developmental stage theories described in Chapter II, this intervention could well be guided by such a theoretical grounding. The absence of such references could imply a need for education and training of therapists to offer courses in these developmental stage theories. Further study would be beneficial to discern the value of such training.

Mindfulness and Buddhist meditation were reported in seven (7) cases.

Mindfulness is a way to stay in the present, being fully awake and aware of everything from washing dishes to answering the phone (Hanh, 1976). The value of staying in the present is to enable clients to work on what they need to rather than avoiding it by focusing on the past, the future, the distant or anything else that can keep them from doing the work. As we have seen, listening prayer is one approach to being mindful. Other approaches include meditation, guided imagery, body scan, chanting; there are many techniques to foster mindfulness. As mentioned above, these paths to mindfulness are most often used to assist the client in focusing more deeply on the issues being dealt with in the therapy process.

The interventions identified as clergy collaboration and clergy referral describe situations in which the therapist works with a religious official to think through issues or gain understanding of the client's religion, or refer the client to a clergy person for a service that the therapist is not qualified to perform. This is related to the intervention

called using community resources in which the therapist suggests activities or services provided by the religious community which help meet the needs of the client. In this study two people were referred to priests, two pastoral counselors were the clergy persons, two participants consulted and collaborated with clergy, and several suggested the use of community resources. This cluster of interventions reflects the holistic approach of most, and perhaps all, the participants.

A related set of interventions are use of sacred story, sacred writings, religious metaphors, and spirituality/religion study. For example, discussion of sacred story was used to discuss betrayal and love since the client was able to relate it to his own experience when he had felt a need for love and when he felt his love had fallen short. This came from his religious tradition. Using sacred writings or sacred story psychodynamically is another reported use of this intervention. This means that the therapist breaks the story down and looks at how it relates to the client's history and life and inner feelings. It is used to give the client strength to do what she or he needed to do to get better. The metaphors are also used in a similar manner in narrative therapy. Spirituality/religion study is having the client read and perhaps discuss with the therapist the writings of some expert who addresses a subject of concern to the client. This is particularly helpful when the author or the person who recommends the reading is respected by the client.

The intervention using ritual and ceremony can be seen to include formal prayers. The intervention identified as absolution is actually a type of ritual. Rituals often help with anxiety. They can help one feel cleansed or made whole, as often happens in Christian rituals of baptism or during the Muslim month of Ramadan when the person

voluntarily fasts for purification. Therapy is a process of changing from one less healthy state to a more healthy state, and many rituals help this occur. A ritual that is more proactive in nature is that of the religious marriage. Part of this is the intervention cited as marriage counseling.

Spiritual direction was mentioned, but it was not specifically cited as being used intentionally by the therapist with the client. Instead, it came up in a case when the client told the therapist that what the therapist was doing amounted to spiritual direction for her. This case raised the question as to what is the difference between psychotherapy that uses spirituality/religion related interventions and what is know as spiritual direction. Such an exploration could be a fruitful research study. The second participant who brought up spiritual direction was describing something that had helped her in her own spiritual growth.

Another intervention hard to name is what I called affirming client strengths that they draw from their faith. In this process the therapist looks to the client's spiritual/religious framework to see what aspects are consistent with their behavior and points them out as an affirmation of the person. Or, the therapist sees something the client is using from his/her own faith tradition to promote health and the therapist affirms that. This is the positive side of confronting dysfunctional beliefs or practices, which was discussed as part of reflection on the client's spiritual/religious framework.

A critical part of the therapeutic process that was frequently alluded to is the client assessment. While it is not generally seen as an intervention, it does actually have the effect of intervening in the way the client thinks about things. It is discussed in the following section.

Success Factors for Interventions

Many of the factors that contributed to the successful use of the interventions are alluded to or described in the sections above, particularly in the discussion of the therapists' views and beliefs about how therapy should be approached and what role spirituality and religion should play in the psychotherapeutic process. It is interesting that the instances of success factors identified by participants were mostly related to the therapist with fewer related to the client and even fewer were instances of factors from the environment. Perhaps this is simply because the participant is most aware of his or her own actions. However, it could be because the therapist has the greatest influence on the therapeutic process, even if it is taking the initiative to assure strong client control of the process. Since this is likely true, it is even more important that the therapist makes the effort to learn what is needed to be culturally competent in relation to the client and to empower the clients as much as possible in the process of their work. It is also likely that the question asked in the interview was not as clear to the respondents and that it came near the end of the interview.

One of the most important implications for how to use spirituality/religion based interventions has to do with cultural competence. In relation to the factors controlled by the therapist that were thought to contribute to success of the intervention, cultural competence in regard to spirituality or religion of the client was the most frequently cited. Several participants reported having to learn as they went about the traditions of their clients. They put in time and effort to become conversant and to understand metaphors and language of their clients. Some pointed out that it was important not to assume that because a client claims to be of the same faith tradition as the therapist that the therapist

understands what the client means by particular words or concepts. Several reported learning from the client by asking to be educated. In this process clients sometimes clarified their own beliefs and at times changed them as a result of attempting to explain them to the therapist. Other specific factors described in Chapter IV should be considered by therapists who seek to develop their own guidelines for using spirituality and religion based interventions. They include: not imposing one's view or seeming to do so; confronting dysfunctional beliefs or practices while honoring the person's faith system; remaining open; sensitively conducting a spiritual and religious assessment; joining with the client and meeting them where they are; providing a holistic context for the therapy; and using spiritual/religious counter-transference constructively.

With regard to client controlled or client manifest success factors, several have implications for how a therapist can increase the probability of success in using spiritual/religious interventions. These include: client's knowledge and expertise about their own needs, client motivation, and client's ability to have insight. Overall, these findings parallel success factors in any therapeutic setting. Namely, recognize and use the client's strengths in this area to foster the goals of therapy. It not only improves the direction of the therapy, but it empowers the client and contributes to their positive self esteem and independence. Furthermore, psychotherapy requires the client to recognize and confront perceptions and experiences from their lives that are unpleasant or painful. Only the client can put out the effort and have the courage to do this. They must therefore have the inner motivation to take the required actions toward their own health and well being. Finally, the therapist can foster this insight, and present concepts or analyses and

hypotheses, but until the client grasps the meaning for him or herself, no real change occurs.

The external environment also contributed to success. The most frequently cited factor is the existence of a religious or spiritual community which can serve as a resource to the client's healing and emotional as well as spiritual growth. These resources include congregations for worship and opportunities to work for social justice and ethical activism, educational programs, libraries, social activities, and religious leaders or spiritual guides. These are resources to which therapists can refer clients, resources clients do not have at the time of entering therapy. These resources were seen as critical to augment the work of the therapist in the course of using the particular interventions within the therapy sessions. In a slightly different way, the client's own religious or spiritual community was identified as a success factor in the environment. A pastoral counselor can influence the community and initiate specific resources to meet the client's needs. Therapists can become familiar with the religious community of the client, if he or she has one, and help the client see how to take fuller advantage of the strengths it has to offer.

Further Training

Based on the extensive training in spirituality several of the participants already had, it was not surprising that only half of them discussed current activities or future plans for further training in the area of spirituality/religion based interventions. What was significant was that a fourth of the participants expressed their beliefs about training in general and seemed to agree that some exposure to spirituality and religion should be provided during the formal training of all therapists and counselors, at least enough for

them to do accurate assessments and refer clients with particular needs for attention to spiritual/religious matters. The 1995 version of CSWE curriculum guidelines call for expanded education in this area (Canda and Furman, 1999).

Overall Study Results

When appropriate, a willingness and ability to include spirituality and/or religion in the psychotherapeutic process is essential to optimal psychotherapy. Here “include spirituality and/or religion” means to make it comfortable for the client to bring up spiritual or religious beliefs, practices, concerns and issues that may be relevant to the therapeutic aims and for the therapist to respond in some manner that contributes to the therapeutic goals. This assertion is contrary to the historic theories dominant in psychotherapy, and often held by both practitioners and patients/clients. However, as participants in this study point out, this assertion is currently gaining support and has been doing so for the past ten or more years. As subjects in this study indicate, therapists who began practice with the belief that spirituality and religion are off limits in psychotherapy have changed their minds and have begun incorporating such interventions.

There are many different approaches a therapist or counselor may take to include spirituality and/or religion in the psychotherapy process. The critical element is that the practitioner should not exclude all consideration of spirituality or religion, nor should the practitioner support any tendencies the clients may have to exclude spiritual or religion based concerns or considerations that are significant to them. The approaches available to the practitioner for including spirituality and/or religion in the therapeutic process range from acknowledging concerns and referring the client to other resources, at a minimum,

to fully partnering with the client in the exploration and bringing significant and appropriate resources into the therapy sessions.

The approach taken by the practitioner is dependent upon his or her particular approach to psychotherapy. The various psychotherapeutic approaches most often reported by the practitioners in this study included: holistic approach, systems approach, CBT, psychoanalysis, psychodynamic, gestalt, eclectic, narrative, and pastoral counseling. The approach taken by the practitioner is equally dependent upon what is useful to the particular client. Factors cited as important to deciding on the usefulness to the client included:

- Spiritual/religious assessment
- Ensuring that the client knows it is acceptable to bring in spirituality/religion
- Fitting with client language and belief system
- Expanding client awareness (illuminating contradictions, facilitating awareness of dysfunctional beliefs)

The approach also depends upon how interested the practitioner is in becoming familiar with different spiritual concepts and religious belief systems and practices. The following summarize guidelines suggested by the participants:

- At minimum, know one's self (consistent with historic analysis, both Freudian and in clinical pastoral education)
- At minimum, become culturally competent at least for the culture of each client accepted, and where religion is important to that client, become familiar enough with that religion to understand client's metaphors and belief structures.

- At minimum, ask what the clients mean by their spiritual/religious references and beliefs.
- Optimally the practitioner is exploring, expanding and enriching his/her own belief system.
- Optimally the practitioner is continuously developing skills in objectivity and openness with all clients.

The approach also depends upon what supplementary spiritual/religious resources are available in the community. Ideas suggested for finding and using such resources included:

- Use a snowball type approach to learn about spirituality and religious resources in the community.
- Consider both referrals to and consulting with spiritual/religious specialists, such as abbot, pastor, guru, rabbi, imam, or priest.

The most significant and dramatic implication of this research project is the support for assertion that: When appropriate, a willingness and ability to include spirituality and/or religion in the psychotherapeutic process is *essential* to optimal psychotherapy. Again, it must be stressed that the phrase “include spirituality and/or religion” is defined as meaning only that the therapist must make it comfortable or safe for the client to bring up spirituality or religion in the therapy sessions, if the subject is relevant to the therapeutic goals. While in most cases therapy that does not do this may be beneficial, there are many cases in which such therapy is less than optimal, while in others it can result in damage to the client. While it is true, as cited by Simmonds (2006), that this assertion is contrary to the historic theories dominant in psychotherapy, and

often held by both practitioners and patients/clients, as participants in this study point out, this assertion is currently gaining support and has been doing so for the past ten or more years. Kurtz (1992), Meissner (1996), and Rizzuto (1981) lend support to this view. As participants in this study indicate, many therapists who began practice with the belief that spirituality and religion are off limits in psychotherapy have changed their minds and have begun incorporating such assessments and interventions. No specific references were found in the literature to describe this transition in therapists' views, so interview material from this finding is particularly enlightening.

The finding that the critical element is that the practitioner should not exclude all consideration of spirituality or religion, nor should the practitioner support any tendencies the clients may have to exclude spiritual or religion-based concerns or considerations that are significant to them begs the question as to why so much opposition to inclusion is perceived among therapists and clients. One speculation is that many people have a limited view of what is meant by such inclusion. There is the frequent perception that it means the therapist might impose his/her own beliefs onto the client. This fear or perception echoes those cited in Simmonds (2006) during the time of Sigmund Freud when religion, particularly Christianity, was known for violent persecutions of those who disagreed with its beliefs. Another basis for resistance is that the clients often fear that they will be judged negatively by the therapist, some thinking therapists consider reference to religions as a symptom of mental illness.

This line of thinking is integrally related to the call for cultural competence among therapists, particularly from clinical social workers. Abernathy et al. (2006) and Shafranske and Malony (1990) describe this need and the relationship between culture

and religion, particularly among non-Caucasian people. This call is strongly supported by the participants in this research. While they urge the appropriate use of spirituality/religion in therapy practice, they frequently make the point that religion as well as spirituality can be either health enhancing or harmful.

Implications of the Study for the Field of Social Work

Social workers are leaders in cultural competence and cultural diversity. This study supports and illustrates the importance of considering spirituality and religion as part of culture. The subjects provided several cases in which sensitivity to the client's culture meant understanding and being sensitive to their spiritual or religious traditions.

Social work is all about improving the lives of the oppressed and disadvantaged. Findings in this study document instances in which one's spiritual or religious beliefs, particularly those that have gone unexamined, have been the source of such oppression and suffering. Only by attending to these contributing causes of mental illness can the clinical social worker address these issues. In addition, without spiritually/religiously sensitive therapists upon whom case workers depend for collaboration in treating the whole person, that case worker has limited resources at her/his disposal.

Social workers are holistic in their approach to clients in all situations. This research study supports the holistic approach to therapy. The systems approach is the term several of the participants used, while others refer to it as holistic, but their descriptions indicate they are using the terms interchangeably.

In addition, this study points out the need for more training and education in schools for social workers regarding inclusion of spirituality in assessment and intervention. Since the education required for certification already carries a heavy

workload, continuing education after the completion of the formal degree may be a way to proceed with meeting this need. This finding agrees with and illustrates the literature in Canda and Furman (1999). As they say in their paraphrase of the NASW Code of Ethics:

- Spiritually sensitive social workers elevate service to others above self interest whenever necessary and always seek mutually beneficial ways of service.
- Spiritually sensitive social workers pursue social change particularly with and on behalf of vulnerable and oppressed individuals and groups of people.
- Spiritually sensitive social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity, religious and spiritual diversity, and all other forms of human variations.
- Spiritually sensitive social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process, including collaboration with religious and non-religious spiritual support systems as relevant to clients.
- Spiritually sensitive social workers are continually aware of the professions mission, values, ethical principles, and ethical standards and practice in a manner consistent with them.
- Spiritually sensitive social workers continually strive to increase their professional knowledge and skills and to apply them in practice, especially in regard to the explicit use of religious or non-religious spiritual beliefs, symbols, rituals, therapeutic practices, or community supports systems.

Recommendations Regarding Future Research

This study generated many possibilities for future research, either to extend this particular study or to answer questions raised during this study. Some of the most promising and pressing areas for further research follow:

1. Conduct the same research project but with more time, more subjects, and more opportunity to go back to the same subjects for clarification and greater detail.
2. Conduct a study and use its findings in a manner that will foster greater consensus regarding the definition of spirituality.
3. Study the question of how therapists made a transition from not using spirituality/religion based interventions into using them.
4. Conduct further research on the interventions identified in this study in order to learn more about how they are used in a broader subject set, particularly with a broader geographic sample.
5. Using a broader sample, compare the use of spirituality/religious intervention among therapist so different disciplines and training.
6. Conduct research into how to include the spiritual/religious dimension in biopsychosocial assessments with a consideration of faith, moral, and religious developmental stage theory.

Conclusion

During my work on this study, I was encouraged to think it will help other social workers have a better understanding of the positive role spirituality and religion can play in therapy. Evidence that this may happen is that several of the participants described resistance they had encountered to the use of spirituality/religion in their practice, and the

fact that they took chances and were then received positively. The thick description of cases and the criteria outlined for using interventions and what leads to successful incorporation of using them makes the possibility of using interventions more accessible. This may well encourage other therapists who read the study to move in this direction if they are so inclined. This is one of the most important benefits this study may have to offer.

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Appendix A

Human Subjects Review Approval



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

February 1, 2007

Deanna W. Dodd
2000 Marchant Street, Apt. 2
Charlottesville, VA 22902

Dear Deanna,

Your revised materials have been reviewed and you have done an excellent job. All is now in order. We are happy to give final approval to your interesting study. I hope the snowball works and that you find professionals that are interested in participating.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads "Ann Hartman".

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Kate Didden, Research Advisor

Appendix B

Informed Consent Form

My name is Deanna Dodd. I am conducting a study of religious/spirituality related interventions used by clinical social workers, psychologists, and counselors and how these interventions contribute to the success of individual treatment. This study is being conducted in partial fulfillment of the requirements for the Master of Social Work degree at Smith College School for Social Work.

I hope you will participate in this study, since I understand that you have successfully used spirituality and/or religion related interventions in your therapy practice. As a subject in this study you will be asked to participate in a phone (or face-to-face) interview, which will be tape recorded and transcribed. Questions, which you will receive in advance, will focus on the religious/spirituality related interventions you have used, what they contributed to the therapeutic process, and what factors you think made them successful. The interview should take an hour or more to complete, depending upon how much detail you are able to provide, and will be scheduled at your convenience. I will then provide a transcription for any comments you wish to make regarding its accuracy.

Your participation is voluntary. Unfortunately I cannot provide any financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed to the effective use of religious/spirituality related interventions in psychotherapy, and you will receive the findings of the study. You may also benefit from being able to tell your story and having your perspective heard. It is my hope that this study will help other mental health professionals have a better understanding of the positive role religion and spirituality can play in therapy, and that they will be helped to join you in this important work.

I see only two risks to participating in this study. One has to do with the use of your time. I hope to make it worthwhile by diligently using your contributions. The other has to do with privacy. Strict confidentiality will be maintained, as consistent with Federal regulations and the mandates of the social work profession. Confidentiality will be protected by coding the information and storing the data in a locked file for a minimum of three years. Your identity will be protected, as names will be changed in the analysis of the data. Your name will never be associated with the information you provide in the interview. The data may be used in other education activities as well as in the preparation for my Master's thesis.

This study is completely voluntary. You are free to refuse to answer specific questions and to withdraw from the study at any time. If you decide to withdraw, all data you have provided will be immediately destroyed.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE

OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

SIGNATURE OF PARTICIPANT

SIGNATURE OF RESEARCHER

DATE

DATE

phone

email

If you have any questions or wish to withdraw your consent, please contact:

Deanna W. Dodd
2000 Marchant St.
Charlottesville, VA 22902
919.225.7646
deannado1@aol.com

Appendix C

Sample Introductory Letter to Potential Participants

Dear xxx:

You have been recommended to me by (name of person who recommended) as a therapist who may fit the criteria for a study I am doing, and if so I would greatly appreciate your assistance.

As a candidate for the Master's in Social Work at Smith College, I am conducting a qualitative research study of spirituality/religion-related interventions used by mental health workers and how these interventions contribute to success in individual treatment.

I hope you will participate in this study, since I understand that you have successfully used spirituality and/or religion-related interventions in your therapy practice. I will ask you to respond by phone or in person to questions I provide in advance. These interview(s) will be digitally recorded and transcribed. Questions will focus on the religious/spirituality-related interventions you have used, what they contributed to the therapeutic process, and what factors you think made them successful. The interview should take about an hour, depending upon how much detail you are able to provide. We may schedule follow-up interviews if you wish to provide more information. I will send the transcription to you for any edits you wish to make.

Unfortunately I cannot provide any financial benefit for your participation in this study. Your participation is voluntary. However, you may benefit from knowing that you have contributed to the effective use of religious/spirituality-related interventions in psychotherapy, and you will receive the findings of the study. You may also value telling your story and having your perspective heard. It is my hope that this study will help other mental health workers have a better understanding of the positive role religion and spirituality can play in therapy, and that they will be helped to join you in this important work.

I see only two risks to participating in this study. One has to do with the use of your time. I hope to make it worthwhile by diligently using your contributions. The other has to do with privacy. Strict confidentiality will be maintained, as consistent with Federal regulations and the mandates of the social work profession.

I do hope you can find the time to participate. If you have questions, call me at me 919-225-7646, and if I am not available due to my heavy schedule with my internship, please leave a message as to when to return your call at your convenience. I regret that I am difficult to reach during counseling hours. If you prefer, contact me via email at deannado1@aol.com.

When you notify me of your willingness to participate, I will mail you an Informed Consent Form along with the questions I will be asking. As soon as I receive the signed Consent Form back we can schedule our interview.

Thank you so much for considering this.

Sincerely yours,

Deanna W. Dodd, BSW

Appendix D

Transcriber's Assurance of Research Confidentiality

STATEMENT OF POLICY:

This thesis project is firmly committed to the principle that research confidentiality must be protected. This principle holds whether or not any specific guarantee of confidentiality was given by respondents at the time of the interview. When guarantees have been given, they may impose additional requirements which are to be adhered to strictly.

PROCEDURES FOR MAINTAINING CONFIDENTIALITY:

1. All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.

2. A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. Depending on the study, the organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested may also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.

It is incumbent on volunteers and professional transcribers to treat information from and about research as privileged information, to be aware of what is confidential in regard to specific studies on which they work or about which they have knowledge, and to preserve the confidentiality of this information. Types of situations where confidentiality can often be compromised include conversations with friends and relatives, conversations with professional colleagues outside the project team, conversations with reporters and the media, and in the use of consultants for computer programs and data analysis.

3. Unless specifically instructed otherwise, a volunteer or professional transcriber upon encountering a respondent or information pertaining to a respondent that s/he knows personally, shall not disclose any knowledge of the respondent or any information pertaining to the respondent's testimony or his participation in this thesis project. In other words, volunteer and professional transcribers should not reveal any information or knowledge about or pertaining to a respondent's participation in this project.

4. Data containing personal identifiers shall be kept in a locked container or a locked room when not being used each working day in routine activities. Reasonable

caution shall be exercised in limiting access to data to only those persons who are working on this thesis project and who have been instructed in the applicable confidentiality requirements for the project.

5. The researcher for this project, Deanna W. Dodd, shall be responsible for ensuring that all volunteer and professional transcribers involved in handling data are instructed in these procedures, have signed this pledge, and comply with these procedures throughout the duration of the project. At the end of the project, Deanna W. Dodd, shall arrange for proper storage or disposition of data, in accordance with federal guidelines and Human Subjects Review Committee policies at the Smith College School for Social Work.

7. Deanna W. Dodd must ensure that procedures are established in this study to inform each respondent of the authority for the study, the purpose and use of the study, the voluntary nature of the study (where applicable), and the effects on the respondents, if any, of not responding.

PLEDGE

I hereby certify that I have carefully read and will cooperate fully with the above procedures. I will maintain the confidentiality of confidential information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, Deanna W. Dodd, for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

s/ Professional Transcriber, Ph.D. Signature

10-26-06 _____ Date

Deanna W. Dodd _____ Researcher

10-26-06 _____ Date

Appendix E

Structured Interview Guide

(Please review and make notes on these items in preparation for the structured interview.)

- A. Please provide the following information about yourself.
1. Gender:
 2. Education:
 3. Licensure information
 4. Coursework/training related to spirituality and religion
 5. Number of years in practice
- B. Briefly describe your approach to therapy/counseling.
- C. Briefly describe your views regarding the use of religion/spirituality in the therapeutic helping process.
- D. Briefly describe your own religious and/or spiritual beliefs and practices, including your definition of religion and of spirituality.
- E. Please describe one or more cases in which you used a religious/spirituality related intervention. For each intervention used, describe the following:
1. Overview of the case
 2. Detailed description of the intervention(s) used in this case
 3. Therapeutic function performed by the intervention, e.g. strengthening ego functions, improved object relations
- F. Please describe the factors contributing to success of intervention.
1. related to the therapist
 2. related to the client
 3. related to the external environment (community, society, organization, setting)
 4. other
- G. Please describe:
1. Lessons you have learned about the use of such interventions
 2. What additional support or training you would like to secure to foster more effective use of such interventions
- H. Please make any other comments you have regarding this study.