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Relationship between Religion, Spirituality, and Psychotherapy: An Ethical Perspective

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Abstract and Keywords

Spirituality and religion are typically a critically important element of most people's lives. They offer an overarching framework for making sense of the world and a strategy to cope with life's stressors. They provide a community and a way to wrestle with life's biggest questions regarding meaning, purpose, and suffering. Mental health professionals are mandated to behave in an ethical manner defined by their codes of ethics. These codes typically understand religion and spirituality a multiculturalism issue. Professionals need to be respectful and responsible and pay close attention to potential implicit bias, boundary crossings, and destructive beliefs and practices. Working with religious professional as helpful collaborative partners also achieves ethically minded best practices. Numerous resources are now available to help professionals develop and maintain their skills in ethically minded clinical practice with spiritual and religious clients. This chapter highlights these issues and offers suggested guidelines toward high quality professional practice.

Keywords: spirituality, religion, ethics, multiculturalism, best practices

Dr. J: A Case Example of Challenges with Religion, Spirituality, and Psychotherapy

Dr. J is a psychologist who does not identify with any religious or spiritual tradition. He grew up in a secular home and never found much interest in religious or spiritual matters. Dr. J is proud to be a rational and empirically minded professional who specializes in behavioral medicine and health psychology-related clinical problems, working in a large university medical center. He'll admit that he believes that religion has done much more damage to the world than good, and thinks that it is a silly, primitive, and delusional preoccupation for many. He rolls his eyes in disdain when someone expresses strong religious beliefs and practices. Dr. J is now treating a patient at the hospital who suffers from cardiovascular dis-

ease who has recently experienced a serious heart attack. Dr. J is asked to work on discharge planning intended to improve the patient's lifestyle with eating, exercise, and stress management strategies to minimize future heart troubles. His patient is a devout Christian who peppers his speech with Bible quotes and references to "the Lord" and "the Lord's will." Dr. J has little tolerance for his patient's religious beliefs and language and rudely suggests that he talks with a hospital chaplain telling him to contact him when he is ready to seriously work on improving his lifestyle without all the "God mumbo jumbo."

Sadly, Dr. J's perspective and behavior isn't that unusual (e.g., Ellis 1971; Freud 1961 [1927]; Watson 1983 [1924]). Many mental health professionals, such as psychologists, have little interest in or experience with religious and spiritual issues and are often uninterested in learning more about them, even when in the best interests of their clients or patients. Some are simply disdainful of those who are actively and passionately engaged and steeped in religious culture, organizations, and thinking. Some don't see religion in the same multicultural and diversity light as they see issues related to race, ethnicity, gender, and other forms of diversity putting it in a separate category that they have little interest in engaging. What Dr. J might not realize and appreciate is that his behavior is ethically highly problematic and professional care requires Dr. J to drastically change his perspective and behavior.

Definitions and History of Religion, Spirituality, and Psychotherapy Relationship

Before further discussion it is important to define what we mean by spirituality and religion (Plante 2009). While definitions vary from different experts and organizations, for the purpose of this chapter *spirituality* is defined as strategies that help people get in closer touch with the sacred or divine. Spirituality involves belief, perspectives, practices, and ways of proceeding that help someone get closer to and connected with what is sacred. *Religion*, on the other hand, involves the organizational structures and traditions that over many years have created dogma, liturgies, practices, and so forth that help their adherents find their way to the scared and divine. Religion includes many of the great wisdom traditions such as Judaism, Christianity, and Islam from the Western Abrahamic traditions and Buddhism and Hinduism coming from the great Eastern traditions. While these five traditions make up the vast majority of the religious persuasions of today there are many smaller religious organizations and many subsets within each one.

The relationship between professional psychology and both religion and spirituality has historically been a tumultuous one. As professional psychology has evolved it has tried to highlight the scientific, research, and evidence-based foundations of our theories and interventions. American psychology in the late nineteenth and early twentieth century was strongly influenced by empiricism and behaviorism and many of the leaders in the field expressed strong views about the need to be scientific in our work and to avoid spiritual or religious engagement. Leaders such as John Watson, B. F. Skinner, Albert Ellis, and

Sigmund Freud, among others were certainly not supporters or fans of integrating religion or spirituality into either professional psychological research or clinical practice (see Ellis 1971; Freud 1961 [1927]; Watson 1983 [1924]).

However, there has always been some interest in the relationship between religion, spirituality, and psychology from the earliest days of psychology. For example, William James's book *The Varieties of Religious Experience* (James 1936 [1902]) was widely read and became a classic in the field. He thoughtfully considered and reflected on the religious experience through his understanding of the psychology of human behavior at the time and didn't offer negative evaluative judgments that his contemporary and well-known colleagues at the time (e.g., Freud) proposed. It set the tone for many other books and articles that followed where the psychology of religion and spirituality became an engaging and acceptable field of study and practice (see Pargament et al. 2013).

Contemporary Relationship between Religion, Spirituality, and Psychotherapy

Fast forward to contemporary times and the psychology of religion and spirituality has become a highly engaging, respected, and productive field of research and practice. The American Psychological Association's Division 36 (The Society of the Psychology of Religion and Spirituality) is a large and vibrant organization with over 1,000 members from across the globe. The American Psychological Association now has published several dozen books on this topic and has started several professional journals (e.g., *Psychology of Religion and Spirituality*, *Spirituality in Clinical Practice*). Outside of the American Psychological Association, new professional organizations have evolved that highlight religion and spirituality-based professional clinical practice. For example, the Christian Association for Psychological Studies (CAPS) and the Catholic Psychotherapy Association (CPA) have large memberships and offer a variety of resources including yearly conventions, engaging listservs, conferences of various sorts, and so forth. The Society of Behavioral Medicine as well as other interdisciplinary professional organizations now offer spirituality and religion-based special interest groups for professionals that also produce conferences, workshops, symposiums, and other professional resources to their members.

Particular aspects of spirituality and religion have become especially popular in the psychological community. Mindfulness, originally rooted in the Buddhist tradition, is an excellent example as it has taken the psychological profession by storm in recent years (Barker 2014; Kabat-Zinn 1990, 1994; Langer 2014; Plante 2016). A recent survey of leaders in the field published in one of professional psychology's primer and prestigious journals, *Professional Psychology: Research and Practice*, found that mindfulness was the top clinical trend in psychology now as well as in the foreseeable future (Norcross et al. 2013). The American Psychological Association's flagship journal, the *American Psychologist*, recently published a special issue focused solely on mindfulness in 2015. Mindfulness has been incorporated into all aspects of professional clinical practice including with

specialty treatments for personality disorders and cognitive behavioral psychotherapy (e.g., Kabat-Zinn 2003; Linehan 1993).

Yoga, from the Hindu tradition, is another excellent example of how a religious and spiritually based activity has been incorporated into professional psychology practice (Hofmann 2013; Horovitz and Elgelid 2015). Research has highlighted how yoga is being used for the treatment of stress, anxiety, and depression as well as increasing well-being in general (Park et al. 2015). Both mindfulness and yoga have lost much of their religious and spiritual rootedness in the United States in order to appeal to a broad and typically secular audience. Yet, the spiritual elements of these interventions remain nonetheless.

More theistically, Christian Counseling is an area of special expertise that has become very popular most especially within the Protestant and evangelical communities (e.g., Greggo and Sisemore 2012). Christian counseling is typically offered by mental health professionals (e.g., psychologists, counselors) who are fully licensed but practice their craft as an identified Christian and use Christian values, readings, and perspectives in their treatment approach. This differs from the pastoral counseling typically offered by clerics who are generally not licensed to practice psychotherapy but offer faith-based spiritual direction and pastoral counseling. Bible-based psychotherapy that includes scripture reading and reflection as well as prayer and attending religious services is often incorporated into Christian Counseling among some professionals. Over time a number of religiously based graduate training programs have opened to train students in these and related approaches as well.

As the relationship between religion, spirituality, and psychotherapy continues to evolve and unfold, it is critical that it does so in a scientific and evidence-based manner consistent with our ethical guidelines articulated in our Code of Ethics (American Psychological Association 2002). Psychologists as well as other professional mental health providers such as licensed clinical social workers, marriage and family therapists, and professional counselors all have ethical obligations to provide state-of-the-art professional and evidence-based services consistent with community standards, federal and local laws, and their respective ethics codes. These codes underscore the importance of being respectful to religious and spiritual individuals, groups, and organizations and to consider religion and spirituality through the lens of multiculturalism. In fact, the APA Code of Ethics makes clear that psychologists must consider religion in a similar way as other diversity issues stating that "psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability" and so forth (American Psychological Association 2002: 1063).

Five Guiding Ethical Principles

The ethics codes for most professional organizations that offer clinical services to clients and patients tend to highlight several critical virtues and values. These include respect, responsibility, integrity, competence, and concern for others (or RRICC; Plante 2004).

This RRICC model becomes an easy to remember filter for thinking through ethical challenges in clinical work including the intersection or religion, spirituality, and psychotherapy.

Respect

Principle F of the APA Ethics Code (2002: 1063) states that we maintain "respect for people's rights and dignity" and thus psychologists should be respectful of the diverse beliefs, practices, and affiliations that religion and spirituality represent. Religious and spiritual people should not be pathologized for their religious identification, development, engagement, attire, and so forth. Their religious models (e.g., clerics, prophets, divinities) should be respected as well. The APA Ethics Code (section 3.01) clearly states that we avoid any type of discrimination based on a variety of qualities including religion. Thus, regardless of our own religious and spiritual beliefs, practices, and identities, ethically we must be respectful of others who are actively engaged with various and diverse religious and spiritual organizations, groups and subgroups, and individual beliefs and practices.

Responsibility

We have an ethical responsibility to be responsible and to be accountable for our actions. This may include having at least some knowledge of the religious and spiritual engagement of our clients when it is relevant to the clinical work that we are asked to do. Having some degree of appropriate religious and spiritual literacy becomes important as it is for other multicultural and diversity issues (American Psychological Association 2002). Yet research suggests that multicultural training, while embraced by psychology as a whole, fails to adequately include religious diversity issues in training (e.g., Russell and Yarhouse 2006). Additionally, getting appropriate consultation including from clerics or other religious leaders involved with our clients should be considered just as we do for professionals working with our clients from other fields (e.g., physicians, attorneys, school teachers, guidance counselors; McMinn et al. 2003; Plante 2009, 2018).

Integrity

Integrity means that we must be honest, fair, and just and make sure that we avoid any possible deception in our work. We need to maintain and protect our professional and personal boundaries which might be challenged while working with religious and spiritual individuals and groups. For example, our own religious affiliations and practices might lead us to believe that we are experts in religion, spirituality, prayer, meditation, theology, and so forth. Our own engagement with religious groups and organizations on a personal level might blur boundaries on a professional level when fellow congregants ask for advice or for professional services (McMinn et al. 2003; Plante 2009).

Competence

Very few graduate training programs offer much in the way of training in working with religious and spiritual diversity. Other than very specific and often religiously affiliated graduate programs (e.g., Fuller Theological Seminary, www.fuller.edu; George Fox, www.georgefox.edu; Regent, www.regent.edu; Biola, www.biola.edu; Rosemead, www.biola.edu/rosemead), religious and spiritual diversity is simply ignored in more secularly based graduate programs across society (Delaney et al. 2007; Hage 2006; Russell and Yarhouse 2006). Thus, trainees and professionals are typically on their own as they seek to develop their professional competences regarding working with religious and spiritual clients. There are a number of helpful resources that are available including professional organizations (e.g., the Society for the Psychology of Religion and Spirituality, Division 36 of the American Psychological Association), books, articles, and new professional journals as well. Additionally, appropriate and specialty listservs can be accessed to find colleagues for consultation and supervision too (see www.apadivisions.org/division-36 and www.iaprweb.org for examples).

Concern

The most critically important ethical value that is near and dear to the heart of the profession is helping others and so concern and compassion for the welfare of our clients is the cornerstone of the profession (American Psychological Association 2002). Sadly and often tragically, many religious and spiritually engaged people have suffered mightily within their religious communities or by leaders of these organizations. People have been sexually or physically victimized or manipulated with guilt and are then severely damaged by their involvement and experience within their religious tradition and congregations. Some religious leaders refuse to refer to or cooperate with secular mental health professionals and see their congregants consulting with them as a betrayal. Additionally, well-meaning but uninformed and often ignorant mental health professionals have made comments about religion and spiritual matters that can be perceived as highly offensive, derogatory, and insulting (e.g., Ellis 1971). Furthermore, sometimes religious engagement and affiliation can be associated with self-destructive beliefs and practices including terrorism, racism, xenophobia, sexism, and so forth. Our concern for others as an ethical cornerstone means that we have a responsibility to be sure that we work for the good of others and for healthy, adaptive, and health promoting functioning.

Three Prominent Ethical Challenges

While integrating spirituality, religious diversity, and psychotherapy several unique ethical challenges often can emerge. These tend to associated with particular themes that include (1) blurred boundaries, (2) bias, and (3) destructive beliefs and practices.

Blurred Boundaries

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Most people who make the effort to learn and engage in spirituality, religious, and psychotherapy integration are typically drawn to these issues through their own personal experience. This is especially true since these topics are rarely taught in typical graduate or postgraduate training programs. For example, those who are drawn to meditation, such as mindfulness, in their personal lives are also drawn to using these popular approaches in their professional lives as well. I don't think I have ever heard a presentation or read an article or book on mindfulness without the presenter or author speaking about the transformative and engaging aspects of their own meditative practices. Similarly, those who are highly engaged in their own particular religious or spiritual tradition, whether it be Zen Buddhism, Evangelical Christianity, or anything in between, are typically drawn to share these personal interests in their professional work. It is hard to imagine an atheist or agnostic practicing Christian Counseling as an example.

Therefore, personal religious and spiritual belief and practices being fused into professional clinical practices creates the enhanced probability that boundaries may be blurred and that potential dual relationships might unfold. For example, professionals who are active and engaged in their own religious and spiritual communities are often approached by fellow community members for professional services making dual relationships possible (Plante 2009). Additionally, the highly personal nature of spiritual and religious beliefs and practices often organize and center one's frame of reference for one's view of the world and one's interactions with others. And so it is easy for professionals to slip into a wide variety of boundary crossing and potential violations (Pargament 2007; Plante 2009, 2018; Sadler et al. 2015). For example, religious and spiritual beliefs, practices, and general dictums may contradict professional clinical practices. These may involve perspectives on women's rights, abortion, divorce and remarriage, and so forth.

Professionals need to be hyper-vigilant about these potential boundary crossings and violations and be sure that they always practice within their professional competence and training, staying within the professional boundaries of their license to practice. They must never impose their personal religious and spiritual point of view upon their clients and they also need to be especially careful about getting referrals from their religious and spiritual communities where dual relationships can so easily emerge. Regardless of one's personal religious and spiritual views and perspectives, one must always follow the legal and ethical dictates of one's professional disciplines.

Case Example 1: Dr. Z

> Dr. Z is actively engaged in the local Zen Center. He offers classes and workshops on mindful meditation practices, enrolls in yoga classes, and enjoys participating in various meditation retreats offered by the Center. He volunteers as an advisory board member for the Center and has come to know most of the members of the community. Since Dr. Z is a highly engaging person who has a thriving full-time professional clinical practice as a psychologist, many members of the Zen Center seek him out for professional psychological services for themselves as well as for their friends and family members. Boundaries are often blurred and Dr. Z talks

about clinical matters with his current and former patients at various Zen Center activities and events with others within earshot of his conversations. A former patient gets enraged when she overhears Dr. Z talking to someone about one of his patients that she is best friends with.

Dr. Z failed to provide clear boundaries between his professional and personal life and while it is understandable and natural for his friends and fellow Zen Center members to want to utilize his professional expertise Dr. Z should have thoughtfully and ethically avoided a potential dual relationships with both boundary crossings and violations involved. Furthermore, talking about clients at the Zen Center violated confidentiality agreements. Dr. Z could have avoided these challenges if he referred Zen Center community members to a colleague who wasn't a member of the Zen Center community or, if there was a compelling reason to professional treat a Zen Center member (e.g., Dr. Z offers highly unique specialty services unavailable elsewhere in the local community), exercised more vigilance and diligence about keeping boundaries clear and professional.

Bias

Spiritual and religious views and beliefs can evoke strong and sometimes tribal emotions focusing on "in-group" and "out-group" dynamics. It is no wonder that the adage of avoiding politics and religious at dinner and cocktail parties is typically wise advice. Mental health professionals are not immune to bias based on spiritual and religious affiliations and beliefs and they are not immune to disparaging and insulting comments toward those who are associated with these perspectives and organizations and whom they may dislike. Famous founding fathers of various important camps within psychology and psychiatry such as Sigmund Freud, John Watson, and Albert Ellis are just a few of many who have been quoted as having made highly disrespectful and off-putting statements about religion and spirituality broadly defined. For example, Watson (1983 [1924]: 1) referred to religion as the "bulwark of medievalism" while Freud (1961 [1927]: 43) referred to it as an "obsessional neurosis." When leaders and founders of important schools within psychology such as behaviorism and psychodynamic perspectives boldly make disparaging comments about religion and spirituality, others tend to follow suit.

The APA Ethics Code (2002) makes very clear that religion and spirituality should be considered as a multicultural issue deserving respect in the same way as diversity associated with gender, age, ethnicity, race, sexual orientation, and other aspects of diversity and multiculturalism. Thus, any form of bias and discrimination based on religious or spiritual affiliation, practices, and beliefs is prohibited by the APA Ethics Code. Curiously, while professionals and student trainees often get a good deal of training in multiculturalism that includes detailed training on issues rated to gender, race, ethnicity, and so forth they still receive little training if any, as a general rule, in multiculturalism as it relates to religion and spirituality (Delaney et al. 2007; Hage 2006; Plante 2018; Russell and Yarhouse, 2006). Thus, bias may more likely creep into professional work in this area than in other

diversity and multicultural areas where much more significant training is offered, high-lighted, and respected.

Case Example 2: Dr. A

> Dr. A. is treating a very depressed adolescent client who is now pregnant from a sexual encounter with her high school boyfriend. The patient is deeply religious and comes from a very conservative Roman Catholic home. In her mind and the mind of her parents, abortion is just not an option. Dr. A. feels like this point of view is crazy and that abortion is a reasonable and the best possible solution. Dr. A. doesn't ask about her religious beliefs or customs and doesn't feel a need to consult with the girl's parish priest or anyone else from her religious community and tradition. After several weeks, the client makes a serious suicide attempt and finds herself at the local psychiatric hospital following an involuntary commit-ment.

Dr. A failed to respect and appreciate the religious inspired perspective of his clients and failed to consult with clerical or other professionals to better understand and integrate treatment that would best serve the patient and her family. Choosing to ignore her religious background likely may have contributed to her suicide attempt. Dr. A could have respectfully investigated the role of the patient's religious background and influence in her stress and decision-making processes and to get adequate consultation, if needed, to better serve his patient and her family.

Destructive Beliefs and Practices

Sadly, religion and spiritual engagements sometimes lead to highly destructive beliefs and practices. Perhaps religiously inspired violence and terrorism is the most prominent example that receives much press attention. Remarkably, some choose to murder others and participate in suicidal aggression somehow justified and inspired by their religious beliefs and practices. Yet, spirituality and religious engagement can be destructive in more subtle and less dramatic ways too. Rigid thinking and behavior might result in self- or other-destructive activities that are health and relationship damaging. These might include self-mortifications or self-injury, extreme fasting, denial of physical pleasures and basic human needs, rejection of friends and family, and so forth. While mental health professionals are well versed in issues related to breaking confidentiality associated with immediate and serious danger to self and others (e.g., suicide and homicide) as well as child and dependent abuse and neglect, professionals may be reluctant to intervene when clients invoke their religious and spiritual beliefs and practices. The spirit of multiculturalism and respecting diversity can work against confidentiality limits. For example, someone with anorexia might harm themselves by engaging in extreme food restriction resulting potentially in an involuntary hospitalization. Yet, when someone states that they are engaging in fasting with religious instructions associated with Yom Kippur, Lent, or Ramadan clinicians may be less likely to intervene or to hospitalize.

Case Example 3: Jim

> Jim is a devout and conservative Catholic. He is homosexual and is disturbed by his sexual longings. He chose to attend a conversion therapy retreat and workshop to see if he could become heterosexual. Although his psychologist advised him against conversion therapy stating that it was not considered an evidence-based intervention and was discouraged by professional organizations such as the American Psychological Association, Jim went anyway. He returned stating that he met a lot of really nice people who he connected to but that, as expected, he remained homosexual in orientation. He then decided to engage in self-mortifications encouraged by peers and clerics associated with a highly conservative sect of the Church. He would harm himself whenever he had a sexual fantasy that involved another man. Jim's therapist encouraged him to consult with a more moderate and mainstream Catholic cleric for additional guidance and reminded him that we wanted to focus on health enhancing, rather than health damaging, coping strategies.

In this case, Jim's therapist thoughtfully considered and respected his patient's religious perspective but also focused on providing evidence-based professional practice and health promoting, rather than health damaging, strategies for managing stressful patient impulses. Seeking appropriate religious consultation was also a helpful way to assist Jim with his concerns.

Focusing on Best Practices

As the relationship between spirituality, religion, and psychotherapy continues to evolve and grow it becomes important to focus on principles of best practices. Certainly, psychotherapy has moved in a direction where evidence-based best practices, sensitivity to diversity and multiculturalism (including those based on religious and spiritual differences), and respectful and generous use of consultation with other professionals (including clerics and other religious experts) are expected in contemporary professional clinical practice. There is no room and perhaps little tolerance for bias, prejudice, discrimination, or ignoring religious and spiritual influences in today's multicultural and diverse society.

Although at this time most graduate and postgraduate training programs still do not offer multicultural and diversity training regarding religion and spirituality on par with their quality training regarding other forms of diversity (e.g., gender, sexual orientation, ethnicity, race) and may need more time and effort to do so, it is critical for trainees and professionals alike to be sure that they take our ethics mandate seriously and ensure that they are both respectful and collaborative with religious and spiritual diversity issues and influences among those with whom they work. Fortunately, there are many resources available to professionals and trainees including a proliferation of new books, journals, continuing education workshops, associations, and so forth that can assist those looking for beginning, intermediate, or advanced professional training. Psychologists and other

mental health professionals can easily avail themselves of these resources if they choose to do so.

Additionally, religious and spiritual professionals such as clerics are often the front line in providing spiritual and psychological care for their congregants. Many clerics have often said that they need more, rather than less, counseling and mental health training since so many of their congregants come to them for emotional, relational, and psychological help and support (McMinn et al. 2003). Additionally, many people who suffer from mental health troubles find their way to religious organizations through soup kitchens, food pantries, private schools, hospitals and clinics, teen centers, and other charitable activities that are affiliated or run by religious organizations. Thus, people with mental health concerns are likely to interact with clerics before they interact with mental health professionals in their offices. Thus, ongoing collaborative relationships between professionals in the psychological and religious communities can be highly advantageous to both parties (McMinn and Dominguez 2005). Mechanisms of interaction and collaboration could and should be developed so that mental health professionals and religious professionals can get to know each other and feel comfortable working side by side to best help those who need their services.

Conclusions and Future Directions

Spirituality and religion are, for better and for worse, an important part of most people's lives. They provide a framework for understanding the world and responding to the various challenges that life brings. They provide a sense of community to many and a structure for grappling with life's biggest questions about meaning, purpose, suffering, and so forth. Mental health professionals are mandated to behave in an ethical manner articulated and defined by their codes of ethics (e.g., American Psychological Association 2002). These codes typically see religion and spirituality as one aspect of multiculturalism in addition to issues related to gender, sexual orientation, race, ethnicity, and so forth. As the relationship between the professional mental health and religious communities evolves and matures it becomes critical for professionals to secure adequate training in how to best serve their clients and patients being mindful of their ethical and legal obligations to provide evidence-based and multicultural sensitive informed services. They need to be careful to be respectful and responsible and to pay particular attention to potential bias, boundary crossings, and destructive beliefs and practices. Seeing clerical professional as collaborative partners also helps to achieve ethically minded practice. There are numerous resources available to help professionals develop and maintain their skills and they would be well advised to make good use of them.

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