Cognitive Therapy and Spirituality:

The Battleground and the Blend

by

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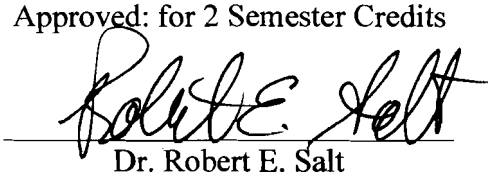

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ABSTRACT

In this thesis, the relationship between spirituality and cognitive therapy is investigated. Care is given to define spirituality and religion and the historical relationship with cognitive therapy as it emerged from other counseling theories over time. Counseling and spirituality share many common goals so that at times they can be seen as running parallel courses in the same race. At the same time there are clearly boundaries and hurdles that must be confronted if one attempts to counsel a spiritually minded client or address a spiritual issue in a secular counseling setting. This paper will attempt to look clearly at the counseling theory of cognitive therapy. It will look at the qualities that make cognitive therapy a desirable counseling theory for use with individuals who are struggling with spiritual issues. This paper will also examine the shortcomings of cognitive therapy and investigate areas where it cannot serve people struggling with

spiritual issues. This thesis places a special significance on the definition of spirituality using Harry Moody's book "The Five Stages of Spirituality" and the actual stages: the call, the search, the struggle, the journey, breakthrough and beyond in order to examine the ability of cognitive therapy to aid clients struggling with these specific stages of spirituality.

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Chapter I: Introduction

Ninety five percent of Americans hold some type of spiritual belief (Baker, 1997). If this is true, one could expect 95% of all counseling situations in America to have the potential to include issues of spirituality. The Diagnostic and Statistical Manual of Mental Disorders – fourth edition (DSM-IV) has a category, V62.89, to be used when the focus of clinical attention is of a religious or spiritual nature. "Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution" (American Psychiatric Association [APA], p. 741).

There are three bodies of literature that shape this study, the first of which is the body of empirical research generated by studies on the role of religious beliefs in cognitive –behavioral therapy and sacred literature supporting the use of cognitive therapy while counseling individuals with spiritual issues. Beck and his colleagues contributed to these studies in 1992 and 1994; Propst in 1980 and 1992 (Shafransky, 1996). The second body of literature that shapes this study is literature addressing the long-standing battle between the science of behavioral psychology and phenomena that is empirically measured versus individuals who choose to believe in the intangible and transcendent. Examples of these stances include individuals who regarded spiritual beliefs with antagonism such as Sigmund Freud and B. F. Skinner, Albert Ellis, and then individuals who regarded spiritual beliefs as assets like Edwin Starbuck, Gordon Allport and James Pratt. The third body of literature began with Abraham Maslow who originated a third movement in psychology that added humanism to behaviorism and

pycho-analysis. Victor Frankl, Rollo May, Carl Rogers, Stanislas Grof among others supported the concept of transpersonal psychology (Ellis, 1973).

Statement of the Problem

Can cognitive therapy address counseling issues of a spiritual nature? The answers lie in different areas: the client, the therapist, the nature of cognitive therapy, the nature of the spirituality for the client and the client/therapist relationship.

The 95% of Americans who hold spiritual beliefs includes a broad spectrum of beliefs and actual variation in degrees of spiritual belief (Baker, 1997; Hamer, 2004). Cognitive therapy is empirically based, so that working with a client with a spiritual issue would require an assessment tool to measure the spirituality of the client and to measure the successful healing of the pathology through use of cognitive therapy with spirituality. A therapist would need to determine importance of spirituality to the client. Collaboratively, they would need to determine the approach. The question important to therapy would be, "Should spirituality be one of many ways that a subject could be addressed in therapy or maybe even the best way for certain individuals?"

A second problem entering the scope of this thesis becomes the client/therapist relationship. There are basic difficulties in the high number of counselors and therapists who claim to be atheistic or agnostic in their own belief systems and the spirituality of the general American population (Shafranske, 1996). Can a therapist who may be atheistic or agnostic in his/her own belief system work through a spiritual issue with a client who believes in that which is intangible and transcendent? The oppositional problem would arise: why would a believer expect empathy from a non- believer? Why would any client enter a therapeutic relationship with a therapist who does not hold their own values or

norms? What would keep a counselor from seeing a client's belief system as a pathology rather than an asset? Or, might there actually be "a case for atheism" as Ellis (1973) puts it; an advantage to a relationship with an observer who could be objective about those areas that are problematic in one's life.

A third question arises: is spirituality on a parallel line with cognitive therapy serving the same purpose of healing and spiritual, physical, and mental wellness or does cognitive therapy simply address the client's thought continuum and pathology?
Is cognitive therapy holistic enough to address mind, body, and spirit? Or is a referral to a spiritual leader all that is necessary?

Purpose of the Study

Cognitive therapy is one of the most taught and used theories of this present time (Leahy, 2004). It is important to recognize the assets and the limitations of cognitive therapy in dealing with spiritually orientated clients or spiritual issues in therapy. The goal of this study is to essentially "try on" cognitive therapy over spirituality and see if it fits. In order to achieve that goal this paper will examine the literature to determine how cognitive therapy can serve the counselor and the client in achieving therapy goals. Practical outcomes of this study should include increased knowledge of applications for cognitive therapy and possible alternative therapies or even dovetail therapies that could work in conjunction with cognitive therapy in the event that it may have a limited application in regard to spirituality.

The basic nature of spirituality takes on a cultural implication, because spirituality stems from a religious cultural context. Application of cognitive therapy to an individual's spirituality engages a cultural dimension. It is imperative that if counselors

expect to serve multicultural groups, individual spirituality and the cognitions that stem from that spirituality must be considered in therapy.

Assumptions of the Study

Assumptions of the study are that the definitions of spirituality taken from Harry Moody's "Five Stages of the Soul" adequately define the transcendent condition of spirituality for the reader of this thesis. The second assumption is that Corey's definition of cognitive therapy from Theory and Practice of Counseling and Psychotherapy (1996) is acceptable to the reader. It is assumed that statistics bear out this high number of people in America who hold spiritual belief systems and that these beliefs would be included in counseling sessions rather than being discarded for other issues that counselors would prefer to work with. It is assumed that cognitive- behavioral counselors would use available assessment tools to determine levels of spirituality and make decisions based on those assessments.

Definition of Terms

Atomism. An area of psychology that supports ideals of materialism, determinism and reductionism. Freud and other psychologists like Skinner, and Ellis believed that they could explain behavior naturally (Miller, 2003). This group supported the concept of determinism- that all behavior is determined and that freedom of choice does not exist; moreover that behavior is controlled through positive reinforcement. Atomists also supported the idea of materialism- that denies both God and soul, advocating the view that in life people attempt to pursue pleasure and avoid pain. Atomists believed that complex behaviors could be reduced to simpler behaviors and that the thinking of human beings could be further reduced

to neurophysiological factors. They supported a mechanistic idea of human beings, that people were in fact like machines and that psychology looks at how they process information.

Cognitive-behavioral therapy. Cognitive- behavioral therapy is a behavioral therapy developed by Aaron T. Beck in the 1960s (Corey, 1996). Cognitive therapy is one of several behavior therapies. Behavioral therapy can be philosophically defined as man taking responsibility for his behaviors. Behavioral therapy applies to a broad category of therapies including rational emotive behavioral therapy, gestalt therapy, and cognitive therapy.

The basic philosophy of cognitive therapy is that cognitions are the major determinant of how we feel and act (Corey, 1996). Individuals have problems when they incorporate faulty thinking into their lives, which leads to emotional and behavioral disturbances. Therapy is primarily oriented toward cognition and behavior and it stresses the role of thinking, deciding, questioning, doing, and re-deciding. Cognitive therapy is a psycho-educational model, which emphasizes therapy as a learning process, including acquiring and practicing new skills, learning new ways of thinking and acquiring more effective ways of coping with problems.

The key concept of cognitive therapy is that a person's belief system is the primary cause of disorders (Corey, 1996). Internal dialogue plays a central role in one's behavior. Clients focus on examining faulty assumptions and misconceptions. Cognitive therapy can be described as an active, directive, time

limited, present-centered, collaborative and structured approach. This therapy uses a phenomenological approach to psychopathology. A phenomenological approach accepts the client's subjective world. The therapist's task is to understand how the patient construes their world and how this construal impacts their behavioral distress and behavioral dysfunction. The empirical focus of cognitive therapy is automatic thoughts or negative self- referent schemata that are subject to close scrutiny or data collection. Once the schemata has been identified, the therapist will attempt to facilitate behavioral, emotional events in or out of session that will stimulate change to the construal process. The therapist prescribes activities designed to aid generalization of in-session therapeutic change that may include homework assignments. The therapy goal is to change the way clients think by increasing client awareness of their automatic thoughts and their core beliefs or core schemata and then to begin to introduce the idea of schemata restructuring. This is done by confronting faulty beliefs with contradictory evidence that clients gather and weigh.

The therapist's goal should be to challenge clients to confront beliefs with contradictory evidence that they gather and evaluate (Leahy, 2004). Other goals are helping clients seek out their dogmatic beliefs and vigorously minimize them. To summarize the whole process one might say the goal of cognitive therapy is to become aware of automatic thoughts and to change them. Cognitive therapy has been widely researched. It has been successfully used in treating phobias, depression, anxiety disorders, psychosomatic disorders, eating disorders, anger, panic disorders, substance abuse, chronic pain and in crisis intervention.

According to Propst (1986), Steps in the cognitive counseling process include the following:

1. *Preliminary concerns and relationship building.* These ingredients are warmth, accurate empathy, trust, genuineness and rapport. Listening and relationship building are the mainstays of any therapeutic relationship.
2. *Diagnosis.* Diagnosis may determine if the client will respond to cognitive therapy.
3. *Presentation of rationale.* Because cognitive therapy is both a teaching and collaborative therapy, it is significant that the client understands something of the rationale behind the procedure (Beck, Rush, Shaw & Emery, 1979). An essential cognitive behavioral rationale in dealing with spiritual issues will include five ingredients:
    1. The idea that thoughts strongly influence feelings.
    2. An example of the above from the client's own experience.
    3. A diagram demonstrating how one's thoughts impact one's feelings and subsequently one's behaviors, which in turn impacts one's environment and thoughts. This cyclic process should be shown to the client.
    4. The idea that the individual must change his feelings by changing his or her thoughts and assumptions.
    5. There should be a rationale from the individual's spirituality for changing his or her thoughts.

4. *Self-awareness and self- examination.* There are two parts to self – awareness in cognitive behavioral therapy. First there must be an awareness of feelings, and then there must be awareness of thoughts. Awareness of feelings is necessary because the client must learn to use this awareness as a cue to examine what he is saying to himself at the moment he feels anxious or depressed.
5. *Cognitive restructuring.* Cognitive restructuring is defined as the transformation of those negative thoughts that plague us into positive or neutral thoughts. People process information in both a verbal mode and a visual mode. Thoughts in a verbal mode are actual thoughts a person may say to him/her self.

From this point on it may not be necessary to use all the following steps with each individuals. The counselor may branch out in a number of directions, depending on the needs of the patients (Propst, 1986).

6. *Dealing with anger and passivity.*
7. *Relaxation skills.*
8. *Communication skills.* Communication skills are the ability to develop friendships and feel comfortable around people. Depressed individuals often lack relationship building ability that may give them emotional sustenance.
9. *Organizing one's life.* Very often, individuals with depression report being overwhelmed by either their job demands or their household tasks.

10. *Adding positive activities.* Depressed persons usually decrease most recreational activities. As a result, they receive very little positive reinforcement from their environment.

Religion. As defined by Webster's Collegiate Dictionary (2001), religion is a belief in divine or superhuman powers to be obeyed and worshiped as the creator(s) or ruler(s) of the universe and also that expression of such a belief in conduct and ritual. The seven great religions of the world include Hinduism, Buddhism, Confucianism, Taoism, Islam, Judaism, and Christianity. Each of these religions contain many sub-groups as in the case of Christianity, which includes Catholics, Lutherans, Baptists, Methodists, Presbyterians and many others all under the title of religion.

Soul. An entity that is regarded as being the immortal or spiritual part of the person having no physical or material reality. The soul is credited with the functions of thinking and willing and thus determining all behavior (Webster's Collegiate Dictionary, 2001).

Spirituality.

> A spiritual character, quality, or nature, religious devotion or piety. The word spirit comes from Middle English from the Old French *espirit*, which comes from the Latin *spiritus*, meaning breath, courage, vigor, the soul life....the life principle especially in human beings, originally

> regarded as inherent in the breath or as infused by a deity.... the thinking, motivating, feeling part of a person, often distinguished from the body, mind intelligence. (Webster's Collegiate Dictionary, 2001, p. 1382)

Spirituality is often linked with religion so that it is necessary to define each of these and their individual significance. For many people the two terms appear to mark a significant difference between, on the one hand, a personal affirmation of the transcendent with a commitment to spiritual/humanistic values and, on the other hand, an affiliation with and allegiance to organized religion (Kelly, 1995). Spirituality, put most simply, would be an individual's belief system emanating from their own soul connecting with the transcendent.

> According to Harry Moody (1998), spirituality refers an experience that (a.) "shifts our center away from the external world and toward the inner life of the soul, (b.) encourages a sense of disengagement from the ordinary problems of daily living, (c.) increases our commitment to virtuous behavior- kindness, generosity, unselfishness, love, (d.) raises our normal state of consciousness to a higher transpersonal level that awakens new and extraordinary faculties within us, (e.) creates a desire to give back to the world what we have gained spiritually and to devote ourselves in service to others." (p. 34)

Harry Moody saw the five stages of the soul as experiences that were spiritual in nature.

Limitations of the Study

All three concepts - body, mind and spirit - need consideration in a holistic study of spirituality and healing through counseling. While body and mind can be measured,

this study is limited by concepts of the immortal and by lack of measurement of spiritual or transcendent things. How does one measure transcendence? How does one accurately measure faith? While there is research that measures faith; individual and spiritual differences as well as cultural differences present a challenge to accurate measurement for faith and transcendence. There are measures of positive results from cognitive therapy using wrong thinking and internal communication and replacing it with spiritual thinking.

The idea of working with communications is valuable as a mind and body concept. Bad thinking and self-communication are certainly identifiable and measurable and can be indicators of the state of one's spirit. There are assessments that measure faith based on spiritual maturity and subjective understanding. Yet remarkable spiritual differences in individuals might indicate that in certain belief systems "an outpouring of the Holy Spirit" and glossolalia might be seen as a measure of a person's faith, while in other systems, devoutness, piety, and meditation might be a measure of faith or spirituality. The uniqueness of each spiritual situation derived from a religious and cultural orientation presents the elements of a cultural challenge in each client/therapist meeting. Spiritual approaches in other cultures present a tremendously vast area for future research in use of spiritually with cognitive therapy. Other limitations within this thesis include lack of familiarity with scriptural forms from other cultures, so that use of examples comes primarily from those sources with which this author claims the most familiarity.

"The spirit groans" refers to a communication of the soul via the Holy Spirit to God in its own language (Swindoll, 2001). Other spiritual communications might include dreams, communication through Holy Scriptures, and communication through listening with the heart. The ability or willingness of an individual to share this kind of spiritual experience is questionable. There are individuals who believe that sharing transcendent experiences may take away from the experiences (Moody, 1998).

Each client and therapist relationship is extremely unique. Data derived can only be as accurate as successes measured by one or the other party. The nature of a client seeking to enrich his/her relationship with the transcendent might base goal attainment on feelings versus actions. Empirical data measuring attainment of a spiritual goal could only be based on specific actions in cognitive therapy. There are subject areas like healing that may be measurable by assessments like the Beck Depression inventory. The nature of depression could be measured pre therapy and post therapy. Feelings may not always lend themselves well to empirical measurement.

There is a range of subject matter that moves between spirituality as a way of healing, to spirituality as a way of being. The far end of this range is measurable only in physical terms like biofeedback; there are spiritual definitions that are not easily identifiable as in the case of the apostle Paul in Second Corinthians, "I know a man in Christ who fourteen years ago was caught up to the third heaven. Whether it was in the body or out of the body I do not know, God knows" (Living Insights Study Bible, p. 1242). Spiritual experiences are not necessarily empirically verifiable.

At the core of this thesis lies the question: What are the issues involving spirituality that a counselor would expect to deal with in therapy? The latitude of this

question is truly unabridged. Literally every aspect of an individual's life that acknowledges the spiritual is potential therapy material. It is therefore necessary to look at the nature of spiritual issues in therapy and look at the review of literature regarding how cognitive therapy has been used or has failed to be used in conjunction with spiritual issues.

Some of the basic spiritual issues in therapy might include working on questions like: How does the client conceive purpose and meaning in their life? Is soul realization the purpose of life? Is finding and awakening the higher parts of oneself a spiritual goal? Are people understanding of their spiritual journey? Answering these questions in therapy might demand reaching beyond the limitations of therapy, advising the client to delve into areas they have previously not pursued, and helping them find adequate resources to answer these questions. This study of cognitive therapy appears limited in its ability to answer these questions based on its orientation towards healing pathology.

Chapter II: Cognitive Therapy and Spiritual Assessment

Do certain individuals or personalities or even certain religions seek interactions with God more than others? It would appear that certain people expect "mountain top experiences" while others do not. It would also appear that certain religions seek mountain top experiences while other traditions do not. Dean Hamer, molecular biologist, has indicated in his new book, "The God Gene: How Faith is Hard Wired Into Our Genes" that there is a variation on a gene know as VMAT2 (vescular monamine transporter). A single change in a single base in the middle of the gene seemed directly related to the ability to feel self transcendence. "VMAT2 appears to code for a protein that controls the ebb and flow of monamines, brain chemicals that play a key role in emotions and consciousness" (Hamer, 2004, p. 213). Simply having these feelings does not mean that individuals would take the next step and translate their transcendence into a belief in or even quest for God. But they seemed likelier to do so than those who never got the feeling at all (Hamer, 2004). The idea that spirituality is inherited has its basis in many faith backgrounds. A Tungus Shaman cited in Joseph Campbell's The Masks of God says, "A person cannot become a shaman if there have been no shamans in his sib" (Hamer, 2004, p. 213). The apostle Paul writes, "I have been reminded of your sincere faith, which first lived in your grandmother Lois and in your mother Eunice and, I am persuaded now lives in you also" (The Living Insights Study Bible, 1996, p. 1310).

The Minnesota Twins Studies that occurred in 1979 (Bouchard, 1999) support this idea that identical twins (those individuals with matching DNA) raised apart, when quizzed on religious values and spiritual feelings, showed a similar overlap. They were twice as likely to believe as much or as little as their sibling did. These numbers did not

hold up when questioned in regard to how faithfully they practiced any organized religion. Clearly, it seemed the degree to which we observe rituals such as attending services is mostly the stuff of environment and cultural whether we are drawn to God in the first place is hardwired into our genes. "It completely contradicted my expectations," said Thomas Bouchard, one of the researchers involved in the study. Similar results were later found in larger twin studies in Virginia and Australia (Hamer, 2004).

While there are statistics that would indicate 95% of Americans believe in God and 85% believe in the power of personal prayer having healing powers (Wallis, 1996), it is also important to note there is a broad spectrum in regard to their spirituality and the nature of their belief. Sixty-two percent of Americans belong to religious organizations, and 60% believe religion is a very important part of their lives (Shafranske, 1996). These statistics would indicate a good case for the use of a spiritual assessment for people in therapy with religious/spiritual issues.

So the question arises: what type of people would come to therapy bringing spiritual issues with them and then what type of spiritual issues would these clients have? In order to think about people and how they fit into counseling situations with their spiritual/ religious differences, Kelly (1995) developed a typology in regard to different types of people and spirituality. Worthington (1991) had developed a similar typology of clientele with the idea that it could serve as a guide to scientific research. Kelly (1995) extended Worthington's ideas, stating that this should not be looked at as a way of pigeonholing clients, but the clients usually have characteristics from more than one category.

1. Religiously committed clients: Clients who use religion to transcend, or move beyond their everyday culture and concerns.
2. Religiously loyal clients: Clients who adhere to religion because it is interwoven with culture, customs and folkways.
3. Spiritually committed clients: "Being spiritually committed involves clients who while not affiliated with organized religion, have a courage to look within and to trust. What is trusted appears to be a deep sense of belonging, of wholeness, of connectedness, and openness to the infinite" (Shafranske & Gorsuch, 1984, p. 233).
4. Spiritually/religiously open clients: These clients do not give evidence of spiritual or religious commitments (Kelly, 1995). During counseling, these clients present as one whose philosophy and life-style make it reasonable, ethical, and potentially therapeutic to include relevant spiritual and /or religious components in the client's overall search for new and altered perspectives to guide personal development and problem resolution.
5. Externally religious client: Clients may appear to be initially loyal, but their external religious expressions show little depth of belief and appear to have no substantive effect on their way of thinking and behaving (Kelly, 1995).
6. Spiritually/religiously tolerant or indifferent clients: Those clients who express indifference to religious or spiritual beliefs, and to whom an introduction of spiritual or religious beliefs might be not justified therapeutically and might be ethically problematic (Kelly, 1995).

7. Nonspiritual/nonreligious clients: These clients view spirituality and religion as expressions of the unreal. They conceptually and personally consider spirituality and religion unnecessary (Kelly, 1995).
8. Clients hostile to religion: These clients not only lack spirituality and religious feelings but are in attitude and behavior actively hostile (Kelly, 1995).

One half of the client types listed in Kelly's typology would qualify for the type of client who could be served by use of spirituality in counseling. The second question then, is what would be the nature of spiritual issues these clients would bring to counseling? There are four broad categories of client issues and problems listed by Kelly (1995):

1. Those areas of one's life where a spiritual/religious issue are the root problem: Issues might include fear of losing one's faith, guilt, consciously and directly connected to a distinct sense of sin, or some violation of religious restrictions, indecision about devoting oneself to a religious vocation, or interpersonal conflicts about differences of opinion about differences of opinion about religious beliefs and practices.
2. Non-spiritual issues with a religious impact. This category includes relationships involving people with spiritual commitment or beliefs, and the type of people in categories with no spiritual beliefs or hostility toward spiritually. This could include ethical situations that interfere with individual functioning due to unacknowledged spirituality. This category could also include issues that involve purpose and meaning in life.

3. Non-spiritual issues and problems with a potential spiritual connection. The clients do not present problems of a spiritual nature, but there is a potential in the nature of the problem that a spiritual or religious perspective on the problem would improve the situation. Examples might include alcohol or drug addiction, understanding purpose in life events, dealing with death, bankruptcy or hardship.
4. Non-spiritual/ religious issues with little apparent or close connection with the spiritual or religious dimension. The clients are non-spiritual, non-religious and issues are not spiritually related. Examples include career dissatisfaction, lack of assertion, and chronic bedwetting. Although there are spiritually minded individuals who consider all areas of life subject to spirituality, this category would include problems not spiritual by nature and individuals for whom proposed spiritual perspective would be non therapeutic.

In summary, there are certain types of individuals who would be candidates for spirituality in therapy and there are certain types of issues that lend themselves to use of spirituality in therapy. The other area that is required would be certain types of counselors who would be willing to include a spiritual component in their therapy.

Assessment Tools for Spirituality

Assessment tools for spirituality might include a simple upfront interview, a possible inclusion of spiritual/religious preference on a form or a spirituality questionnaire. There are many types of assessment tools. Some occur within other types of assessments. Others occur specifically within the context of a spiritual/religious assessment. Some of these assessments are workable in secular and religious settings and some are not advisable in secular settings by their creator.

While statistics that would indicate 95% of Americans believe in God and 85% believe in the power of personal prayer having healing powers (Wallis, 1996), it is also important to note there is a broad spectrum in regard to their spirituality and the nature of their belief. Sixty two percent of Americans belong to religious organizations, and 60% believe religion is a very important part of their lives. These statistics would indicate a good case for the use of a spiritual assessment for people in therapy with religious/spiritual issues. A cognitive therapist would be likely to use a spiritual assessment because cognitive therapy is empirically based and it would provide a basis of measurement, as well as informative information.

Kelly (1995) presents a good description of a variety of spiritual assessment tools. Some tools evaluate spirituality in the holistic sense, irrespective of particular religious content, while others measure spiritual attitude, specific behavior, and beliefs. There are some commonly used assessment tools where spirituality and religion are subsets of the assessment instrument like the Family Environment Scale (FES; Moos & Moos, 1981), The Mooney Problem Checklist (1950), and the Campbell Interest and Skill Survey (1990). There are other groups of instruments that measure wellness and holistic functioning. The Wellness Inventory (WI; Palombi, 1992; Travis, 1981) contains two spiritually oriented categories: finding meaning and transcending. The Life Assessment Questionnaire (LAQ; DeStefano & Richardson, 1922; National Wellness Institute, 1983; Palombi, 1992) measures 10 different dimensions of overall wellness including the spiritual dimension.

Two of the most used holistic models are the Wheel of Wellness by Whitmere and Sweeney (1994) and A Model for Spiritual Assessment and Intervention by Farran,

Fitchett, Quiring-Emblem, and Burch (1989). The last model was designed from a nursing perspective and provides assessment and intervention in which the spiritual dimension is separate from the religious dimension. Both models focus on elements especially related to spirituality for example, meaning in life, a sense of transcendence, attitudes toward a higher power, inner harmony, connectedness with the universe, etc. as distinguished from a particular religious belief.

Assessments can measure spiritual distress: the state in which an individual or group experiences or is at risk of experiencing a disturbance in the belief system that provides strength, hope, and meaning to one's life (Kelly, 1995). Assessments also measure spiritual health, spiritual well-being, and spiritual experience in addition to helping the therapist to provide spiritual diagnosis. Kelly advises secular counselors to consider carefully the therapeutic value and ethical propriety of a specifically religious assessment. Kelly advised that the counselor be reasonably confident of his/her understanding of the client's religion or at least confident that he or she can empathically and respectfully learn about the client's religion from the client from study and consultation as necessary. The client must be aware of and accepting of a religious assessment and the counselor must be able to make it clear to himself or herself how a religious assessment is therapeutically relevant to the client's developmental and problem solving progress. The counselor who is prepared to make a religious assessment is faced with the difficult point of religious diversity along with theological and personal interpretation.

There is an even more thorough interview and assessment procedure called the Religious Status Inventory and Religious Status Interview. It was developed by Maloney

with the idea of measuring religious maturity or optimal religious functioning (Kelly, 1995). This particular assessment would take the counselor and client very deeply into the religious value world of the client. It must be emphasized that the more deeply and extensively the counselor explores this dimension with the client, the more expert the counselor must be in this area and the more confident the counselor must be that this exploration is conductive to the client's self-determined welfare.

Rather than making a comprehensive religious assessment, a counselor in secular practice is more likely to use a religious assessment instrument or interview procedure as part of a general assessment. "In the absence of religious competence the counselor working with the highly religious client whose religion appears very relevant to the counseling should probably make a referral and or seek appropriate consultation" (Kelly, p. 184).

Chapter III: Literature Review

The Opposition

In the time line of psychology, the battle began around the 1890s with the founding of the American Psychological Association and the writings of Sigmund Freud (Comer, 2001). At the turn of the century, psychology attempted to position itself as a science based on universal laws that explained humans and human behavior. Freud saw religion as an illusion or an expression of neurosis (Kelly, 1995). He claimed the need for religion resulted from infantile neurotic impulses of the client and felt that the mature person needed to abandon religion. Fervent belief in the father-god and obligatory rituals were the two outstanding features of religion according to Freud. He noted the compulsive-obsessive qualities of the rituals, the guilt feelings involved, and the fear of divine retribution. Freud saw religious beliefs and experiences as rooted in early experiences of childhood and saw the obedient submission to God as the projected infantile father relationship reestablished (Shafranske, 1997).

In the 1920s, behaviorist psychology started to dominate the new field of psychology (Wulff, 1997). Behaviorist leaders like Watson believed that all behavior is determined and that it is the result of positive reinforcement. Whether it was an antagonistic role (Wulff, 1997) or a neutrality role (Corvelyn, 2000), exclusion of belief in God and the transcendent was either holding psychology back in its development or did not simply interact with psychology (Miller, 2003). Skinner (1953) explained religion: "Just as pigeons will exhibit nonfunctional but persistent 'superstitious' behaviors in response to random reinforcement, so humans will fasten onto odd ritual

observances if these behaviors are by chance followed by a reinforcing stimulus" (Shafranske, 1996, p. 49).

Vetter (1958) contended that religious behaviors are the human response to unpredictable and uncontrollable situations. Vetter identified two classes of religious behaviors: entreaty behaviors and orgy-type behaviors. Entreaty behaviors include prayer and meditation and orgy-type behaviors are ceremonies that distract the person long enough to allow the problem to dissipate on its own. Vetter objected to these behaviors because they were like drugs to those suffering and did not address real problem solving (Wulff, 1996).

Albert Ellis, father of Rational Emotive Behavioral Therapy and grandfather to cognitive therapy, explicitly made naturalism a part of the fundamental commitments he brought to a scientific task (1980). Ellis contended that all forms of religious belief were damaging, less mature, and irrational. Ellis viewed religious beliefs as a regression to magical or unscientific thinking or as a reversion to reliance on religious authority (Propst, 1988; Shafranske, 1996).

One of the other significant ideas that colored the psychoanalytic and behavioral movements was the concept that the therapist was a blank slate (Patterson, 1958). Clinical pragmatism and humanistic idealism were major psychotherapy orientations developed under this blank slate assumption (Bergin, 1980a). From 1940 through the 1970's, the idea that therapists could keep values out of therapy was challenged (Beutler, 1972). By the 1980's many in the field agreed that it was impossible to keep values out of psychological work (Bergin, 1980a).

Spiritual Friendly Therapies

William James, psychologist, philosopher, writer, and teacher, defined religion as "the feelings, acts and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they many consider the divine (James, 1961). "James looked at the ways that 'personal religious life,' although subject to considerable distortion and perversity, represents a set of belief experiences linking individual humans to a more spiritual universe from which they draw significance." (Beit-Hallahmi, 1989, p. 20.) William James contributed the idea that spirituality and religion when combined with healthy-mindedness can have the potential to equal "positive humanizing of the personal and social life" (Kelly, 1995, p. 59).

Philosopher, psychologist, and writer Victor Frankl contributed to the psychological humanistic tradition in his unique existential view of "will to meaning' as the most important part of human meaning" (1948; 1975, Frankl). This involves a self-transcendence in which meaning is achieved through commitment to and responsibility for an important humanizing task, a significant human relationship, or the choice of personal dignity in the face of dehumanizing conditions. The failure to choose such meaning responsibly and freely lies at the core of human deterioration in neurosis and antisocial behavior. Religion viewed in Frankl's way refers to man's expression of a free personal choice toward ultimate meaning congruent with what is most important to man. "Frankl clearly ties positive human development and therapeutic /counseling to a search for meaning that is inherently associated with a spiritual self- transcendence and with the unconscious God touched by the religious unconscious" (Kelly, 1995, p. 67).

Almost simultaneously with the behavioral movement, a humanistic psychology movement began with the advent of the twentieth century. Leaders involved in this combination of existential and humanistic psychology included: Gordon Allport, Erich Fromm, Paul Pruyser, and Abraham Maslow. This group viewed human behavior as more complex than the psychoanalytical and behavioral perspectives. They viewed human beings as having positive potential and incorporating spiritual needs and values not necessarily addressed by religions. Allport was one of the founders of the Humanistic Existential Psychology Movement. He had a developmental view of religious sentiment based on what he termed "the defensible theory of the nature of human personality" Allport, 1950, p. 53). Allport defined six characteristics of religious maturity:

1. It is differentiated. It is a result of critical cognitive discriminations based on accumulation of information and life experience toward an organized lifestyle pattern of living and understanding.
2. It is self-governing and always changing. It acts as a spark for humanizing personal and social development.
3. Consistent morality is the result of religious maturity. There should be congruence between beliefs and practices.
4. Comprehensive inclusion of philosophy that addresses meaning and purpose in life are included in religious maturity.
5. The mature religious individual should demonstrate an essential understanding of the relationship regarding some of the outrages of existence, as well scientific knowledge in relation to their religious knowledge.

6. Religious maturity should be like a hypothesis- open to reformulation and development as the individual gains life experience and knowledge.

Fromm, a non- theist humanistic psychologist of the 1950s, also believed that religion could be helpful to his clients (Fromm, 1950). Fromm saw humans as needing a guiding framework and a place of devotion to cope with the realities of aloneness. Fromm understood the value of a humanistic religion that focuses on human self-realization and the development of human potential as a way of meeting this existential need. Fromm maintained that humanistic and authoritarian religion may be associated with either theistic or atheistic traditions. Fromm identified the factor that set the idea of positive religion apart was not a belief in God or the supernatural, but the extent to which one's basic framework of understanding and one's basic object of devotion lifts up human development toward love, the assertion of one's own powers and a humanized society, rather than lead people toward fear and submission.

Paul Pruyser, like Freud, also looked at religion as an illusion (1968). His question was, "...If illusions are needed, how can we have those that are capable of correction, and how can we have those that will not deteriorate into delusions?" (p. 8). Pruyser identified an intra-psychic diffusion of spirituality and religion. Pruyser felt that all activities, processes, behaviors, objects and objects relations might have a religious significance for the patient or the therapist or both. He valued therapy as a meeting place of psychology and religion and the opportunity to work with profound hopes, wishes, and spiritual/religious imaging. Pruyser also identified some of the negative consequences of what he called neurotic religion as psychologically oppressive. These negative consequences included disassociation and denial (i.e. shutting out information that might

conflict with one's religious beliefs or ignoring social miseries while maintaining a Pollyanna or detached religious attitude); religion used for fraudulence and dishonesty; religiously motivated physical severity toward presumably offensive or offending body parts; and crass forms of magic and ritual and symbolism as expressed in Satanism, occultism and obsessive compulsive religiosity.

In keeping with this dichotomous idea that there is positive therapeutic gain through positive spirituality, as well as the potential of damage through negative spirituality of fear and submission, Antonovske in his 1979 book *Health, Stress, and Coping* presents a case for both improved functioning through use of positive spirituality in therapy. He suggests that individuals need a sense of coherence, a generalized, long lasting way of seeing the world and one's life in it. Such a sense of meaning leads to less vulnerability to stress.

Research by Woolfolk and Lehrer (1984) demonstrates a dichotomy in regard to healthy as well as unhealthy spiritual beliefs as well. They point out that adhering to spiritual beliefs or worldviews because of its inherent value is self-limiting and self defeating. Woolfolk and Lehrer indicate that things like feelings of alienation and defeat are only overcome through some passionate commitment to a direction in life. For this passionate commitment to be healthy it should contain the following elements: recognition and acceptance of the inevitable misfortunes in life, tolerance for the imperfection of oneself and others, involvement in the process of life rather than its results, a commitment to something outside oneself, and a balance between effortful striving and detached observation.

Bridges from Spirituality to Psychology: Humanistic Psychology to Transpersonal Psychology

Maslow (1964) saw the dichotomizing of religion and science as pathologizing. He felt that religion and science needed each other and that science had a blindness of researching raw facts in their reduction to concrete thinking. Maslow saw that the transcendent and the sacred needed to be scientifically studied. He felt that everything in religion could bear naturalistic observation. Maslow approached the notion of peak and plateau experiences with the idea that these are simply the result of a highly self-actualized person. He saw these experiences as a naturalistic core that cut across all institutionalized and ritualistic expressions of religion. Maslow saw this like the other humanist psychologists in line with the focus on the positive rather than the negative debilitating forms of religiosity.

Maslow's work in humanistic psychology became the major influence for transpersonal psychology (Kelly, 1995). From Maslow's work the application of the scientific methods advanced to those areas of the human experience beyond the strictly empirical. This area includes unitive consciousness, mystical experience, transcendence of self, spirit and spiritual practices, meditation, and compassion based in cosmic consciousness. Leaders in the transpersonal psychology movement have been Roberto Assagioli and Ken Wilber. Assagioli developed a transpersonal model for integration of spirituality and psychotherapy. Wilber, Engler, and Brown (1986), developed a complete spectrum model of human growth and development that incorporated hierarchically ordered prepersonal, personal, and transpersonal levels of development with

corresponding levels of disease and therapeutic treatment and transpersonal levels that make up contemplative or spiritual realms of development. The transpersonal realm of psychology includes degrees or levels of spiritual experience described primarily in the language of Eastern religious/ psychological thought. The levels of spiritual experience move toward enlightened oneness with ultimate reality.

In summary, transpersonal psychology is the part of psychology movement that reaches between the great divide between behavioral psychology and spirituality (Vaughn, Wittine, & Walsh, 1995). Transpersonal psychologists maintain this experience that appears supernatural is part of a human existence. Transpersonal psychology has come to give particular attention to Eastern religious experience and Eastern psychology. Transpersonal psychology has taken supernatural experiences and empirically mapped them. The transpersonal psychology movement moved the whole psychology community toward a point where the positive aspects of religion and spirituality were seen as desirable regardless of the specific type of the spirituality or religion.

At the close of the twentieth century Vande Kemp (1996) argued that psychology and religion are legitimate subdisciplines in psychology as evidenced by names, professional groups, degree programs, journals, research programs, textbooks, treatment centers, internships and theoretical literature. He pointed to groups that merged religious and mental health professionals like the National Academy of Religion and Mental Health-1954 and the American Foundation of Religion and Psychiatry-1958. Vande - Kemp also pointed to special interest groups within larger groups like the Friends Conference on Religion and Psychology within the World Conference of Friends at Swarthmore-1937; Psychology of Religion- division 36 within the American

Psychological Association; Association for Spiritual, Ethical and Religious Values in counseling within the American Counseling Association-1950s; and Psychological Interpretations in Theology within the American Academy of Religion-1973.

Vande Kemp (1996) also noted that integration appeared in the form of APA approved religious colleges and universities that offer doctorate degrees in psychology; publications that integrate religion and psychology like Quarterly Review of Religion and Mental Health (1961), Journal of Psychology and Judaism (1976), and Journal of Psychology and Theology (1973); in addition to published books regarding the integration of psychology and religion (Miller, 2003).

Miller (2003) points out that cognitive psychology, which blossomed in the 1960's allowed for the idea of self-control, thereby creating another opening for psychology to the inner world of the individual, an inner world that can include the spiritual dimension. With the advent of a therapy that relied on the feedback of empirical data for support and the use of biofeedback, researchers began looking to test any and all influences of behaviors including religion and spirituality (Martin, 1988, as cited in Miller, 2003). Combining behaviorism with spiritual strategy demonstrates a variety of successful applications in dealing with pathology. Friedman et al (1984) and Thoresen (1987) provide significant feedback over an extended period that gives evidence of the effectiveness of spiritual-behavioral intervention with coronary patients. Spiritual aspects are singled out as contributing to the physical and behavioral effects noted. Spiritual goals and health goals are coordinated and tailored to individual subjects. Martin and Carlson (1988, as cited in Miller, 2003) advanced the notion that certain health problems are treated without really examining or understanding the patient's spiritual orientation,

health or lack of spiritual health. Their conclusion was that the best health may be somewhat dependent on spiritual as well as social and behavioral factors.

Review of Literature and Cognitive Therapy

Research of literature with cognitive therapy focuses around different issues: how a client's or therapist's spiritual orientation may influence therapy and how religion or spirituality is used effectively in cognitive therapy. Kelly (1994b); Sansone, Khatain, and Rodenhauser (1990); and Shafranske and Malony (1990b) indicate a passive neutrality in regard to a client's spiritual/religious dimension in secular counseling settings.

> This stance is often unarticulated, the mark of American society in which the typical cultural norm is that the individual's religion and spirituality are private matters usually confined to specifically religious settings and activities and separated from the day to day affairs of the secular world (p.42).

Houts and Graham (1986), Wadsworth and Checketts (1980), and Gibson and Herron (1990) examined how counselors looked at their clients based on their pathology and their expectations. Christian and secular counselors have been found not to differ in their degree of rating of the pathology of the clients or in their degree of liking of the clients or in their expectations of clinical success with religious clients (Worthington & Scott, 1983).

McCullough and Worthington (1994) indicated the highly religious client as the possible exception to the significance of the counselor client match and the significance of the therapist belief system with the highly religious client. The highly religious client would be more likely to do better in counseling and be less likely to drop out of counseling when matched with a counselor with similar religious values.

E.W. Kelly (2003) indicates that there are large numbers of counselors who value spiritual and religious beliefs irrespective of their work settings and that this large number of counselors should increase the possibility that clients could receive counseling that is willing to address spiritual issues. He also demonstrates that a counselor's own spirituality might allow the counselor to have increased sensitivity to the spiritual perspective of a client's issues.

Effective Use of Spirituality in Cognitive Therapy

Christian Therapist, L. Rebecca Propst has done the lion's share of research regarding cognitive therapy. Propst began her research by demonstrating the effective use of religious imagery versus non- religious imagery for the treatment of mild depression in religious individuals in 1980 (Propst, 1988). Propst makes an effective case for use of cognitive therapy in changing one's thoughts, transforming one's ways through Christian scripture, healing relationships with others, meditation, surrendering to God, and Christian imagery use.

Propst continued her research in 1992 testing two forms of cognitive-behavioral treatment, one with religious content and one without. The participants were tested against four different scales: The Beck Depression Inventory, the Hamilton Rating Scale for Depression, the Global Severity Index and the social adjustment rating scale. The four groups included: Non cognitive therapy with religious therapist (Non-specific religious counseling (Pastoral counselors who did not use cognitive behavioral therapy) 2) Religious cognitive therapy with religious therapist, 3) Religious cognitive therapy and non- religious therapist, and 4) Non- religious cognitive therapy with non- religious therapist. Results indicated all groups were significantly less depressed. Both the

religious cognitive-behavioral treatment patients and the pastoral counselors reported significantly lower post treatment depression and better adjustment scores than the non-religious cognitive behavioral treatment or the wait list control group. Summary indicates that the group that performed most poorly was that group receiving nonreligious cognitive therapy from non-religious therapists. The Hamilton Rating scale for participants indicated that the group that performed significantly better than the wait list control group were the non-religious therapists who used religious cognitive therapy.

Propst, Ostrom, Watkins, Dean and Mashburn (1992) found that salvation, an explicitly religious value, was the only single client-therapist value that they studied on which therapists and clients significantly differed (due largely to the non-religiosity of therapists in the study) meaning that the patient-therapist similarity on religious values may be one of the best predictors we have of successful outcome and thus a variable on which client and therapist ought to be matched. Results suggest that use of religious faith in therapy can improve the therapy.

William Backus and Marie Chapian, Christian psychologists (1980) address finding one's way out of depression, anxiety, fear, anger and other common problems by applying the principles of Misbelief Therapy. Misbelief Therapy is based wholly on Ellis, Beck, M. J. Mahoney, D. Meichenbaum and Arnold Lazarus. It is identifying thought distortions (misbeliefs), removing them and replacing them with corrective beliefs based on their scriptures. Christian principles like confession and forgiveness are combined with cognitive therapy concepts like identify your misbeliefs, behave according to the scriptures, and pray answers instead of problems. The client learns to accept the new belief that nothing is impossible through Christ. This includes elimination

of bitterness and anger in one's life. The authors of Misbelief Therapy completed a research project to ascertain how well it had worked. The authors claimed that 95% of the clients that had been treated at the Center for Christian Psychological Services had improved compared to 67% improvement for other therapies.

Cognitive Therapy and Alcohol

Brown, Peterson, and Cunningham (1988b) describe a behavioral/cognitive approach to the use of 12 step spirituality in counseling with clients who are alcoholics or otherwise addicted. Stressing especially the behavioral component, they encourage the client's use of a "daily spirituality, including, morning prayer/ meditation, contact with sponsor, performance of caring behavior toward spouse, listening to cassette or reading assigned material, conducting nightly self-evaluation, nightly prayer/meditation, attendance at 12 step meetings (three nights a week), weekly attendance at after care and daily self-reinforcement behavior" (p.178) Building on the client's distinctive belief system and assuming the readiness and openness of the client, the counselor can adapt this technique of a behavioral checklist to include potentially therapeutic spiritual/ behaviors that encourage and support specific client action on problems.

Cory Newman (2004) indicates cognitive therapy is used to "dovetail" or work in tandem with the twelve-step program and that it is not intended to replace 12-step facilitation. The ideal use of cognitive therapy is that it compliments Twelve Step Facilitation (12SF), pharmacology, and other social learning approaches. Newman points out that cognitive therapists work at understanding their clients' lack of adherence to chemical treatments. They also work to help the client to understand maladaptive beliefs about pharmacology treatments. Therapists also encourage their substance- abusing

patients to respect the power of addictive cravings, and to assess their rationalizing for why it is okay to drink or use. Cognitive therapists do not require their patients to adopt a position statement of powerlessness in fighting addiction. A cognitive therapy framework emphasizes importance of learning skills that will bolster their sense of empowerment and self-efficacy.

Cognitive therapy supports many social learning models by placing importance on the individual's belief systems. This does not imply spiritual belief, but rather a cognitive belief about their relationship with substances, the nature of the cravings, the risks involved in various situations and states of mind that substances induce.

The original authors of the 12 step-program advanced the theory that every person has a "God space" and that people who have addictions have been feeling empty and have tried to fill this space with other things like alcohol, without success. Part of the twelve- step process is to reach to the power beyond one's power. "Higher power" in more recent times has been amended to be more politically and socially accepting of individuals who did not believe in a divine power, but also a power of someone outside of oneself, actually removing the spiritual component to make it more applicable to a wider more diverse group. In the examination of the five stages of the soul, Moody (1997) comes to the concept that "Redrawing the map of life depends in crucial ways on how we conceive the role of purpose and meaning in life. The search for meaning must be recognized as the driving force in the construction of new paradigms for growth and development over the life course" (p. 28). While the twelve step program focuses on the higher power to help redraw this map of one's life, cognitive therapists

work with their clients using cognitive therapy's thought transforming abilities to complement the twelve-step spiritual approach.

Chapter IV: Cognitive Therapy and Cultural Considerations

Does cognitive therapy serve only a western model of counseling or does cognitive therapy effectively cross cultural lines which may also be religious/spiritual lines? Is cognitive therapy an individualistic, future oriented philosophy that is oppositional to other cultures? The concept of individual autonomy and controlling one's own destiny may be foreign and unpalatable concepts to certain people for example, Native American, Latino, and Hmong (Sue & Sue, 1999). The ability to channel and control power in therapy becomes the crux of the cultural question.

According to Duran and Duran (1995), Carl Rogers' client centered therapy (1942) that introduced basic modern counseling skills, presents a paradoxical use of power in western therapy. The client has the right to make choices and the therapist must also be a catalyst in the therapeutic relationship. The western therapist works by giving up power thus allowing the client to become empowered, whereas "the shaman is perceived as powerful within his/her community and the power that is enacted in the ritual engulfs the client and the shaman in a powerful experience in which the cure occurs" (p. 63).

The following case related by Vang Xiong (Sue & Sue, 1999) regarding undesirable spirits and sudden death phenomena among the Hmong demonstrates a case that would be difficult to approach with cognitive therapy because of its cultural context and its spiritual context.

> The most recent attack in Chicago was not the first encounter my family and I have had with this type of spirit, a spirit we call Chia. My brother and I endured similar attacks about six years ago back in Laos. We are susceptible to such

> attacks because we didn't follow all of the mourning rituals we should have when our parents died. Because we didn't properly honor their memories we have lost contact with their spirits, and thus we are left with no one to protect us from evil spirits. Without our parent's spirits to aid us we will always be susceptible to spirit attacks. (p. 193)

An American therapist may have labeled Vang's problem as post traumatic stress disorder and survivor guilt. Mrs. Thor, the shaman in this case, treated Vang by making a home visit, burning incense, lighting candles, using a newspaper, chanting, making a spiritual diagnosis, and employing her expertise to get in touch with the hidden world of the spirits. The authors (Sue & Sue, 1999) do note that both non-Western and Western forms of healing were combined for maximum effect. The presence of a mental health treatment facility that employed bilingual/ bicultural practitioners, its vast experience with Southeast Asian immigrants and its willingness to use indigenous healers provided Vang with a culturally appropriate form of treatment that probably saved his life.

Cognitive therapy supports a meta-cognitive (mental control) coping strategy for post traumatic stress disorder (Leahy 2004; Wells, 2004).

> Treatment techniques focus first on challenging the negative beliefs concerning uncontrollability. Beliefs about uncontrollability are modified by verbal reattribution methods involving reviewing the evidence for evidence and counter evidence for absence of control. The natural modulators of worrying are discussed in this context to show how competing or distracting activities can displace the act of worrying. (Leahy, 2004, p. 185)

Vang's spiritual belief system and his cultural orientation rendered western psychological services inoperable. The mental health treatment facility was able to recognize the need for indigenous healers that saved Vang's life.

The concept of individual autonomy and controlling one's own destiny may be foreign and unpalatable concepts to the cultural belief system of Native Americans (Sue & Sue, 1999). Ideas of separation, isolation and individualism are features of the European-American world-view. Non-western forms of healing take on a holistic outlook. Many non-western cultures believe strongly in the unity of spirit, mind and matter. They make minimal distinction between physical and mental functioning.

A good example of a "non-western" spiritual and cultural view is the Native American culture (Garret & Garret 1994). A general overview of Native American belief is simply all things have life. Everything has spiritual energy and importance. A fundamental belief is that all things are connected. The universe consists of a balance among all of these things and a continuous flow of cycling of this energy. Traditional Native American belief is that people have a sacred relationship with the universe that is to be honored. All things are connected, all things have life, and all things are worthy of respect and reverence.

> Spirituality focuses on the harmony that comes from our connection with all parts of the universe in which every thing has the purpose and value exemplary of personhood including plants, the land, the winds, the sun, the moon etc...Spiritual being essentially requires only that we seek our place in the universe; everything else will follow in good time. Because everyone and everything was created with

> a specific purpose to fulfill no one should have the power to interfere or impose on others the best path to follow. (p. 187)

Can cognitive therapy serve this unique worldview in a spiritual way? Therapy of choice for Native Americans has been their own tribal shaman if possible and therapy more Jungian in nature when therapy is sought (Duran & Duran, 1993). Among Native Americans values are honor gained by sharing, tribe and family take precedence over the individual, noninterference with others, orientation with the present time versus future time, and the importance of inter-relationships between a large number of relatives. Native Americans believe spirituality transcends time and space. Their sacred relationship dictates being in harmony with the life process. Need for healing can only be explained as loss of harmony for the person or for the community. Many of their values like family and sharing have a spiritual basis that is in conflict with the philosophy of individual freedom and choice.

Grof & Grof (1989) see "the worldview created by traditional Western science and dominating our culture is in its most rigorous form, incompatible with any notion of spirituality" (p. 3). Essentially Grofs address eastern religions, eastern thought, individuals experiencing peak experiences, and past lives therapy. Grof and Grof (1989) make a case for the phenomena of psychosis. This does not refer to the organic psychosis where there is underlying anatomical, physiological or biochemical changes in the brain or in other parts of the organism. Grof identifies another form of psychosis- called a functional psychosis as a non-pathological state. The Grofs see the functional psychosis as a state that needs to be worked through. They term the functional psychosis a spiritual emergency and see it as an opportunity for healing. Cognitive therapy addresses

psychosis only as a pathology: hearing voices, having delusions, having hallucinations treatment with pharmacology and coping strategies.

Native Americans have practiced a shamanic tradition for centuries that embraces Grof's idea of the functional psychosis. Central to their philosophy is a tradition called vision quest (Moody, 1998). It involves higher forms of perception out of ego-bound consciousness. It entails a journey involving separation from the group, transformation through struggle and suffering. They moved from the ordinary self to a higher self. They go through a symbolic death and rebirth, communion with divinities, spirits and powers in lonely spots. Propst's work with cognitive therapy has been essentially with Christian clientele, although she indicates her techniques would work with other faiths. This vision quest and other culturally different philosophies have not been researched because it would require a counselor of similar spiritual values.

Other Limitations

Ethics is highly significant to the integration of spirituality into counseling (Miller, 2003). There are many issues where the setting of the counseling agency may be at odds with delving into spiritual matters such as crossing a boundary like praying with a client. After considering if the counseling agency would be accepting of using spirituality within counseling, a counselor has to decide if they will intentionally include spirituality into the session. Miller defines implicit counseling as recognizing spiritual values, but not using those resources. Explicit counseling is addressing spiritual or religious views in counseling. Intentional integration (Miller's recommendation) is where the counselor decides on implicit or explicit based on the client needs, problem, his/her

own training, and inclinations. Informed consent that is well planned and implemented is necessary to use spirituality in a counseling session.

APA Ethical Principles of Psychologists (Miller, 2003) indicate that psychologists provide services only in the boundaries of their competence. APA principles also indicate providing services in new areas only after undertaking appropriate training. So that with each client who asks for explicit spiritual counseling a counselor would have to ask himself /herself if they have the information necessary to counsel someone of this religious/spiritual perspective? Sometimes the client's needs might be so focused that the counselor could not respond within their area of competence. Some of the counseling areas significant to counseling of different belief systems would include gender issues and roles based on genders. Transference and counter transference that might take place in each counseling situations would also need to be carefully considered.

The counseling relationship itself may become a relationship where differences in values are significant to the counseling relationship. The client may feel uncomfortable not sharing a spiritual basis. Many of their values are in conflict with the philosophy of the values of cognitive therapy model: individualism and freedom of choice.

Cognitive therapy uses many techniques. Some of these are emotive and behavioral techniques that might include engaging in a Socratic dialogue, debating irrational beliefs, carrying out homework assignments, gathering data on assumptions, record keeping of activities, forming alternative interpretations, learning new coping skills, changing one's language and thinking patterns, role playing, imagery and confronting faulty beliefs. Some clients may find these strategies too structured.

"Cognitive therapy tends to play down emotions, and does not focus on exploring the unconscious or underlying conflicts, and sometimes does not give enough weight to the client's past" (Corey, 1996, p. 475). Leanne Payne's book, *The Broken Image, Restoring Personal Wholeness Through Healing Prayer* is a spiritual based book that supports of the Psychoanalytic, Jungian, and Primal theories in that it demonstrates the damage of repressed memory and the need to identify and relive certain early experiences in order to heal. Payne advocates that the client be able to revisit their early circumstances and even in- womb experiences in order for the client to pray and for her own healing prayers to be effective.

Sometimes service to a time limited Health Maintenance Organization (HMO) oriented system may not provide the time and orientation to work through significant aspects of client's past. The therapist/client relationship is one of a collaborative nature. The ability of a client to interact in a collaborative way may depend on his/her cultural background (Sue & Sue, 1999). Some clients find the therapist's "non-friendship" outside of the therapy setting an undesirable aspect of professional western ethics.

Some of the other issues that limit cognitive therapy with spirituality involve a division between pathos and religion. The goal of cognitive therapy is to change faulty thinking. It aids in healing by identifying and working on the faulty thinking. The goal of spirituality is far more diverse - like the five stages of the soul.

Chapter V: Cognitive Therapy and Discussion of the Five Stages

Cognitive Therapy and the Call

Moody (1997) tells us "Sometimes... people hear the call when they have everything they want from life and then discover it's not enough" (Moody, 1997, p. 42). The spiritual call can occur at any time in our adult life. It is not age related. It is an entirely personal inner experience. Sometimes the call can be recognized with the passage of time. The call may be manifest in a hunger like existential depression, sickness, setback, sufferings - situations so intolerable that an individual is forced into taking refuge in something stronger than the ordinary mechanisms of the ego. The call could take the form of a moment of epiphany, a dream, an event. The way that the call enters a person's life depends on who we are, where we are, and what we need. Many situations listed in Moody's definition of the call could constitute a lead-in to work in a cognitive therapy session. It would be essential that the counselor be cognizant of the spiritual call concept or that the client would recognize the spiritual call in order to work with life's material within the context of the call. Although a spiritual assessment may be given prior to therapy, Moody's "call" definition indicates that the individual might or might not be spiritually mature, and that the circumstances of the call could happen easily to non-spiritually-minded people as in the case of Isaiah 65:1 "I revealed myself to those who did not ask for me. I was found by those who did not seek me..." (N.I.V. Study Bible, p. 746).

According to sacred traditions the location of the soul is within oneself. "....the kingdom of God is within you" (N.I.V. Study Bible, Luke 17, p. 1097). The main vehicle of articulation for the soul is dreams, sacred art, sublime sounds that speak to the

deepest sectors of our consciousness, physical austerity, meditation. This articulation of the soul, then, is the material that cognitive therapy would need to address. Propst (1988) suggests "centering down" as in the case of the Quakers. "As we begin to focus we begin to listen, to our thoughts and to God's thoughts" (p. 72.)

Cognitive therapy (Leahy, 2004) is essentially about listening to our thoughts, identifying our thoughts, becoming more self aware, and ultimately removing the pathology from our thoughts that keep us from healthy functioning. Can this identification of thoughts, and pathos be considered part of identifying the call? (Propst, 1988) notes that theological models of transformation contain many of the same themes of change that appear in psychological models. We are taught to find our selves, not to allow the world to squeeze us into its mold, we are taught to examine that world and become aware of its impact on us. We are counseled to stop living a limited existence, to discontinue allowing old ways of seeing things, or doing things, to determine our existence. Finally, we are challenged to risk, to make a commitment to change our minds and to choose life.

Changes in a person's core assumptions (Beck, 1979) are an important ingredient in cognitive therapy. Recognizing the call could potentially have the ability to change core assumptions (Beck, Rush, Shaw & Emery, 1979). Beck describes the deeper process of changing the individual's depression causing assumptions.

> These assumptions are basic beliefs that predispose the person to depression or anxiety. Each individual has a unique set of rules about how he and his world should be viewed. If these rules are not changed even after the depression has

> abated, the individual will remain vulnerable to future problems. These underlying beliefs must be identified and changed. (p. 252)

Cognitive therapy could be used to identify individuals' unique set of rules. It could be used to recognize and assist the client to change their rules. Using spirituality, the therapist might help the client to understand that these "rules" are not working any more, and that there is something else within that can recognize this error and transcend. In order for a true response to a call it would be essential that the cognitive therapist ask, "Do you feel this is a spiritual call?" Or, that the client would respond "I think this could be some kind of spiritual call." Apart from this recognition of a spiritual call cognitive therapy could simply work toward a change in the client's underlying assumptions.

Answering the Call, Beginning the Search

Does one have to hear the call to begin the search? That answer might have to be yes, or at least a strong maybe in order to answer the call by beginning a search. A scenario for this situation might include a cognitive therapist with a spiritually oriented client who has been plagued by a situation that is seemingly out of control. The client's life is so overwhelming that the spiritually oriented client has concluded that the events of their life constitute some type of spiritual call. How can cognitive therapy allow the therapist to work with the spiritually oriented client to answer the call and begin the search? Propst (1988) proposes techniques of transformation methods to use in cognitive therapy to begin to learn alternative ways of viewing oneself. Essentially she proposes answering the call by getting outside oneself and viewing oneself. She proposes three steps: meditation, adopting a problem solving attitude, and facing the worst.

Answering the call can take the form of opening new rooms in ourselves - maybe the masculine and feminine gender rooms. Answering the call calls us to find qualities in ourselves we were not aware of and to use them to become more integrated individuals. "... the call is the two halves of our own psyche begging to be made whole" (Moody, p.109). Whatever form the call happens to take, however it is always driven by the same purpose, it is letting us know at an inner level that the life we are leading is not our own. Propst cites Karl Barth (1948/60) in that each person has a spirit. She uses Barth's imagery of the individual reflecting upon his self and understanding his self. This individual can also take responsibility for himself, and act. The soul stands at a distance from his desiring. He reviews himself. He becomes an object to himself. This freedom to stand at a distance from ourselves allows us to see who we really are in the proper context.

In summary, to begin the search in response to the call a cognitive therapist would need to encourage removal from our current world ridden self by stepping apart self through means of meditation, then problem solving, then-facing the worst. Once the client has managed to step out of him/herself and reflect, problem solving can take place in a more objective and less defensive way. The key element in cognitive therapy (Leahy 2004) is the idea that our thoughts and beliefs largely determine our emotions and feelings. An anxious individual who was able to step out of his/her self could step apart from their world and the demands of that world on their soul. Apart from their worldly self, the spiritual self of the anxiety ridden individual would be more likely to see that the path they felt compelled to follow in daily living is unfulfilling and not spiritually centered (Propst, 1988).

> Beyond the problem-solving attitude, Propst (1988) proposes expecting the worst. The individual in pain must learn to understand at a very deep level that life is full of problems. Life holds a tragic element. Never will everything be perfect. Never will everyone like us. Never will we find a perfect solution to our problems. (p. 41).

So, the spiritual client in cognitive therapy is encouraged to embark on a spiritual search. It is a search to recognize one's illusions and to define exactly what it is one's soul is searching for.

Cognitive Therapy and the Struggle

"Therefore, take up the full armor of God, that you may be able to resist in the evil day, and having done everything, to stand firm." (N.I.V. Study Bible, Ephesians 6:12, p. 1261). Johari's window (Luft, 1969) divides into four panes, significantly of the four there is this one pane that shows the part of ourselves that we cannot see, that everyone else sees. The personal demons we struggle with in life that keep us from our spiritual goals are so familiar a part of our every day makeup that they often go unobserved by self (Warren, 2002). The signature sin, the struggle between the heart and the mind defines the ongoing battle. The shadow as Jung (Crowley, 1999) refers to it or the dark side of one's personality. Seeing directly into our own nature is always just a step away, hidden. People are over come with immediate demands in their lives that beg for immediate attention to be given to something "Peace will never come as long as we listen to them" (Moody, 1998, p. 187).

What exactly defines the struggle? Moody (1998) touches on several areas in discussing the struggle. The struggle is learning to live each moment in the here and now

instead of with ongoing habituation or tuning out most of life. The struggle is dealing with regrets of life, bad moral decisions, reviewing one's life, both dark and light to recognize and deal with guilt, feeling sorry, making amends, recognizing good parts, recognizing false regrets, unresolved problems, perspective on situations that might appear to have been a calamity. The question is: how can cognitive therapy assist the client to cope with the struggle. First of all, the client struggles between doubt and faith. Despite the affirmation of answering the call, the client may struggle to find in-depth focused time to get into scriptures, to meditate on God, to spend time in God's presence. For Christians, Propst (1988) recommends surrendering first one's thoughts to Christ. She recommends using a visual image of Jesus.

> There is the image of surrender. Various images of giving oneself to Christ can be therapeutic. There is the image of Christ's reaction to us. There is the image of Christ with us as we engage in specific tasks. And finally, there is the image of Christ within us. (p. 128)

Propst demonstrates this surrender and focus of attention in treating insomniacs whose primary issue is racing thoughts by use of this verse: "Cast all of our anxieties on Him for He cares about you" (Swindoll, 1996, I Peter 5:7, p.1359).

Imagining Christ's reaction to us is a technique Propst (1988) recommends for use with a Christian client. The client use a problem similar to one that Christ dealt with in the Bible. Once the scriptural scene has been imagined it serves as a lead in to one's own problem. A client who is suffering from anxiety might think about the Martha/Mary scenario (Luke 11:38) and feel that their anxiety is not unlike Martha's. They might in fact hear Jesus say, "be anxious over nothing" or "one thing is needful" as a reaction to

their anxiety and follow his divine instructions and simply sit at Jesus' feet in his presence like sister Mary. Even though surrender has taken place, the client is encouraged to imagine Christ with them in specific tasks through out the day. The client needs to invite Christ to drive to work, to sit at the table, to join in the phone conversation. Whatever happens, Christ is there.

Lastly, Propst (1988) asks the client to conceptualize Christ in us. Propst again calls the Christian client to imagine exactly where in us, Christ dwells. This very healing experience enhanced with the image that the power that flows through Christ flows through us is particularly healing to those who struggle with low self-esteem.

Many clients struggle with the events of his/her life and deals with the regrets. Moody uses the example of alcoholics anonymous to demonstrate correct response to regrets. Face the wrongs committed. Feel genuinely sorry. Make amends in whatever way we can. Develop an understanding that our struggle is not simply a random happening, but part of a universal spiritual struggle.

Use of scripture for past as well as present experiences is a valuable application from a spiritual client. Often clients need to revisit past events for which they continue to feel lack of forgiveness. Cognitive therapy can be used to get clients to deal with unresolved issues in their lives by identification with Christ's suffering (Propst, 1988). Sometimes Christ heals by providing the client a peaceful focus for painful thoughts. From a Christian perspective Christ heals by accepting the client when they find themselves unacceptable.

The Breakthrough

Breakthrough experiences involve oneness, wholeness, loss of ego, and unity with the ultimate (Moody, 1998). Ultimately breakthrough occurs once a person has answered the call, embarked on a journey, struggled spiritually with the dark side. Not everyone who embarks on a spiritual quest will experience a breakthrough. If this happens- it happens, if not that is okay also. There are types of experiences that can occur artificially with LSD or mushrooms as temporary expansions of consciousness, but peak experiences happen more significantly with true seekers (Grof, 1975). Robert Assagioioli describes the breakthrough experience in several ways, a harmonious inner awakening, it is characterized by a sense of joy and mental illumination (Moody, 1998). It may bring with it meaning and purpose of life. It may dispel doubts and solve many problems. The individual involved in breakthrough is a spiritually mature person, a seeker that has arrived, a struggler that has overcome. Breakthrough is the direct result of correct response to the call, the search, and spiritual struggle. Moody tells us that everyone's experience is different. He describes the breakthrough as "A sense of timelessness, enormous love, and compassion, being in eternity" (p. 272). Maslow says that he used to talk about peakers and non-peakers (1964). Maslow finally realized that the non-peaker was not an individual who was unable to have peak experiences, but rather a person who is afraid of peak experiences. A non-peaker suppresses, denies, turns away from those peak experiences and forgets.

Propst (1988) does not refer to this experience as "peak or breakthrough." She does refer to the end result of struggling through prayer and meditation as transformation. Her therapy supports the idea that a Christian's power comes from continuously looking

at God (NIV Study Bible, Heb. 12:2). Propst uses this imagery: to descend with the mind into the heart and there, stand before the face of the Lord, ever-present, all seeing, within you. Propst advocates transformation that occurs when we stop gaining our self-definition from those around us and start taking our cues from God. So the breakthrough ushers in the fifth area of Moody's stages of spirituality: the desire to give back to the world what we have gained spiritually and to devote ourselves in service to others.

Cognitive therapy does not have literature addressing the area of breakthrough experiences as understood in Moody's definition. Although cognitive therapy encourages meditation and prayer the main thrust of meditation is dealing with pathology like anxiety disorders. A person interested in peak experiences and therapy that involves reaching peak experiences might consider some of the alternative therapies like Transpersonal Psychology, Jungian therapy, and Existential Therapy. Cognitive therapy by definition is by definition aimed at pathology and changing the thoughts that create that pathology.

Giving Back

People who have been through the breakthrough experience return to normal conscious states and every day life with an increased tolerance and understanding (Moody, 1998). Tasks at this stage are to integrate what they have experienced into daily lives, to continue spiritual growth, to give back to others something we have learned. Moody notes that sociologist, Robert Wuthnow (1970) collected data showing that people who experience mystical or spiritual peak experiences tend to be less materialistic and status conscious than people who reported no peak experiences.

Propst (1988) recommends listening to God as we continue to hear the voice of God in our own lives. God may speak to us in our present situation. This message should

come from listening to God. "Faith is ultimately this redirecting of our sights toward God" (p. 115). Preoccupation and absorption into the mind of God should free us to listen to our own self- directions rather than the expectations of others. Passionate commitment should include recognition and acceptance of the inevitable misfortunes and difficulties of life. The healthy individual will realize that the tragedies of life will leave the person with uncertainties and ambiguities that will not be clarified. These are accepted as part of the "dark night of the soul."

Propst (1998) also lists acts of compassion at the end of our spiritual journey. "Jesus has said that we have arrived in his Father's Kingdom when we have fed the hungry, listened to the hurt and visited those in difficulties" (Matthew 25:35-36, p. 1035).

In conclusion, to serve a spiritual client with a spiritual problem cognitive therapy could be used with the five stages of spirituality. Cognitive therapy could be used to assist the client in all five stages. While the examples presented have been Christian, Propst (1988) maintains that other spiritual or religious philosophies could also be used to help a spiritual client with a spiritual problem. A cognitive therapist could address the client in the identification of the call, assist in beginning the search by teaching meditation, adopting a problem solving attitude, and facing the worst. Cognitive therapy uses a number of techniques to assist the client through the spiritual struggle. These include using imagery, assessing the struggle between the heart and the mind, dealing with regrets, reviewing the darks and lights, and recognizing the good. Using a spiritual base, cognitive therapy recognizes the breakthrough stage, as "looking at the face of God" but the therapy itself is focused on fixing pathology, learning new patterns of thinking and self- communication and behavior (Leahy, 2004). While the breakthrough,

spiritual stage five (Moody, 1998) may be a result of the call, the search and the struggle, there is not literature to support working with the breakthrough or transcendent experience as in the case of Maslow (1964). The therapist and client could potentially use the transcendent/peak experience in therapy, but literature does not support cognitive therapy in this application the way it supports the other stages. The therapist could potentially borrow from an alternative therapy that does support the break through/peak experiences, or depend on a spiritual leader to provide guidance in the breakthrough area to the client.

Discussion of Alternative or Dovetail Therapies

Existential therapy. Existential therapy or a combination with existential therapy might be one of the considerations in terms of an alternative therapy or dovetail therapy. Existentialists emphasize these dimensions for the human condition: the capacity for self awareness, freedom and responsibility, creating one's identity and establishing meaningful relationships with others, the search for meaning, purpose value and goals, anxiety as a condition of living, awareness of death and non being (Corey, 1993). Existential Therapy clearly deals with one's value system and what are inherently spiritual themes. Existential therapy does not depend on assessments to determine client status. Rather the therapist and the client can jointly investigate the significance of spirituality and religion together.

The focus of existential therapy is on understanding the client's phenomenological world including their cultural background (Corey, 1993).

> When a person-centered, or existential counselor… who works in a setting with no requirements for specific assessments and diagnosis….. and he/she does not

> share a belief system with the client, it is the counselor who becomes the instrument of assessment, facilitating the client's ongoing self- exploration and expanding self understanding. (Shafranske, 1996. p. 346)

In this approach to counseling, the interview method becomes the assessment tool. This includes the counselor's way of being and responding in relationship to help the client expand and deepen his or her self- presentation and come to more self-actualizing experiences of the self. Existential therapy can help clients to examine their options to change, within the context of their cultural realities. Existential therapy can give the client empowerment in an oppressive society. At the same time the values of individuality, autonomy and self-realization may conflict with collective values of collectivism, interdependence, respect for authority, and respect for a cultural tradition. The absence of techniques in existential therapy might be an asset to some clients and therapists compared to the many strategies of cognitive therapy. Paradoxically, some clients may feel a need for strategies and techniques, and assessments. In summary Existentialists believe that health comes when a person adopts the perspective that he is not helpless any longer and that they can choose a meaningful perspective on their existence.

Transpersonal psychology. Maslow (1964) applied scientific measurement to peak experiences and those areas of experience thought to be beyond empirical measurement. He addressed areas like unitive consciousness, mystical experience, transcendence of self, spirit and spiritual practices, meditation and compassion based in a cosmic consciousness. Transpersonal psychology grew from Maslow's work. It gives particular attention to Eastern religions and Eastern psychology. It involves levels of

spiritual experiences- described primarily in terms of Eastern spiritual and psychological thought -moving toward oneness with ultimate reality (Kelly, 1995). It involves three stages prepersonal, personal, and transpersonal. These can be seen as bands in a spectrum of identity extending from the isolated individual to the wholly inclusive and universal. Transpersonal psychology recognizes the therapist's unfolding awareness of the self and his or her spiritual worldview as central in shaping the nature, process, and out come of therapy (Shafranske, 1996). Transpersonal therapists are characterized by their dedication to a spiritual path, defined as a disciplined course of action (Kelly, 1995). Transpersonal psychology is a process of awakening from a lesser to a greater identity. "Crises that are specifically associated with transpersonal experiences have been described as 'mystical experiences with psychotic features,' 'spiritual emergencies,' and 'transpersonal crises'" (Grof, 1988, p. 3). They can occur either within or outside a conventional religious setting. What seems clear is that a period of psychological disturbance may often be associated with significant growth and development. Consequently, some psychological disturbances, such as mid life crises may be introduced by practices such as intensive meditation, if appropriately mediated, can result in a higher level of functioning than before the initial crisis began. Grof identified this list of varieties of spiritual emergencies: (1) The shamanic crisis, (2) The awakening of the Kundalini, (3) Episodes of unitive consciousness, ("peak experiences"), (4) Psychological renewal through return to center, (5) The crisis of psychic opening, (6) Past life experiences, (7) Communications with spirit guides and "channeling," (8) Near death experiences, (9) Experiences of close encounters with UFOs, (10) Possession states. Transpersonal psychology clearly addresses the spiritual problems and ultimately the breakthrough

experience and stage five- of the definition from Moody. It may not be palatable to certain clients with certain monotheistic backgrounds like: Christian, Jewish, Islamic, due to its emphasis on eastern philosophy and psychology.

Jungian therapy as an alternative therapy. Jung has been an important figure in religious psychotherapy because of his contention that religious symbols are reflected in all of religions of the world (Propst, 1988). He maintains that these symbols arise from the unconscious to perform an integrating function in our lives. Jung's use of symbols has drawn a dynamic connection between emotional healing and spirituality. Jung believed in a teleological basis to his therapy (that is, a passive waiting for the unconscious.) Dreams are part of the awareness that emerges from the depths of the unconscious. Dreams, according to Jung, have had an important role to all peoples. Jung works with the idea of the shadow, or recognizing the opposite in one's own personality. Jungian therapists work with dreams helping people to prepare themselves for events in the future, and also serving as a compensatory function. Dreams work to bring about a balance between opposites in the person. Jung maintained that our personality is determined by who, and what we have been, and also by the person we hope to become (Corey, 1996). His theory of self- actualization is future oriented. Achieving individuation or the harmonious integration of the conscious and unconscious aspects of personality is viewed as the innate and primary goal in Jungian therapy. Carl Jung wrote "The Stages of Life" (1955) to describe a spiritual sequence in the life course. Jung points out how an "inexorable inner process" takes place when people reach 35 or 40.

> Youthful illusions are shed. Repressed childhood ideals resurface. Early interests and ambitions lose their fascination and more mature ones take their place. A person gropes toward wisdom and a search for enduring personal values begins. Either we begin a quest for meaning at midlife or we become simply an applauder of the past. (Moody, 1997, p.29)

Jungian therapy in conjunction with shamanism is advocated as choice of acceptable therapy by Duran&Duran (1995) for Native Americans because it supports process thinking as opposed to content thinking found in the Western world. It supports the idea of mind body and spirit being one. It also supports the idea of being one with the creation.

Discussion

Propst, Ostrom, Watkins, Dean and Mashburn (1992) demonstrated that non-spiritual/ religious therapists actually did significantly better with religious cognitive therapy than all of the other groups. Propst demonstrated that non-religious counselors could advantageously work with spiritual issues and in fact work with religious cognitive therapy. Salvation is a point of issue on which clients and therapists differed significantly (Propst, Ostrom, Watkins, Dean & Mashburn, 1992). This difference in values indicates that patient/ therapist outcome is directly related to the match of significant values in certain cases. McCullough and Worthington (1994) indicate the highly religious client would be more likely to do better in counseling and less likely to drop out when matched with a counselor with similar values. Propst (1992) advocated that cognitive therapy can be used with other faiths. Kelly (2003) indicated that there are a large number of counselors who value spirituality and religion so that the likelihood of spiritual/religious

clients receiving counseling explicitly attuned to the religious dimension is increased. The odds are good for a good client/counselor match if one has a spiritual/religious issue or if one is a spiritual or religious person in need of counseling. However, the more spiritual or religious the client is; the more increased the need for a counselor more in tune with that client's values.

Twelve-Step use of spirituality in alcohol or drug abuse therapy with addictions builds on the distinct spiritual belief system of the client. Leahy (2004) advocates a dovetail use of cognitive therapy. Cognitive therapy is not expected to replace the Twelve- Step therapy with alcohol and drug addictions, it is intended to add to the client's self efficacy and to add to their cognitive belief about their relationship with substances, the nature of the cravings and the risks involved with substance abuse (Leahey, 2004; Newman, 2004).

Another area where cognitive therapy may not be the therapy of choice in spiritual issues was demonstrated by the lack of ability of American therapists to provide successful counseling/therapy to a Hmong immigrant. Duran &Duran (1995) makes a case against the approach of western therapy because it involves giving up power and allowing the client to become empowered based on Carl Roger's Client-Centered Therapy (1942). Client empowerment is a concept central to western therapeutic relationships excepting psychoanalysis. The whole concept of individual autonomy and controlling one's destiny may not be acceptable to many cultures. It may not even be acceptable to highly religious clients in American culture. This idea of personal freedom is actually a pivotal point for the application of cognitive therapy.

Non-western forms of healing have a more holistic outlook with belief strongly in the unity of the spirit, mind, and matter (Garret et al., 1994). Grof (The Spiritual Emergency, 1989) makes a case against traditional western psychiatry and psychology that dominates American culture. Grof advocates Eastern psychology and eastern religious thought as being more congruent with Buddhist and Hindu thought.

Some of the possible alternatives to cognitive therapy that were considered were Existentialism, because of its focus on spiritual values and lack of strategies and techniques so that the spiritual issues purpose and meaning, would be foremost in therapy. Existentialism does emphasize personal freedoms and making choices, which is a Western notion. It does emphasize self-transcendence.

Jungian therapy as an alternative to cognitive therapy was considered because of the global spiritual appeal of Jung's archetypal symbols, dream work, and teleological approach (that is, the unconscious waiting to unfold). Jung developed a spiritual approach that places great emphasis on being impelled to find meaning in life rather than being driven by psychological and biological factors (Corey, 1996). Jung's ideas clearly look at life as a spiritual application. Jungian therapists deal with the psyche in crisis in terms of a renewal process. They deal with symbols of self in turmoil and confusion, visionary states- like the sacred marriage, and transcendence. The Jungian renewal process moving toward individuation might be a viable therapy for use with Harry Moody's Five Stages of the Soul.

Transpersonal psychology was also considered as an alternative therapy because it acknowledges the breakthrough spiritual stage and the struggles of spiritual seekers. It serves Hindu, Buddhist, and Eastern thought with mind body and soul concepts.

Transpersonal Psychology in its acceptance of an "all roads lead to God" ideal, alienates monotheistic thought like Christian, Judaic, and Moslem faiths that are unaccepting of this concept.

Cognitive therapy fared well therapeutically when evaluated for therapeutic performance ability placed next to Harry Moody's Five Spiritual Stages. Propst was able to effectively demonstrate the merits of cognitive therapy in answering the call, starting the search and engaging in the struggle. The lack of research in therapeutically dealing with breakthrough experiences indicates what seems a limitation of cognitive therapy to focus only on pathology and a lack of recognition of the unconscious and other modes of consciousness. Cognitive therapy deals with the statements of the mind. It looks at messages that the mind is sending to self. Regardless of whether the messages are spiritual messages or distorted messages the therapist should be accepting of the client's phenomenological world. To use a hypothetical example, if a client like- Joseph Smith (founder of the Latter Day Saints of America) came to therapy troubled over a vision that God and Jesus had visited him and told him that he should found a church (Brodie, 1972); one wonders if the cognitive therapist would be effectively able to work with him. One would question if the therapist would look for pathology or examine his prophetic vision for faulty thinking?

Smith would be considered a highly religious client requiring a counselor with equal religious values to be effective (Corey, 1995). Based on cultural counseling format, a counselor would advise the client to talk with their religious leader about the vision, and the therapist would get a consult for himself/herself. If Smith arrived at therapy troubled about his first vision, therapy would be orientated toward Smith's cognitions: the major

determinants of how he was feeling and acting. The philosophy of cognitive therapy is that individuals tend to incorporate faulty thinking, which leads to emotional and behavioral disturbances. Therefore, Smith would be challenged to confront faulty beliefs with contradictory evidence that he and the therapist would collaboratively gather and evaluate. Therapy would work to help Smith seek out his dogmatic thoughts and vigorously minimize them. Smith would be asked to keep a journal of his automatic thoughts and to change them if they were based on faulty beliefs. The therapist would promote corrective experiences that lead to new learning skills.

A spiritually oriented counselor might be able to look at Smith's prophetic vision as an example of a higher call and investigate the nature of a higher call. Since the philosophy of cognitive therapy assumes that there is some faulty thinking going on, it would be imperative to establish some kind of understanding regarding Smith's faith regarding prophetic visions before cognitive therapy could move forward. Without an understanding of Smith's spirituality he could easily be perceived as delusional or hallucinating, and the therapist would be looking for distortions.

Conclusion

The more deeply and extensively a counselor explores the dimension of spirituality with a client, the more expert the counselor must be in the area of the client's spirituality. Counselors who are willing to work with clients on issues of spirituality or willing to work with spiritual/ religious clients need to have clear written ethics regarding the nature of the spirituality and exactly what practices are acceptable in a clinical setting and by their licensing organization. Many spiritual issues are closely linked with cultural issues, so that spiritual issues may need to be treated like working with a client from

another culture. Counselors need to be mindful of using referral sources to ministers, rabbis, shamans, priests, and other spiritual leaders. Counselors need to be willing to increase their knowledge of each spiritual situation and consult spiritual leaders when they are out of their area of expertise.

Cognitive therapists should be able to work with religious/ spiritual types of clients and should be able to work with issues like the call, the search, the struggle, the breakthrough and beyond. Research and practice (Propst, 1992; 1988) supports use of cognitive therapy in the call, the search and the struggle and in the service of giving back to others. Cognitive therapy research and practice lacks research and literature regarding the breakthrough or peak experience. In this case an alternative therapy or even a dovetail therapy that works in tandem for use with the breakthrough experience might be Jungian or Transpersonal Psychology.

Cognitive therapy does not claim to be a holistic experience large enough to address mind, body, and spirit. Cognitive therapy addresses pathology and distorted thoughts. Although it seems to occupy a parallel path to spirituality its main goal is a healing goal, whereas spiritual goals are found along the five stages of life. Working with a spiritual client or spiritual issue cognitive therapy can be an effective healing experience.

Recommendations

The central idea of cognitive therapy, to examine one's automatic thoughts is viable to many modes of spirituality. The notion that a person has the freedom and ability to make changes is a very western idea and may not be acceptable for individuals of other cultural or spiritual orientations. Consideration should be given to the idea of dovetailing

therapies that include elements from other therapeutic orientations that are more adaptable to meeting certain spiritual needs in the same way that cognitive theory works with the twelve- step theory using of a person's "higher power" while working with their thought process to change their thoughts regarding alcohol. Once this increased collaboration has taken place between cognitive therapy and other therapies that embrace spirituality, increased research into the area of peak experiences is recommended. Failure to research the peak experience indicates a possible lack of understanding for the significance of the peak experience, lack of ability to use the peak experience with cognitive therapy, or the possibility that a blind spot may exist in American culture regarding spirituality.

Increased research is essential to determine if issues of spirituality are handled differently in American culture. Research by Kelly, (1994b) Sansone, Khatain and Rodenhauser, (1990) and Shafransky & Maloney (1990b) implied that American culture had a blind spot called passive neutrality in the area of spirituality which makes current data on the whole topic skewed. If this blind spot exists, increasing need should be placed on all therapists to become trained to see all areas of individual need and to increase awareness of their own cultural shortsightedness. In conclusion, cognitive therapists working in collaboration with spiritual friendly therapies need to research cognitive therapy and peak experiences. Research on the implied cultural blind spot should be pursued to ensure that all clients entering into cognitive therapy are treated in the most holistic and client centered manner possible.

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