2012

Counseling and Psychotherapy Within and Across Faith Traditions (Chapter 17 in The Oxford Handbook of the Psychology of Spirituality)

Mark R. McMinn
George Fox University, mmcminn@georgefox.ed

CHAPTER

17 Counseling and Psychotherapy Within and Across Faith Traditions

Mark R. McMinn, Kimberly N. Snow, *and* Justin J. Orton

Abstract

This chapter begins with general considerations for religiously and spiritually oriented psychotherapy, including the importance of seeing religion and spirituality as dimensions of cultural diversity, considering clients' welfare and autonomy, and maintaining competence. Three types of religious and spiritual intervention approaches are then discussed: assimilative, accommodative, and collaborative. Assimilative approaches introduce spiritual interventions or considerations into a standard psychotherapy approach. Accommodative approaches involve adapting a standard psychotherapy regimen to include religious or spiritual matters. Collaborative approaches entail a mental health professional and religious leader working in tandem for the sake of clients' welfare. Next, specific issues related to counseling within (when the client and counselor share the same beliefs) and across (when the client and counselor hold differing beliefs) faith traditions are offered. The chapter concludes with some thoughts regarding future directions of religious and spiritual interventions in counseling and psychotherapy.

Key Words: religion, spirituality, religious counseling, spiritual issues in psychotherapy, religious diversity, religiously accommodative psychotherapy, psychology-clergy collaboration

Introduction

With five minutes remaining in our final session, a psychotherapy client asked me (Snow), "So what do you think about me and God?" The majority of our sessions had been spent discussing specific sources of anxiety, concerns about the future, and ways of coping with these fears. My mind traveled back to conversations early on in therapy regarding my client's religious struggles, including some feelings of frustration and disappointment with God. Now in the waning moments of our sessions together he chose to broach the topic once more. It struck me that perhaps there was a well of unprocessed material waiting to be tapped, beliefs and values waiting to be uncovered—a vast driving force in my client's life. But then again, maybe my client's question reflected his comfort with me, as he chose to ponder issues of ultimate meaning even during the final moments of our therapeutic work together. Perhaps his question was a measure of some success, suggesting that in treating his anxiety I had also helped him feel comfortable pondering profound questions about faith and his experience with the Divine.

As with the client described in this anecdote, most people who seek the services of counselors and psychotherapists have spiritual experiences and beliefs (Gallup Polls, 2009), they look to religion as they cope with life challenges (Pargament, 1997, 2007), and they face ultimate concerns that involve religion and spirituality (Emmons, 1999). Even with religion becoming less important to US residents over the past 15 years, 80% still report religion to be very important or fairly important to them, down from 87% in 1992. In 2008, 61% still

belonged to a church or synagogue and 38% had attended services in the past 7 days (Gallup Polls, 2009). An additional portion of people—perhaps as many as one-third of all US residents—describe themselves as spiritual but not religious (Gallup, 2003).

Given the prominence of religion and spirituality in society, it is wise for mental health professionals to understand something about their clients' religious and spiritual beliefs and behaviors in order to provide effective assessment and treatment. But this is not to suggest that counselors and psychotherapists should be religious advisors, pastoral counselors, or spiritual directors. Although some overlap exists, the goals and methods of mental health counseling and psychotherapy are distinct from the goals and methods of spiritual interventions, and these distinctions ought to be respected and maintained (Gonsiorek, Richards, Pargament, & McMinn, 2009). Herein lies a major challenge facing contemporary mental health professionals, and a substantial challenge facing us as authors of this chapter: How do we embrace the importance of understanding spiritual and religious issues while still affirming the distinct contribution of mental health training and practice?

In this chapter, we first suggest several general considerations, including culture, client welfare, client autonomy, and therapist competence. Next, we look at existing interventions and describe three possible approaches: assimilative, accommodative, and collaborative. Then we turn our attention to counseling when the counselor and client share the same faith. Finally, we consider counseling when the counselor and client have different faiths.

General Considerations for Counseling Within and Across Faith Traditions

Religion and Spirituality as a Cultural Issue

Over the past several decades counselors and psychotherapists have become increasingly aware of the importance of understanding the cultural diversity among their clients (Sue & Sue, 2007). Every client, and every therapist, is shaped by the mores, assumptions, and values emerging from her or his ethnic and cultural communities. I (McMinn) recall working with a client many years ago who reported feeling like an incomplete woman because of her hysterectomy. After several weeks of using standard cognitive therapy strategies to help her see her situation differently, my supervisor pointed out that her beliefs about womanhood may actually be closely tied to the cultural community that helped define her throughout the 167 hours each week that were not spent in my office. One hour per week in my office could not compete with powerful cultural messages that helped define her, nor was it fitting for me to try to compete with the community that helped her find hope and meaning and sustained her through challenging life situations. It was only when I recognized my cultural insensitivity (with the help of my supervisor), apologized to my client, and began helping her evaluate her beliefs in a more culturally inclusive manner that she made progress in therapy.

In the same way, religious and spiritual issues are often powerful influences for counseling and psychotherapy clients. If overlooked, the results of our interventions may be compromised, or even damaging to clients. Consider something as basic as the definition of health. An agnostic cognitive-behavioral therapist may see health as the capacity to reinterpret difficult life situations without letting the situations become too upsetting. In contrast, a devout Buddhist or Hindu client may desire to accept suffering as an inevitable part of living, and ultimately to transcend suffering through spiritual practices and the wisdom gained from spiritual mentors. A devout Jewish, Christian, or Muslim client may see health as the ability to maintain faith and find meaning in the midst of suffering.

Just as it is important for mental health professionals to know basic information about different cultures and ethnicities, so also it is important to have basic knowledge of different religious systems, spiritual beliefs, and practices. This basic knowledge can be obtained through taking a world religions course or reading a world religions text, by having open conversations with friends and acquaintances about their spiritual beliefs and practices, by attending workshops and seminars on religious and spiritual issues in psychotherapy, or by getting supervised training on the topic.

One challenge in learning about culture in psychotherapy is not to overgeneralize. For example, a therapist learning about Asian American culture may start assuming that all Asian American clients have communitarian values, emphasize achievement and diligence, avoid bringing shame to their families, and so on. But, of course, there are many cultures in Asia, various levels of acculturation to consider, and individual differences from one client to another. It would be a mistake to assume too much based on general knowledge of cultural categories. In the same way, knowing about religious systems can easily lead to overgeneralizations and

faulty conclusions. It is important to recognize vast diversity within every major faith tradition, and to realize there is a good deal of individual variation in how people experience and express their faith-related beliefs.

Ms. Davison comes for psychotherapy because of a persistent generalized anxiety disorder that contributes to insomnia, inhibits her relationships, and leads to feelings of dread and apprehension about the future. She and her psychotherapist set goals for the first session—to learn ways to manage and reduce her feelings of anxiety, to establish closer relationships with family members and colleagues at work, to reduce her tendency toward perfectionism, and to sleep better as she learns to manage her anxiety. In the middle of the first session, Ms. Davison mentions that she is an elder at the Presbyterian church she attends, and that she would like a therapy approach that is respectful of her faith.

As the psychotherapist ponders the best treatment for Ms. Davison, it will be important to consider something about her religious faith, both in terms of understanding the basic themes of the Christian faith, and also in terms of the individual nuances of her particular faith experience. Christians generally believe in an afterlife, and they seek to live in a way that reflects the example of Jesus Christ. Perhaps Ms. Davison puts a good deal of pressure on herself to be perfect, and then feels defeated and anxious when she falls short of these lofty standards. But then again, Presbyterian theology emphasizes that good works can never earn approval with God—that is only accomplished by God's undeserved favor. So perhaps Ms. Davison's faith is actually a protective factor that keeps her from even greater levels of perfectionism and anxiety. And it will be important to consider that she is an elder in the church. What does her leadership role in a faith community say about the levels of stress she experiences, about the respect she garners in relationships, about how much weakness and struggle she can reveal to others in her faith community, and about her capacity to manage stress? What sort of gender issues might arise with being a woman leader in a religion that generally has male leaders? All these matters, and more, are worth exploring in the context of counseling.

Client Welfare

One of the most fundamental principles of professional psychologists and other health professionals is that we promote the welfare of our clients. This is foremost in the mental health practitioner's mind, just as it is foremost in our ethical standards. The beginning words of ethics Principle A for psychologists read, "Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons..." (American Psychological Association [APA], 2002, p. 1062).

Client welfare is important to consider when counseling within and across faith traditions. On one hand, because faith-related beliefs and practices are held as important to many clients, and because these beliefs and practices often enhance a person's well-being, it is important for mental health professionals to be respectful rather than dismissive when religious and spiritual issues come up in therapy. On the other hand, some religious and spiritual beliefs can be damaging to self and others, so at times it is important for mental health professionals to help clients think incisively about their various beliefs and practices. Both the positive and negative dimensions of religion and spirituality must be considered.

POSITIVE DIMENSIONS OF RELIGION AND SPIRITUALITY

For many years, it was common to hear or read psychologists' disparaging comments about religion (e.g., Ellis, 1962, 1971, 1983). But the tide has shifted. Many respected professionals, both religious and nonreligious, have made the study of religion and spirituality and health an established field within social science (see Miller & Thoresen, 2003; Powell, Shahabi, & Thoresen, 2003; Seeman, Dubin, & Seeman, 2003). Going along with this trend, the fields of counseling and professional psychology have become more open to religion and spirituality, both as an important diversity issue, and further, as a potential benefit to client health (Aten & Leach, 2009; Miller & Delaney, 2005; Pargament, 2007; Richards & Bergin, 2005; Shafranske, 1996; Sperry & Shafranske, 2005). We approach this topic with the assumption that religion may bring potential benefits to client health and wholeness.

This assumption has been supported by recent research suggesting that the relationship between religion and health is strikingly positive in terms of its average effects at the population level (see Koenig, McCullough, & Larson, 2001; Priester, Khalili, & Luvathingal, 2009). Epidemiological studies on the effects of religion on health and morbidity have explored both preventive and curative effects of religion and spirituality (for reviews of these

findings and related measurement issues, see Hill & Pargament, 2003; Koenig et al., 2001; Miller & Thoresen, 2003). Religion's benefits extend to both physical and mental dimensions of health and well-being. While a majority of this research has focused on Christianity, the benefits of other religious faiths and nonreligious forms of spirituality have been supported as well.

There are several dimensions of religious life that may affect a person's understanding of health—either implicitly or explicitly—and engagement in healthful activities. First, religious and spiritual systems often help people make meaning of life, including the difficult aspects of life (Slattery & Park, 2011). Religious meaning is often promoted by associations with particular faith-based institutions, clergy, and by the sacred texts and traditions associated with the faith. For example, members of various religious institutions are taught to seek maturity in living through dedication to a purposeful life; among the various behaviors that may be emphasized are social action, altruistic behavior, peace seeking, forgiveness, community involvement, abstinent lifestyle, and relationship fidelity. Altruistic and prosocial behaviors have positive effects on mental health (Post, 2005; Schwartz, Meisenhelder, Ma, & Reed, 2002) while also serving the well-being of society as a whole. Other religious and spiritual traditions may emphasize seeking transcendence, and cultivation of an interior relationship with the divine. For those who are intrinsically religious, relationship with God is a powerful motivating force behind outward behavior. This meaning-making dimension of faith is often important to consider in working with religious and spiritual clients,

Second, being a member of a religious or spiritual community provides a social support network for adherents that should not be underestimated. Religious social support can offer clients valuable relationships; a socially transmitted understanding of their faith beliefs; shared experience of rituals related to coming of age, partnering, and death; and access to communal spiritual activities such as collective prayer and worship. In times of stress, religious activities can be positive forms of coping, whether practiced individually or with a group, offering people meaning and hope when facing either life trauma or everyday stressors (see Pargament, 1997, for an extensive review of religious coping).

Third, religious resources may be sources of help in the midst of life troubles. Many clergy spend a substantial amount of time counseling parishioners (Weaver, 1995), and many are open to collaborating with mental health workers (Benes, Walsh, McMinn, Dominguez, & Aikins, 2000; Edwards, Lim, McMinn, & Dominguez, 1999; Lish, McMinn, Fitzsimmons, & Root, 2003; McMinn, Aikins, & Lish, 2003; McMinn, Chaddock, Edwards, Lim, & Campbell, 1998). There is also a substantial amount of religious and spiritual self-help material available in bookstores, some of which has been written by counseling and psychology professionals and may prove very useful for bibliotherapy. And sacred texts can also be useful for self-help and bibliotherapy purposes. Paradoxically, one of the most vocal opponents of religion in professional psychology—Albert Ellis—conceded that "the Judeo-Christian Bible is a self-help book that has probably enabled more people to make more extensive and intensive personality and behavioral changes than all professional therapists combined" (Ellis, 1993, p. 336). Interestingly, Ellis even went on to coauthor a book addressing how to effectively use rational emotive behavior therapy with religious clients, respecting their beliefs and even incorporating scripture in the counseling process (Nielsen, Johnson, & Ellis, 2001). A number of accommodating approaches to therapy such as this one have been developed. Research has generally supported these approaches as similarly effective as nonaccommodating approaches, with the potential benefit of increasing client cooperation (McCullough, 1999).

The literature at this time clearly supports a positive link between religion and spirituality and health. Some researchers have suggested that the relationship is mediated by various factors; still, other researchers suggest that the benefits of religion and spirituality may extend beyond any mediating factors, being intrinsically tied to the very nature of religion and spirituality (see Hill & Pargament, 2003). It is possible that perceived closeness with God, as viewed from an attachment perspective, may be its own predictor of health (see Hill & Pargament, 2003). It is important to remember that degree of religiosity or spirituality will differ from client to client and, therefore, potential benefits of incorporating faith into the therapy process will have to be assessed on an individual basis.

As practitioners, then, it behooves us to understand how our clients benefit from their religious and spiritual practices. It is possible that the faith of our clients can contribute to positive therapeutic outcomes in a variety of ways—by fueling a desire and motivation for well-being, and by offering many potential resources that can be both psychologically and spiritually nurturing.

NEGATIVE DIMENSIONS OF RELIGION AND SPIRITUALITY

Although the historical tendency of the psychological community to declare spiritual beliefs and practices as harmful is reversing, religion and spirituality continue to be marginal concepts in academic and clinical settings (Young, Cashwell, Wiggins-Frame, & Belaire, 2002). Even among mental health professionals who accept the potential positive impact of spiritual and religious beliefs on the well-being of clients, there often remains reservation concerning some mainstream religious beliefs (O'Connor & Vandenberg, 2005). Though Ellis (2000) acknowledged the potential positive influence of spirituality and religion late in his career, and even coauthored a book on the topic (Nielsen et al., 2001), he continued to warn against a number of potential drawbacks. He wrote that those who accept spiritual and religious systems are at risk for prejudice and dubious mental-emotional health (Ellis, 1999, 2000; Ellis & Harper, 1997), ego inflation and conditional self-acceptance (Ellis, 2000), as well as extreme obsession that leads to poor self-care (Ellis, 2000; Ellis & Harper 1997; Ellis & MacLaren, 1998). Ellis's warnings against the potential negative consequences of holding religious and spiritual beliefs are neither unique (e.g., Greene, 2008) nor unsupported. Hood, Spilka, Hunsberger, and Gorsuch (1996) demonstrate that religiosity in the United States is indeed linked to rigid thinking, prejudice, and narrow-mindedness. Pargament, Kennell, Hathaway, and Grevengoed (1988) reported a pattern of passive religious coping that is linked to lower self-esteem, lower personal control, poorer problem-solving skills, and a greater intolerance for differences between people, and subsequent studies have found similar results (Hathaway & Pargament, 1990; McIntosh & Spilka, 1990; Schaefer & Gorsuch, 1991).

Moreover, highly religious individuals and those in spiritual distress may have negative anticipations of counseling in general and especially with nonreligious counselors (Keating & Fretz, 1990). And although those with intrinsic faith commitments tend to be less prone to depression and hostility than others, those with extrinsic and prosocial approaches to faith have increased risk of physical complaints and psychological distress (Hackney & Sanders, 2003; Salsman & Carlson, 2005).

One of us (Orton) once saw a client whom we will call Joe. He was a model Marine sergeant—muscular, dedicated, and seemingly fearless. Joe's troops saw him as unshakable. Unbeknownst to his subordinates, Joe cried himself to sleep nearly every night, terrified that he was going to hell. No matter how much Joe tried to live up to his lofty spiritual standards, at the end of each day he knew he had failed. Failure, Joe's religious convictions taught, was inevitability met by terrible wrath. The man, who was so confident before others, was reduced to a weeping hulk when faced with the belief that God was against him. Joe's struggle highlights the reality that not all religious and spiritual experiences promote client welfare. Joe's pervasive experience of spiritual failure is not uncommon, as spiritual and religious distress often includes struggles with religious and moral guilt (Kennedy, 1999; Lukoff, Lu, & Turner, 1998), as well as anger toward God (Fitchett, Rybarczyk, DeMarco, & Nichols, 1999).

For clinicians committed to their client's welfare, these findings about negative religious experiences are concerning, especially because they are associated with poor health outcomes (Fitchett et al., 1999; McCullough, Hoyt, Larson, Koenig, & Thorsesen, 2000; Pargament, Koenig, Tarakeshwar, & Hahn, 2001). Johnson and Hayes (2003, p. 417) reported that clients with religious or spiritual concerns are "25% more likely than other clients to experience distress related to sexual concerns, 22%–29% more likely to experience distress related to relationships with peers, 34%–37% more likely to be concerned about thought of being punished for ones sins, and nearly twice as likely as other clients to be confused about their beliefs and values." Some conservative religious beliefs also contribute to internalized homophobia, which can be damaging to gay, lesbian, and bisexual clients (Bartoli & Gillem, 2008; Beckstead, 2001).

When considering client welfare, it is important to recognize both the positive and negative dimensions of religion and spirituality. Religious and spiritual beliefs can sustain and enhance mental health in difficult times, and they can also lead to distress and despair (Plante, 2011). Discerning the difference is one of the challenges of effective clinical work.

Client Autonomy

Psychotherapists have an ethical obligation to respect the autonomy and dignity of counseling and psychotherapy clients. The APA (2002) ethics code states:

> Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination... Psychologists are aware of and respect cultural, individual, and role

differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.
(p. 1063)

This ethics principle serves as a reminder that religious persuasion is typically not the goal of mental health interventions. When religious values are discussed, it is within a context of affirming the client's right to self-determination. Consider the following case example:

Melissa is a 17-year-old high school student seeking help for depression. She discloses to her therapist that she is pregnant and trying to decide how to tell her parents. The following session, Melissa reports that she mustered the courage to tell her parents, who responded lovingly and supportively. They are suggesting that Melissa terminate the pregnancy. This seems like a good idea to Melissa also, but she wonders if she might regret the decision later. The father of the child wants nothing to do with Melissa or the decision about whether to abort the fetus. The counselor schedules a family session with Melissa and her parents to discuss the situation, and in the process he asks about religious values regarding abortion. Melissa does not identify with any religion. Her parents report being Catholic, but they state that they have lapsed from their faith and that this is not an important consideration. Melissa and her parents leave the session in agreement that abortion is the best option. This creates inner turmoil for the counselor, who is a committed Roman Catholic and opposed to abortion.

As difficult as this situation may be for the counselor, the client's autonomy remains a guiding principle for ethical counseling and a distinguishing feature between mental health counseling and religious guidance. The counselor is correct to assess religious values during the family session, and the counselor is also correct to grant Melissa—in consultation with her family—self-determination in the choice she faces. Likewise, if the roles were reversed—with a counselor who believed abortion to be the best option and a teenager who chose to give birth because of moral objections to abortion—then the counselor would likewise be obligated to be respectful of the client's values and autonomy.

Client autonomy should not be confused with unrealistic efforts to remove all persuasive influence from counseling and psychotherapy. Virtually all counseling and psychotherapy involves exerting influence. For example, a couples therapist may help a person become more communicative and assertive in a relationship, even if the person initially does not see any reason to change. An individual psychotherapist may empower a depressed client to exercise more frequently or use stress-provoking exposure techniques to treat a client with an anxiety disorder. An addictions counselor might help a client acknowledge a problem with alcohol abuse. Exerting influence is a common part of counseling and psychotherapy, but within the context of informed consent and in a way that is respectful of the client's self-determination and autonomy. Efforts to persuade a client to change religious viewpoints are generally discouraged in counseling and psychotherapy, and they may only be appropriate in certain situations. For example, if a psychotherapist is convinced that a client's religious views are causing damage to the client or others, then some level of persuasion might be fitting, but only if the psychotherapist's intent is described in the treatment consent form, if the religious change is clearly associated with a mental health outcome, and if the religious issues are discussed in a relational context where the client feels fully respected and accepted regardless of the outcome of the conversation.

Therapist Competence

The final general consideration discussed here pertains to therapist competence. As is true with any area of specialty or multicultural practice, competence in handling religious and spiritual issues requires adequate training, experience, and sensitivity. Consider the following situation:

You are working as a psychologist at a university teaching hospital. Much of your work involves consulting with physicians on medical/surgical floors and in outpatient clinics. Today you are called to an inpatient neonatal unit to visit with Ms. Ayer, a 26-year-old, first-generation Sikh immigrant from Punjab who recently gave birth to her first child, a 3-pound baby girl. Ms. Ayer has been commuting to the hospital each day to be with her child. The neonatal pediatrician who talks with Ms. Ayer frequently is concerned that she may be experiencing postpartum depression. The purpose of your consultation is to help the pediatrician determine whether Ms. Ayer is depressed and, if so, to recommend an appropriate treatment.

It is unlikely that the hospital in this situation employs a Sikh psychologist, so matching the religious values of client and therapist will not be possible. Still, the psychologist bears responsibility to be informed and respectful regarding the client's religious and spiritual values.

Hathaway and Ripley (2009) have provided a thoughtful list of "preliminary practice guidelines when working with religious and spiritual issues" (p. 46). They divide these guidelines into three areas: assessment guidelines, intervention guidelines, and multicultural/diversity guidelines. Notice that all three of these areas are relevant in the previous example of working with a Sikh immigrant who may be experiencing symptoms of postpartum depression.

Among the assessment suggestions, Hathaway and Ripley (2009) emphasize attentiveness to spiritual and religious concerns, including screening questions for all clients as well as more extensive assessment when spiritual and religious issues are particularly salient (see also Richards & Bergin, 2005). They also emphasize the importance of learning what is normative for a particular religious group so that a client's particular beliefs and behaviors can be interpreted in light of normative faith practices. In assessing Ms. Ayer, it will be important to know how closely she identifies with the Sikh faith, what immigrating to another country means about her connection to family and faith community, whether the father of the child is still part of her life, and, if so, the nature of that relationship. It will also be helpful to know the meaning of her giving birth to a girl, and how depression is viewed within her Punjabi culture and among others of similar faith.

Regarding intervention, it is important to seek client consent before using spiritually oriented interventions while also recognizing that established evidence-based interventions should be preferred over untested spiritually oriented interventions and that religious and spiritual treatment goals should always be relevant to the primary mental health treatment goals. With devout clients, competent therapists should understand and attempt to accommodate the client's spiritual and religious beliefs while not compromising the integrity of the treatment being offered. Also, it is important to recognize that religious and spiritual interventions may be harmful in some situations, such as working with a psychotic client who is having religious delusions (Hathaway & Ripley, 2009). If a psychologist were to offer treatment to the client in the previous case example, it would be important that the primary goals of treatment be focused on mental health (e.g., treatment of postpartum depression) rather than on religious education or spiritual transformation. Religious and spiritual beliefs may be a frequent topic of conversation throughout the intervention, and perhaps some spiritually oriented techniques would be used, but the primary goals and methods of treatment would remain focused on mental health issues.

Finally, Hathaway and Ripley's (2009) multicultural/diversity suggestions emphasize that psychologists learn about clients' religious and spiritual values, that psychologists gain self-awareness of their own beliefs and values and do not coerce or impose their values on clients, and that psychologists be wise about whether to disclose their religious and spiritual views to clients. Hathaway and Ripley also state the importance of obtaining continuing education, supervision, and consultation, and encourage psychologists to recognize the complexity of religious and spiritual variables in relation to other areas of diversity such as sexual orientation, age, gender, and so on. In the previous example, it will be important for the psychologist to consider how giving birth to a female child may affect Ms. Ayer's perceptions of parenting, her relationship with the child's father, and others in her family and social support network.

We have offered four general considerations here—religion and spirituality as a cultural issue, welfare of the client, client autonomy, and therapist competence. These set a context for considering particular intervention approaches when counseling within and across faith traditions.

Intervention Approaches

Religion and spirituality may be integrated into counseling and psychotherapy in a variety of ways, making any taxonomy likely to minimize the creative and artistic aspects of mental health professionals' work. Still, taxonomies can be useful in order to consider the range of possible interventions and the place that each gives to religion and spirituality. We suggest three general types of approaches: assimilative, accommodative, and collaborative.

Assimilative Approaches

Therapists may choose to assimilate spiritual interventions in the context of a standard psychotherapy intervention. For example, a counselor may encourage an anxious client to engage in spiritual journaling (Frame, 2003; Wiggins, 2011) though the majority of each session is devoted to standard

therapeutic activities such as cognitive restructuring, exposure treatments, considering developmental issues, exploring emotions, discussing past and current relationships, and so on. The spiritual intervention—journaling, in this case—is not the main focus of treatment, but it allows a client to consider how religious and spiritual matters may relate to symptom patterns and the other material being explored in the context of counseling. Schlosser and Safran (2009) provide a list of many spiritual interventions that can be employed in mental health treatment, including forgiveness, prayer, spiritual history, spiritual genograms, spiritual relaxation, and so on; and Aten, McMinn, and Worthington (2011) provide a more intensive exploration of several spiritual interventions. Some of these treatment methods can be assimilated into standard treatment, while others require that the treatment itself be altered to make intentional use of religious and spiritual interventions. Altering a treatment because of religious and spiritual considerations is considered an accommodative approach.

Accommodative Approaches

Whereas an assimilative approach may draw upon spiritual interventions from time to time, accommodative approaches are those that have been transformed by the integration of religious and spiritual principles and methods. Schlosser and Safran (2009) distinguish between spiritually accommodative approaches and spiritually oriented approaches, both of which would fall under our domain of accommodative approaches.

Spiritually accommodative approaches tend to be standard treatment protocols—often manualized treatments—that have been altered to incorporate a particular religious or spiritual approach. The most common example of this is cognitive-behavioral therapy that has been adapted for Christian clients, though cognitive-behavioral therapy has also been adapted for Muslim clients (Hook et al., 2010; Schlosser & Safran, 2009). For example, religious imagery may be used instead of standard imagery, and sacred writings may be used to help identify and correct dysfunctional thought patterns.

Schlosser and Safran (2009) describe spiritually oriented approaches as "less standardized and more inclusive" than spiritually accommodative approaches (p. 200). For example, a spiritually oriented approach can be seen in Benner's (2005) provocative model for integrating insight-oriented psychotherapy with spiritual direction, in Sperry's (2005) Integrative Spiritually Oriented Psychotherapy, and in Richards and Bergin's (2005) Theistic-Integrative Psychotherapy. None of these approaches use treatment manuals, but rather they discuss how religious and spiritual worldviews and methods can be incorporated into the overall approach that a mental health professional employs.

Collaborative Approaches

A third category involves the collaboration of mental health professionals and religious leaders (Benes et al., 2000; Edwards et al., 1999; McMinn et al., 2003). Rather than assuming that a mental health professional can address the various spiritual and religious needs of their clients, the collaborative approach assumes that a religious leader or spiritual expert—typically someone who is already part of the client's life—can provide important guidance and support in the process of treatment. For example:

> *A nonreligious counselor sees a married couple to help improve their relationship. Both husband and wife are Muslim. In the first session, it becomes clear to the counselor that certain religious issues are likely to affect the process and outcome of treatment. For example, the counselor does not feel adequately prepared to fully understand the couple's view of gender roles and sexuality. The counselor asks the husband and wife for written authorization to discuss basic treatment progress and questions about faith with the imam at the mosque where they attend. Both partners sign the authorization and express appreciation that their faith will be respected in the process of treatment.*

As this example illustrates, when a counselor or psychotherapist lacks expertise in particular religious or spiritual beliefs, it is often wise to consult with a religious leader who is part of the client's social support system. At other times a client may be referred directly to a religious or spiritual leader to address a value or belief that is unfamiliar to the mental health professional.

Collaborative approaches can also be used outside of traditional psychotherapy interventions in order to enhance the mental health of larger groups of people. For example, Budd (1999) collaborated with chaplains in the US Air Force to develop an effective suicide prevention effort for Air Force personnel (see also Budd & Newton, 2005).

Determining Which Approach to Use

When should assimilative, accommodative, and collaborative approaches be used? We have no firm answers to this question because the creative

dimensions of therapy and the diversity of client characteristics, interests, and needs demand flexibility in how spirituality and religion are addressed. We suggest three factors for mental health professionals to consider when determining which approach to use.

First, it is important to consider client beliefs and desires. Some clients are highly interested in incorporating religion and spirituality in treatment, and others are not. It is useful to assess this early in the treatment relationship. Richards and Bergin (2005) advocate a two-level approach to assessing religious and spiritual beliefs. The first level is to discern a global sense of the role of religion and spirituality in a client's life. This is typically done with a simple probe on the intake form or in the first interview. For example, "Tell me some about your religious and spiritual beliefs and how important they are to you." For clients who identify closely with religious and spiritual values, a more detailed level of assessment can be pursued. Here the clinician attempts to understand the client's experience of the Divine, the orthodoxy of the client's religious beliefs, how religion may be used for coping, a sense of the client's spiritual well-being, and so on. Assimilative approaches to treatment can be used in a wide variety of contexts, though they assume at least a modest level of interest in religion or spirituality on the client's part. Accommodative approaches are typically used with clients who have a high degree of commitment to a religious or spiritual worldview and would like their beliefs to play an important role in treatment. Collaborative approaches are likely to be used for clients who are part of a faith community and are interested in having a religious or spiritual leader involved with their treatment.

Second, it is important to consider issues of competence. Though a client may desire an accommodative approach, a counselor who has no training or experience with spiritually oriented interventions should not attempt to provide this treatment. Referring the client to another mental professional would be appropriate in this case. Similarly, assimilative approaches require some expertise in one or more spiritually oriented intervention and should not be attempted without some background or training on the part of the mental health professional. Collaborative approaches are generally accessible to all mental health professionals, assuming they have basic respect for religious leaders and can communicate effectively with them (McMinn et al., 2003).

Third, the research base for spiritual and religious interventions should be considered when selecting an intervention approach. We turn to this topic next.

Outcome Data on Religious and Spiritual Intervention Approaches

A recent and extensive review of religious and spiritual interventions revealed a total of 24 outcome studies on the topic (Hook et al., 2010). The interventions were used to treat a variety of problems, including anxiety, depression, and even schizophrenia. Almost all of the existing research is limited to what we have called accommodative approaches, and most of this focuses on what Schlosser and Safran (2009) call "spiritually accommodative approaches." That is, current research tends to focus on relatively standardized forms of treatment that have been adapted to include religious and spiritual variables. Most of the published studies have been with Christian interventions, though some have considered other faiths, including Islam, Buddhism, Taoism, and nonspecific spirituality (Hook et al., 2010). In general, research evidence suggests that some accommodative approaches are as effective as standard approaches, but most are not more effective than standard treatment. Of the 24 studies reviewed, Hook et al. (2010) deemed two therapies efficacious. Two additional therapies were deemed efficacious when combined with medication, two more when combined with existing inpatient treatments, and six treatments were considered possibly efficacious. Three treatments were not considered efficacious. Treatments in each category are listed in Table 17.1.

Most of these studies have methodological limitations, many use analog clients, and the standardization of treatment approaches leaves much to be desired. More and better research is needed to understand the effectiveness of religious and spiritual approaches to counseling and psychotherapy (McMinn, Worthington, & Aten, 2011).

In summary, we have described three types of intervention approaches that consider religious and spiritual issues. Assimilative approaches add religiously or spiritually oriented interventions or homework to a standard treatment approach. Accommodative approaches are treatments that have been modified from their standard form in order to introduce religious and spiritual issues. Collaborative approaches involve communicating with religious or spiritual leaders throughout the treatment process. The client's beliefs and desires, the psychotherapist's competence, and empirical support for various treatment options should be

Table 17.1 Religious and Spiritual Treatments With Empirical Support

Efficacious treatments
Christian accommodative cognitive therapy for depression
Twelve-step facilitation for alcoholism
Efficacious treatments when combined with medication
Muslim accommodative psychotherapy for depression
Muslim accommodative psychotherapy for anxiety
Efficacious treatments when combined with existing inpatient treatment
Spiritual group therapy for eating disorders
Buddhist accommodative cognitive therapy for anger
Possibly efficacious treatments
Christian devotional meditation for anxiety
Taoist cognitive therapy for anxiety
Christian accommodative group treatment for unforgiveness
Spiritual group treatment for unforgiveness
Christian accommodative group cognitive-behavioral therapy for marital discord
Christian lay counseling for general psychological problems
No evidence for efficacy
Spiritual group cognitive-behavioral therapy for anxiety
Muslim accommodative cognitive-behavioral therapy for schizophrenia
Christian accommodative cognitive-behavioral therapy for eating disorders

Source: Hook et al., 2010.

considered when determining which approach to use with a particular client.

Special Issues When Counseling Within Faith Traditions

Engaging in counseling with a client who shares a common faith system with the counselor provides both opportunity and possible barriers to success in promoting mental health. Indeed, being intimately familiar with core values and beliefs that a client holds can be of immediate benefit in the process of developing a helpful conceptualization of the client's strengths, needs, struggles, and desires. Though insider experience can be a rich resource to draw upon when conceptualizing clients, clinicians should be wary of relying on generalizations with clients who claim to share their religious and spiritual beliefs. When counseling within religious traditions, skilled psychotherapists will realize there are nuances within every belief system, and they will carefully assess for this rather than make assumptions.

Potential Benefits

Life for most is complex, and struggle is a common human condition. Regardless of the specific treatment goals, the process of therapy can be enriched for clients who feel confident that their therapist is a fellow companion traveling a similar faith journey. Common among many faith traditions is the teaching that fellow believers are spiritual brothers and sisters. Safety, understanding, loyalty, acceptance, and love between spiritual siblings are powerful ideas often wrapped within this common faith belief. Knowing that one's therapist is a spiritual sister or brother has power in establishing immediate alliance within the therapeutic relationship. Many therapists have experienced similar reactions from clients when a shared faith commitment is made known: "Thank goodness; I am so happy to hear that, I was really hoping you would share the same faith as me; I was worried you wouldn't be a believer; Good, now I know you are safe." In choosing a provider, clients may view the religious beliefs of a therapist as a deciding factor, potentially more important than the provider's education, experience, and training.

Cultural differences may serve as an obstacle to forming a therapeutic alliance, but when the psychotherapist and client share the same religious or spiritual faith, it often serves as a powerful point of connection even when other cultural characteristics are not shared. An example of this is seen in McMinn's (2006) work with a stressed and anxious client. McMinn, a European American man, and his client, an African American woman, created a therapeutic bond based on shared faith experience despite their other differences. Sisemore (2006) observes, "As this White male works with an African American woman, we assume cultural distance. Yet, they share a vital 'culture' in common, the Christian faith."

Beyond establishing rapport, seeking a counselor or psychotherapist with similar faith beliefs may help clients overcome the stigma that is commonly

attached to seeking mental health treatment within some prominent religious groups. This barrier is most easily overcome if the counselor discloses information about similar faith beliefs to the client early in the treatment relationship. Thus, working within faith traditions can provide the safety and security that many clients need in order to enter into and benefit from professional counseling.

Potential Concerns

The psychotherapist working within faith traditions ought to take heed, however, for while doing so may promote an immediate connection with the client and facilitate openness to psychotherapy, it can later present a formidable barrier to the therapeutic process. Clients who knowingly share a religious tradition with their therapist may feel less comfortable discussing personal thoughts and behaviors that do not conform to what is generally considered acceptable within the system. Indeed, sharing common beliefs regarding what is morally acceptable may lead to feelings of shame within the client–therapist relationship when the client's behaviors conflict with religious norms and values. The power of unconditional positive regard experienced from therapist to client has been thoroughly researched, and this essential common factor in most therapeutic interventions can be sabotaged by the faith-sharing client's internal sense of shame.

Being an insider within a client's faith-influenced worldview can potentially limit a therapist's ability to assist a client in modifying thought processes or schemas. Perhaps the religious beliefs contribute in some way to the client's inability to identify and restructure thinking patterns that are maladaptive, such as when someone with a rigid belief system is forced to grapple with life circumstances that are fraught with complexity and ambiguity. Indeed, when faced with tragedy, it is not uncommon for people to struggle with their faith, even to the point of abandoning their beliefs altogether (Exline & Rose, 2005). For clients dissatisfied with a faith system that encourages reliance on long-established tenets to explain suffering and hardship, a therapist who shares the same faith might be tempted to focus on resolving the clients' questions rather than allowing the client to accept the ambiguity and uncertainty of life. Training and supervision can help a therapist working with clients who share his or her faith tradition to maintain a broad perspective when considering treatment options.

The possibility of detrimental internal reactions when working within faith traditions is not limited to clients. Therapists are prone to experiencing varying levels of personal distress as well, such as when working with clients who are struggling with faith beliefs, disillusioned with their faith, in the process of leaving their faith, or understand their faith in ways contrary to the therapist's interpretation. It is important in these instances for the clinician to avoid exerting undue power or influence over clients to bend their thought processes back into what the therapist deems religiously or theologically appropriate. Doing so would be overstepping the role of a psychotherapist. In this instance the psychotherapist would be attempting to assume the role of a religious leader. Whereas debating theology or spiritual issues may be appropriate for a rabbi, pastor, priest, or monk, doing so does not fall within the bounds of most professional psychotherapist–client relationships. For those therapists who believe such discussion might be helpful to a client, referral to religious and spiritual professionals within the clients' faith community is often the best solution.

Therapists working within faith traditions, particularly when clients come from the same religious community, should carefully consider the presence and effect of multiple role relationships. Working within one's own spiritual community highly increases the risk of clinicians forming multiple relationships with clients. Indeed, because of this Richards and Bergin (2005) discourage clinicians from working within their local congregations. They support this stance with a number of arguments. First, the client and therapist are more likely to make outside social contacts, as they frequent the same religious services. These contacts increase the risk of developing therapist-personal friend, therapist-lover, or therapist-business partner dual relationships. Second, clients who have shared intimate life details with a therapist who attends the same religious gatherings may feel embarrassed, awkward, and uncomfortable. Such clients may go on to discontinue attending religious services in order to avoid encountering their therapist. Third, therapists are more at risk of violating their clients' confidentiality. Therapists may inadvertently disclose information discussed in a therapy session, mistakenly believing it was learned outside of treatment.

Richards and Bergin (2005) recommend the following dos and don'ts for therapists practicing within their own faith communities (p. 187–188):

1. Therapists should avoid therapist–religious leader and therapist–religious associate dual relationships.

2. After carefully considering the circumstances, if a therapist believes that a dual relationship may be in a person's best interest, the therapist should, before entering into such a relationship, consult with his or her supervisor and professional colleagues to see whether they agree.

3. If the therapist and professional colleagues agree that the risk of a professional–religious dual relationship is warranted, the therapist should carefully define and limit the extent of the dual relationship and explain the risks and boundaries to the client.

4. The therapist should consult frequently with professional colleagues about the case as the dual relationship proceeds. If at any time the client, the therapist, or the therapist's professional colleagues believe the client is being harmed by the dual relationship, the therapist should terminate the relationship and refer the client to another therapist.

5. The therapist should continue to consult with and inform professional colleagues about the case until the dual relationship has ended and the case has been carefully documented.

Special Issues When Counseling Across Faith Traditions

Counseling across faith traditions brings potential challenges. Although these challenges can be bridged, it takes understanding and effort on the part of the therapist. For starters, most faith traditions inherently bring with them specific definitions of health and healing. While we would love to say that therapy is a purely objective enterprise, experience tells us that subjectivity always plays a role in the process of therapy. Just as counseling across cultures requires keen self-awareness on the part of the counselor, so also it is imperative that therapists explore their own religious and spiritual beliefs, and potential biases and limitations, when it comes to working across faith traditions. Training and supervision should be sought out where appropriate in order to maintain cultural sensitivity and to counter the potential pitfalls of issues such as countertransference, misguided interventions, and misdiagnoses stemming from cultural biases.

It is also useful to consider the disclosure of one's faith values. Therapists may choose to advertise their faith tradition, to join with religious leaders as sources of networking and referral for religious clients, or to disclose their faith within informed consent, either verbally or written. While this may appeal to some clinicians, others prefer to keep their personal lives more private. Still, there is always the possibility that clients may inquire about their psychotherapist's faith background. Answering such questions may encourage the establishment of rapport. Self-disclosure in this instance may be a culturally sensitive strength, as therapists can join their client around notions of ultimate meaning and spiritual quest, without having to share the same religious worldview. Exploring the client's reasons for asking such questions may lead to important insights that can add to the richness of therapy for the client.

A client may have fears about working with a therapist who does not share her or his worldview; these fears can be discussed openly, much as fears about ethnic and cultural differences might be discussed. Therapists may wish to share their theoretical orientation and typical way of conducting therapy; then, clients can choose whether to pursue psychotherapy. Most important may be the client's desire to see how the therapist responds to faith beliefs in general. Is the therapist respectful versus shaming, and open-minded versus stereotyping?

Some clients may be relieved to have a therapist who does not share their faith tradition but is rather a neutral party. For example, this might be the case when a client is struggling with faith beliefs, wrestling with issues that are not well received by the person's faith community, or struggling against religious power systems or unjust treatment by members of a religious community. In these cases, the therapist would do well to align with his or her client's experiences, while simultaneously avoiding criticism of the client's beliefs.

In addition to issues of disclosure, counselors and psychotherapists ought to consider basic knowledge of religious systems. Mental health professionals should have at least a basic understanding of world religions. This is a vital aspect of cross-cultural competency, which has been recognized by APA (2002) and continues to be a growing topic in the field. If their education has not included such a course, therapists can educate themselves about religious systems in advance.

When counseling across faith traditions, the knowledge that a psychotherapist brings into the consulting office should always be accompanied by a posture of learning and exploring with the client what faith has meant to him or her as an individual. As unique participants in their faith traditions, clients will present with highly varied experiences. Even within the majority of world religions, there are diverse streams and innumerable subtleties that

go beyond the terms "Muslim" and "Christian," for example. Questions such as the following may be helpful:

What about your faith is most significant to you personally?

What does your faith look like in your daily life?

How do you view yourself, others, and the world in light of your faith?

Priester, Khalili, and Luvathingal (2009) suggest the following potential questions (pp. 107–108):

What was your experience of religion as a child?

What aspects of your parents' religion did you like and/or dislike?

Did you go through any major religious changes in your life? Any conversion experiences? Any changes in denomination?

What religious beliefs bring you the most comfort?

What religious practices bring you the most comfort or feelings of support?

At what point in your life did you feel closest to your God(s)?

At what point in your life did you feel most distant from God?

Finally, when providing mental health services across faith traditions, it is important to consider collaborative models of intervention, as described earlier in this chapter. If a patient's presenting problem is faith based in nature, or the person requests spiritually oriented interventions, it may be helpful to consult with a clergy member from the patient's religious faith tradition. Most religious clergy will be happy to consult, and doing so may again help to build rapport with the client. In some cases, a psychotherapist may wish to refer a client to a clergy member or layperson who shares the client's faith tradition, as an additional source of support. When considering referring a client to a clergy member for care, and also discontinuing treatment, it is important to consider why the client originally came to seek help from a psychotherapist, as well as the severity of the psychological symptoms being treated.

Conclusion

In this chapter we have discussed general considerations for religiously and spiritually oriented psychotherapy and counseling. These include viewing religion and spirituality as cultural diversity issues, considering the welfare of the client, respecting the client's autonomy, and maintaining competence. We then considered different intervention approaches, including assimilative, accommodative, and collaborative approaches. Finally, we addressed specific issues related to counseling when the client and counselor share the same beliefs, and when the client and counselor hold differing beliefs. In the process we have cited the sparse outcome literature that is available and suggested that a great deal more research is needed.

Most world religions teach something akin to the Golden Rule—that we should treat others the way we would like to be treated ourselves. Perhaps this is the most fitting and useful summary statement than can be offered when considering religious and spiritual issues—an area that has received relatively less attention than other forms of human diversity in counseling and psychotherapy. Until we have clearer research findings and clinical practice guidelines, it may be most useful to use the Golden Rule as a standard of care. Do we offer our clients the same sort of respect and autonomy that we ourselves wish to have with our spiritual and religious values? Do we have the basic knowledge to engage in informed conversation and understand the nuances of our clients' beliefs? Are we willing to keep mental health goals the first priority, recognizing the need to protect our clients by practicing within the scope afforded us by our training and professional credentials? Do we stay current with the literature so that we can offer clients the best care available, in a way that is sensitive to human diversity?

Future Directions

We suggest two primary areas for future development: research and training. Regarding research, there is currently a paucity of research on religious and spiritual approaches to psychotherapy, and what little has been reported has focused entirely on accommodative approaches. Most of these studies have focused on religion rather than spirituality that is not linked to religious belief. Questions for the future include the following:

1. What effects on outcome and therapeutic alliance result when a counselor or psychotherapist introduces a spiritually oriented intervention in an otherwise standard approach to treatment (assimilative approach)?
2. To what extent do the therapist and client need to share a similar faith perspective when an accommodative intervention is used?
3. We need to move beyond global questions of whether religiously based approaches are effective. A more refined question for the future is, Which therapies are useful for which individuals holding which religious and spiritual beliefs?

4. What interventions work best with those who identify themselves as spiritual but not religious?

As with research, training in religious and spiritual issues is still in its infancy. Practice standards are being discussed (Hathaway & Ripley, 2009), but they have not yet been developed and formalized, which means that no standardized training models or criteria are available. Moreover, there seems to be some ongoing resistance to training in religious and spiritual interventions, with a majority of APA internship training directors reporting that they do not foresee training students in religious or spiritual issues (Russell & Yarhouse, 2006) and only a small minority of APA accredited doctoral programs providing systematic education regarding religious and spiritual issues (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002). Thus, we offer the following training-related questions:

1. What minimal standards in religious and spiritual issues should be expected of all professional psychology and counselor education training programs?

2. Much as cultural diversity training begins with self-awareness, how can self-awareness be enhanced regarding religious and spiritual worldview issues?

3. What sort of practicum and internship training opportunities might be available if we considered collaborative training opportunities within religious communities?

4. What ethical issues need to be considered and reconsidered in light of current practices for counseling within and across faith traditions?

Counselors and psychotherapists are routinely invited into the most intimate places of clients' lives. Some would call them sacred places. Learning to enter quietly, respectfully, and appreciatively is a worthy endeavor.

Further Reading

Aten, J. D., & Leach, M. M. (Eds.). (2009). Spirituality and the therapeutic process: A comprehensive resource from intake through termination. Washington, DC: American Psychological Association Books.

Aten, J. D., McMinn, M. R., & E. L. Worthington, Jr. (Eds.). (2011). Spirituality oriented interventions for counseling and psychotherapy. Washington, DC: American Psychological Association.

Pargament, K. I. (2007). Spiritually integrated psychotherapy: Understanding and addressing the sacred. New York: The Guilford Press.

Richards, P. S., & Bergin, A. E. (2005). A spiritual strategy for counseling and psychotherapy (2nd ed.). Washington, DC: American Psychological Association.

Sperry, L., & Shafranske, E. P. (Eds.). (2005). Spiritually oriented psychotherapy. Washington, DC: American Psychological Association.

References

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. American Psychologist, 57, 1060–1073.

Aten, J. D., & Leach, M. M. (Eds.). (2009). Spirituality and the therapeutic process: A comprehensive resource from intake through termination. Washington, DC: American Psychological Association.

Aten, J. D., McMinn, M. R., & Worthington, E. L., Jr. (Eds.). (2011). Spirituality oriented interventions for counseling and psychotherapy. Washington, DC: American Psychological Association.

Bartoli, E., & Gillem, A. (2008). Continuing to depolarize the debate on sexual orientation and religion: Identity and the therapeutic process. Professional Psychology - Research and Practice, 39, 202–209.

Beckstead, A. L. (2001). Cures versus choices: Agendas in sexual reorientation therapy. Journal of Gay and Lesbian Psychotherapy, 5, 87–115.

Benes, K. M., Walsh, J. M., McMinn, M. R., Dominguez, A. W., & Aikins, D. C. (2000). Psychology and the church: An exemplar of psychology-clergy collaboration. Professional Psychology: Research and Practice, 31, 515–520.

Benner, D. G. (2005). Intensive soul care: Integrating psychotherapy and spiritual direction. In L. Sperry & E. P. Shafranske (Eds.), Spiritually oriented psychotherapy (pp. 287–306). Washington, DC: American Psychological Association.

Brawer, P. A., Handal, P. J., Fabricatore, A. N., Roberts, R., & Wajda-Johnston, V. A. (2002). Training and education in religion/spirituality within APA-accredited clinical psychology programs. Professional Psychology: Research and Practice, 33, 203–206.

Budd, F., & Newton, M. (2005). Healing the brokenhearted: Cross and couch together. In M. R. McMinn & A. D. Dominguez (Eds.), Psychology and the church (pp. 89–93). Hauppauge, NY: Nova Science Publishers.

Budd, F. C. (1999). An Air Force model of psychologist-chaplain collaboration. *Professional Psychology: Research and Practice, 30*, 552–556.

Edwards, L. C., Lim, R. K. B., McMinn, M. R., & Dominguez, A. W. (1999). Examples of collaboration between psychologists and clergy. Professional Psychology: Research and Practice, 30, 547–551.

Ellis, A. (1962). Reason and emotion in psychotherapy. Secaucus, NJ: Lyle Stuart.

Ellis, A. (1971). The case against religion: A psychotherapist's view. New York: Institute for Rational Living.

Ellis, A. (1983). The case against religiosity. New York: Institute for Rational-Emotive Therapy.

Ellis, A. (1993). The advantages and disadvantages of self-help therapy materials. Professional Psychology: Research and Practice, 24, 335–339.

Ellis, A. (1999). How to make yourself happy and remarkably less disturbable. San Luis Obispo, CA: Impact Publishers.

Ellis, A. (2000). Spiritual goals and spirited values in psychotherapy. Journal of Individual Psychology, 56, 277–284.

Ellis, A., & Harper, R. A. (1997). A guide to rational living (3rd ed.). North Hollywood, CA: Melving Powers.

Ellis, A., & MacLaren, C. (1998). Rational emotive behavior therapy: A therapist's guide. San Luis Obispo, CA: Impact Publishers.

Emmons, R. A. (1999). The psychology of ultimate concerns: Motivation and spirituality in personality. New York: The Guilford Press.

Exline, J. J., & Rose, E. (2005). Religious and spiritual struggles. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 315–330). New York: The Guilford Press.

Fitchett, G., Rybarczyk, B. D., DeMarco, G. A., & Nichols, J. J. (1999). The role of religion in medical rehabilitation outcomes: A longitudinal study. Rehabitation Psychology, 44, 1–22.

Frame, M. W. (2003). Integrating religion and spirituality into counseling: A comprehensive approach. Belmont, CA: Brooks/Cole.

Gallup, G. H. (2003, February 11). Americans' spiritual searches turn inward. Retrieved July 2009, from http://www.gallup.com/poll/7759/Americans-Spiritual-Searches-Turn-Inward.aspx

Gallup Polls, Inc. (2009). Religion. Retrieved June 2009, from http://www.gallup.com/poll/1690/religion.aspx

Gonsiorek, J. C., Richards, P. S., Pargament, K. I., & McMinn, M. R. (2009). Ethical challenges and opportunities at the edge: Incorporating spirituality and religion into psychotherapy. Professional Psychology: Research and Practice, 40, 385–395.

Greene, B. (2008). African American women, religion, and oppression: The use and abuse of spiritual beliefs. In C. A. Rayburn & L. Comas-Diaz (Eds.), WomanSoul: The inner life of women's spirituality (pp. 153–166). Westport, CT: Praeger Publishers/Greenwood Publishing Group.

Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A meta-analysis of recent studies. Journal for the Scientific Study of Religion, 42, 43–55.

Hathaway, W. L., & Pargament, K. (1990). Intrinsic religiousness, religious coping, and psychosocial competence: A covariance structure analysis. Journal for the Scientific Study of Religion, *29*(4), 423–441.

Hathaway, W. L., & Ripley, J. S. (2009). Ethical concerns around spirituality and religion in clinical practice. In J. D. Aten & M. M. Leach (Eds.), Spirituality and the therapeutic process: A comprehensive resource from intake through termination (pp. 25–52). Washington, DC: American Psychological Association Books.

Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. American Psychologist, 58, 64–74.

Hood, R., Spilka, B., Hunsberger, B., & Gorsuch, R. (1996). The psychology of religion: An empirical approach (2nd ed.). New York: The Guildford Press.

Hook, J. N., Worthington, E. L., Jr., Davis, D. E., Jennings, D. J., II, Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. Journal of Clinical Psychology, 66, 46–72.

Johnson, C., & Hayes, J. (2003). Troubled spirits: Prevalence and predictors of religious and spiritual concerns among university students and counseling center clients. Journal of Counseling Psychology, *50*(4), 409–419.

Keating, A. M., & Fretz, B. R. (1990). Christians' anticipations about counselors in response to counselor descriptions. Journal of Counseling Psychology, 37, 293–296.

Kennedy, S. M. (1999). Religious perfectionism: A first step toward conceptualization and assessment (Ph.D. dissertation, Pennsylvania State University, 1999). Dissertation Abstracts International, *59*, 4531.

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). Handbook of religion and health. Oxford, England: Oxford University Press.

Lukoff, D., Lu, F., & Turner, R. (1998). From spiritual emergency to spiritual problem: The transpersonal roots of the new DSM-IV category. Journal of Humanistic Psychology, 38, 21–50.

Lish, R. A., McMinn, M. R., Fitzsimmons, C. R., & Root, A. M. (2003). Clergy interest in innovative collaboration with psychologists. Journal of Psychology and Christianity, 22, 294–298.

McCullough, M. E. (1999). Research on religion-accommodative counseling: Review and meta-analysis. Journal of Counseling Psychology, *46*, 92–98.

McCullough, M. E., Hoyt, W. T., Larson, D. B., Koenig, H. G., & Thoresen, C. (2000). Religious involvement and mortality: A meta-analytic review. *Health Psychology, 19*, 211–222.

McIntosh, D., & Spilka, B. (1990). Religion and physical health: The role of personal faith and control beliefs. Research in the Social Scientific Study of Religion, *2*, 167–194.

McMinn, M. R. (2006). Christian counseling [DVD in APA Psychotherapy Video Series]. Washington, DC: American Psychological Association.

McMinn, M. R., Aikins, D. C., & Lish, R. A. (2003). Basic and advanced competence in collaborating with clergy. Professional Psychology: Research and Practice, 34, 197–202.

McMinn, M. R., Chaddock, T. P., Edwards, L. C., Lim, R. K. B., & Campbell, C. D. (1998). Psychologists collaborating with clergy: Survey findings and implications. Professional Psychology: Research and Practice, 29, 564–570.

McMinn, M. R., Worthington, E. L., Jr., & Aten, J. D. (2011). Spiritually oriented interventions: Future directions in training and research. In J. D. Aten, M. R. McMinn, & E. L. Worthington, Jr. (Eds.), Spiritually oriented interventions in counseling and psychotherapy (pp. 345–351). Washington, DC: American Psychological Association.

Miller, W. R., & Delaney, H. D. (Eds.) (2005). Judeo-Christian perspectives on psychology: Human nature, motivation, and change. Washington, DC: American Psychological Association.

Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. American Psychologist, 58, 24–35.

Nielsen, S. L., Johnson, W. B., & Ellis, A. (2001). Counseling and psychotherapy with religious persons: A Rational Emotive Behavior Therapy approach. Mahwah, NJ: Erlbaum.

O'Connor, S., & Vandenberg, B. (2005). Psychosis or faith? Clinicians' assessment of religious beliefs. Journal of Consulting and Clinical Psychology, 73, 610–616.

Pargament, K. I. (1997). The psychology of religion and coping: Theory, research, practice. New York: The Guilford Press.

Pargament, K. I. (2007). Spiritually integrated psychotherapy: Understanding and addressing the sacred. New York: The Guilford Press.

Pargament, K. I., Kennell, J., Hathaway, W., & Grevengoed, N. (1988). Religion and the problem-solving process: Three

styles of coping. Journal for the Scientific Study of Religion, *27*, 1, 90–104.

Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2001). Religious struggle as a predictor of mortality among medically ill elderly patients: A 2-year longitudinal study. *Archives of Internal Medicine, 161,* 1881–1885.

Plante, T. G. (2011). Addressing problematic spirituality in therapy. In J. D. Aten, M. R. McMinn, & E. L. Worthington, Jr. (Eds.), Spiritually oriented interventions in counseling and psychotherapy (pp. 83–106). Washington, DC: American Psychological Association.

Post, S. G. (2005). Altruism, happiness, and health: It's good to be good. International Journal of Behavioral Medicine, *12*(2), 66–77.

Powell, L. H., Shahabi, L., & Thoresen, C. E. (2003). Religion and spirituality: Linkages to physical health. American Psychologist, 58, 36–52.

Priester, P. E., Khalili, S., & Luvathingal, J. E. (2009). Placing the soul back into psychology: Religion in the psychotherapy process. In S. Eshun & R. A. R. Gurung (Eds.), *Culture and mental health: Sociocultural influences, theory, and practice* (pp. 91–114). Oxford, England: Blackwell Publishing.

Richards, P. S., & Bergin, A. E. (2005). A spiritual strategy for counseling and psychotherapy (2nd ed.). Washington, DC: American Psychological Association.

Russell, S. R., & Yarhouse, M. A. (2006). Religion/spirituality within APA-accredited psychology predoctoral internships. Professional Psychology: Research and Practice, 37, 430–436.

Salsman, J. M., & Carlson, C. R. (2005). Religious orientation, mature faith, and psychological distress: Elements of positive and negative associations. Journal for the Scientific Study of Religion, 44, 201–209.

Schaefer, C., & Gorsuch, R. (1991). Psychological adjustment and religiousness: The multivariate belief-motivation theory of religiousness. Journal for the Scientific Study of Religion, *30*(4), 448–461.

Schlosser, L. Z., & Safran, D. A. (2009). Implementing treatments that incorporate clients' spirituality. In J. D. Aten & M. M. Leach (Eds.), Spirituality and the therapeutic process: A comprehensive resource from intake through termination (pp. 193–216). Washington, DC: American Psychological Association Books.

Schwartz, C., Meisenhelder, J. B., Ma, Y., & Reed, G. (2002). Altruistic social interest behaviors are associated with better mental health. Psychosomatic Medicine, 65, 778–785.

Seeman, T. E., Dubin, L. F., & Seeman, M. (2003). Religiosity/spirituality and health: A critical review of the evidence for biological pathways. American Psychologist, 58, 53–63.

Shafranske, E. P. (1996). Religious beliefs, affiliations, and practices of clinical psychologists. In E. P. Shafranske (Ed.), Religion and the clinical practice of psychology (pp. 149–162). Washington, DC: American Psychological Association.

Sisemore, T. A. (2006, December 27). Christian counseling: An area of cultural diversity? PsycCritiques, 51(52).

Slattery, J. M., & Park, C. L. (2011). Meaning-making and spiritually oriented interventions. In J. D. Aten, M. R. McMinn, & E. L. Worthington, Jr. (Eds.), Spirituality oriented interventions for counseling and psychotherapy (pp. 15–40). Washington, DC: American Psychological Association.

Sperry, L. (2005). Integrative spiritually oriented psychotherapy. In L. Sperry & E. P. Shafranske (Eds.), Spiritually oriented psychotherapy (pp. 307–329). Washington, DC: American Psychological Association.

Sperry, L., & Shafranske, E. P. (Eds.) (2005). Spiritually oriented psychotherapy. Washington, DC: American Psychological Association.

Sue, D. W., & Sue, D. (2007). Counseling the culturally diverse (5th ed.). New York: Wiley.

Weaver, A. J. (1995). Has there been a failure to support parish-based clergy in their role as frontline community mental health workers? A review. The Journal of Pastoral Care, 49(2), 129–149.

Wiggins, M. I. (2011). Spiritual journaling. In J. D. Aten, M. R. McMinn, & E. L. Worthington, Jr. (Eds.), Spirituality oriented interventions for counseling and psychotherapy (pp. 303–321). Washington, DC: American Psychological Association.

Young, J. S., Cashwell, C., Wiggins-Frame, M., & Belaire, C. (2002). Spiritual and religious competencies: A national survey of CACREP-accredited programs. Counseling and Values, 47, 22–33.