

The Incorporation of Spirituality Into Counselling Within a Holistic Paradigm in a Secular
World

Vanessa Liu

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Approved by

Steve Conway, Thesis Advisor, Masters of Counselling Faculty

Karen Grant, Faculty Reader, Masters of Counselling Faculty

Abstract

In the last few decades, there has been an increase of research and literature on spirituality in psychotherapy (Bhagwan, 2009; Bryant-Davis & Wong, 2013; Bryant-Davis, Ellis, Burke-Maynard, Moon, Counts, & Anderson, 2012; Gubi, 2007; Lees & Tovey, 2012; Mytko & Knight, 1999; Richards & Bergin, 2005; Sternthal, Williams, Musick, & Buck, 2010). The current thesis presents the compatibility of spirituality and psychology (Muller, 1999; Powell, Shahabi, & Thoresen, 2003; Stanley et al., 2011). The study reveals the positive and negative impacts of incorporating spirituality into counselling, and presents different spiritual interventions that can be incorporated into counselling. The literature emphasizes the importance for counsellors and psychotherapists to maintain openness to discussing spiritual issues (Martinez, Smith, & Barlow, 2007; Walker, Reese, Hughes, & Troskie, 2010). This study emphasizes the importance of incorporating spirituality into counselling and psychotherapy while providing examples of interventions that can be used, in addition to the prominence of maintaining spiritual competency and being aware of ethical issues that may arise.

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Introduction

Life is journey with prosperity and adversity. Prosperities such as good health, financial satisfaction, and close social relations positively correlate with positive feelings and well-being (Diener, Ng, Harter, & Arora, 2010; Haller & Hadler, 2006). Adversities may alter our perspectives on life and may have a significant impact on our worldview and on our well-being depending on the genetic makeup of the individual, history of exposure to stress, and individual factors such as personality, coping style, and social support (Das, Cherbuin, Tan, Anstey, & Easteal, 2011). Past literature mainly focused on the emotional, cognitive, and behavioural strategies of coping, and on the impact of these types of coping on our well-being (Cousson-Gélie, Bruchon-Schweitzer, & Atzeni, 2011; Kirmayer & Looper, 2006). Emotional, cognitive, and behavioural coping strategies include logical analysis, optimistic comparison, emotional control, and emotional avoidance through denial, repression, or non-expression (Cousson-Gélie et al., 2011; Holahan & Moos, 1987). These coping strategies may help individuals improve or worsen their adjustment to distress (Cousson-Gélie et al., 2011). However, human beings not only connect with others emotionally, intellectually, physically, and socially; they also connect with each other spiritually. The purpose of this chapter is to introduce the topic of incorporating spirituality into psychotherapy. First, I will present the rationale, purpose, structure, and methodology of this study. Then, I will define some of the terms that are used within the study. I will also present scholarly context relating to the topic of this study.

Rationale of the Study

Recent literature shows a growing interest in incorporating spirituality and religion into therapy for helping professions of mental health and psychology, particularly in the field of medicine for cancer patients and in the field of mental health (Bhagwan, Creating sacred

experiences for children as pathways to healing, growth and transformation, 2009; Bryant-Davis & Wong, 2013; Bryant-Davis, Ellis, Burke-Maynard, Moon, Counts, & Anderson, 2012; Gubi, 2007; Lees & Tovey, 2012; Mytko & Knight, 1999; Richards & Bergin, A spritual strategy for counseling and psychotherapy, 2005; Sternthal, Williams, Musick, & Buck, 2010). Spirituality has been included as a dimension of World Health Organization's definition of health, along with physical, psychological, and social dimensions (WHOQOL Group, 1997). A growing openness to the incorporation of spirituality and religiosity in therapy may strengthen therapeutic alliance and enable counsellors to better promote change in clients. Maintaining openness to spirituality and a neutral stance would increase clients' comfort and level of trust in counsellors' insight, enhancing the possibility of positive change (Martinez, Smith, & Barlow, 2007; Walker, Reese, Hughes, & Troskie, 2010) The research question for this study is: "How can spirituality be incorporated into counselling within a holistic paradigm in a secular world?"

Purpose of the Study

The purpose of this study is to explore how spirituality can be incorporated into counselling. The positive and negative impact of spirituality on emotional well-being is explored, common spiritual practices that can incorporated are discussed, and ethical issues concerning the incorporation of spirituality into the counselling session are highlighted.

Structure of the Study

This thesis is organized into four chapters. In the first chapter I introduce the topic and its relevance while presenting research that demonstrates how spirituality and counselling coincide. In the second chapter I focus on the positive and negative impacts of spirituality on emotional well-being. In the third chapter I present common spiritual interventions that can be incorporated into counselling along with the challenges. In the final chapter I discuss the

importance for counsellors to develop spiritual competency, ethical issues, and challenges that counsellors may face when incorporating spirituality into counselling, in addition to other implications for counsellors.

Methodology

This is a manuscript thesis that reflects a comprehensive literature review to discuss and present benefits and challenges from recent literature on incorporating spirituality into counselling. Key search terms included spirituality in counselling, impact of spirituality, maladaptive spirituality, spiritual practices in counselling, and spirituality and ethical issues.

Definitions of the Terms

Spirituality

Many authors have defined spirituality in the literature and each definition varies slightly from the others. Casarez and Engebretson (2012) examined the Hebrew and Latin root of spirituality and discovered that the spirit is defined as wind, air, breath of life, and that it implies intelligence, consciousness, and conscientiousness. Pargament and Saunders (2007) defined spirituality as a relationship with the sacred, a higher power, divine being, or God, which differs from religion as which is defined by a set of beliefs and behaviours that are shared within a community. Hodge and McGrew (2006) found that the most common definition of spirituality was the feeling or experience of connectedness with God/Christ/higher power/transcendental being and the second most common definition of spirituality was a personal belief or faith in God/higher power/personal values. Spirituality often incorporates the meaning and purpose in life, in addition to divine existence (Pesut, Fowler, Taylor, Reimer- kirkham, & Sawatzky, 2008). Spirituality moves individuals towards love, meaning, peace, hope, connectedness, wholeness, and transcendence from the present, (Bryant-Davis et al., 2012; Miller, 2003).

Spirituality can also be defined as the expression or practice of what an individual holds as sacred (Bryant-Davis et al., 2012). In this thesis, spirituality is used in a broader sense than religion and is one's striving for and subjective inward experience of the essence of life, focusing on the meaning and purpose of life and using spiritual beliefs to seek these answers to shape one's worldview and personal identity (Bryant-Davis et al., 2012; Lambie, Davis, & Miller, 2008; Lima et al., 2013; Visser, Garssen, & Vingerhoets, 2010). Spirituality, therefore, may involve but is not limited to one's religious beliefs and practices (Desrosiers & Miller, 2007; Lambie et al., 2008).

God

Some people believe that a supreme or transcendent being created the universe. Other terms for this Supreme Being include Higher Power, the Great Spirit, God, Allah, Universal Energy (Exline, Park, Smyth, & Carey, 2011; Moivic, 2004; Monteiro & Wall, 2011; Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005; Sanderson & Linehan, 1999). Children may view God as a creator of nature, sunshine, or protector (Bhagwan, Creating sacred experiences for children as pathways to healing, growth and transformation, 2009). God is sometimes viewed as a safe haven, a deity who provides support, care, and protection during times of distress (Hill & Pargament, 2003). For consistency and brevity, the term God will be used throughout this study and will be defined as a supreme being of deity who created the universe and offers support and comfort.

Soul

The soul is sometimes described as the nature of consciousness (Moivic, 2004). Aurobindo (1970) describes the soul as buried deep within the heart behind the mind and body that is born from the divine and serves as an inner voice that is immortal and evolves through

reincarnation. In the Merriam-Webster (2015), soul is defined as the spiritual part of humans that gives life to the body, that represents one's moral and emotional nature, and that is immortal. In this thesis, the definition of soul is adopted from Merriam-Webster.

Spiritual Essence

Spiritual essence refers to an individual's spirit (Leseho & Maxwell, 2010). Merriam-Webster (Merriam-Webster Incorporated, 2015) defines the spirit as the inner force or supernatural essence within an individual that gives the body energy, power, and life. Spiritual essence also refers to the connection to one's core and to the divine, representing wholeness (Leseho & Maxwell, 2010). It also represents the divine energy from within that can radiate in times of darkness and act as a source of motivation for striving to one's potential (Carroll, 2001; Leseho & Maxwell, 2010).

Spiritual Practices

Spiritual practices are actions with which an individual expresses his/her spirituality or with which one strengthens one's faith development and can function as a source of value and guidance for conducting one's life (Gall & Cornblat, Breast cancer survivors give voice: a qualitative analysis of spiritual factors in long-term adjustment, 2002). Some examples of spiritual practices include prayer, meditation, scripture reading, sacred ceremonies, yoga, acceptance, obedience, and forgiveness (Bhagwan, Creating sacred experiences for children as pathways to healing, growth and transformation, 2009; Entwistle, 2009; Kim & Esquivel, 2011; Moivic, 2004; Sanderson & Linehan, 1999).

Faith

Faith is defined as a strong belief in the existence of God or refers to strong religious beliefs that an individual may possess (Merriam-Webster Incorporated, 2015). An aspect of

spiritual faith is having hope and optimism in divine intervention (Kim & Esquivel, 2011). The development of spiritual faith is complex and a lifelong process (Kim & Esquivel, 2011).

Spiritual faith development can be fostered in religious communities and through relationships with role models who can mentor them through personal experience in their faith journey (Kim & Esquivel, 2011).

Religiosity

Religion differs from spirituality in that it puts spirituality in a context of beliefs, values, and practices of an organized institution (Bhagwan, 2009; Cascio, 1998; Visser et al., 2010).

Religion is one way of expressing spirituality and implies a congregation of people who share a common belief system and gather to worship (Desrosiers & Miller, 2007; MacDonald, 2004).

Religion attempts to answer our deepest questions about our existence, life, and death (Exline, *Stumbling blocks on the religious road: Fractured relationships, nagging voices, and the inner struggle to believe*, 2002). Religion is prescriptive and presents guidelines as to how we are to live our lives (Exline, *Stumbling blocks on the religious road: Fractured relationships, nagging voices, and the inner struggle to believe*, 2002).

Religious Coping

Religious coping refers to strategies that are used within a religious context that an individual uses to cope with adversities (Entwistle, 2009). These strategies include prayer, meditation, visualization, meaning-finding, attendance or participation in ceremonies or rituals, support within religious congregation or from God, reading sacred texts, and drawing pictures that reflect faith (Gall & Cornblat, *Breast cancer survivors give voice: a qualitative analysis of spiritual factors in long-term adjustment*, 2002; Hill & Pargament, 2003; McConnell, Pargament, Ellison, & Flannelly, 2006; Simon, Crowther, & Higgerson, 2007).

Wellness/Well-being

Wellness or well-being is described as the optimal health and functioning of a person (Whitmer & Sweeney, 1992). Optimal wellness is a holistic construct that includes physical, emotional, social, and spiritual well-being of an individual (Geffen, 2004; Whitmer & Sweeney, 1992). The characteristics of a healthy person and wellness are expressed in five tasks of spirituality, self-regulation, work, love, and friendship (Whitmer & Sweeney, 1992).

Emotional Well-being

Emotional well-being encompasses several components including overall life satisfaction, satisfaction with important areas of life (e.g. work satisfaction, family relations, intimate relationships), high levels of positive affect (pleasant emotions), low levels of negative affect (unpleasant emotions) (Diener, 2000; Exline et al., 2011). Meaning and purpose in life are essential to positive emotional well-being (Frankl, 1963).

Psychotherapist/Counsellor

The terms psychotherapist and counsellor have been used interchangeably though they have distinctive differences (Canadian Counselling and Psychotherapy Association, 2015). Psychotherapy refers to the treatment that pertains to presenting mental health issues such as depression, anxiety disorders, attention deficit hyperactivity disorder, and other disorders (CCPA, 2015). Psychotherapy primarily focuses on principles that modify behaviour and on helping clients understand the foundations of their feelings, thoughts, and behaviours more clearly (Bordin, 1955; Martin, 2015). Psychotherapy is a long-term process that helps people gain deep awareness in identifying and understanding psychological issues that have been accumulating over a long period of time (Martin, 2015). In Canada, a psychotherapist is an

individual with a Master's Degree who focuses on treating mental health issues (CCPA, 2015). Counselling focuses on promoting wellness while providing insight or leading clients to achieve insight to overcoming their presenting challenges and issues (CCPA, 2015). Compared to psychotherapy, counselling is a short-term process that focuses on promoting change by exploring personal development and focuses on helping clients who struggle with emotional or motivational issues (Bordin, 1955; Martin, 2015). In Canada, a counsellor should also have a Master's Degree and should have acquired supervised practicum (CCPA, 2015). However, psychotherapists and counsellors may use similar techniques when working with clients (CCPA, 2015). Furthermore, psychotherapists may choose to identify themselves as counsellors to attract potential clients since the term psychotherapy may seem intimidating (Martin, 2015).

Research on Spirituality and Psychology

Throughout history, there have been various perspectives on the role spirituality plays in mental health, physical health, and psychological health, ranging from the view at one extreme that spirituality leads to mental illness (Ellis, 1980), to the other extreme that spirituality is the only solution for curing physical illnesses (Entwistle, 2009). Renowned psychologists such as William James, Sigmund Freud, and Carl Jung struggled between theism and agnosticism when it came to the topic of spirituality within psychology (Freud, 1961; James, 1982; Jung, 1989). Ellis (1980) once wrote, "religion sabotages mental health" (p. 5), believing that religion and psychological health were incompatible. At the other extreme, there was a case in which a 15-month-old child was declined treatment for pneumonia and secondary blood infection and was treated solely on prayer in accordance to the parents' religious beliefs (Entwistle, 2009). This 15-month-old child tragically died due to the lack of medical treatment (Entwistle, 2009). There were also other incidences—deaths of 78 minors due to the lack of medical treatment

(Anonymous, 2008; Van Biema, 1998). These tragic deaths could have been prevented with the use of antibiotics or with medical attention (Entwistle, 2009).

In the late nineteenth century, psychology emerged to be understood as mediated by biological, psychological, and social factors (Entwistle, 2009). Present-day counsellors tend to avoid incorporating spirituality into counselling as they may perceive issues of faith and spirituality as inappropriate and detracting from the progress of counselling or they may avoid it due to limited knowledge on the topic, the differences in beliefs and perspectives from clients, or biases they may have towards the clients' beliefs (Lambie et al., 2008). Recent literature has shown a trend of incorporating spirituality into helping professions to provide a holistic approach of care in the fields of health care, mental health care, psychology, and school counselling (Alexander, Kruczek, & Ponterotto, 2005; Casarez & Engebretson, 2012; Hill & Pargament, 2003; Pesut & Thorne, 2007; Sink & Devlin, 2011). Spirituality has been found to play a significant role in social, emotional, and physical well-being and for promoting constructive change and is crucial in one's holistic development (Lambie et al., 2008).

Compatibility of Spirituality and Psychology

Stanley et al. (2011) conducted a study that examined the potential value of incorporating spirituality and religiosity into treatment for older adults with depression or anxiety. Sixty-six older adults were given four measures to assess the severity of depressive or anxiety symptoms, attitudes towards incorporating spirituality and religiosity into psychotherapy, religious and spiritual coping, and religious and spiritual beliefs and behaviours (Stanley, et al., 2011). The results of the measure that assessed clients' attitudes towards incorporating spirituality and religiosity into psychotherapy showed that those who engaged in religious practices and beliefs had a higher preference for incorporating spirituality and religion into therapy for anxiety and

depression (Stanley, et al., 2011). Stanley et al. (2011) found that those who valued the importance of incorporating spirituality and religion into therapy had positive religious-based coping and greater collaborative problem-solving skills. Specifically, those who incorporated general spiritual beliefs in their daily lives had greater preferences for including spirituality rather than religion into counselling than those who had stronger community-based religious practices, who preferred to incorporate religion rather than general spirituality into counselling (Stanley, et al., 2011). Generally, all 66 participants who engaged in spiritual or religious practices thought that incorporating spirituality or religion into counselling would increase support, acceptance, and comfort (Stanley, et al., 2011). The discussion involving spirituality and/or religion could serve as a component for counselling or as a separate component outside of therapy (Stanley, et al., 2011).

Powell, Shahabi, and Thoresen (2003) found that religion and spirituality had the most protective effect on healthy people against mortality. They also suggest that social support within a religious community may be deeper and broader than the support in a secular setting (Powell et al., 2003). Examples of support and response to personal crises within a religious community include provision for childcare, financial help, meal preparation, emotional support, and moral support through acts of forgiveness and practicing grace (Powell et al., 2003). The church community could also connect individuals with other resources and support (Powell et al., 2003). Within a religious community group, individuals' senses of self-worth may be strengthened through the act of helping others (Powell et al., 2003). Individuals who regularly attend church services experience ongoing positive emotions elicited by the experience of the service through prayer and through the transcendent state of the mind and body, and by the habitual commitment of reserving a whole day of rest (Muller, 1999; Powell et al., 2003). They

also commune with others who hold values that are consistent with being compassionate, positive, hopeful, and caring behaviours in life situations promoting a healthy lifestyle by demonstrating calming coping strategies in pain and suffering (Powell et al., 2003).

Spirituality Through a Holistic Lens

Western models of counselling and psychology tend to compartmentalize the healing experience while Eastern models look at the human experience holistically, examining the physical, mental, emotional, social, and spiritual aspects (Chan, 2008). Holism can be defined as the wholeness of a human being that is achieved through the balance of our physical, psychological, spiritual, and social needs, and that our wholeness is dependent on our relationships with each other and with the environment (Patterson, 1998). To be considered whole, each organism has the ability to function independently and interact within a system to maintain the system (Patterson, 1998). Psychotherapy in this perspective is about making changes in habits, behaviours, thoughts, feelings, lifestyles, and environments (Bojuwoye & Sodi, 2010).

In 1958, the World Health Organization defined health not as the absence of illness and disease, but as a physical, mental, and social well-being in addition to spiritual well-being (Whitmer & Sweeney, 1992). The Christian theological view conceptualizes human beings as a holistic unity of bio-psycho-social and spiritual factors (Entwistle, 2009). The prevalence of religious coping ranges from 20% to 90% (McConnell, Pargament, Ellison, & Flannelly, 2006). In holistic psychology, issues are examined in light of the interrelationships of the individual, and the relationship one has within oneself—the physical body, emotions, and spiritual (Bhagwan, *Creating sacred experiences for children as pathways to healing, growth and transformation*, 2009). These aspects are in synchrony with each other (Bhagwan, *Creating*

sacred experiences for children as pathways to healing, growth and transformation, 2009). In holistic psychology, spirituality (purposiveness and values) is at the centre of wholeness (Whitmer & Sweeney, 1992).

Entwistle (2009) stated that a holistic unity between the supernatural and natural recognized the boundaries of the natural world while affirming the spiritual nature of human beings. A holistic perspective allows us to see that spiritual realities can be mediated through the natural world (Entwistle, 2009). Entwistle (2009) gave an example of how the prayer of a lonely, depressed, and isolated person can be answered and shown through social connections within his or her religious community. Such a tangible benefit can be achieved through spiritual practices and beliefs (Entwistle, 2009).

Maslow (1943) presented his theory on the hierarchy of needs through a holistic lens. Along with the needs of security, physiology (food, shelter, water), love and friendship, esteem, and self-actualization (seeking for growth in health and for one's fullest potential), Maslow's theory (1970) emphasized the need for a higher goal outside of one's self in spirituality and in altruism. It is through these lenses that this thesis is written. Spirituality, which is part of self-actualizing, is a basic need for psychological well-being, although it is not a basic survival need. From this theory, spirituality—along with physicality, emotions, intellectuality, and sociality—is one of the five basic needs for maintaining and promoting psychological well-being. Hence, in this thesis, spirituality will be examined as one of the dimensions of a human being, the other dimensions being the intellect, physicality, emotions, and social environment.

Conclusion

This chapter was an introduction to this thesis and presented the topic of spirituality and religiosity and its evolution in the field of psychology from the past to present-day. The

scholarly research presented the compatibility of spirituality and psychology, and the perspective of spirituality as a significant aspect of achieving wholeness, wellness and well-being through a holistic lens.

Spirituality and Religiosity in Emotional Well-Being

Spirituality and religiosity have been found to be beneficial in maintaining wellness and emotional well-being. Some helping professionals have recently been incorporating spirituality into therapy and implementing spiritual practices as coping strategies for clients and patients (Bhagwan, 2009; Bryant-Davis & Wong, 2013; Bryant-Davis, Ellis, Burke-Maynard, Moon, Counts, & Anderson, 2012; Gubi, 2007; Lees & Tovey, 2012; Mytko & Knight, 1999; Sternthal, Williams, Musick, & Buck, 2010). These spiritual practices have been incorporated in the field of mental health, nursing, and counselling psychology. There is conflicting literature that supports and refutes the positive impact of spirituality and religiosity on emotional well-being. The purpose of this chapter is to present the positive and negative impact that spirituality and religiosity may have on the emotional well-being of cancer patients, people with depressive symptoms, and trauma survivors, in addition to synthesizing the similarities and differences between these impacts by reviewing several of the studies available in recent literature.

The Impact of Spirituality and Religiosity on Emotional Well-Being

According to literature, there are positive and negative impacts of spirituality and religiosity on emotional well-being (Connor, Davidson, & Lee, 2003; Pargament, Smith, Koenig, & Perez, 1998). Spirituality and religiosity may enhance the ability to cope with negative events, yet they may also create greater distress (Connor et al., 2003). This section discusses the ways in which spirituality can positively and negatively impact emotional well-being.

Positive Spiritual Coping

According to recent literature, spirituality and religiosity play significant roles in the positive coping with serious illness including cancer, in addition to having a positive impact on psychological issues such as depression and trauma (Bryant-Davis & Wong, 2013; Grossman,

Sorsoli, & Kia-Keating, 2006; Holt, Wang, Caplan, Schulz, Blake, & Southward, 2011; McIntosh, Poulin, Silver, & Holman, 2011; Miller, Wickramaratne, Gameraff, Sage, Tenke, & Weissman, 2012; Simon, Crowther, & Higgerson, 2007; Sternthal, Williams, Musick, & Buck, 2010; Trinkaus et al., 2011; Walker, Reid, O'Neill, & Brown, 2009). Examples of positive results include greater strength in resilience for coping with negative symptoms, gaining a sense of meaning and purpose in life, and increasing hope and optimism (Bryant-Davis & Wong, 2013; Miller et al., 2012; Simon et al., 2007; Trinkaus et al., 2011; Walker et al., 2009). Furthermore, a relationship with a benevolent God has been found to be a stable source of support for people when coping with adversities and as a source of peace and comfort (Gall, Basque, Damasceno-Scott, & Vardy, 2007). This stable source of support serves as a protective measure for other significant relationships in the lives of the victims (Gall et al., 2007).

Strengthening resilience. Recent studies show that spirituality plays a crucial role in strengthening resilience for people who experience adversities such as cancer or depression (Miller et al., 2012; Simon et al., 2007; Trinkaus et al., 2011). Resilience refers to the ability to cope in difficult situations and to grow adaptively through the adversities in preventative measures to cope with future adversities (Dillen, 2012). Some people see God as the source of resilience and resurrection as relating to hope (Dillen, 2012). Research shows that spirituality and religion strengthen resilience by increasing the ability to cope with negative symptoms in cancer patients before and during treatment, stimulating openness to try alternative possible treatment options, providing opportunities for growth and developing, increasing social support, or having protective measures for suicidality in people with depression (Gall et al., 2007; Kim & Esquivel, 2011; Miller et al., 2012; Simon et al., 2007; Trinkaus et al., 2011). In one study on the role of spirituality in the cancer experience, some of the participants showed the importance

of spirituality in their coping experiences by raising the topic of spirituality and religiosity before the questions regarding this topic were asked, and all 18 participants reported that spirituality played a significant role in their experience with breast cancer, from diagnosis to treatment and survivorship (Simon et al., 2007). Research also shows that spirituality strengthens resilience in cancer patients by using prayer to decide on treatment options, which help them cope with side effects such as nausea, hair loss, pain, and sleep issues (Simon et al., 2007; Trinkaus et al., 2011). These findings support the positive impact that spirituality has on emotional well-being.

Finding meaning and purpose. Spirituality positively influences emotional well-being by helping individuals find meaning and purpose in their suffering and find meaning in life, especially for trauma victims and cancer patients (Bryant-Davis et al., 2012; Dillen, 2012; Grossman et al., 2006; Peres, Moreira-Almeida, Nasello, & Koenig, 2007; Simon et al., 2007; Walker et al., 2009). Some cancer patients (35/39, 11/18, 59/123) used spirituality to accept the diagnosis, to find meaning in the situation, and found that spirituality provided a sense of purpose throughout treatment and experience (Gall & Cornblat, 2002; Simon et al., 2007; Trinkaus et al., 2011). The authors also found that spirituality enhanced the quality of life for cancer patients, helping them to find the will to live and protecting them from end-of-life despair and depression (Simon et al., 2007; Sternthal et al., 2010; Trinkaus et al., 2011). Spirituality can help individuals find meaning and purpose by focusing on how one is living, being an example for others, strengthening one's self through suffering, and focusing on the lessons learned from their experiences to altruistically care for others (Gall & Cornblat, 2002; Grossman et al., 2006; Simon et al., 2007). Altruistic behaviours include empathizing with other victims, defending and protecting others who may be outcasts, or volunteering at various agencies to find a way of making positive effects in their worlds of the trauma survivors (Grossman et al., 2006). Among

survivors of child abuse, spirituality has been utilized to make meaning of the experience, freeing them of the blame and guilt from the abuse (Bryant-Davis et al., 2012; Grossman et al., 2006; Valentine & Feinauer, 1993; Walker et al., 2009). They may engage in prayer, social support, pastoral care, and reframing of the traumatic experience (Bryant-Davis et al., 2012). By finding meaning in the negative events, people can find a positive attitude to accept and endure the events (Gall & Cornblat, 2002; Gall et al., 2007).

Despite the findings that support spirituality as a means of making meaning and finding purpose, Grossman et al.'s (2006) study found that spirituality played a minimal part in making meaning for male trauma survivors. Grossman et al. (2006) gathered information about family history, past and current symptoms, abuse experiences, experiences with psychotherapy, and perceptions of the participants' own resiliency but did not state how they assessed the participants about the involvement of spirituality and religion in their experiences during the five-hour in-depth semi-structured interviews, nor did they collect information regarding spirituality or religious background even though the analysis of their results included spirituality as a type of meaning-making. Participants may have talked about their experience of meaning-making with spirituality in the back of their minds without making direct references. Also, since there were only 16 participants, 6% represents one person, hence making the differences seem large. Furthermore, since the participants were male survivors of sexual abuse, these results cannot be generalized to a broad range of clients with other traumatic experiences. Grossman et al. (2006) recognized this limitation and reasoned that this study served as a preliminary study to examine how men make meaning from their traumatic experiences. This study, in addition to the other literature provided, indicates the importance of meaning-making in the healing process of

trauma survivors by allowing them to find a new sense of purpose within the negative event and to develop a positive attitude, which is a positive aspect of spirituality on emotional well-being.

Hope and optimism. Hope and optimism for the future are positive aspects of spirituality that impacts the promotion of emotional well-being (Hill & Pargament, 2003; Simon et al., 2007; Trinkaus et al., 2011). Spirituality provides hope for survival during the treatment for cancer patients through the belief that God will heal them or that God will be with them through the process (Simon et al., 2007). The correlation between high spiritual faith and the openness to alternative treatment methods suggests that cancer patients may turn to alternative treatments or spirituality in addition to the treatment methods that they have tried to increase their hope of survival or for a miracle to occur (Trinkaus, et al., 2011). Hope and self-acceptance increases for victims of trauma through a relationship with and the belief in a benevolent God (Gall et al., 2007). Spirituality contributes to positive well-being because having faith that God has the ability to heal or to be present when enduring adversities relates to hope and optimism, which enhances the progress of healing and personal growth (Bryant-Davis & Wong, 2013; Gall et al., 2007; Hill & Pargament, 2003; Walker, Reid, O'Neill, & Brown, 2009). Hope and optimism in God also strengthen resilience to endure and grow from negative events (Bryant-Davis et al., 2012; Gall et al., 2007; Hill & Pargament, 2003).

Synthesis of the results. The results from the selected literature signify the positive impact of spirituality and religiosity on psychological resilience, particularly the adaptive ability to cope with difficulties (Kim & Esquivel, 2011; Miller et al., 2012; Simon et al., 2007; Trinkaus et al., 2011). The positive impacts of strengthening resilience, finding meaning and purpose, and increasing hope and optimism are related; as people find meaning in their suffering and find purpose for their lives, the meaning and purpose increases their sense of hope and optimism for

their current situation and future, thus, strengthening their resilience to cope (Bryant-Davis et al., 2012; Dillen, 2012; Gall & Cornblat, 2002; Gall et al., 2007; Kim & Esquivel, 2011; Simon et al., 2007; Sternthal et al., 2010). However, there are several limitations to these studies. Some of the sample sizes in these studies were generally small ranging from 16 to 18 due to the nature of qualitative studies (Grossman et al., 2006; Simon et al., 2007). The majority of the participants came from a background of Christian faith (Dillen, 2012; Gall et al., 2007; Simon et al., 2007). Future research should include bigger sample sizes or conduct more studies to generalize the findings. It would also be beneficial to conduct studies that are specific to participants with spiritual faith aside from Christianity to explore the positive and negative impacts of spirituality in other religions and faith. Another limitation is that the analysis of the excerpts for the studies that were conducted in interviews may have been subjective (Grossman et al., 2006; Simon et al., 2007). Furthermore, Trinkaus et al. (2011) suggested that the correlation between higher spiritual faith and the willingness to try complementary and alternative treatment methods may indicate that the spiritual needs of these individuals are unmet as spirituality tends to be addressed in these alternative treatments compared to conventional medicine. Overall, the literature suggests that spiritual care is an important aspect of psychological resilience and a source of strength and comfort amidst adversities (Kim & Esquivel, 2011; Miller et al., 2012; Simon et al., 2007; Trinkaus et al., 2011).

Spiritual Struggle and Negative Spiritual Coping

Although many people turn to religiosity and spirituality to find comfort among adversity (Bryant-Davis & Wong, 2013; Gall et al., 2007; Simon et al., 2007; Sternthal et al., 2010; Trinkaus et al., 2011; Walker et al., 2009), some people experience spiritual struggle, which may strain their ability to cope with their adversities by creating more psychological symptoms,

emotional distress, and pathology (Connor et al., 2003; Ellison & Lee, 2010; Exline, Park, Smyth, & Carey, 2011; Hill & Pargament, 2003; McConnell, Pargament, Ellison, & Flannelly, 2006; Pargament, Smith et al., 1998; Peres et al., 2007). The Diagnostic Statistical Manual of Mental Disorders (5th ed.; American Psychiatric Association, 2013) includes religious or spiritual problems as a criterion. This criterion includes distressing issues relating to the loss of faith or doubts in faith, conversions to a new faith, or the questioning of spiritual values (American Psychiatric Association, 2013). Psychological symptoms and pathology may result since spiritual struggles reflect conflict at fundamental levels of existence, values, and beliefs (McConnell et al., 2006). Spiritual struggles include concerns ranging from guilt about one's sinfulness, the perspective of God as punitive, doubting God's existence, uncertainty regarding being loved by God, disagreement with religious doctrines, negative encounters with coreligionists, and anger towards God (Ellison & Lee, 2010; Exline et al., 2011; Exline, Yali, & Sanderson, 2000; Hill & Pargament, 2003; Walker et al., 2009).

Some people may have negative conceptions of God due to their negative experiences with their parents in their upbringing, either through their parents' disciplining or through the examples that their parents model (Exline, 2002). Examples include parents making references to the Bible to teach their children a lesson when they have done wrong or in the ways parents punish their children (Exline, 2002). Others may experience tension and conflicts interpersonally within the context of religion or spirituality, such as disagreements regarding doctrines, or experiencing conflicting relationships within the community of same faith (Exline, 2002; Pargament, Zinnbauer, et al., 1998; Richards & Bergin, 2014). People often find attributions or reasons for negative events, and some people may attribute certain events to God

or a divine being (Exline et al., 2011). Attributing a negative event to another person or to God may result in psychological reactions such as blame or anger (Alicke, 2000).

Guilt. Spiritual guilt is a spiritual struggle that many people may experience (Exline et al., 2000; Exline et al., 2011). Spiritual guilt may result when people view negative events happening due to God's punishment (Exline et al., 2000; Exline et al., 2011; Pargament, Zinnbauer, et al., 1998). Pargament, Zinnbauer, Scott, Butter, Zerowin, and Stanik (1998) conducted a study that examined different warning signs for spiritual strain. They found that some people felt guilty for disagreeing with friends and family about doctrines, for doubting the existence of God, for feeling that their lack of spirituality was responsible for the negative event, felt that they deserve to be punished for their thoughts and behaviours, felt that they had failed God, and believed that God would not have allowed the negative event to happen unless they themselves caused the negative events to happen (Pargament, Zinnbauer, et al., 1998). Spiritual strain may lead to suicidality if it is not resolved, with guilt and fear as the greatest predictors (Exline et al., 2000). This guilt that leads to suicidality is associated with the feeling of hopelessness that comes from the belief that one's sin is too big to be forgiven in addition to lower self-esteems and greater anxiety (Exline et al., 2000; Pargament, Zinnbauer, et al., 1998). Due to the critical predictability to suicidality, it is crucial for counsellors to address spiritual guilt issues with clients to help them find ways of relieving their sense of guilt.

Anger. Anger towards God may result when people attribute the responsibility of the negative events to God (Exline et al., 2011; Pargament, Zinnbauer, et al., 1998; Walker et al., 2009). However, anger may also result when people believe that God allowed negative events happen to good people, that God did not answer their prayers, that God seemed cruel and punitive, that God was not being fair to them, or that the faith communities were unsupportive or

unavailable during times of need (Pargament, Zinnbauer, et al., 1998). This anger may also result when people put hope and trust in God, praying and asking for a specific outcome only to be unanswered (Exline, 2002). The intensity of anger may be associated with the severity of harm suffered from the negative event; greater anger may result with severe harm as people would question why God would not intervene and would passively allow the negative event to happen (Exline, 2002; Exline et al., 2011; Walker et al., 2009). Anger from spiritual struggle can resolve more easily when cognitive-based strategies are used, such as helping people find insight and meaning to the negative event or suffering either through the offender's explanation or through one's own ability to empathize (Exline et al., 2011; Walker, Reese, Hughes, & Troskie, 2010). By reframing the negative event to the idea that the event was not caused by God, by reflecting the negative event to a positive intent or outcome, or by reminding them of their previous commitment and belief in God, anger may lessen (Exline, 2002; Exline et al., 2011). However, anger can lead to maladjustment and to more intense anger if the violations are meaning-related or if people conclude that God is cruel (Exline et al., 2011). Spiritual anger may also be associated with adjustment issues (Exline et al., 2011). Exline et al. (2011) found that increased anger towards God in the span of a year was positively correlated with declining adjustment. Anger towards God can also result for atheists and agnostics, for people who do not believe in God or for people who do not participate in a religion or spiritual practice as they may also view God as punitive and cruel (Exline et al., 2011). However, as Exline et al. (2011) mentioned, some of the results that were provided by atheists and agnostics in the studies may have been based on hypothetical reasoning rather than on actual experience.

Implications for counsellors.

Since spiritual struggles may result in psychological symptoms and pathology, it is crucial for counsellors and helping professionals to assess and evaluate people's religious coping. Religious coping can be evaluated by three criteria: content criteria, pragmatic criteria, or process/integration criteria (Pargament, Zinnbauer, et al., 1998). The content criteria approach assumes that certain spiritual beliefs or practices are more effective than other spiritual beliefs or practices (Pargament Zinnbauer, et al., 1998). This approach is suitable for evaluating effective and ineffective coping strategies within a specific religion and cannot identify common ineffective coping strategies across different religions or spiritual beliefs (Pargament, Zinnbauer, et al., 1998). The pragmatic criteria approach focuses on identifying the coping strategies that lead to positive outcomes as useful and effective, and identifies the coping strategies that lead to negative outcomes as maladaptive (Pargament, Zinnbauer, et al., 1998). However, this approach has its limitations—it is possible to have negative outcomes despite using positive or useful coping strategies, and for positive outcomes to result despite using maladaptive coping strategies (Pargament, Zinnbauer, et al., 1998). Thus, in these cases, it is difficult to evaluate how well one has coped (Pargament, Zinnbauer, et al., 1998). The process/integration criteria approach evaluates the effectiveness of one's coping in the context of one's beliefs, values, emotions, behaviours, and social environment (Pargament, Zinnbauer, et al., 1998). The effectiveness of one's coping depends on the integration of all these components (Pargament, Zinnbauer, et al., 1998). This approach is difficult to measure. However, the complexity of this approach is similar to the complexity of the factors that are examined by psychological assessments; thus, this approach is parallel to clinical practice (Pargament, Zinnbauer, et al., 1998). In addition to religious coping, spiritual struggles should also be assessed to incorporate intervention early in

the treatment process to resolve the struggles before they become problematic (McConnell et al., 2006). Positive coping results when there is security in the relationship with God, a strong sense of meaning in life, and emotional comfort that result from connectedness with others within the spiritual community (Pargament, Smith et al., 1998). Counsellors can also encourage clients to express their anger and confusion by using techniques such as trauma narrative, letter to God, or open chair technique (Exline & Rose, 2005).

Conclusion

In this chapter, I presented the positive and negative impacts of spirituality and religiosity in positive coping during adversity in cancer patients, people with depressive symptoms, and survivors of trauma. The studies reviewed in this chapter revealed the effectiveness of spirituality, particularly by strengthening resilience, having a sense of purpose and meaning, and increasing hope and optimism have strong effects on promoting emotional well-being (Bryant-Davis & Wong, 2013; Miller et al., 2012; Simon et al., 2007; Trinkaus et al., 2011; Walker et al., 2009). However, spirituality can also have negative impacts in coping, especially for people who are experiencing guilt and anger (Exline et al., 2000; Exline et al., 2011; Pargament, Zinnbauer, et al., 1998). Finding meaning and increasing hope can also have a negative impact on emotional-well-being when people believe that the reason for a negative event was a punitive or unavailable God (Exline, 2002; Pargament, Zinnbauer, et al., 1998). It is important for counsellors to listen to the pain and assess the impact of spirituality in the issues that clients present.

Incorporating Spiritual Interventions into Counselling

Several helping professionals have incorporated spirituality and spiritual practices into psychotherapy (Bhagwan, 2009; Coyle & Enright, 1997; Hanna, 1968; Leseho & Maxwell, 2010; Marlatt & Kristeller, 1999; McCullough & Larson, 1999; Parker, 2011; Richards & Bergin, 2005). In this chapter I will present several theoretical models on spirituality that therapists have used in psychotherapy. I will also present a few examples of spiritual practices that psychotherapists may encourage clients to engage in or incorporate into psychotherapy.

Spiritual Models for Therapy

Fowler (1981) developed faith developmental theory (FDT), which provides a developmental model for understanding spiritual and religious changes. This model identifies the crises and transitions between the stages of faith (Parker, 2011). Fowler's model is universal and not specific to one religion, hence allowing counsellors to work with clients generically without the challenges of specific religious beliefs (Parker, 2011). Fowler defines faith as the relationship between spirituality and religion (Parker, 2011). Fowler's model incorporates Piaget's developmental stages in regards to how one makes sense of the world in relation to social awareness (Parker, 2011). Like Miller's stages of change (1997), Fowler's stages of faith allows counsellors to identify the stage the client is in when working with his or her spirituality in counselling. These stages include undifferentiated stage, intuitive-projective stage, mythic-literal stage, synthetic-conventional stage, individuative-reflective stage, conjunctive stage, and universalizing stage (Fowler, 1981). In the undifferentiated stage, Fowler (1981) proposes that individuals aged 0-2 (ideally) experience trust and safety in the environment. In the intuitive-projective stage, values are shaped through experiences, stories, and images (Fowler, 1981). In the mythic-literal stage, individuals have a strong sense of justice and fairness and comprehend

metaphors and symbols literally (Fowler, 1981). In the synthetic-conventional stage, individuals conform to religious authorities without questioning their own beliefs about these rules and they start forming a sense of personal identity (Fowler, 1981). In this stage, one's sense of worth is determined by the approval of others and the person may over-internalize others' judgements (Fowler, 1981). In the individuative-reflective stage, one takes responsibility for one's own beliefs and feelings, strengthening awareness and critically reflecting on one's conflicts in values and beliefs (Fowler, 1981). Individuals understand social relationships as part of social systems and may have overconfidence in resolving social issues (Fowler, 1981). In the conjunctive stage, individuals resolve the conflicts of their belief from previous stages by understanding the complexity in faith and opening up to their deeper issues and unconscious motivations (Fowler, 1981). In the universalizing stage, individuals reach enlightenment and are able to altruistically view other people with compassion and treat others with love and justice (Fowler, 1981). By knowing the stages of faith and assessing the client's current faith stages, counsellors can help clients use the strengths of the current stage to facilitate change (Parker, 2011).

Geffen (2004) created a model to understand the healing process of cancer patients. According to Geffen (2004), cancer patients and their family members experience healing through seven levels when seeking for wholeness in the time of crises. The first six levels include (1) gaining education and information about the illness; (2) connecting to others to reduce feelings of anxiety, depression, and pain; (3) viewing the body as a garden and that doctors are the gardeners who discover and heal the root of the disease by examining daily food choices and activities; examining the emotions of their internal world such as fear, pain, anger, grief, sadness, and turmoil to discover ways of releasing such emotions; (5) developing an understanding between the conscious and unconscious thoughts that impact their experiences and

their responses to treatment; (6) exploring their reasons for living by assessing their goals in life and prioritizing these goals to strengthen their resilience to meet the challenges of the illness (Geffen, 2004). Spiritual healing, the seventh level, may be the most important level of healing for cancer patients (Geffen, 2004). Geffen (2004) describes the spirit as the true nature of humankind—the source of all awareness, creativity, and healing. Spirituality is a timeless, eternal, and dimensionless construct of the human being, giving cancer patients hope for what is beyond their physical body, relieving their feelings of anxiety and distress (Geffen, 2004). Geffen (2004) proposes that the deepest healing takes place in this level as the patients discover their spiritual essences through nature, silence, meditation, and prayer.

Spiritual Practices in Psychotherapy

Prayer

Prayer is a form of connecting with the spiritual world that therapists have incorporated into their therapy with clients and which is found to have a positive effect on psychological symptoms (McCullough, 1995; Moivic, 2004). The word prayer is derived from the Latin word to retreat (Whitford & Olver, 2011), and can be defined as nonverbal or verbal communication or conversation with divine power (Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005). Prayer is profoundly spiritual and not merely a religious act as it is a powerful way of connecting with the supernatural and the sacred (McCullough & Larson, 1999). Prayer represents one of the core elements of spirituality and includes thoughts, attitudes, and actions to express connection to the supernatural world, and it can be used to process and find meaning in psychotherapy even when it is separated from traditional religious frameworks and religious communities (McCullough & Larson, 1999). Prayer varies from person to person as it is highly individualized (Farah & Mccoll, 2008), and includes asking the divine something for

one's self, for someone else, confessing and repenting of sins, asking for forgiveness, lamenting, honouring the divine, and offering gratitude (Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005). Other types and forms of prayer include spontaneous, recited or using spiritual passages, sung, meditative, communal, and private (Farah & Mccoll, 2008; Poloma & Gallup, 1991). McCullough (1995) found that prayer promotes health by facilitating relaxation, which improves mood and well-being, bringing peace and comfort during times of trials and providing inspiration and intimacy, increasing motivation and a sense of purpose.

Research has shown that therapists have incorporated prayer into their work with clients by praying silently for clients during and outside of sessions, praying vocally with clients during sessions, and encouraging clients to pray outside of sessions (Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005). A study conducted in cancer research examined whether intercessory prayer positively impacted spiritual wellbeing (Whitford & Olver, 2011). In this study, 999 patients were randomized to receive remote Christian prayer or no prayer, with the intervention revealed from the patients (Whitford & Olver, 2011). Their results showed that patients with prayer improved slightly in their spiritual well-being compared to the control group that received no prayer (Whitford & Olver, 2011). Whitford and Olver (2011) found that there was a significant improvement for the experimental group on their emotional well-being. However, there were no data on the effective use of intercessory prayer (Whitford & Olver, 2011). It was also unclear how spiritual and emotional well-being was measured in the study.

According to McCullough and Larson (1999), there are five ways in which therapists can productively use prayer in the course of mental health treatment. First, therapists can assess the

types of prayer that their clients use to understand their overall religious coping styles (McCullough & Larson, 1999). Assessing the types of prayer may reveal the coping styles of clients—between positive or negative, active or passive (McCullough & Larson, 1999). This information helps therapists assess the overall effect spirituality has on the client's health and well-being (McCullough & Larson, 1999). Secondly, therapists can also encourage clients to pray outside of sessions (McCullough & Larson, 1999). Prayer may help clients become more susceptible to counselling and treatment by strengthening hope for resolution to their issues, providing comfort for the healing process, and by allowing clients to be open to the psychological work (McCullough & Larson, 1999). Thirdly, therapists can use prayer with clients who are highly religious or spiritual to facilitate cognitive-behavioural change by incorporating therapy into their worldview (McCullough & Larson, 1999). Therapists can facilitate changes in clients' self-talk and self-beliefs by redirecting clients to positive or hopeful forms of prayer (McCullough & Larson, 1999). Fourthly, therapists can pray with clients during sessions (McCullough & Larson, 1999). McCullough and Larson (1999) suggest that therapists should pray with clients only when all three conditions are achieved:

- (a) The client requests in-session prayer; (b) a thorough spiritual and religious assessment and psychological assessment have convinced the therapist that engaging in such explicitly spiritual and religious activities would not lead to the confusion of therapeutic role boundaries; and (c) competent psychological care is being delivered. (p. 101)

Richards and Bergin (2005) suggest that therapists should only use prayer in session when the client and therapist endorse a highly similar spiritual and religious worldview as this would decrease the potentiality of ethical issues. And lastly, therapists can pray for clients in their personal times (McCullough & Larson, 1999). Praying with clients during sessions or praying

for clients privately outside of sessions may open therapists' minds and also allow therapists to achieve insight about clients' lives (McCullough & Larson, 1999).

Meditation

Meditation has been helpful in physical treatments like for cancer and AIDS, and it is also helpful in the treatment of psychological problems (Marlatt & Kristeller, 1999). Meditation is a form of relaxation but it is also a technique in achieving mindfulness physically, psychologically, or spiritually (Marlatt & Kristeller, 1999). Mindfulness is the state of being mindful in the present moment, which "is to be aware of the full range of experiences that exist in the here and now" (Marlatt & Kristeller, 1999). Mindfulness is an attitude of acceptance—to accept all thoughts, emotions, and events, whether positive or negative, as they are (Marlatt & Kristeller, 1999). According to Marlatt and Kristeller (1999), most of the research on meditation focuses on two types of meditation—concentrative meditation and mindfulness meditation. Concentrative meditation focuses on a specific object or action such as inhaling and exhaling, a candle flame, or a specific sound (Marlatt & Kristeller, 1999). Mindfulness meditation focuses on developing awareness of mental content such as thoughts, imagery, physical sensations, or feelings (Marlatt & Kristeller, 1999).

Marlatt and Kristeller (1999) suggest that therapists can introduce meditation to clients as a way of attaining a balanced lifestyle. They encourage clients who are new to meditation to begin with concentrative meditation (Marlatt & Kristeller, 1999). Therapists can guide clients through a concentrative meditation by asking clients to sit in a comfortable upright position with feet on the floor (Marlatt & Kristeller, 1999). Therapists can guide clients by asking them to breathe in and out through the nose and to notice each breath one at a time and feel the warmth and coolness of each breath (Marlatt & Kristeller, 1999). Therapists can guide clients to notice

the movement of the abdominal muscles and the movement of the chest (Marlatt & Kristeller, 1999). Therapists can remind clients that when they are distracted during the meditation exercise, to notice that they have been distracted and to return attention to the breathing and to the movement of the chest and abdominal muscles as they move with each breath (Marlatt & Kristeller, 1999). After 10 minutes, the therapist can ask clients to return by signalling a bell or by asking clients to gently and slowly open their eyes to return back to the space of the room when they are ready (Marlatt & Kristeller, 1999). After coaching the clients through the exercise, therapists can recommend that clients practice the exercise regularly or even on a daily basis (Marlatt & Kristeller, 1999).

After the client has become comfortable with concentrative meditation, therapists can introduce mindfulness meditation to cope with stressful situations as they occur (Marlatt & Kristeller, 1999). Clients can use the method of focusing awareness that they learned from concentrative meditation to focus on thoughts, imagery, physical sensation, or feelings during mindfulness meditation (Marlatt & Kristeller, 1999). The objective is for clients to attend to those thoughts, imageries, physical sensations, or feelings without making mental judgment or evaluation (Marlatt & Kristeller, 1999). Mindfulness meditation can be used for clients who are fighting urges for addictive behaviours. They can practice meditation when they notice the urge, and to focus on the thoughts, sensations, or feelings that arise from the urge as they breathe (Marlatt & Kristeller, 1999). Clients can use metaphors with their meditation exercises to balance the discomfort from urges of the addictive behaviours (Marlatt & Kristeller, 1999).

Spiritual Dance

Jung developed the idea of incorporating dance into psychotherapy in 1916 (Leseho & Maxwell, 2010). Dancing as a therapeutic technique allows clients to artistically express through

their bodies and to connect their emotions with their physical body (Leseho & Maxwell, 2010). Dancing incorporates movement, music, rhythm, and breathing, and can also be used as an expression of connecting with the spirit—the innermost soul or essence of an individual that is difficult to be expressed by words—and could be more powerful than traditional talk therapy when healing the spirit (Leseho & Maxwell, 2010). Webster’s online dictionary defines spirit as the inner quality, nature, or soul of a person that gives the body life, energy, and power (Webster, 2014). Dancing allows individuals who have experienced trauma or abuse to tell their stories through the expression of their bodies, connecting their inner selves with physicality and with the environment (Leseho & Maxwell, 2010). Dancing allows trauma victims to connect the sacred from outside and within themselves (Leseho & Maxwell, 2010). Leseho and Maxwell (2010) conducted a qualitative study in which they interviewed 29 female victims of abuse with various spiritual backgrounds and occupations from 12 different countries. Leseho and Maxwell (2010) examined the meaning that these women gave to dancing within their healing journeys. They found that dancing allows individuals to cope with the changes in their bodies from distressing issues such as cancer and trauma by embodying abstract concepts and ideas, enabling feelings of transcendence (Broadbent, 2004; Leseho & Maxwell, 2010), by allowing the individuals to connect with their inner beings, bringing out their inner spirit allowing them to express their intense feelings from brokenness, fostering healing and resilience (Leseho & Maxwell, 2010). By connecting to their inner selves, clients who use dance in healing feel more whole than they did prior to dancing (Leseho & Maxwell, 2010).

Monteiro and Wall (2011) found that the movement and ritual of traditional African dance was effective in working through trauma. They discovered that the African community believed in the necessity of rituals (Hanna, 1968) to incorporate community, mind, and body in

order to facilitate healing (Monteiro & Wall, 2011). Traditionally, African people believe that psychological illnesses result as a disintegration with the spiritual world or with the community through failure to honour the spiritual realm, neglecting rituals, neglecting social responsibilities and obligations, disrespecting community leaders, or losing personal faith (Monteiro & Wall, 2011). Traditional healing methods include the holistic use of plants and herbs or a ceremony featuring music, dance or the interpretation of dreams (Monteiro & Wall, 2011). The movement of dance, in particular, is a form of healing, and it also represents a narrative of the personal, communal, and social aspects of the person (Monteiro & Wall, 2011). African dance has been found to lessen and neutralize the impact of trauma and on relieving symptoms of psychological distress (Monteiro & Wall, 2011), as dance is an organic, natural, and immediate expression of emotions (Leseho & Maxwell, 2010). Ritual dance, in addition to expressing emotions for a cathartic release, also offers a method of coping by desensitizing the traumatic experience (Hanna, 1968). The rituals of dance can promote resilience and help individuals desensitize from traumatic stimuli by using familiar situations to stimulate the emotions and using the movement of the body from dance to express and reduce their emotions to a manageable level, allowing the individuals to feel a sense of achievement for managing their overwhelming emotions (Hanna, 1968).

Counsellors can incorporate dance into psychotherapy by encouraging clients to dance to music at home, to sign up for dance classes, or refer them to dance therapists (Leseho & Maxwell, 2010). Counsellors can process with clients through talk therapy the emotional release that the clients encountered during their dance sessions (Leseho & Maxwell, 2010). Counsellors can provide coping strategies to clients for managing distressing emotions that may surface during the dance sessions (Leseho & Maxwell, 2010).

Sacred Spaces

The sacredness of spaces is important for healing in different cultures and religions (Cohen, 2003). Declaring a place as sacred removes it from the ordinary, imparting the place with distinctiveness and symbolic value (Schramm, 2011). Ancient Greeks sought healing dreams in temples, while Native Americans of North America and Christians have made pilgrimages to seek healing in sacred places (Cohen, 2003). Native Americans considered the medicine wheel—stone monuments that are constructed by placing loose stones in a circle—as sacred healing sites in which spiritual and cultural rituals are held (Geist, 1993; Grinnell, 1922; Mazzola, 1988). The medicine wheel represents holistic balance and symbolizes the interconnections of life, the cycles of nature, and the circular journey of life, connecting members of the tribe to the environment, to each other, and to their inner selves (Gone, 2011; Mazzola, 1988). The medicine wheel consists of four quadrants that are created by two bisecting perpendicular lines: red, white, black, yellow, each colour representing a direction (north, south, east west), a season (spring, summer autumn, winter), an element (air, fire, water, earth), an aspect of the person (mind, body, emotion, and spirit), a psychological power (innocence/trust, wisdom/objectivity, introspection, spiritual insight), and a construct of the person (values, decisions, actions, and reactions) (Mazzola, 1988; Warne, 2005). First Nations people believe that values are interpreted into decisions in the mind, and then transferred into actions to the physical body, which then leads to reactions in the emotional realm (Warne, 2005). By keeping the conditions of the medicine wheel, harmony and balance are reached, while mixing the conditions create imbalance and discourse (McCabe, 2008). The inner dialogue of a person can help the individual find balance again within the discourse (McCabe, 2008). Each quadrant on the medicine wheel also symbolizes a different approach in life—a subjective approach to self, a

subjective approach to others, an objective approach to others, and an objective approach to self (Mazzola, 1988). Individuals can become aware of the weaker approaches or psychological powers and focus on cultivating and developing them to find balance and to grow as a whole person in the dynamics of healing (Mazzola, 1988).

Faith homes have been established within the Christian community that enables people to seek divine healing within a nurturing and hospitable environment (Curtis, 2006). Within these faith homes, individuals may find physical healing and spiritual holiness through quiet submission to God (Curtis, 2006). Visitors to these faith homes are encouraged to consider themselves as adoptive members of a family that is bound together by a common faith (Curtis, 2006). Guests who are visiting and staying at these faith homes were given liberty to seek healing through spiritual retreat with the flexibility of participating in daily activities such as communal meals, Bible studies, and prayer services (Curtis, 2006). These sacred spaces allowed guests to distance themselves from the societal norms that shaped the ways they interpret and respond to suffering, providing time and space for them to practice alternative perspectives to healing (Curtis, 2006).

Sacred spaces can also be defined as a nurturing environment in which clients feel safe to open themselves emotionally and psychologically to make meaning within their conflicts and difficulties (Fraser, 2000). Sacred spaces provide safety for clients as they explore and strengthen their self-worth and the value of their relationships and environments (Fraser, 2000). Sacred spaces allow children to feel spiritually safe allowing them to express hurts and struggles (Bhagwan, 2009). Some children view divine beings as protectors, as the sunshine or angel watching over them; hence, through sacred spaces, practitioners can foster the child's connection with divine beings, which fosters transformation and healing, promoting the child's well-being

(Bhagwan, 2009). Fraser (2000) suggests that the sacred space could be fostered through talk therapy, prayer, meditation, guided imagery, artwork, journaling, music, and silence.

Forgiveness

Forgiveness is one of the spiritual practices often encouraged by psychotherapists for clients to implement into their healing processes (Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005). The act of forgiving is to give up anger and the actions associated with anger such as revenge (Sanderson & Linehan, 1999). Individuals who struggle with forgiving others over minor hurts are considered as psychologically troubled (Sanderson & Linehan, 1999). According to American Psychiatric Association (2013), those who hold grudges against others interpret ambiguous remarks from others as threatening, may be suspicious of the faithfulness of intimate partners, and may be suffering from psychiatric symptoms. Forgiveness involves a personal change in thoughts and feelings that results in reduced anger, anxiety, and grief (Coyle & Enright, 1997). Forgiveness is not simply an internal change of feeling; it is a willing effort to change one's thoughts, actions, and attitude towards another who was hurtful (Sanderson & Linehan, 1999). Forgiveness is not merely an act of grace towards another; it is a skill that requires practice (Sanderson & Linehan, 1999). Therapists have often encouraged clients to forgive the following: (a) parents or others who have abused or offended them; (b) themselves for failures and mistakes (Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005). They have also encouraged clients to accept forgiveness from others and from God (Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005).

Therapists need to assess the clients' readiness to forgiveness before incorporating this spiritual practice into their treatment (Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005). Clients who have been abused need to go through other phases of their

healing processes such as acknowledging the experience, experiencing the different emotions, receiving validation that they have been wronged, and repairing boundaries, before considering forgiving the perpetrators (Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005). Regardless of the possibility of reconciliation or the discontinuation of the relationship, forgiveness is encouraged for intrapersonal healing (Coyle & Enright, 1997; Sanderson & Linehan, 1999; Worthington & Drinkard, 2000). Therapists need to be aware of clients who struggle with forgiving themselves for personal limits or failings and to help them forgive themselves and let go of anger for imperfections and errors (Sanderson & Linehan, 1999). At times, anger is a secondary emotional response to a primary emotional response such as fear (Sanderson & Linehan, 1999). When anger is present as a secondary emotional response, it may hinder adaptive emotional processing for recovery from emotional trauma; hence helping clients to forgive may help them access their primary emotions to facilitate the healing process (Sanderson & Linehan, 1999). Sanderson and Linehan (1999) suggest the following steps for clients when practicing forgiveness: (a) consider the pros and cons of forgiving versus not forgiving; (b) empathize with offender to understand the offender's behaviour; (c) practice validating the offender's distress if the offender is sincerely regretful; (d) engage in reconciliatory behaviours.

Repentance, which serves as a prelude to forgiveness, is to change for the better as a result of remorse for one's wrongdoing (Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005). Those who struggle with asking for forgiveness when they have wronged others are also considered as psychologically troubled (Richards & Bergin, A spiritual strategy for counseling and psychotherapy, 2005). The motivation to repent and to reconcile with others can help facilitate the change process in therapy (Richards & Bergin, A spiritual

strategy for counseling and psychotherapy, 2005). When the offender seeks forgiveness, the offender is taking responsibility for the wrongdoing and makes it easier for the person who is hurt to deal with the pain (Worthington & Drinkard, 2000). Guilt may also be a driver of the motivation to repent, which in this case, serves beneficially as clients seek to do the right thing to relieve of the pain in their consciences (Richards & Bergin, A spritual strategy for counseling and psychotherapy, 2005). For the offender, Sanderson and Linehan (1999) suggest five steps to achieve: (a) attain personal responsibility; (b) express earnest regret and remorse; (c) make suitable compensation; (d) promise to discontinue the offending behaviour; (e) request for forgiveness. Forgiveness cannot be requested before the offender has taken responsibility for the wrongdoing as it would be insincere (Richards & Bergin, A spritual strategy for counseling and psychotherapy, 2005). Seeking forgiveness by offering insecure apology may harm the victim further (Richards & Bergin, A spritual strategy for counseling and psychotherapy, 2005). Only after the offender has taken responsibility can he or she offer an apology and seek forgiveness to the person he or she has offended (Richards & Bergin, A spritual strategy for counseling and psychotherapy, 2005). Apology is a big component of forgiveness, and the degree of authenticity that is portrayed within the apology of the offender affects the likelihood of forgiveness (Sanderson & Linehan, 1999). Therapists need to work with the initial emotions such as shock, grief, anger, hurt, and shame of the clients, whether they are offenders or victims, before seeking or receiving forgiveness (Sanderson & Linehan, 1999).

Conclusion

In this chapter, I presented spiritual models that practitioners can incorporate into psychotherapy with clients. A few spiritual practices such as prayer, meditation, spiritual dance, sacred space, and forgiveness have been presented as examples of spiritual techniques that

practitioners can encourage and incorporate into their clients' healing journeys. Although these techniques are spiritual, practitioners are not required to have specific religious backgrounds in order to effectively use these practices with clients.

Issues for Consideration

Counsellors who incorporate spirituality and religiosity into the healing processes of their clients may face several challenges. These challenges include spiritual competency (explained further below) and recognizing their own biases that may affect the therapeutic alliance (Hage, Hopson, Siegel, Payton, & Defani, 2006; Lambie, Davis, & Miller, 2008; Richards & Bergin, 2014; Yarhouse & Johnson, 2013). Counsellors who are incorporating spirituality and religiosity into their work with clients need to do so with spiritual competency by assessing the degree of the client's involvement with the spiritual or religious tradition, whether the client's beliefs and practices pertain to the standard for that faith, and whether the practices and beliefs are utilized in adaptive ways (Richards & Bergin, 2014; Shaw, Bayne, & Lorelle, 2012). This will be further explored in the section below. In this chapter, implications to counsellors and helping professionals will be discussed in addition to limitations and ethical issues.

Implications for Counsellors

Spiritual Competency

Within North America, the majority of people profess a spiritual faith and proclaim the importance of religion with approximately 266.630 million Christians, 6.040 million Jews, 3.860 million Buddhists, 3.480 million Muslims, 2.250 million Hindus, and 1.020 million Folk Religionists (folk or traditional religions of Africa, China, Native America, and Australia) (The global religious landscape, 2012). Within spirituality and religiosity, there is a rich variety of “customs, beliefs, doctrines, myths, rituals, music, buildings of worship, clothing, sacred writings, spiritual practices, and healing traditions” (Richards & Bergin, 2014, p. 9). Hence, it is essential for counsellors to gain spiritual competency and understanding of various spiritual beliefs and practices and to understand which behaviours may be considered normative in

religious or spiritual contexts to distinguish between clients' issues in spiritual distress, spiritual immaturity, and spiritual ill health (Hage et al., 2006; Richards & Bergin, 2014). This spiritual knowledge can be acquired by conducting research on the different spiritual practices and beliefs that are relevant to clients, in addition to talking to clients about the standards that the clients perceive to pertain to their beliefs and practices (Hage et al., 2006; Richards & Bergin, 2014). Not all graduate studies programs directly include spiritual diversity training for students in psychotherapy or counselling even though they include general training in multicultural counselling; spiritual diversity requires specialized knowledge and training (Sink & Devlin, 2011; Richards & Bergin, 2014). Thus, it is the counsellor's responsibility to pursue professional development in ethical and effective ways of incorporating spirituality for clients with diverse spiritual backgrounds (Richards & Bergin, 2014).

Regardless of their own spiritual backgrounds, psychotherapists and counsellors should at least be able to (a) understand and show respect for clients' religious beliefs and values, (b) establish a spiritually safe and affirming therapeutic environment for spiritual clients, (c) conduct an effective spiritual assessment (d) encourage clients to find support from their spiritual communities, and (e) effectively collaborate with spiritual leaders (Richards & Bergin, 2014). The following principles also strengthen spiritual competency: (1) discerning similarities and differences between spirituality and religiosity, (2) describing spiritual practices and beliefs in a cultural context, (3) engaging in self-exploration to increase sensitivity and understanding for one's belief system, (4) demonstrating acceptance and sensitivity to a variety of spiritual or religious expression in the client's communication, (5) identifying one's limitations to understanding the client's spiritual expression and providing appropriate referrals, (6) assessing spiritual domains that may be related to the client's therapeutic issues, (7) be respectful of the

client's preference and use the client's spiritual beliefs that may cultivate beneficial therapeutic goals (Burke, 1998; Yarhouse & Johnson, 2013). Prior to integrating spirituality into the healing process, psychotherapists and counsellors need to gain a broader understanding of the client's religious and/or spiritual background, which would help psychotherapists and counsellors understand how the client's spiritual background may play as an external factor in relation to the client's presenting issue (Richards & Bergin, 2014).

Spiritually competent counsellors and psychotherapists: (1) have self-awareness regarding their own spiritual backgrounds, beliefs, values, and biases that could affect their clients who have different spiritual backgrounds; (2) learn to appreciate and understand different religious and spiritual traditions that are different from their own; (3) show respect to clients even when spiritual backgrounds and values differ; (4) seek to understand how the client's spiritual background may affect identity and emotional functioning; (5) avoid assumptions and myths about the client's spiritual traditions and to seek further knowledge about the client's specific beliefs and traditions regarding his or her spirituality and religiosity; (6) learn to respectfully handle conflicts and disagreements that may arise due to differences in the worldviews of the therapist and client regarding spirituality; and (7) use spiritual interventions that are similar to the client's spiritual beliefs, practices, and traditions when the therapist sees as beneficial in promoting therapeutic change and emotional healing (Hage et al., 2006; Lambie et al., 2008; Richards & Bergin, 2005; Yarhouse & Johnson, 2013). The American Counseling Association (ACA, 2014) and the Canadian Counselling and Psychotherapy Association (CCPA, 2007) have included spiritual competency in their codes of ethics and encourage counsellors to engage in self-care activities to maintain spiritual well-being in addition to emotional, physical, and mental well-beings to promote professionalism to their clients in addition to assessing

spiritual issues that may play as factors of the clients' presenting issues. Counsellors and psychotherapists can gain these characteristics and gain spiritual competency by reading scholarly literature on psychology and spirituality, learning about world religions, acquiring knowledge on spiritual issues that are frequently encountered in psychotherapy, and seeking supervision (Hage et al., 2006; Richards & Bergin, 2005). It is important for counsellors to seek supervision from other therapists who have also used spiritual interventions as these supervisors can serve as role models for achieving spiritual competency (Hage et al., 2006).

One of the ways counsellors can strengthen spiritual competency is to review case studies of clients to explore their own values, beliefs, and attitudes about their potential spiritual influence in counselling sessions (Shaw et al., 2012). Counsellors can strengthen self-awareness by noticing their initial reactions and responses for each client in the case studies and in actual sessions with clients (Shaw et al., 2012; Yarhouse & Johnson, 2013). Through exploring these case studies, counsellors have the opportunity to reflect on questions regarding making referrals, the influence that they may have on clients or on the counselling sessions regarding spirituality and religiosity, and how may relate to clients even when values and beliefs differ from their own (Shaw et al., 2012). Counsellors can also strengthen spiritual competency by strengthening their sensitivity in listening and identifying spiritual issues by reflecting on the way one has derived at holding particular beliefs (Shaw et al., 2012). Exploring one's own in addition to the client's family beliefs or the changes in clients' beliefs allows counsellors to gain a better understanding of how clients and themselves arrive at certain beliefs that comprise their worldviews (McAuliffe & Milliken, 2009).

Due to racial and ethnic diversity in North America, spiritual competency also requires addressing differences between religions in addition to addressing differences within the same

religion based on different cultural backgrounds. Christianity for example is one of the biggest religions in the world, with 2.2 billion believers, which amounts to 32% of the world population (The global religious landscape, 2012). Yet within Christianity alone, there are many denominations such as Catholicism, Protestantism, Independents, and marginal Christians (Richards & Bergin, 2014; The global religious landscape, 2012). Within Catholicism, there are two denominations: Roman Catholicism and Eastern Orthodoxy (Richards & Bergin, 2014). Within Protestantism alone, there are many different denominations with different doctrines; these denominations include Adventist, Anabaptist, Anglican, Baptist, Evangelical Lutheran, Mennonite, Methodist, Pentecostal, Presbyterian, Reformed, and Southern Baptist (Emberson, 2013). Thus, it is crucial for therapists to learn about the traditions and beliefs specific to the client's spiritual and religious practices and not to carry assumptions and biases into the work with their clients, especially since clients may feel concerned with raising doctrinal issues or doubts due to the incompatibility of the therapist's knowledge or belief (Exline et al., 2000; Lambie et al., 2008; Shaw et al., 2012). Spiritual competency can be strengthened by exposing one's self to different spiritual and religious beliefs (Alexander, Kruczek, & Ponterotto, 2005).

Ethical Issues

Although not everyone experiences spirituality as essential, counsellors need to understand that spirituality is an important part of the counselling experience as everyone seeks for the meaning in life, which comes from the spiritual dimension (Burke, 1999; Kelly, 1999). Based on the code of ethics by the ACA (2014), counsellors who disregard the spirituality of their clients due to their own discomfort of dealing with spiritual issues may be practicing unethically if they fail to address a vital aspect in clients' lives (Casarez & Engebretson, 2012; Lambie et al., 2008; Pargament & Saunders, 2007). Spirituality does not need to be the focus of

psychotherapy; nonetheless, counsellors need to be open and available to explore this area of life if clients choose to do so (Lambie et al., 2008).

There are several ethical issues to be attentive to when incorporating the topic of spirituality and religiosity into counselling. It is crucial for a counsellor to provide a comfortable environment and to be open to exploring different perspectives and aspects of spirituality rather than advocating for a particular religious or spiritual philosophy (Lambie et al., 2008). There is an increased risk of confusion in role boundaries when therapists incorporate spiritual practices such as prayer in therapy sessions by praying with clients during sessions (Richards & Bergin, 2005). This may confuse clients of the role of a professional therapist as opposed to the role of a religious leader (Richards & Bergin, 2005). Clients may seek spiritual guidance that is beyond the expertise of a counsellor or may have expectations that are beyond the role of a counsellor (Richards & Bergin, 2005). Furthermore, there is an increased risk of developing dual relationships of therapist–religious leader if counsellors choose to incorporate spiritual practices directly into counselling sessions with clients, especially if the client and counsellor share the same faith (Richards & Bergin, 2005). Dual relationships should be avoided for several reasons. Firstly, clients may feel guarded to freely disclose and explore issues if the therapist is also a religious leader in their community and has religious authority over them (Richards & Bergin, 2005). Clients may feel guarded to disclose sexual, violent or other sensitive issues if there is a risk of persecution or excommunication from the faith community due to the dual role of the therapist and religious leader (Richards & Bergin, 2005). Secondly, the conflict of interest is greater in dual relationships; a therapist may feel tempted to make numerous referrals to one's private practice to gain financial benefits (Richards & Bergin, 2005). Thirdly, clients may feel awkward in religious functions and may avoid them altogether with the fear of bumping into the

therapist, with whom they have shared private information (Richards & Bergin, 2005). Lastly, religious leaders are not obligated as counsellors are to breach confidentiality when abuse has been reported (Richards & Bergin, 2005). Breaching confidentiality as a religious leader may lose the confidence and trust of the client (Richards & Bergin, 2005). As the role of a religious leader, the therapist may also feel tempted to rebuke the client within the setting of the faith community, hence risking the violation of confidentiality (Richards & Bergin, 2005). Furthermore, as mentioned in the code of ethics of ACA (2014) and of CCPA (2007), dual relationships such as familial, social, business, and personal relationships should be avoided to prevent the risk of losing professional objectivity or from increasing harm to the client.

Another ethical issue that rises is that counsellors may feel tempted to counsel and advise a client based on their own moral standards and values of the situation that the client presents (Yarhouse & Johnson, 2013). Counsellors need to remember that they are to focus on their code of conduct and not to focus on imposing their own ethical or moral standards within spiritual or religious system, though they can encourage clients to reflect on the clients' ethical issues based on their belief systems, creating a safe environment for clients to maximize their autonomy for decision making (Yarhouse & Johnson, 2013). Counsellors need to remember that they should not engage in discrimination based on religion (ACA, 2014; CCPA, 2007). However, when spiritual or religious beliefs appear harmful pertaining to health and safety (Griffin, 1996), counsellors can consider challenging the clients to reflect on the beliefs and practices that appear harmful (ACA, 2014; Knapp, Lemoncelli, & Vandecreek, 2010). Examples of harmful spiritual practices and beliefs that clients may suffer from include sexual abuse or harassment by religious leaders, fear of divorce despite experiencing emotional or physical abuse, and racial or sexual discrimination (Greene, 2009; Griffin, 1996; Knapp et al., 2010). Counsellors need to remember

that in cases in which clients disclose incidences of harm, counsellors have a duty to provide disclosure to authority figures to protect clients from serious harm (ACA, 2014; CCPA 2007).

Therapists may hesitate to incorporate spirituality and religiosity into psychotherapy with clients as there are people who believe religiosity has done a great deal of harm in the world (Richards & Bergin, 2014). However, there are benefits of incorporating spirituality into therapy despite the harm that has been associated with religiosity (Richards & Bergin, 2014). As mentioned in Chapter 2, there are positive and negative impacts of spirituality on emotional well-being. Hence, it is crucial for therapists to gain spiritual competency despite their biases towards spirituality or religiosity and to discern the aspects of spirituality and religiosity that are beneficial or harmful in the client's healing process (Richards & Bergin, 2014; Shaw et al., 2012). Counsellors need to work within the religious framework of clients and not impose their own beliefs and practices onto clients (Richards & Bergin, 2005). Counsellors need to be aware of the risks of countertransference issues such as projecting their own spiritual issues onto clients, in addition to the risks of making inaccurate assessments of spiritual concerns that relate to clients' issues, offering inappropriate interventions that are incompatible to the clients' belief system, or setting inappropriate therapeutic goals (Casarez & Engebretson, 2012; Martinez, Smith, & Barlow, 2007; Miller, 2003). Counsellors can work on countertransference issues by examining and assessing their own spiritual development, seeking supervision, learning about other spiritual and religious beliefs, and learning how to incorporate spiritual aspects into therapy (West, 2000). Counsellors need to be sensitive to the spiritual and religious needs of the clients as they are not exempt from being subjective and need to continuously self-assess and increase self-awareness in their beliefs, values, and biases to increase insight and enhance their understanding for their clients' spirituality (Casarez & Engebretson, 2012; Hage et al., 2006;

Lambie et al., 2008; Miller, 2003). Examining their own biases and assumptions by assessing their personal beliefs and attitudes, professional boundaries, and competence in spiritual knowledge of their clients helps counsellors to identify appropriate limits of practice and make appropriate referrals when necessary (Sink & Devlin, 2011; Yarhouse & Johnson, 2013).

Conflicts between the counsellor and client may arise in therapy sessions if counsellors are not respectful or sensitive to the differences in values regarding spirituality and religiosity (Yarhouse & Johnson, 2013). Counsellors, therefore, need to be prepared in handling such conflicts and may need to address such conflicts with clients (Yarhouse & Johnson, 2013). Not all conflicts may need to be addressed; counsellors need to assess and identify whether the conflict is substantial enough to affect the therapeutic relationship or the client's well-being (Yarhouse & Johnson, 2013). Some differences may not need to be addressed but simply to be recognized by the counsellor and to focus on fulfilling the role of a counsellor as opposed to the role of a spiritual mentor (Yarhouse & Johnson, 2013). In addressing significant differences, counsellors should try to understand the client's perspective and spiritual issue in light of the client's spiritual background to develop their spiritual competency, which cultivates trust in the therapeutic relationship (Yarhouse & Johnson, 2013). Strengthening empathy towards clients' insights allows counsellors to explore options beyond their spiritual scope in decision making (Yarhouse & Johnson, 2013).

Due to the ethical issues described, it is crucial for counsellors to discuss spiritual concerns in supervision with spiritually competent supervisors to explore different perspectives and gain a greater understanding of spirituality in the worldview of clients (Hage et al., 2006). Counsellors can use informed consent when addressing spiritual issues or when introducing spiritual interventions (Miller, 2003). This consent can be given during the initial phase of

treatment or the assessment phase to prevent counsellors from remembering to hand out the consent form to specific clients (Miller, 2003). Taking professional precautions such as using informed consent when incorporating spirituality into counselling would also help counsellors ensure objective judgment and to prevent the occurrence of exploitation (ACA, 2014; CCPA, 2007). Counsellors who choose to explicitly work with spiritual and religious issues may need to have an open dialogue with clients first about how the spiritual aspect would be incorporated into psychotherapy (Miller, 2003). It is wise for counsellors to document which spiritual interventions were used in addition to the rationale for such interventions (Miller, 2003).

Limitations of This Study

There are several limitations that need to be noted in the present study. Although there is a rising interest in literature for spirituality and religiosity in the helping profession (Bryant-Davis, et al., 2012; Hill & Pargament, 2003; Martinez et al., 2007; Moivic, 2004; Shaw et al., 2012; Stanley et al., 2011; Walker, Reid, O'Neill, & Brown, 2009; Walker, Reese, Hughes, & Troskie, 2010), the research in the present study was limited to recent literature written in the past two decades, hence, neglecting older literature that could have been a significant source of discussion for the study. Secondly, although there is a wide range of possible impacts of spirituality and religiosity on emotional well-being, only a few of the positive and negative impacts that spirituality and religiosity have on emotional well-being were discussed due to time constraints. Moreover, spirituality and religiosity were discussed together, which are not exclusive terms in recent literature. Although it is important, it was beyond the scope of this study to discuss the similarities and differences between spirituality and religiosity and their impacts on emotional well-being. Thirdly, there is inconsistency within the literature regarding positive or negative impact of religiosity due to the uncertainty of whether depression or

religiosity came first (Balbuena, Baetz, & Bowen, 2013). Furthermore, alternative treatment is loosely defined and includes, but not exclusively, meditation, prayer, yoga, relaxation, massage, and spiritual healing (Whitford & Olver, 2011). Due to the focus on the present study, only a few of these alternative treatments were discussed. Fourthly, most of the research found in literature is conducted in qualitative design rather than in quantitative styles; it is more challenging to find empirical evidence for the impact of spirituality on well-being (Bojuwoye & Sodi, 2010). Lastly, most of the research on spirituality and religiosity focuses on Christianity and Christians and the research subjects are more likely to represent samples drawn from the North America (Richards & Bergin, 2014; Worthington, Hook, Davis, Gartner, & Jennings, 2013). Thus, the results may be relevant specifically to counsellors who are working with clients of a Christian faith and background.

Future Recommendations

Since there is a growing interest towards spirituality and since issues in spirituality and religion intersect with other aspects in counselling, graduate programs in counselling and psychology should include courses that address spiritual diversity in the curriculum to cultivate spiritual competency (Cashwell & Young, 2004; Hage et al., 2006). An important area in future research will be to focus on the impacts of spirituality exclusively from the impacts of religiosity on emotional well-being since each area is broad and incorporates many beliefs, doctrines, and traditions. Research is also needed to examine the cross-cultural similarities and differences of the positive and negative impacts of other major religions such as Buddhism, Hinduism, Sikhism, Islam, and Judaism in addition to the indigenous traditions of Africa, America, Europe and Asia.

Conclusion

Counsellors need to be aware that spiritual coping is neither constantly positive nor always negative and be sensitive to the potential beneficial and harmful impacts of spirituality (Pargament, Zinnbauer et al., 1998). At times, clients may experience negative impacts such as spiritual guilt, anger towards God, ambivalence about God's existence, or conflicts within spiritual community over doctrines or interpersonal interactions while using spirituality and religiosity to cope (Connor, Davidson, & Lee, 2003; Ellison & Lee, 2010; Exline, Park, Smyth, & Carey, 2011; Hill & Pargament, 2003; McConnell, Pargament, Ellison, & Flannelly, 2006; Pargament, Smith, Koenig, & Perez, 1998; Peres, Moreira-Almeida, Nasello, & Koenig, 2007). It is important for counsellors to assess the spiritual struggle early in the counselling experience and incorporate effective and appropriate interventions before the struggles become difficult to resolve (McConnell et al., 2006).

Spiritual interventions such as prayer, meditation, spiritual dance, sacred spaces, and forgiveness are beneficial in cultivating emotional well-being by helping cancer patients cope with symptoms and the process of the cancer experience, alleviating symptoms of depression, and helping trauma survivors find hope and purpose through their experiences (Fraser, 2000; Leseho & Maxwell, 2010; Marlatt & Kristeller, 1999; McCullough, Prayer and health: Conceptual issues, research review, and research agenda, 1995; Monteiro & Wall, 2011; Richards & Bergin, 2005; Sanderson & Linehan, 1999; Whitford & Olver, 2011). Although spirituality strengthens resilience by finding meaning and hope, it is crucial for counsellors to listen to the pain and suffering of the client and not focus on the need for resilience and hope too soon, as this would neglect the pain and suffering of the client (Dillen, 2012).

Despite the importance of incorporating spirituality, not all counsellors may choose to incorporate spirituality into therapy. However, it is important for counsellors to be open to incorporate spirituality into counselling sessions since there may be spiritual concerns within the presenting issues of clients. It is crucial for counsellors to assess the role of spirituality in clients' presenting issues and to utilize appropriate spiritual interventions when necessary (Hage et al., 2006; Lambie et al., 2008; Richards & Bergin, 2014; Yarhouse & Johnson, 2013). Counsellors need to promote a respectful and safe environment when working with clients on spiritual issues, show spiritual competency by being aware of their own biases and assumptions towards the clients' spiritual beliefs, show openness to diverse expressions of faith, acquiring knowledge about the clients' spiritual perspective, and find supervision with other therapists who are experienced in using spiritual interventions (Hage et al., 2006; Lambie et al., 2008; Pargament, Smith, et al., 1998; Richards & Bergin, 2014; Yarhouse & Johnson, 2013). If counsellors assess that the spiritual issues are beyond their scope of practice and that continuation may hinder the healing progress of the client, referrals to the clients' religious resources should be made at the earliest time possible to facilitate positive outcomes of therapy (Burke, 1998; Yarhouse & Johnson, 2013).

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