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ASSESSING COMPETENCIES FOR INTEGRATING
RELIGION AND SPIRITUALITY
INTO COUNSELLING

By

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DEDICATION

This thesis is dedicated to

My children... Kelsey, Sam, and Hannah....

ABSTRACT

This is a quantitative study using a self-administered survey as its methodology. The purpose of this study is to gain insight into how practicing therapists view the place and limits of religion and spirituality in therapeutic work. The main areas that were explored included: counsellor spiritual and religious identity and practice; counsellor beliefs about the importance of spirituality for mental, physical, and community health; and, counsellor beliefs and practices regarding the appropriateness of addressing spirituality and religion within the context of therapy. Other areas that were explored included counsellors' identifying their education and training in this realm, and perceived abilities regarding comfort and competence when working with religious and/or spiritual clientele. Three hundred and forty-one members of the British Columbia Association of Clinical Counsellors participated in this study. The results showed that the participants believe that spirituality, but not necessarily religion, are important dimensions in their lives and in their work with clients. The results also showed that although participants indicated that they support specific interventions, less than half indicated that they are using these interventions in their practice. What is needed is more research on this subject, specifically in the area of determining or understanding why counsellors are not feeling comfortable, confident, or competent regarding introducing or initiating a conversation on the dimensions of religion and spirituality in the counselling process.

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ASSESSING COMPETENCIES FOR INTEGRATING RELIGION AND SPIRITUALITY INTO COUNSELING

Chapter One: Introduction

Recently clinical research has emphasized the importance of integrating religion and spirituality into the counselling process and the need for training in this area (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Burke, Hackney, Hudson, Miranti, Watts, & Epp, 1999; Carlson, Kirkpatrick, Hecker, & Killmer, 2002; Eck, 2002; Frame, 2001; Griffith & Griffith, 2002; Hoffman, Cox, Ervin-Cox, & Mitchell, 2005; Larimore, Parker, & Crowther, 2002; Quackenbos, Privette, & Klentz, 1986; Walsh, 1999). As counsellors working with diverse clientele we are presented with an array of multicultural issues that include differing worldviews on religious and spiritual epistemology and practices. Thus, it is important to include in our therapeutic alliance with clients a framework that encourages spiritual expression; “for the majority of clients, religion and spirituality are important to them and that they would like to be able to talk about this area of their lives in therapy. Therapists should facilitate this by creating a setting of openness, trust, and respect for client spiritual expression” (Eck, 2002, pg. 269).

The research presented in this paper has a predominantly Judeo-Christian bias (as does the researcher) as the bulk of the research in the field of counselling psychology and psychology in general, on integrating religion and spirituality into counselling, is from American academics and practitioners. The American Religious Identification Survey (ARIS) 2008 reported that 76.0% of the adult Americans surveyed identified as *Christian*, 15.0% as *no religion*, 5.2% as *did not know/refused to reply*, and 3.9% identified as *non-Christian religions* (Religion in the United States). The non-Christian religions included *new religious movements* (1.2%), *Jewish* (1.2%),

Eastern (0.9%), and *Muslim* (0.6%) (Religion in the United States). Given these statistics, it is arguably practical that American researchers would focus on integration from a Christian perspective. This being noted, this researcher emphasizes the importance of mental health practitioners being not only sensitive to and respectful of differing religious and spiritual beliefs and practices, but also prepared to include these dimensions as part of the therapeutic process in their work with clients.

The following sections provide an overview on this important issue by describing the relationship of religious and spiritual beliefs and practices to the following:

- The field of psychology
- Canadian and American populations
- Mental and physical health
- Clinician competency and clinical programs
- Ethical issues and clinical supervision
- Constructs and definitions

The final section of this chapter describes the purpose of this study.

The Field of Psychology

The importance of integrating religious and spiritual beliefs into psychotherapy is not a new concept. Early 20th century Swiss protestant clergyman Oskar Pfister attempted to incorporate Freud's psychoanalytic model into pastoral therapy (Quackenbos, Privette, & Klentz, 1986). He despaired in his attempts while attributing his failure to the rigidity of theologians whose concerns were about keeping with the status quo of church laws and dogma rather than being interested in the person (Quackenbos et al., 1986). Likewise, proponents for the field of psychology have, until the past decade or so, rejected religion and spirituality as important

dimensions in the counselling/therapeutic process for clients; this has often resulted in religion and spirituality becoming an ‘off-limits’ taboo for clinical training programs of psychiatrists, psychologists, and counsellors (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Burke, Hackney, Hudson, Miranti, Watts & Epp, 1999; Griffith & Griffith, 2002; Plante, 1999; Walsh, 1999).

In the attempt of the field of psychology to become recognized or established as a scientific-based discipline the dimensions of religion and spirituality have been described as non-empirical and therefore dismissed as an appropriate area for study (Brawer et al., 2002). The lack of interest in and blatant disrespect of a religious worldview were publicly expressed in Seymour Sarason’s 1992 centennial address to the American Psychological Association (APA) as follows:

I think I am safe in assuming that the bulk of the membership of the APA would, if asked, describe themselves as agnostic or atheistic. I am also safe in assuming that any one or all of the ingredients of the religious worldview are of neither personal nor professional interest to most psychologists... Indeed, if we learn that someone is devoutly religious, or even tends in that direction, we look upon that person with puzzlement, often concluding the psychologist obviously had or has personal problems. (as cited in Plante, 1999, pg. 541)

The counterpoint to Sarason’s vies is that hope and faith are part of the human experience when facing life’s difficulties, challenges, and crises, and for many people it involves the religious and spiritual dimensions of themselves. Traditional psychology’s perspective of hope is a “faith in humanity” whereas, “when religion speaks of hope, it is speaking of faith in the transcendent” (Cox, 1997, pg. 512).

Canadian and American Populations

Populations in Canada and the United States have become increasingly diverse regarding religious and spiritual worldviews and practices—this may be due to “higher education, media, world-consciousness, individualism, and most importantly, immigration” (Hoge, 1996, cited in McLennan, Rochow, & Arthur, 2001, pg. 2).

Statistics Canada reports that “in 2004 over half of Canadians ages 15 to 29 and almost 60% of British Columbians either had no religious affiliation or did not attend any religious services” (Clark & Schellenberg, 2006, pg. 2). However, the 2002 Ethnic Diversity Survey revealed that many Canadians, although they did not participate regularly in formal religious services, did engage in personal religious practices privately:

Of those who infrequently attended religious services over the previous year, 37% engaged in religious practices on their own on a weekly basis. And of those who had not attended any religious services over the previous year, 27% engaged in weekly religious practices on their own. Overall this group of adults who regularly engage in private religious practices, but infrequently or never attend religious services, represent, 21% of the adult population.

In the United States, “94% of adult Americans are members of a church, synagogue, or place of worship, and 58% of the same population rate religion as being very important in their lives” (Gallup, 1996, cited in Wolf & Stevens, 2001, pg.1). *Free Inquiry*, an agnostic orientated publication, doubted prior reports indicating the extreme prevalence of religiosity and spirituality in American society. To challenge these reports they conducted their own survey; “To its surprise, almost 90% of those interviewed expressed belief in a personal God who can answer prayer” (Griffith & Griffith, 2002, pg.5).

Given the interest in, and personal centrality of, religious and spiritual beliefs in Canadian and American society one might argue that well-rounded psychological clinicians need to be prepared to incorporate spirituality and religion into their professional practice. The next section looks at the potential risks and benefits to mental and physical health.

Mental and Physical Health

Cross-sectional and prospective cohort research studies indicate that religious and spiritual beliefs and practices are beneficial for improving and/or maintaining good mental and physical health (Larimore, Parker, & Crowther, 2002). Qualitative consumer accounts indicate key themes in the benefits of spirituality in dealing with mental illness: strength for coping and in making decisions, enhanced social support (tangible and emotional), and personal coherence or wholeness (Fallot, 2001). One study that looked at the effects of religious beliefs on coping with chronic illness found that religious women coped better than the majority of women who had no religious beliefs and/or viewed religion as unimportant (Gordon, Feldman, Crose, Schoen, Griffing, and Shankar, 2002).

Psychology in its recent trend of moving away from pathology has found that religion and spirituality have contributed to increased rates of well-being and life satisfaction and decreased rates of “suicide, substance abuse, and antisocial behavior” (Brawer et al., 2002, pg. 4). Religion and spirituality can help but it can also hinder the healing process as one therapist describes:

There are many ill persons who find comfort, understanding, and meaning in their relationship with their God, but others feel abandoned by God, feel guilty for having become ill, or neglect their health by adhering to religious beliefs or practices. Clearly, religion can both heal and harm. (Griffith & Griffith, 2002, pg. 8)

Ellis (2000) also differentiated between those who have a positive view of God *versus* those who have a negative view. He noted the extensive empirical research that found that “people who viewed God as a warm, caring, and lovable friend and saw their religion as supportive were much more likely to have positive outcomes and to stay free from substance abuse than those with a more negative view of God” (Ellis, 2000, pg. 29).

Clinicians also note the negative impact of religious experiences on patients suffering from mental illness as major depression may be deepened by rigid religious beliefs such as sinfulness and guilt, while grandiosity, delusions, and hallucinations may be accentuated by religious content (Fallot, 2001).

Clinician Competency and Clinical Programs

Graduate programs in counselling are lacking when it comes to preparing students to invite clients to “share their spiritual or religious concerns, issues, and values in the same way they share any other area of their life” (Eck, 2002, pg. 269). Hoffman et al. (2005) emphasize that the complexity and diversity of religion and spirituality makes attempting integration of these dimensions into psychotherapy all the more challenging. These authors believe that mental health professionals require a foundational approach to the integration of religion and spirituality through the knowledge and understanding of the following:

- Definitions
- Interrelationships between religion, spirituality, and mental health
- Developmental issues
- Ethical issues
- Diversity issues

(Hoffman, Cox, Ervin-Cox, & Mitchell, 2005)

They subscribe to the belief that a comprehensive foundation is necessary before applying a variety of approaches and techniques in therapy; including appropriate and relevant clinical supervision (Hoffman et al., 2005).

Bergin (1988) argues that the traditional behavioral movement that provided building blocks for behaviour change within a framework that is mechanistic, naturalistic, and humanistic, is no longer sufficient in today's "widespread cultural phenomenon, a kind of return to the study of values including spiritual values" (pg. 26). Pargament, Murray-Swank, and Tarakeshwar (2005) advocate for "an empirically-based rationale for a spiritually-integrated psychotherapy"(pg. 155), as research indicates that: (a) Spirituality can be part of the solution; (b) spirituality can be part of the problem; (c) people want spiritually-sensitive help; and (d) spirituality cannot be separated from psychotherapy. Some risks to implementing spiritually-integrated psychotherapy may include attitudes that trivialize or overstate the importance of spirituality as counsellors' religious and spiritual ideology may affect treatment goals and methods (Pargament et al., 2005).

Eck (2002) begs the questions, "if clients prefer that therapists include their religious and spiritual values in treatment, why don't more clients' bring them up in therapy... given these client and cultural contexts, why hasn't spirituality and religion become better incorporated within our clinical models, training, practice, and protocols?" (pg. 268) The silence in this area may be due to an unspoken rule of "don't ask, don't tell" where both the therapist and the client are uncomfortable to speak about such matters (Eck, 2002). Clients may hold back because they may prefer to keep the "sacred from the secular", and/or they may have fears of "religious coercion" by therapists discussing their own religious and spiritual beliefs (Eck, 2002).

There are many reasons as to why clinicians, counsellors, and therapists are ill-equipped to work within the dimensions of religion and spirituality. These may include:

- A lack of training about bringing existential issues into therapy in their graduate programs.
- Skepticism about religion and spirituality that has its root in psychology and the natural sciences including the linkage of religiosity and spirituality as a form of psychopathology.
- The belief in the division of the sacred from the secular.
- The counsellors' related personal experiences and assumptions.

(Frame, 2001)

Similarly, Wolf & Stevens (2001) list barriers to inclusion as follows:

- Historical exclusion based on the belief that spirituality and religion are unobservable and non-scientific, and cannot be objectively measured.
- The belief that the discussion of religion and spirituality falls under the domain of spiritual leaders.
- The Freudian-based belief system of linking religion and spirituality to pathology.
- Personal barriers such as differing viewpoints of counsellor and client and/or the counsellor's feelings of inadequacy in this area.

A survey done in 1997 reported that the majority of 151 therapists (98%) would integrate spiritual issues into the counselling process but only on the initiative of the client (Griffith & Griffith, 2002). On the other hand, 60% of therapists were willing to initiate a discussion on spirituality, but only 42% were willing to initiate a discussion on the topic of God (Griffith & Griffith, 2002). This study also revealed that most therapists had received discouraging messages about discussing God with their clients through their respective training programs, but were encouraged to discuss God by clients and patients (Griffith & Griffith, 2002). Other

barriers to inclusion were “concerns about imposing their belief systems on their clients, convictions that reliance on God was disempowering of people, and a fear that religious differences between client and therapist could put a barrier between them” (Griffith & Griffith, 2002, pg. 31).

A study done by marriage and family therapists (MFT) regarding the appropriateness of addressing religious and spiritual issues in therapy noted that “some of the discomfort of the participants in addressing specific spiritual interventions may be related to a lack of training or awareness of how to go about this process in therapy” (Carlson, Kirkpatrick, Hecker, & Killmer, 2002, pg. 168). Clinical program institutions are also reporting an increase interest in religious and spiritual issues as almost one-half, “have students who report religion/spirituality to be their major area of interest” (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002, pg. 205).

One study that surveyed clinical psychologists found that more than two-thirds (74%) recognized the need for inclusion of religion and spirituality into clinical practice, while two-thirds also reported that “psychologists in general” are not aptly trained with helping clients process religious and spiritual issues (Griffith & Griggs, 2001). The American Psychological Association affiliates also recognize that there is a lack of training in the areas of religion and spirituality (Brawer et al., 2002). Their research indicated that, “as few as 5% of clinical psychologists report having had religious or spiritual issues addressed in their professional training... and no internship programs report offering education or training on spiritual or religious issues” (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002, pg. 203).

Brawer et al. (2002) recommend the following for implementation in training programs for clinical psychologists: (a) Increased sensitivity for bias; (b) curriculum additions; (c) competence

in the use of assessment measures in this area; (d) the use of mentors – psychologists that have an interest in religion and spirituality; (e) guest lecturers to enhance student knowledge and promote diversity; (f) an availability of books and journals that address this area of interest; and, (g) access to conferences and seminars that examine the issues of religion and spirituality in clinical practice.

A recent study involving student counsellors at the masters level revealed that most students had discomfort when discussing spiritual issues in counselling mainly due to fears of offending or of being judged personally (Souza, 2002). Students vary regarding viewing spirituality as negative or positive based on their own experiences which could produce counter-transference issues... “For example, it is possible for a student’s disillusionment with religion to interfere with her or his ability to counsel a religious client. On the other hand, a fervently religious student may be unable to relate to nonreligious clients” (Souza, 2002, pg. 214). Another area of concern for students was in defining spirituality as one student expressed his view in the following way:

When you try to take this kind of thing and put it into words, I think it’s difficult because I think it is much more intangible. If you haven’t experienced some of these things, I think it is more difficult to understand. (Souza, 2002, pg. 214)

A third concern for the student counsellors in this study involved the dilemma about who should introduce spiritual issues in the counselling process, the counsellor or the client (Souza, 2002). This is an area of concern for counsellor educators and is one that should not be avoided, especially due to the controversy or opposing views involved; “counselors need to decide where they stand on this issue” (Souza, 2002, pg. 216). One final area that the study looked at was student opinions on the type of educational approaches to incorporating the dimensions of

religion and spirituality into psychotherapy. Some students wanted elective courses on the topic of spirituality and counselling, and others wanted spirituality workshops, but overall they supported the inclusion of training in this area (Souza, 2002). As previously mentioned, counsellors' 'fears of offending' the client is one of the many ethical issues related to risks that can arise when incorporating the dimensions of religion and spirituality into psychotherapy.

Ethical Issues and Clinical Supervision

Ethical practice has shifted with the respect to the inclusion of religion and spirituality:

APA ethical codes require a therapist to assess, understand, and respect the religious and spiritual beliefs, values, and practices of their clients, and to obtain the training and experience necessary to sensitively and appropriately address this aspect of a client's life in their clinical practice." (Eck, 2002, pg. 267)

As previously mentioned, integrating religion and spirituality into the counselling/therapeutic process for clients does have the potential for harm (Ellis, 200; Fallot, 2001; Griffith & Griffith, 2002; Plante, 1999). Therefore, more research on developing assessment tools, frameworks, and therapeutic techniques is essential for building clinician competency with the purpose of reducing the risk for harm to the client. This includes relevant and competent clinical supervision.

As important as it is to include appropriate curriculum in training programs so too is the need for supervision training that will include monitoring "clients' needs relative to this issue and address supervisees' knowledge and skills, as needed" (Polanski, 2003, pg. 131). Polanski (2003) focuses on three key skill areas for supervision: intervention, conceptualization, and personalization. Fukuyama (1999) views inclusion of religion and spirituality as a multicultural component to training and recognizes that this area of training "may be a challenge for students

who follow an absolutist belief system” (pg. 190). Frame (2001) recommends the spiritual genogram not only for clients, but for clinical supervisors and counselling students as well. The genogram can help to identify a family’s history of religious and spiritual beliefs and practices and the developmental influences on a family member’s worldview (Frame, 2001). Berkel, Constantine, and Olson (2007) also address supervisor multicultural competence... “In order for faculty supervisors to be effective in helping trainees to adequately address issues of religion and spirituality with their clients, they must first achieve a certain level of competence in these areas”(pg. 7). In summary, multicultural literature offers guidelines to clinical supervisors on how to achieve competence in the dimensions of religion and spirituality. Some of these include the need for self-understanding, clinical support, continuing education that includes cultural relevance and diversity, knowledge of relevant community resources, and exposure to discussions of religion and spirituality (Berkel, Constantine, & Olson, 2007). Part of achieving competence in clinical supervision is the knowledge and understanding regarding relevant constructs and definitions.

Constructs and Definitions

Religion and spirituality have been referred to as a dichotomy (Wolf & Stevens, 2001). Yet they can also be understood as overlapping or interrelated phenomena with important psychological meaning. One can be spiritual and irreligious or religious and unspiritual, and one can be both religious and spiritual (Wolf & Stevens, 2001). Religion has been described as referring to a shared institutionalized belief in God and a religious community involving public rituals whereas spirituality has been described as a personal experience or intimate relationship with a Supreme Being or life-force with or without a formal religious structure (Wolf & Stevens, 2001). Based on the confusion over terms and the multiplicity of definitions a more distinctive

term, *positive spirituality*, came about and is defined as, “a developing and internalized personal relationship with the sacred or transcendent. This relationship is not bound by race, ethnicity, economics, or class and promotes the wellness and welfare of others and self” (Larimore, Parker, & Crowther, 2002, pg. 71).

Pulleyking (2005) recognizes the need for definitions of religion and spirituality that will “fit the requirements and situation of the academic or clinical psychologist” (pg.19). Religion and spirituality can be defined by descriptive, normative, functional, and phenomenological perspectives, but the current literature on the integration of spirituality and psychology leans toward defining religion and spirituality from a functional perspective (that includes operational and behavioral perspectives) (Pulleyking, 2005). A descriptive definition is a label used for demographic purposes such as, “Catholic or Buddhist”, while normative definitions imply a judgment of sorts, i.e. the achievement or purposes of a religion such as high morals (Pulleyking, 2005). Functional definitions look at the mechanisms of religion and are commonly used for the purpose of understanding religion, while phenomenological definitions “strive to take an overview of all religious traditions and to bring together the common features of the human experience of religion and spirituality” (Pulleyking, 2005, pg. 20). Phenomenological definitions also have the following shortcomings: (a) Difficult to develop; (b) look beyond history and tradition, therefore non-contextual and may lose meaning; and, (c) vulnerable to “spiritual syncretism” (Pulleyking, 2005). When using a phenomenological perspective the researcher or clinician would need to appropriate or integrate understandings “back into the appropriate religious context in a meaningful way that does not violate the theological system of a particular tradition” (Pulleyking, 2005, pg.21).

For the purpose of this study religion and spirituality will be defined from Prest, Russell, and D'Souza (1999) as follows:

- *Spirituality*, “the human experience of discovering meaning, purpose, and values, which may or may not include the concept of a God or transcendent being”;
 - *religion*, “the formal institutional contexts for spiritual beliefs and practices.”
- (pg. 64)

Purpose of the Study

The purpose of this study is to gain insight into how practicing therapists view the place and limits of religion and spirituality in therapeutic work. In the process of more in-depth research on this topic I have come to realize my naivety regarding the place of spirituality and religion in my professional life. I can also see that my own religion and spirituality do not qualify as guides by themselves. What is called for is more research.

My hypotheses for this study include the following:

- 1) The results of this study will be congruent with previous studies that indicate that mental health practitioners are not feeling comfortable and competent to work within the context of the religious and spiritual dimensions of clients;
- 2) Counsellors will engage in discussions on clients' spiritual and/or religious dimensions, but only at the initiation of the client;
- 3) The participants believe that there should be more training on the inclusion of the dimensions of religion and spirituality in psychotherapy through their respective graduate programs, and through continued education.

In the next section I will continue to address this issue by looking at what the literature reports on the following relevant topics:

- (1) Theoretical viewpoints on how religion and spirituality influence psychological well-being;
- (2) The benefits and risks of including religion and spirituality in the counselling/therapeutic process;
- (3) How integrating religion and spirituality into secular counselling might differ from chaplaincy or pastoral counselling;
- (4) How the tenets of religion and spirituality can be integrated into psychotherapy: competency, assessment, and integration.

Chapter Two: Literature Review

Research on the effects of religion and spirituality on mental and physical health has increased over the past decade and has included contributions from a variety of disciplines such as psychology, medicine, sociology, gerontology, and education (Seybold & Hill, 2001). This researcher agrees with Koenig (2008) in that “religion is an important psychological and social factor that may serve either as a powerful resource for healing or be intricately intertwined with psychopathology” (pg. 201). Integrating religion and spirituality into counselling psychology can facilitate collaboration in promoting mental, emotional, physical, and spiritual wellness. Therefore counsellors not only need to be comfortable but competent as well when working within the religious and spiritual dimensions of clients.

In the following sections I will review what the literature reports on:

- (1) Theoretical viewpoints on how religion and spirituality influence psychological well-being;
- (2) The benefits and risks of including religion and spirituality in the counselling/therapeutic process;
- (3) How integrating religion and spirituality into secular counselling might differ from chaplaincy or pastoral counselling;
- (4) How the tenets of religion and spirituality can be integrated into psychotherapy: competency, assessment, and integration.

This researcher acknowledges that each of these items warrant thesis topics on their own.

The Influence of Religion and Spirituality on Psychological Well-being

There is a correlation between clients who claim to engage in religious and spiritual beliefs and practices, and positive influences on mental and physical health (Brawer, Handal,

Fabricatore, Roberts, & Wajda-Johnston, 2002; Fallot, 2001; Gordon, Feldman, Crose, Schoen, Griffing, and Shankar, 2002; Larimore, Parker, & Crowther, 2002; Seybold & Hill, 2001). It is plausible that the theoretical position that a counsellor/therapist ascribes to in the helping relationship influences his or her perspective in this regard, and therefore whether or not religion and spirituality are integrated into his or her clinical practice. What do the psychoanalytic, behavioural, cognitive, existentialist etc. counselling theories say about psychological and emotional health with respect to religion and spirituality?

Entwistle (2009) highlights proponents of what he describes as *naturalistic metaphysical extremism* as those who believe that, “human nature—indeed all of nature—is a purely naturalistic system and that any reliance on religious systems is likely to be damaging psychologically” (pg. 141). He included practitioners/researchers such as Albert Ellis, a pioneer in the development of cognitive-behavioural therapy (CBT) and rational-emotive behavioural therapy (REBT), and Sigmund Freud as he believed that religion was “a form of communal neurosis with rituals and practices that acted as a defence against forbidden desires” (Hayes & Cowie, 2005, pg. 29). Hill and Hood (1999) studied the relationship between affect, religion, the unconscious, and personality. These authors cite Epstein’s (1973, 1993, and 1994) provocative Cognitive-Experiential Self -Theory (CEST) as important for understanding the process of the integration of religious experiences (as cited in Hill & Hood, 1999).

CEST maintains that there are two parallel, interacting modes of information processing: a (largely conscious) rational system and an affectively based (largely unconscious) experiential system, with a third mode, an associational system, bridging the two. (Hill & Hood, 1999, pg. 1022)

Included in the two modes of information processing (the rational and affectively based experiential systems) are four belief systems and four associated basic needs that require a collaborative balance for effective cognitive and behavioural adaptation (see Table 1) (Hill & Hood, 1999). Early 19th and 20th century German theologians Friedrich Schleiermacher (*father of modern theology*) and Rudolph Otto, respectively, suggest that, “the universality of religiousness (i.e., its species-typical pattern) is found in its affective nature rather than the content of its belief systems” (Hill & Hood, 1999, pg. 1023).

Table 1

CEST four belief systems and four basic needs

Rational System (Conscious)	Experiential System (Unconscious)
Perception of world; benevolent or malevolent	Basic need of managing pleasure or pain
Perception of world; meaningful or meaningless	Need to develop a coherent conceptual system
Perception of people; comforting, trustworthy and dependable versus dangerous and undependable	Need for relatedness
Perception of self; worthy versus unworthy	Need for self-esteem

Gurney and Rogers (2007) compare the psychoanalytic approach of object-relations theory to spirituality by describing their points of convergence and divergence. Both object-relations theory and spirituality emphasize relationships. Human beings need relatedness and attachment to significant others; attachment theory postulates that without a secure attachment one does not develop a healthy sense of self-worth and value (Gurney & Rogers, 2007). Similarly, spirituality aligns itself with this view of attachment in that, “one who senses purpose in life, believes in a life force that gives energy and meaning to the material world, and/or feels loved by a higher power will, to use object-relations language, develop a secure internal working model” (Gurney & Rogers, 2007, pg. 965-66). Object-relations theory is reductive in that it materializes human

behaviour and emotion while spirituality is nonreductive in that it “seems to search outside the physical and material, focusing less on things that are determined and more on things that are beyond control of the corporeal” (Gurney & Rogers, 2007, pg. 969). This being noted, spirituality is not completely beyond the influence of reductionism in that although “object-relations suffers from limiting clients to their historical relationship with others, spirituality may conversely suffer from a nebulosity that renders it vulnerable to be determined by human ascription. The difference is that spirituality is less fixed and may be open to the interpretation the client brings to the table, whereas object-relations provides the interpretation” (Gurney & Rogers, 2007, pg. 970). Views on stages of growth regarding object-relations theory and spirituality differ in that, “one is moving from enmeshment to healthy separateness and the other moves from separateness toward healthy union” (Gurney & Rogers, 2007, pg. 971). Bergin (1988) addresses the roots of human nature, behaviour, and spirituality as he describes *three contributions of a spiritual perspective to psychotherapy and behavior change*: a conception of human nature, a moral frame of reference, and a set of techniques.

A Conception of Human Nature

Bergin (1988) introduces a frame of reference that includes both the “mechanistic notions such as the existence of classically conditioned responses, and the idea that people have a mental apparatus with cognitive, agentive, and spiritual aspects” (pg. 28). He suggests that both the psychobehavioural and biological aspects of organisms are multisystemic in nature. Bergin (1988) emphasizes the importance of the spiritual impact of spiritual experiences on behaviour change by looking at empirical studies from behavioural and materialist positions. He states that, “people who report spiritual experiences appear to manifest connections between those

experiences and the material world, such as in those behaviors that reflect mental status and life-style” (Bergin, 1988, pg. 28).

A Moral Frame of Reference

Bergin (1988) cites a *moral frame of reference* as being a determinant for setting goals in treatment... “All goals, whether they are goals for symptom relief or to modify a life-style are subtended by value systems” (pg. 29). He believes there is a universal moral law and that precise obedience to it is just as important as precise obedience to physical laws. Bergin (1988) suggests that “behavioural laws” are comparable regarding precision and obedience and are “just as essential to obtaining desirable and predictable consequences” (pg. 30). He emphasizes the importance of a spiritual orientation in that it allows mental health workers to be “open, specific, and deliberate about values... helping people activate values that can be used as cognitive guides in their self-regulation and life-styles” (Bergin, 1988, pg. 33).

A Set of Techniques

Bergin (1988) proposes that a spiritual orientation also allows for intrapsychic techniques or methods such as, “the use of prayer, scripture study, rituals and inspirational counseling to family and social system methods that use group support, communication, mutual participation, communal spiritual experience, and group identification” (pg. 33). When describing possibilities for healing in pathological families, Bergin (1988) engages religious concepts and traditions such as sacrifice versus retribution, that includes responses such as self-denial, forgiveness, and reconciliation in order to stop “the process of transmitting pain from generation to generation” (pg. 34).

Beverage and Cheung (2004) discuss the importance of using a spiritual framework in counselling in the context of integration theory. Self-integration as described in the case study of

Amy, an incest survivor who was molested by her stepfather at the age of 10, is “the complex process in which the survivor identifies and disputes her irrational beliefs, retrieves her lost self, and gains control over her environment” (Beverage & Cheung, 2004, pg. 116). In light of Amy’s self-disclosed distorted religious and spiritual beliefs about her trauma and victimization, three principles were used to help Amy to “work toward a strong spiritual foundation” (Beverage & Cheung, 2004, pg. 116):

- The importance of assessing the impact of spiritual beliefs, particularly as they relate to the meaning of forgiveness in the client’s life;
- The relevance of distorted and conflicted values and religious dogma in the trauma of incest and how attention to these issues can facilitate healing;
- The power of individualized spiritual affirmations in growth, development, and environmental control.

Another fundamental therapeutic precept used in Amy’s treatment process was “symptom relief and the exploration of the meaning of the trauma” (Beverage & Cheung, 2004, pg. 115-116).

Brown (2008) also emphasizes the importance of the existential component of meaning making in trauma therapy as follows:

The path to trauma recovery must in some way address the insult to meaning and identity as well as that to safety. Culturally competent trauma therapists must thus not only make room for faith but actively find ways to foreground the issue of meaning making, be it through formal religious systems, non-religious systems of spirituality, or forms that do not resemble their understanding of what makes meaning but do so effectively for their clients.(pg. 229-230)

Walker, Reid, O'Neill, and Brown (2009) reviewed 34 retrospective empirical studies on child abuse to determine if the abuse altered the role of religion and spirituality in the lives of survivors, and if it was a mediator in the recovery process. The researchers found that “childhood physical and sexual abuse tends to damage one’s faith, whether individual or corporate forms of religion and spirituality” (Walker, et al., 2009, pg. 139). They also found that the studies they reviewed “suggest that religiousness/spirituality may, in some cases, be a moderator of the development of posttraumatic and other Axis I symptoms and their associated disorders” (Walker, et al., 2009, pg. 139). Implications for treatment included a recommendation to trauma therapists to be cognizant that clients will have mixed feelings regarding religion and spirituality and their abuse, and to “initially maintain an open but supportive neutral stance” in this regard (Walker, Reid, O’Neill and Brown, 2009, pg. 140). Other recommendations to therapists included acknowledging value differences. Therapists need “to take stock of their own biases and sources of countertransference in such situations and to carefully consider the potential impact of their own approach to religion and spirituality in their work with abused clients” (Walker, et al., 2009, pg. 140). Religious and spiritual assessments help therapists in knowing where vulnerabilities exist for a client regarding their abuse; i.e. anger toward God for their suffering; oppression and control by perpetrators that may include parents or clergy, in justifying “religion-related or religion-based” abuse (Walker, et al., 2009).

The mere existence of religion-related abuse of power by proponents of religious doctrine supports existential ideology on the importance of subjectivity versus “blind” corporate allegiance to a religious doctrine (Schneider, 2008). Existential writers such as Kierkegaard, Buber, and Tillich emphasized an “authentic faith” for psychological health...“faith, belief, or religious practice is personal and subjective if it is to be healthy” (Schneider, 2008, pg. 188).

*Helpful and Harmful Effects Associated with Integrating
Religion and Spirituality into Counselling*

Ankrah (2002) emphasizes the risks for clients wanting to explore spiritual experiences in counselling... “a person coming into a counselling relationship who has experienced a spiritual emergency, or some other state of spiritual consciousness, runs the risk of having their spiritual experiences misinterpreted or not feeling there is space or permission to share that part of the self, and so feel silenced” (pg. 58). Ankrah’s (2002) descriptive and heuristic research found that for 25% of the participants, their counselling experiences were negative in that their spiritual experiences were either pathologized and/or dismissed by their counsellors. The results also showed that the non-European participants experienced racism regarding their spiritual beliefs and experiences (Ankrah, 2002).

Koenig, Larson, and Matthews (1996) stress that when religion is brought into the therapeutic relationship transference and countertransference reactions may be intensified. Therapists can deal with these reactions by first acquiring understanding and experience about the neurotic and nonpathological use of religion in clients’ lives—this may include inferences of clients trying to “defray or cover an underlying conflict” and/or inferences that may indicate a “mature religious faith that is usually adaptive, supportive, and freeing” (Spero, 1981, as cited in Koenig, et al., 1996, pg. 180). In this respect, Spero (1981) also adds that therapists need to compare and contrast their own religious beliefs to those of their clients’ (as cited in Koenig, Larson, & Matthews, 1996). Negative emotional responses whether due to “overconcern or overidentification” also need to be recognized and prevented from interfering with therapy so as to continue to appreciate and respect client needs (Spero, 1981, as cited in Koenig et al., 1996).

Lastly, Spero (1981) emphasizes that it is important for a religious therapist working with a religious client to remember that

he or she is a mental health professional with the goal of enhancing the patient's psychological stability and range of functioning, not a religious professional with the primary goal of enhancing spiritual development. (as cited in Koenig et al., 1996, pg. 181)

Koenig (2008) cautions therapists about the use of religious and spiritual interventions before establishing a "firm therapeutic alliance". Dobbins (2004) proposes that the therapeutic alliance can be strengthened "when the therapist shares common resources of faith with the client" (pg. 117). In his treatment of a client suffering with dysthymia and alcoholism, Dobbins (2004) used spiritual interventions known as "praying through" and "putting off the old person and putting on the new person". He found that the use of prayer and scripture reading were powerful tools for facilitating healing in the therapeutic process (Dobbins, 2004).

In the treatment of psychiatric patients it is important to respect and support religious and spiritual beliefs even if they are clearly pathological as "they often hold the patient's psyche together" (Koenig, 2008, pg. 202). It is important to take a neutral stance before gently challenging beliefs that may be preventing a patient to move forward in his or her life. Koenig (2008) recommends taking a "thorough spiritual history" as well as including the patient's clergy in therapeutic conversations before challenging religious and spiritual beliefs.

Praying during a session can be powerful and positive for a religious patient and for strengthening the therapeutic alliance but it can also be "a dangerous intervention" (Koenig, 2008). Koenig (2008) stresses that prayer should only occur if, a) initiated by the patient, b) the practitioner is "comfortable doing so", and c) has a similar religious background as the patient.

He notes that, “even if all the right conditions are present, there will be some patients for whom prayer would be too intrusive, too personal and may violate delicate professional boundaries” (Koenig, 2008, pg. 203). Gubi (2001) also supports the use of prayer and other spiritual techniques in mainstream counselling while focusing on counselling ethics. In his research, Gubi (2001) interviewed seven counsellor trainers at the Masters or Doctoral level from British Universities to explore the ethical considerations of integrating prayer effectively into the counselling process for clients. He began with establishing a working definition of prayer that was the product of consultation and collaboration with the seven interviewees... “Prayer is “I” connecting with, or communication with, “other”, where “other” relates to a non-physical object or being, e.g. God, Higher Being, Inner Light, Spiritual Self, etc.” (Gubi, 2001, pg. 427). It was concluded that both the overt and covert use of prayer engages with the therapeutic process but in different ways. Covert prayer prepares the counsellor for spiritual guidance while “upholding” the client whereas overt prayer can be used as “a means of reformulation, and be a cathartic use of ‘acting out’ emotions” (Gubi, 2001, pg. 433). Ethical considerations discussed included boundary concerns and the therapeutic alliance involving mutuality and power levels that may evoke issues of “transference, counter-transference, spiritual inadequacy, and compliance” (Gubi, 2001, pg. 432). The author also notes that “prayer can carry connotations of magic, victimhood, and helplessness and is therefore a risky concept to introduce into the counselling agenda” (Gubi, 2001, pg. 433). Counsellors need to consider the language they use with clients and attend to the client’s “values and level of spiritual development, and to their understanding of prayer, if they are not to impose their belief system on the client” (Gubi, 2001, pg. 433).

Baetz, Larson, Marcoux, Jokie, and Bowen (2002) surveyed 42 religious Canadian psychiatrists on their views regarding clinical interventions for their religious clients. The results indicated that, “the psychiatrists were more likely to recommend Bible reading and prayer as adjuncts to traditional treatments for patients of like faith. Bible and prayer were perceived as more useful when medication was not effective” (Baetz et al., 2002, pg. 559). The psychiatrists surveyed also stated that they found Bible reading and prayer more efficacious in treating grief reaction, alcoholism, and sociopathy than the use of medication and/or insight-orientated psychotherapy (Baetz et al., 2002). In the treatment of acute Schizophrenia, mania, and depression, the participants rated medication being “significantly more effective than the use of psychotherapy or the use of Bible and prayer” (Baetz, Larson, Marcoux, Jokie, & Bowen, 2002, pg. 558).

A qualitative research study by Richards, Hardman, Jensen, Berrett, and Jensen (2006) looked at 36 participants’ responses to how the role of spirituality affected their recovery process from an eating disorder. The top ten spiritual practices that helped the respondents in recovery are in order of most frequently used as follows:

- prayer
- forgiving self
- expressing gratitude to God and others
- giving service to others
- keeping a spiritual journal
- reading scripture
- showing kindness and compassion to others
- talking about spiritual issues with leaders or friends

- attending spiritual services
- forgiving others

(Richards, et al., 2006, pg. 270)

Treatment interventions by therapists and other treatment staff that the respondents found helpful included:

- encouraged to identify miracles in [my] life
- hearing the miracles of others in group
- encouraged to create images of God through artwork
- encouraged to pray, meditate, and contemplate spiritual things
- encouraged to write a letter to God in which I told him all about everything I was feeling including my hurt, pain, questions, fear, gratitude and so forth
- therapist taught me about the importance to find a calm environment and to listen to my heart – this has helped me feel God’s love
- therapist encouraged me to write about how my spiritual beliefs could help me in my recovery
- therapist encouraged me to write a letter to myself from God, emphasizing how precious and loved I am to Him

(Richards, et al., 2006, pg. 270)

Hodge (2006) reviewed the research on the effectiveness of spiritually modified cognitive therapy. The results showed that cognitive therapy, “has been used in diverse settings with a variety of faith groups to address a wide array of problems” (Hodge, 2006, pg. 157). However, the American Psychological Association only endorses the use of spiritually modified cognitive therapy for the treatment of depression as an “empirically-validated treatment” intervention on

Christians...“this approach also borders on meeting the criteria for a probably efficacious intervention for depression among Muslims” (Hodge, 2006, pg. 162).

Pastoral Counselling Versus Secular Counselling

What is pastoral counselling and how is it different from secular counselling that integrates the religious and spiritual dimensions of clients? Hunter (1990) describes the essence of pastoral care as “soul care” (as cited in Foskett, 2001). Foskett (2001) distinguishes between those “who have a generic cure of souls”, who he identifies as pastors, and those both clergy and lay people who he describes as pastoral counsellors and mental health care chaplains, that have “specialist knowledge and expertise in mental health” (pg. 101).

Benner (2002) states that spirituality and psychology cannot be separated as humans are psycho-spiritual-somatic beings... *a spirituality that is not psychologically grounded is of no more use than a psychology that is not spiritually grounded* [italics added] (pg. 359). He describes spiritually-sensitive psychotherapists and spiritual directors as both being concerned with the soul care of their clients while comparing and contrasting the relationship between those who offer psychotherapy, and those who offer spiritual direction (Benner, 2002). Some commonalities include:

- presence and attentiveness
- emotionally aware and accessible
- think about what they are hearing and make responses that are designed to help
- may employ techniques such as guided meditation, reframing of the way one views an experience, exploration of feelings, prayer, discussion of dreams, or silence
- frequently hear about common human problems of life experiences
- attend to aspects of experience that are not fully conscious

- deal with the influence of one's history on one's inner life and outer behaviour
(Benner, 2002, pg. 359)

Some differences include:

- Psychotherapists approach the inner world with empathy. Their focus is that inner world. Spiritual directors, on the other hand, attend as much to the Spirit as they do to the person with whom they meet.
- Psychotherapists seek to understand the inner world and relieve impediments to further growth in those they seek to help. This constitutes what we could describe as the clinical or therapeutic focus of psychotherapists. Spiritual directors, in contrast, are not invested in solving problems. I understand their primary job to be to help the one they seek to help attend and respond to God.
- The focus of spiritual direction should never be, therefore, simply one the self and one's conflicts. The focus should always be on one's experience of God and one's relationships with persons, God, the world as well as one's self.

(Benner, 2002, pg. 359-60)

Bruinsma-de Beer (2006) also differentiates between pastoral care and psycho-social therapy. She notes that twentieth century society launched the work performed in pastoral care into the hands of "psycho-social experts" (Bruinsma-de Beer, 2006). Pastoral care and psycho-social therapy have both similarities and differences—"the context and the issues are different... pastoral care usually deals with religious and faith issues, whereas psycho-social therapy deals with psychological issues" (Bruinsma-de Beer, 2006, pg. 167). Both, however, counsel people with problems. The author argues from the viewpoint of anthropological presuppositions based on the ideas and theology of Henning Luther, a German theologian, in that, "psycho-social

therapy and pastoral care are diametrically opposed to each other regarding the perspective from which they observe the individual subject” (Bruinsma-de Beer, 2006, pg. 168). Luther believed that psycho-social counselling approaches the client from a deficiency model while looking for “solutions and rehabilitation” to problems, whereas pastoral care “starts with the life, questions, fears and hopes of the whole person” (Bruinsma-de Beer, 2006, pg. 172). Bruinsma-de Beer (2006) summarizes the purpose of pastoral care as the empowerment of individuals... by listening to and addressing concerns and questions regarding their political, economical, and/or societal landscape.

From an American perspective pastoral counselling is defined as, “spiritually integrated counselling and psychotherapy, requiring graduate academic and clinical work in these disciplines as well as graduate education in religious studies” (Woodruff, 2002). The identity and function of pastoral counselling is distinguished by not only integrating “the spiritual and psychological dimensions of human experience”, but also “attending to the values and beliefs of the client” (Woodruff, 2002, pg. 95). Pastoral counsellors in the United States include methodologies by various psychological theoretical viewpoints in their work with clients but “what makes them pastoral is the conscious and intentional integration of a theological/spiritual perspective with the relevant psychological method of the counselor/therapist” (Woodruff, 2002, pg. 95).

British academics believe that the discipline of pastoral counselling has become fragmented (Foskett & Lynch, 2001). British society has shifted in recent years to an interest in spirituality but a lack of interest in traditional religious institutions. This new trend has affected pastoral counselling... “clients may prefer to explore questions of spirituality with a counselor who is not explicitly affiliated to a church, than with a church-based counselor who may be perceived as

representing a dogmatic or irrelevant faith tradition” (Foskett & Lynch, 2001, pg. 374). In an academic symposium British pastoral counselling affiliates reflected on the factors related to the “uncertain current standing of this discipline”, and addressed three central issues (Foskett & Lynch, 2001). First, the fragmentation of the discipline of pastoral counselling in Britain is viewed as a reflection of the lack of solidarity regarding organizations as there is no “lead body” or organization for pastoral counsellors to look to due to a division between conservative and liberal theological standpoints (Foskett & Lynch, 2001). This has led to an incoherent profile for pastoral counselling within “the wider counselling scene in Britain” (Foskett & Lynch, 2001, pg. 374). During the past 20 years pastoral counselling has been perceived as, “professional counselling conducted in religious settings or by those with explicit religious affiliations” to a “relational attitude that can be embodied in a range of different settings” (Foskett & Lynch, 2001, pg. 376). A second focus of the symposium included a critical exploration of the value and limitations of historical pastoral care therapeutic interventions such as the role of prayer and the relevance of forgiveness, and “what it means in practice to work appropriately with clients’ spirituality”(Foskett & Lynch, 2001, pg. 378). Lastly, the British academics expressed concern regarding the use of empirical research as the literature typically has focused on theory and case studies (Foskett & Lynch, 2001). The authors believe that more empirical research is needed that offers “in-depth explorations of the process and outcomes of pastoral counselling work” (Foskett & Lynch, 2001, pg. 378). They are hopeful that the outcomes will debunk the view that, “religious resources are more often an impediment than an aid to human well-being” which is often a concern held by the “wider counselling movement” and society in general (Foskett & Lynch, 2001, pg. 378).

Thorne (2001) supports the reasoning that clients, especially those who have been wounded by organized religion, are more likely to look to secular therapists for help with spiritual issues rather than “clergy or designated faith counselors”. Thorne (2001) acknowledges the cultural shift of clients preferring to identify with being ‘spiritual’ versus ‘religious’ persons and notes that the labels are, respectively, being construed as complimentary versus insulting. He emphasizes the influence of the ideas of Carl Rogers as, “a beacon for the pastoral counsellor of the future”, which involves integrating science and religion while offering “the vision of common ground for all those faiths which honour the spiritual essence of humanity” (Thorne, 2001, pg. 440). Thorne (2001) refers to the future of pastoral counsellors as being, “prophetic voices to religious institutions”, in that, “their ministry must transcend denominational, creedal, and social boundaries if it is to penetrate the inner loneliness which is the greatest disease of our age” (pg. 444).

Barrett (2002) describes the essence of a spiritual director as a “wounded healer”...someone who has experienced “struggle, passion, conflict, spiritual darkness, and light” (pg.298). He differentiates between the process and goals of spiritual direction versus pastoral counselling—Spiritual direction connects the role of “God, with Christ, in the Holy Spirit” in healthy relationship with “self, others and the world”, whereas, “the material and goal of psychotherapy is healthy relationship with self, others and the world” (Barrett, 2002, pg. 299-300).

Davis (2008) describes working definitions for what she deems as, “three pastoral interactions”: pastoral care, pastoral counselling, and pastoral psychotherapy. Pastoral care involves a minister, priest, rabbi, imam etc. giving his or her presence and support during a crisis while pastoral counselling, which as well as giving presence and support, includes guiding a person to access inner and outer resources when confronting a problem (Davis, 2008). Pastoral

psychotherapy, on the other hand, involves going deeper... “the pastoral psychotherapist gives presence, support, and guidance or coaching as a person accesses inner feelings, thoughts, beliefs, and body sensations in order to bring about healing and transformation, in order to see the world and themselves differently” (Davis, 2008, pg.667).

Schlauch (1985) presents a *pastoral psychotherapist model* that includes the therapist applying his or her observations, understanding, and interpretation of the psychological, religious, and moral dimension of clients’ dilemmas through the use of psychological, theological, and ethical resources.

A prospective study by Baker (2000) investigated *pastoral care interventions as a treatment for depression among continuing care retirement community residents*. Baker (2000) views the role of a pastoral caregiver as a helper, sustainer, and supporter... helping the person to use spiritual resources while sustaining his or her humanity through supporting his or her self worth. Results showed that specific pastoral care interventions reduced depression scores while enhancing scores for spiritual well-being. These included, “prayer, counseling for issues raised, grief work, the provision of blessings, active listening, and life review” (Baker, 2000, pg. 82). As with Baker (2000), Hermsen and ten Have (2004) recognize the growing need, through ever-increasing older populations, to provide care that will meet the spiritual and religious needs of geriatric patients in continuing and palliative care facilities. The authors reviewed the topic of pastoral care, spirituality, and religion by auditing 12 palliative care journals from 1984 to 2002—they found 80 articles that covered four central issues related to their topic:

- concepts of pastoral care, spirituality, religion, and patients’ search for meaning;
- coping with terminal disease and the experience of hope;
- the nature of suffering;

- education and training

(Hermsen & ten Have, 2004)

While reviewing these articles Hermsen and ten Have (2004) found that there was a lack of clarity regarding the central concepts especially between religion and spirituality. The authors also found a disconnection between the essence of spirituality and religion but not necessarily from the search for meaning, in particular, the meaning of life and death. When looking at hope and the nature of suffering, Hermsen and ten Have (2004) found that the articles explored hope as a dynamic experience regarding meaning making in life and death, and with coping with chronic illness. Having a faith in God impacts chronically ill and dying patients both positively and negatively, including eliciting a spiritual crisis while patients try to understand and/or control suffering and the onset of death (Hermsen & ten Have, 2004). Education and training are important aspects of providing ethically competent care to culturally and religiously diverse clientele. This includes training caregivers in nursing and residential homes on introspection or self-reflection about their beliefs and attitudes on life and death and how these might affect their work with patients (Hermsen & ten Have, 2004).

Clergy-psychotherapist collaboration is as necessary as collaboration with other health care professionals in the holistic care of clients—especially the underserved groups who turn to clergy for their emotional problems... “Establishing collaborative relationships with clergy may increase referrals for mental health treatment for clients who might otherwise never enter psychotherapy” (Aten & Worthington, 2009, pg. 226).

Integration: Competency, Assessment, Theoretical Techniques and Practices

Competency

A study by Frazier and Hansen (2009) asked the question, *do we do what we believe to be important?* These researchers surveyed 96 psychologists about their perceived importance and use of 29 religious/spiritual psychotherapy behaviours... the results showed that, “for 90% of the individual items, clinicians engaged in these religious/spiritual psychotherapy behaviors less frequently than their importance ratings suggested they should” (Frazier & Hansen, 2009, pg. 81). They also found that “the greater the practitioners’ religious/spiritual self-identification, the more likely they were to report using these behaviors in psychotherapy” (Frazier & Hansen, 2009, pg. 81).

Research indicates that many therapists are integrating religion and spirituality into counselling but due to the lack of training in these areas, “it seems that most integration of religion and spirituality in counseling occurs through intrapersonal integration as a result of therapists’ own religious or spiritual experiences” (Walker, Gorsuch, & Tan, 2004, pg. 77). This can be problematic in that it “creates a risk of therapists imposing their own values or applying religious or spiritual interventions inappropriately” (Walker, Gorsuch, & Tan, 2004, pg. 77).

Tisdale, Doehring, and Lorainne-Poirier (2003) also emphasize skill *versus* personal experience in the soul care of clients as well as acknowledging personal influences that affect the approach to client care... “the approach one takes to care is profoundly affected by one’s biography or history, which in turn influences both one’s theoretical and theological orientation”(pg. 65).

Hodges (2007) emphasizes that expertise in “all religious or spiritual pathways” is not possible for mental health clinicians. He proposes that active learning in and increased

sensitivity to religion and spirituality from a cultural perspective will allow counsellors to “understand that religious and/or spiritual issues may be very important for the client” (Hodges, 2007, pg. 39).

Gonsiorek, Richards, Pargament, and McMinn (2009) address the competency issue regarding clinicians also trained in theology and/or pastoral counselling as follows:

Psychologists additionally trained as clergy or theologians might appear to satisfy competence needs. This is not so. Such training provides depth, but rarely breadth; individuals are typically trained only in particular faith traditions. Unless the competence is limited to that particular tradition, they will have the same challenges as do other psychologists in developing general competence in spiritual and religious issues. (pg. 386)

These authors also discuss the issue of skill *versus* personal experience, and the necessity to reduce *balkanization*—“the assumption that clients are best treated by psychotherapists who are like them” (Gonsiorek et al., 2009, pg. 386).

Richards and Bergin (2005) address ethical guidelines for working with religious/spiritual clientele while stressing the importance of not practicing outside the boundaries of competence. These authors provide a check list of educational and training standards that they believe are important for professional psychotherapists in addressing competency in this regard, these include:

- training in multicultural attitudes and skills
- reading books and scholarly journals on relevant topics
- continuing education in the form of workshops or classes
- acquiring knowledge about religious traditions frequently encountered in therapy

- seeking specialized supervision and/or consultation when presented with religious or spiritual issues unknown to the therapist, and when incorporating religious and spiritual interventions

(Richards & Bergin, 2005)

A national survey of American Counseling Association members (ACA), that included 505 respondents, supported the nine competencies presented for effectively addressing spiritual and religious issues in counselling practice as follows:

1. A counselor should be able to explain the relationship between religion and spirituality, including similarities and differences.
2. A counselor should be able to describe religious and spiritual beliefs and practices within a cultural context.
3. A counselor should engage in self-exploration of his/her religious and spiritual beliefs in order to increase sensitivity, understanding, and acceptance of his/her belief system.
4. A counselor should be able to describe his/her religious and/or spiritual belief system and explain various models of religious/ spiritual development across the life span.
5. A counselor should demonstrate sensitivity to and acceptance of a variety of religious and/or spiritual expressions in the client's communication.
6. A counselor should identify the limits of his/her understanding of a client's spiritual expression and demonstrate appropriate referral skills and general possible referral sources.
7. A counselor should assess the relevance of the spiritual domains in the client's therapeutic issues.
8. A counselor should be sensitive to and respectful of the spiritual themes in the counseling process as befits each client's expressed preferences.
9. A counselor should use client's spiritual beliefs in the pursuit of the client's therapeutic goals as befits the client's expressed preferences. (Young, Wiggins-Frame, & Cashwell, 2007, pg. 47)

Hathaway (2008) cites the need for a regulatory body for those clinicians working within the dimension of religious/spiritual issues (RSI). He states that the "dizzily diverse landscape of

American religious and spiritual life”, has created a “practice niche” for clinicians and believes that, “it would be propitious for practice with RSI to emerge as a formally recognized specialty” (Hathaway, 2008, pg. 21). Hathaway (2008) summarizes an assessment under six domains for guidelines regarding establishing RSI as a specialty (see Table 2) (pg. 20).

Table 2

Practice with Religious/Spiritual Issues & Specialization

Requisite Knowledge Base	<ul style="list-style-type: none"> • Knowledge about relevant features of client religiousness/spirituality in one’s client population. • Awareness of the difference between the normative or Atypical expressions of RSI in client population, in light of their own faith traditions • Knowledge of clinical research on practice with RSI
Requisite Clinical Competencies	<ul style="list-style-type: none"> • Consultation/collaboration skills with members of religious/spiritual communities • Mastery of relevant religious/spiritual techniques
Client Population Foci	<ul style="list-style-type: none"> • RSI likely to be broadly encountered in clinical practice • Practice niche may develop from referrals from religious/spiritual communities
Praxis Foci	<ul style="list-style-type: none"> • May cultivate practice focused on working with RSI • May cultivate a practice focusing on working with RSI characteristic of a particular faith tradition
Training Pathways	<ul style="list-style-type: none"> • Graduation from an integrative program • Graduation from a general program or internship completion with a religious/spiritual concentration • Adjunctive training & experience (e.g., CE, consultative training, post-doctoral experiences)
Recognition Process for Specialists	<ul style="list-style-type: none"> • De facto within the context of Professional Psychology • Certification procedures exist with religious/spiritual organizations for pastoral counselors

A study that surveyed 115 American Masters level counselling students regarding their religious/spiritual affiliation, comfort level when counselling clients with religious/spiritual issues, and spiritual health and level of coping with stress found that

religion and spirituality positively correlated with coping with stress.

Counseling students who expressed spirituality through religious beliefs

had greater spiritual health and immunity to stressful situations than

counseling students who identified as spiritual but not religious. Counseling

students with a religious/spiritual affiliation indicated more discomfort

counseling clients hostile to religion compared to counseling students with a

spiritual-only affiliation. (Graham, Furr, Flowers, & Burke, 2001, pg. 2)

These authors believe that future research that examines, “the sources of discomfort may help determine if counselors lack knowledge and skills in addressing religious or spiritual issues or if personal beliefs and issues create the discomfort” (Graham et al., 2001, pg. 11). The implications for clinical practice described in this study included:

- The need for a spirituality course in counseling curricula to help counseling students become aware of their own beliefs about religion and spirituality and the impact of these beliefs on the counseling relationship.
- Counseling curricula may benefit counseling students by providing guidance needed to assist religious/spiritual clients in using their religious/spiritual resources for coping with stress by helping counseling student know when to consult and when to refer clients. (Graham et al., 2001, pg. 10-11)

Better clinical training on religion and spirituality in coursework and in the practicum component is necessary as well as continuing education for seasoned practitioners (Aten &

Worthington, 2009). These authors believe that training on these subjects should begin in undergraduate work and continue on in graduate clinical programs. Items endorsed in this regard included: “integrating discussions into diversity, interviewing skills, personal adjustment, or internship courses... the irony is that for most therapists in training, they probably are already working with clients who consider religion important” (Aten & Worthington, 2009, pg. 227).

Aten and Hernandez (2004) argue for the use of clinical guidelines in supporting supervisee competence when working with religious clients and issues; this includes the use of Stoltenberg and Delworth’s (1987) integrative development model (IDM) in clinical supervision. The authors list eight domains that supervisors can use to prepare supervisees in their work with religious clients, these include:

- Relevant interventions skills
- Relevant assessment approaches and techniques
- Address individual and cultural differences between supervisee and clients
- Use interpersonal assessment to avoid countertransference issues
- Discuss what the theoretical orientation of supervisee teaches about religion
- The use of problem conceptualization or case studies on religious issues
- Selecting treatment goals and plans that fit clients’ beliefs, values, and practices
- Discuss professional ethics – codes and guidelines pertaining to religiously committed clients (Aten & Hernandez, 2004)

Gubi (2007) explored the supervision experience of 19 mainstream counsellors who integrate prayer into counselling. He found that many were reluctant to, “express and explore”, their experiences within this realm of the counselling process with their supervisors for the following reasons:

- If prayer was explored it had to be disguised with acceptable labels and language
- The context of the supervision determines the viability of what is shared and how it is shared
- In group supervision, the make-up of the group impacts on what is shared and how it is shared
- Any experience of seeing their supervisor shocked at the disclosure that prayer had been used with a client
- Fear of not being understood, being judged, losing respect and credibility, or being criticised for not being a good-enough counsellor
- Fear of being thought of as transgressing
- Fear of exposure and lack of trust in how the supervisor will treat the disclosure
- Reticence because of a difference in the way that the counsellor and the supervisor view things spiritually
- Uncertainty about the appropriateness of prayer within specific counselling modalities
- Fear of condemnation and dismissal of something that is important to the counsellor
(Gubi, 2007, pg. 119)

These interviewees felt, “alone and isolated”, and found that “good supervision at the spiritual level was problematic and difficult”, and some, “had to have more than one supervisor” for these reasons (Gubi, 2007, pg. 119). This research raises questions regarding ethics and the essential element of supervision, which is trust, so as to “create a culture of openness and a collaborative working alliance where all aspects of the counselling process can be explored with appropriate

theoretical consideration and personal challenge, where the supervisee feels accepted, able and open to explore all aspects of the work with the same supervisor” (Gubi, 2007, pg. 120).

Berkel, Constantine, and Olson (2007) believe that faculty members of clinical programs in counselling can increase their competence, and the competence of their students, in their work with clients that includes the dimensions of religion and spirituality through the following processes:

- self-understanding
- continuing education
- addressing cultural issues
- utilizing community resources
- support
- experiencing multicultural activities
- initiating discussion of religion and spirituality in the counselling process

Chappellee (2000) developed *an ethical decision making template for the use of spiritual interventions in psychotherapy* for Christian counsellors. The template is divided into two stages. Stage one includes three steps:

1. Evaluate one’s role as a Christian therapist (e.g., is it appropriate to use spiritual disciplines given the boundaries and responsibilities of one’s role?).
2. Identify the setting of therapy (e.g., is it appropriate to use spiritual disciplines given the public or private setting in which psychotherapy occurs?).
3. Evaluate the reason the client is seeking therapy (e.g., is the use of spiritual interventions relevant to the client’s presenting problems?).

Stage two includes the following legal and ethical issues:

4. Obtain informed consent (e.g., seek consent from the client, as well as the therapist’s supervisor, before using spiritual interventions in the process of therapy).

5. Evaluate competency to utilize a specific spiritual intervention (e.g., obtain the necessary education and training requirements).
6. Maintain professional and scientific responsibility (e.g., the spiritual intervention must be applied in an empirical, ecumenical, and denominationally specific fashion).
7. Respect the religious values of the client (e.g., do not proselytize or use therapy as a “pulpit” for imposing the therapist’s religious values on the client).
8. Document the use of spiritual interventions (e.g., maintain a record that clearly documents the rationale, use, and effectiveness of each spiritual intervention employed in the process of therapy).
9. Make appropriate arrangements regarding financial reimbursement (e.g., as early as possible, determine the appropriate fee for spiritual interventions).
10. Promote the welfare of the client (e.g., always consider the safety and wellbeing of the client with any intervention that is employed in the process of therapy).
(Chappelle, 2000, pg. 46)

Assessment

Cotton, Grossoehme, and Tsevat (2007) reviewed the literature of the past two decades on the effects of religious and spiritual beliefs and practices in the lives of American youth from the ages of 12 to 20 years on mental, emotional, and physical well-being. The authors found that, “in general, adolescents that have higher religiosity and/or spirituality fare better than their less religious or spiritual peers” (Cotton et al., 2007, pg. 146). This included, “lower rates of risky health behaviors and fewer mental health problems—even when taking into account other factors that may affect health outcomes such as age, sex, or family income” (Cotton et al., 2007, pg. 146). Cotton, Grossoehme, and Tsevat (2007) looked at hypotheses related to how spirituality may influence health in adolescents, in particular indirect effects such as social support and positive role models, and direct effects from coping mechanism such as prayer. Further, these researchers identified that religion and spirituality can play a negative role in the lives of teenagers, i.e. risk of sexually transmitted diseases and/or pregnancy due to the disbelief in

contraception; feeling ostracized for their sexual orientation and/or pre-marital sexual activity in general (Cotton et al., 2007). Cotton, Grosseohme, and Tsevat (2007) emphasize the need for a spiritual screening or spiritual assessment initiated by the helping professionals involved in the lives of youth for the purpose of developing “an appropriate plan of care”. One such screening tool described by Cotton et al., (2007) is the FICA:

- **F** (faith): What is your faith tradition?
- **I** (important): How important is your faith to you?
- **C** (church): What is your church or community of faith?
- **A** (address): How would you like me to address these issues in your healthcare?

(pg. 149)

The authors differentiate between spiritual screening and spiritual assessment tools in that spiritual screening tools help to identify the spiritual needs versus resources available in the lives of adolescents while spiritual assessment tools are more formal in that they allow for, “gaining very specific information about a person’s religious/spiritual experiences, particular beliefs, or practices” (Cotton et al., 2007, pg. 149).

Koenig, Larson, and Matthews (1996) support the use of religion in therapy when working with older adults and endorse taking a religious history assessment. Koenig et al. (1996) believe that by assessing a client’s religious history the therapist accomplishes a set of goals for therapy:

- History taking validates religion as an important part of the patient’s life and identifies a potential coping resource;
- It draws the persons attention to past circumstances when religion may have been used successfully to combat a stressor;

- Past negative experiences with religion may be uncovered and worked through so that the person may be free to use religion as a resource now if he or she chooses;
- It provides vital information that is necessary in designing any future interventions that may include the patient's religious faith. (pg. 169)

When incorporating religion and spirituality into counselling it is important to get an understanding of what these terms mean to clients, and how they might define or describe religion and spirituality. Aten and Worthington (2009) express the need for a *clinical definition* for religion and spirituality due to the inconsistency among current definitions in the field of counselling psychology as well as in other disciplines. Definitions are subjective, therefore, "it may be helpful for therapists to consider multi-level or transtheoretical definitions that leave room for the subjective experience of clients and for contextual factors" (Aten & Worthington, 2009, pg. 225).

Theoretical Techniques and Practices

Koenig, Larson, and Matthews (1996) describe the importance of integrating religion into the various theoretical approaches to therapy when working with older adults including supportive, cognitive-behavioural, and psychodynamic methods and practices. Supportive therapy is helpful when a client's ego is weak and when distress is acute as it "seeks to strengthen healthy defences and coping behaviors that the patient has previously found helpful in relieving distress"...this may include religious beliefs and practices (Koenig, Larson, & Matthews, 1996, pg. 170). Integrating religious teachings into cognitive-behavioural therapy (CBT) can be helpful, in particular Judeo-Christian teachings, "as they contain many principles common to CBT... scriptures counteract pessimistic attitudes and discourage negative thinking by stressing the positive outcomes that are possible in all situations (Romans 8:28)" (Koenig et al., 1996, pg.

174). As well as giving examples of behavioural strategies that are helpful for relaxation during stressful circumstances, such as prayer and meditation, biblical scripture is useful in the behavioural technique of modeling (Koenig, Larson, & Matthews, 1996). There are many role models in the Bible, both patriarchs and matriarchs, “with genuine human faults and weaknesses with whom older adults may readily identify” (Koenig, Larson, & Matthews, 1996, pg. 175). The goals of psychodynamic therapy and Judeo-Christian religious teachings are compatible in that they, “seek to free the individual from unconscious neurotic influences... increasing conscious awareness of motivation; preventing and resolving internal conflict; and encouraging character maturation and change” (Koenig, et al., 1996, pg. 176, 178).

Guterman and Leite (2006) present a solution-focused framework for working with religious and spiritual clients. Solution-focused counselling is a collaborative effort of counsellor and client to

- co-create or define the problem and to set goals
- amplify or highlight the exceptions (whether actual or potential) when the problem is non-existent or diminished in capacity
- assign tasks that help to identify exceptions
- evaluate the effectiveness of the tasks
- re-evaluate the problem and goals

(Guterman & Leite, 2006)

The authors emphasize the “strategic approach to eclecticism in solution-focused counselling” that allows for the application of the religious and spiritual dimensions of clients (Guterman & Leite, 2006, pg. 42). It is important that the counsellor includes the clients’ worldview in the dialogue regarding who and/or what the client attributes the source of the problem; “clients’

personal values and belief systems inevitably influence how the problem is understood” (Guterman & Leite, 2006, pg. 42). Religious and spiritual content can be used in solution-focused counselling if it fits with the worldview of the client. Other counselling models can be integrated into this process and might include the counsellor or the client introducing solutions or ideas such as recovery programs, i.e., Alcoholics Anonymous (AA), reading material, and/or spiritual activities or rituals (Guterman & Leite, 2006).

Blanton (2005) asks the questions... *are narrative family therapy and spiritual direction compatible, and can they strengthen and enrich one another?* Blanton (2005) developed a paradigm that compares each of these disciplines through five categories: The Problem, therapy goals, focus of therapy, therapeutic tools, and the therapeutic relationship (see Table 3) (pg. 70).

Table 3

Comparing Spiritual Direction and Narrative Therapy on Five Dimensions

Dimensions	Spiritual Direction	Narrative Therapy
Problem	Hidden vision of God False self Cultural beliefs	Problem-saturated story The problem Cultural stories
Goals	Intimacy with God True self	New story Preferred self Liberation from cultural stories
Focus	Experience Meaning	Experience Meaning
Tools	Prayer Listening Questions Dialogue	Dialogue Questions Listening
Relationship	Contemplative Not-knowing Collaborative De-centered	Collaborative Not-knowing Co-author De-centered

Blanton (2005) concludes with describing how narrative therapy and spiritual direction can inform one another. First, narrative therapy can inform spiritual direction through, “beginning therapy with old stories, separating the person from the problem, identifying preferred directions, developing the new story, and linking the new story to the past” (Blanton, 2005, pg.75). Second, spiritual direction can inform narrative therapy through, “adding spirituality below the surface, adopting a contemplative position, including the voice of God in therapy, and considering the concept of soul” (Blanton, 2005, pg. 75).

Bartz (2009) describes “how existential psychotherapy can be harmonized with theism” (pg. 78). He compares and contrasts a theistic model of existential psychotherapy with Yalom’s (1980) existential model (as cited in Bartz, 2009). Bartz (2009) concludes with noting significant differences of a theistic model of existential psychotherapy that has “broad clinical applicability”:

- It broadens and clarifies the existential psychodynamic framework;
- It reconceptualizes the ultimate concerns in light of people’s spiritual natures;
- It recognizes several additional ultimate concerns that are more apparent when the spiritual dynamics of life are considered;
- It endeavours to facilitate confrontation with existential fear;
- It provides clients with spiritual resources that help them to wade through their existential fears;
- Theistic existentialists are careful to promote responses to existential fear that align with their clients’ healthy spiritual values;
- It fosters client-centred inspiration;
- It encourages therapists to seek inspiration regarding treatment. (pg. 78)

Duba and Watts (2009) present Adlerian treatment principles to working with religious couples. Adlerian and Christian beliefs and practices are compatible as both are, relationship-focused; seek to understand lifestyle choices and the effects on interpersonal relationships; concerned with “one’s sense of belonging or attachment, and one’s ability to contribute to the well-being of others” (Duba & Watts, 2009, pg. 214-215). Duba and Watts (2009) present an assessment formulation for exploration and discussion in therapy with couples (see Table 4) (pg. 216).

Table 4

Assessment of Couple: The Inclusion of Religious Factors

Dimension	Religious influences and factors to be explored
Intrapsychic	<ol style="list-style-type: none"> 1. How religious beliefs informs one’s beliefs and thoughts 2. What feelings or experiences are generated when one is behaving or thinking according to the religious beliefs 3. How does one’s religion/faith bring meaning to life 4. What intrapersonal struggles related to living out one’s faith are experienced
Interpersonal	<ol style="list-style-type: none"> 1. How religious beliefs informs one’s interactions with partner 2. What guidance religious community provides about one’s role in marriage 3. How one’s religion helps or gets in the way of developing and maintaining meaningful relationships, (e.g., marriage) 4. Beliefs about how partners should (or can) share meaningful religious experiences together
Systemic	<ol style="list-style-type: none"> 1. Religious practice in family-of-origin 2. How religion was used in positive and negative ways in family-of-origin 3. How religion/faith guided relationship between parents, and among family members 4. Acceptable practices of faith in family-of-origin 5. Support of community to practice faith

An in-depth examination of spiritually oriented interventions (Western and Eastern) and the use of more sophisticated clinical assessments will help to “develop more complex treatment conceptualization, plans, and strategies for attending to client religious and spiritual issues and

experiences” (Aten & Worthington, 2009, pg. 226). More research is needed in the area of evidence-based practices, including clinical trials that are, “tailored to specific religious groups (e.g., Muslim, Jewish, Christian) or for addressing specific religious problems (e.g., religious strain)” (Aten & Worthington, 2009, pg. 227). The authors identify “two camps” in the area of research on religion and spirituality within this discipline— academic researchers and seasoned clinicians (Aten & Worthington, 2009). More practitioner-driven research is needed for sophisticated clinical research... “Efforts toward connecting the voluminous research on the psychology of religion and spirituality and clinical practice are warranted” (Aten & Worthington, 2009, pg. 227).

Chapter Three: Methodology

The purpose of this study is to assess the beliefs, attitudes, and behaviours of clinical counsellors regarding competencies for integrating religion and spirituality into counselling.

The data was collected using a self-administered survey methodology developed by the researcher at *SurveyMonkey.com*, and was distributed to the participants through electronic mail that included an introduction and instructions with a high-lighted link to the survey (see appendix A). The on-line system is anonymous and confidential.

Participants

Membership of the British Columbia Association of Clinical Counsellors (BCACC) was invited to participate in this study. The B.C.A.C.C. is a regulator of counselling practice in British Columbia and has a membership of over two thousand therapists who carry the designation of Registered Clinical Counsellor. Minimal requirements for designation are a master's degree, a competency evaluation, professional references, criminal record check, proof of insurance, and an undertaking to adhere to the BCACC code of ethics and standards of practice. The participants were permitted 24 days to access the survey. Three hundred and forty-one counsellors participated in the survey, giving a response rate of 17.1 %. Participation was voluntary and anonymous. Informed consent was established by clicking on the survey link and following through to complete the survey. No reward or incentive was involved save for the possible satisfaction of participating in research intended to enhance the profession of counselling. Summary results will be shared with the BCACC for distribution to their membership.

Risks

It is possible that some participants may experience distress over religious ideas and their reaction to them. However, since there is no direct demand to participate in, or complete the survey, and it is entirely anonymous, the risk of such distress in a sophisticated sample is very small. On the other hand, there are many benefits to participating in the survey, including a thoughtful review of the issue.

Instrument

The survey instrument of known external validity was adapted from an instrument developed by Prest, Russel, and D'Souza (1999) that was previously adapted from a survey of Sheridan, Bullis, Adcock, Berlin, and Miller (1992). It provided a profile of registered clinical counsellors regarding their religious beliefs, attitudes, and practices in both their personal and professional lives.

The survey contained 35 closed-ended exploratory questions to which participants were to respond using a five-point Likert-scale (strongly agree to strongly disagree), two comment sections, and four opened-ended questions. Respondents were presented with working definitions of 'spirituality' and 'religion' taken from Prest, Russel, and D'Souza (1999). Spirituality was defined as referring to, "the human experience of discovering meaning, purpose, and values, which may or may not include the concept of a God or transcendent being". Religion was defined as, "the formal institutional contexts for spiritual beliefs and practices" (Prest, Russel, and D'Souza, 1999, pg. 64).

The survey included four sections: 1) Demographics, 2) practitioner ideology, 3) appropriateness of spiritual and religious interventions, and 4) education, comfort, and competence.

Section one included questions on sex, age, and number of years practicing in the field.

Section two examines respondents' ideological orientation towards spirituality and religion by asking them to select an ideological position (see Table 5). Next, respondents are asked to rate themselves as either spiritual and/or religious persons and to identify whether or not they regularly spend time getting in touch with their spirituality and/or religion; this includes a comments section. The last part of this section examines respondents' attitudes towards spirituality and wellness (see Table 6); this part also includes a comments section.

Section three of the survey examines respondents' attitudes and practices regarding the appropriateness of integrating spirituality (see Table 7), and religion (see Table 8) into professional practice.

The fourth and last section of the survey examines respondents' attitudes regarding their graduate programs with respect to training in the areas of religion and spirituality and their views on their comfort and competence when working with religious and/or spiritual clients.

The items for the section on graduate training included:

1. I am satisfied with the content related to religion and/or spirituality presented in my graduate program;
2. I want to learn more about integrating religion and spirituality with assessment and interventions;
3. please comment below on the types of education/training you would like to see included as either elective or core courses in your graduate program on religion and spirituality (i.e. courses and/or workshops) and the types of expertise regarding instruction on religion and spirituality that may interest you (i.e. professors trained in religious studies, theologians, clergy, spiritual leaders).

The items on comfort and competency included:

1. I am comfortable working with religious and/or spiritual clients;
2. I believe I am competent and/or prepared to work with religious and/or spiritual clients;
3. Please qualify your answers to the previous two statements regarding comfort level and competency or preparedness when working with religious and/or spiritual clients.

Table 5

Epistemological positions regarding spirituality and religion

- 1 There is a personal God of transcendent existence and power whose purpose will ultimately be worked out in history
 - 2 There is a transcendent aspect of human experience which some people call God but who is not imminently involved in the events of the world and human history
 - 3 There is a transcendent or divine dimension that is unique and specific to the human self
 - 4 There is a transcendent or divine dimension found in all manifestations of nature
 - 5 The notions of God or the transcendent are illusionary products of the human imagination; however, they are meaningful aspects of human existence
 - 6 The notions of God or the transcendent are illusionary products of the human imagination; therefore, they are irrelevant to the real world
-

Table 6

The importance of spirituality for wellness

- 1 There is a relationship between spiritual health and mental health
 - 2 There is a relationship between spiritual health and physical health
 - 3 There is a relationship between spiritual health and the health of the community
-

Table 7

The integration of spirituality and professional practice

- 1 Ask a client about his/her spirituality
- 2 Wait until the client brings up his/her spirituality
- 3 Help client to develop spiritually
- 4 Discuss client's spiritual experiences
- 5 Use spiritual language
- 6 Discuss client's spiritual symbols
- 7 Recommend spiritual program
- 8 Pray for client
- 9 Pray with client
- 10 Meditate with client
- 11 Recommend spiritual books
- 12 Discuss own spirituality
- 13 Discuss meaning of life
- 14 Refer to 12-step program
- 15 Use spiritual issues to connect with community

List the items that you are using in your work with clients

Table 8
The integration of religion and professional practice

1	Ask clients about their religion
2	Wait until the client brings up his/her religion first
3	Recommend client join a religion
4	Recommend client leave a religion
5	Recommend participation in a religious program
6	Discuss own religious beliefs
7	Talk with client about God
8	Recommend religious books
9	Use religious language
List the items that you are using in your work with clients	

Data Analysis

Descriptive statistics were used to summarize the beliefs, attitudes, and behaviours of the graduate-level clinical counsellor participants.

The data was collected, summarized, and analyzed/scored by *SurveyMonkey.com* and this researcher had access to produce analyses and reports/graphs through membership to this on-line professional survey organization.

The data from Survey Monkey will be stored for seven years per the British Columbia Association of Clinical Counsellors standards on a password protected hard-drive within the researcher's office, which is also secured. The researcher is the only person with access to this office, and to the pass-word protected computer system.

Chapter Four: Results and Analysis

Three hundred and forty-one clinical counsellors of the British Columbia Association of Clinical Counsellors started the survey for this study; three hundred and forty-one participants completed the demographic questions, while two hundred and seventy-three completed all of the questions in the survey (80.1%).

Demographics

Sex, Age, and Number of Years Practicing in the Field

The sex of the participants included 95 males (27.9%) and 246 females (72.1%). The number of participants for the combined age categories included: 53 (15.5%) for the *20 to 40* year categories, 208 (61.0%) for the *41 to 60* year categories and 80 (23.5%) for the *over sixty* categories (see Figures 1 & 2). *Number of years practicing in the field* included: 59 (17.3%), 58 (17.0%), 55 (16.1%), 51 (15.0%), and 118 (34.6%) respectively, for the corresponding groups (see Figure 3).

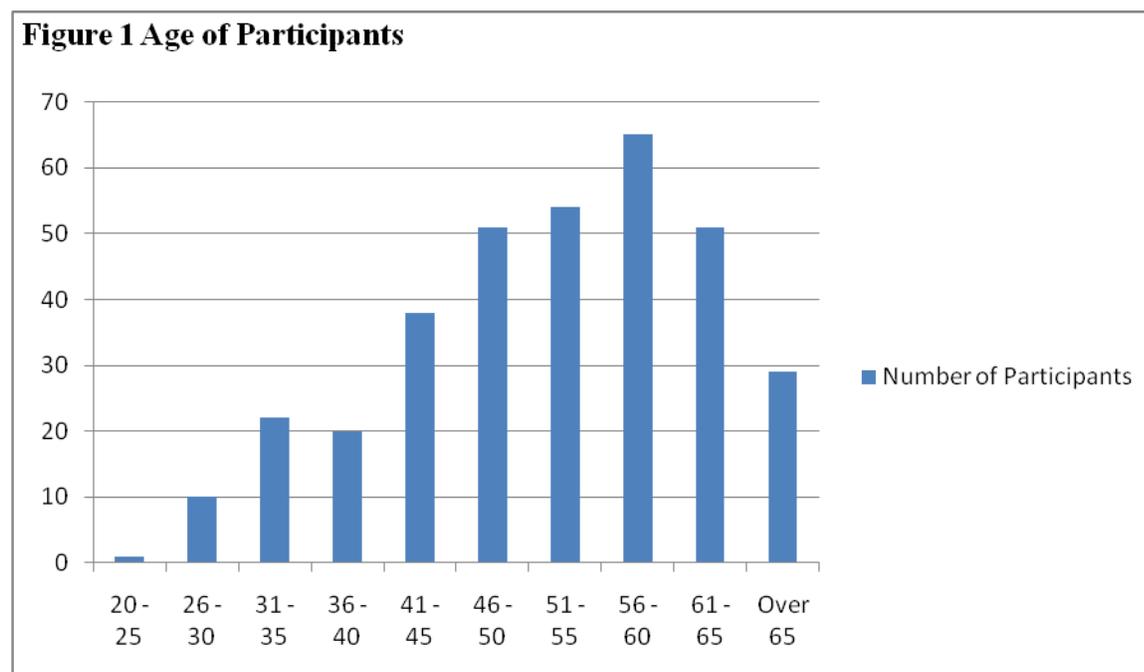
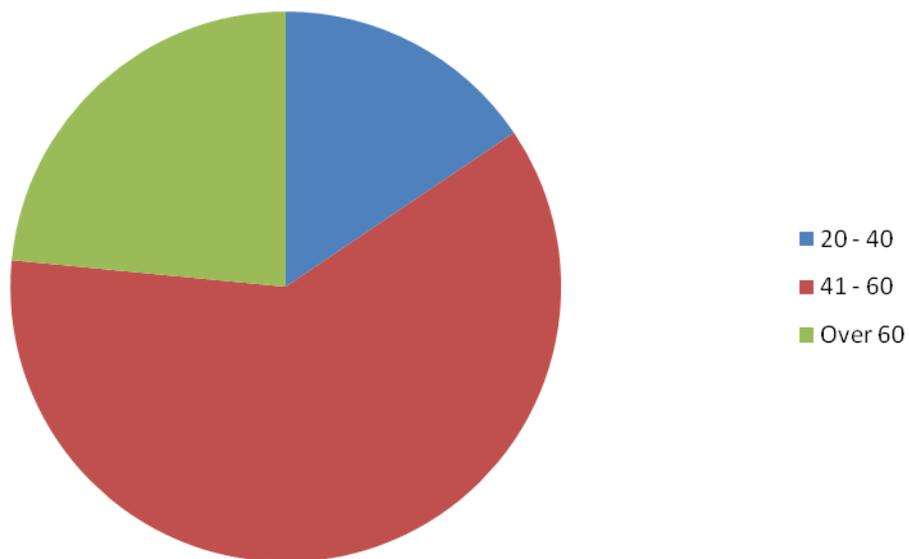
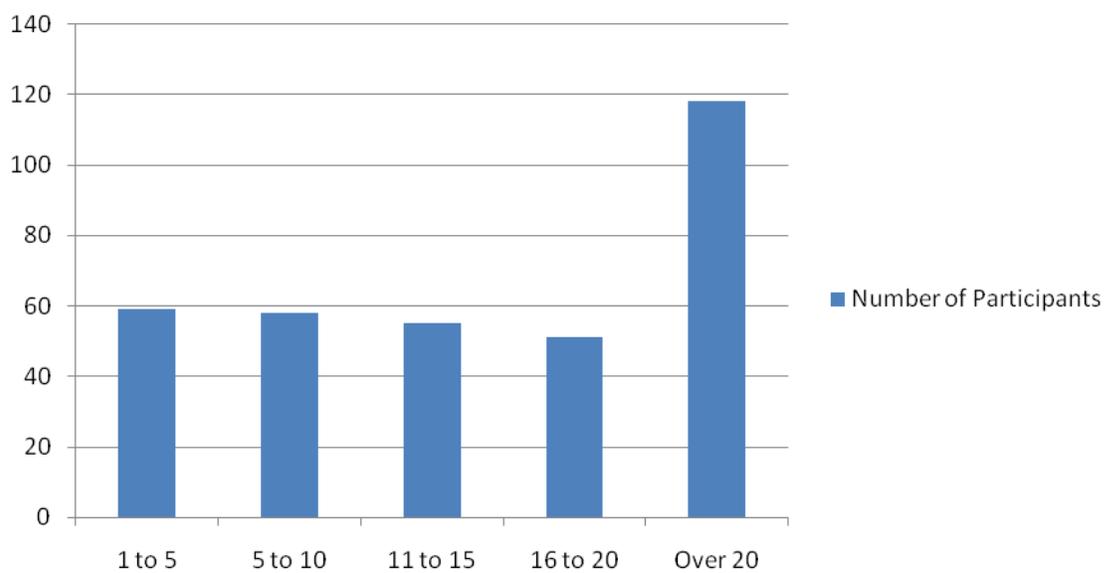


Figure 2 Combined participant age categories**Figure 3 Number of years practicing in the field**

Practitioner Ideology

Religious and Spiritual Epistemology

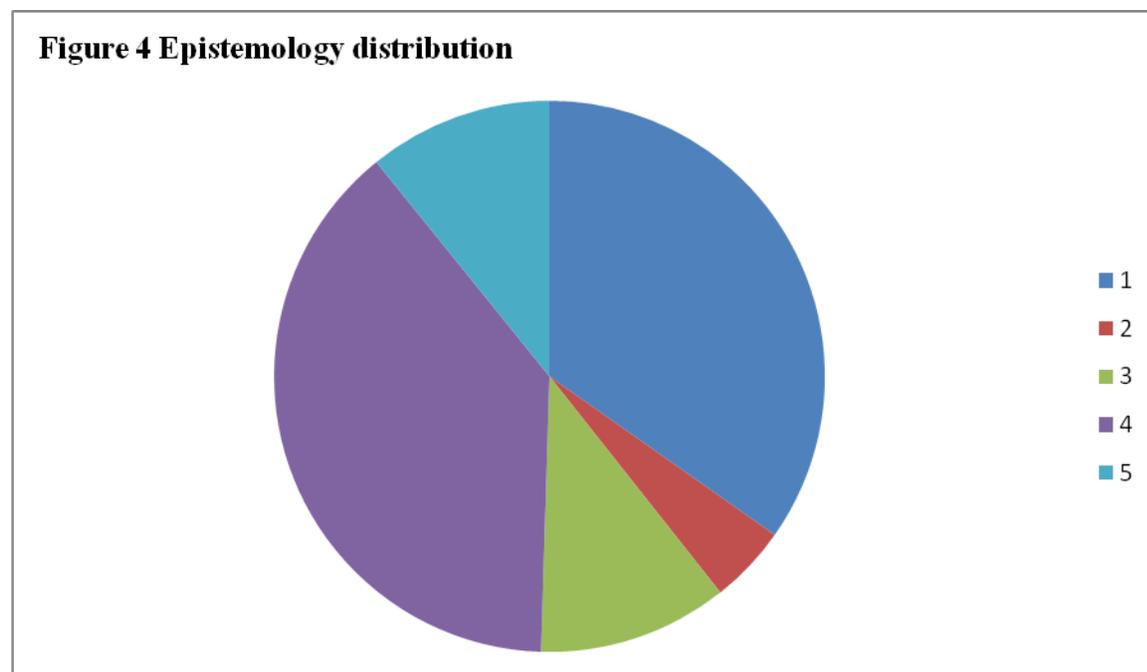
Three hundred and nine participants answered the question on their religious and/or spiritual epistemology, while 32 skipped the question.

For the five consecutive epistemology positions, the number of respondents included: 106 (34.3%), 14 (4.5%), 34 (11.0%), 118 (38.2%), and 33 (10.7%) respectively, (See Table 9 & Figure 4). The results for position six (4 respondents, 1.3%) is not represented on the pie graph.

Table 9

Epistemology positions regarding spirituality and religion

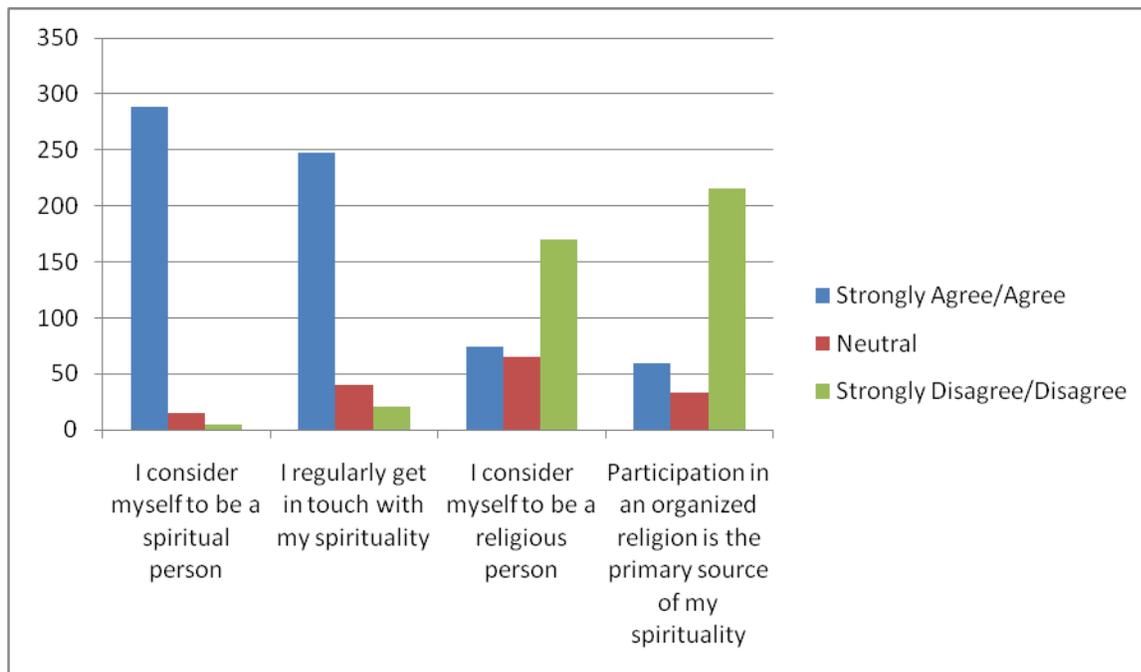
1	There is a personal God of transcendent existence and power whose purpose will ultimately be worked out in history
2	There is a transcendent aspect of human experience which some people call God but who is not imminently involved in the events of the world and human history
3	There is a transcendent or divine dimension that is unique and specific to the human self
4	There is a transcendent or divine dimension found in all manifestations of nature
5	The notions of God or the transcendent are illusionary products of the human imagination; however, they are meaningful aspects of human existence
6	The notions of God or the transcendent are illusionary products of the human imagination; therefore, they are irrelevant to the real world



Spirituality and Religion in the Participants' Life

The number of respondents for all four questions was 309; 32 skipped the questions, while 67 commented (see Figure 5).

Figure 5 Number of respondents, spiritual and religious identity and practice



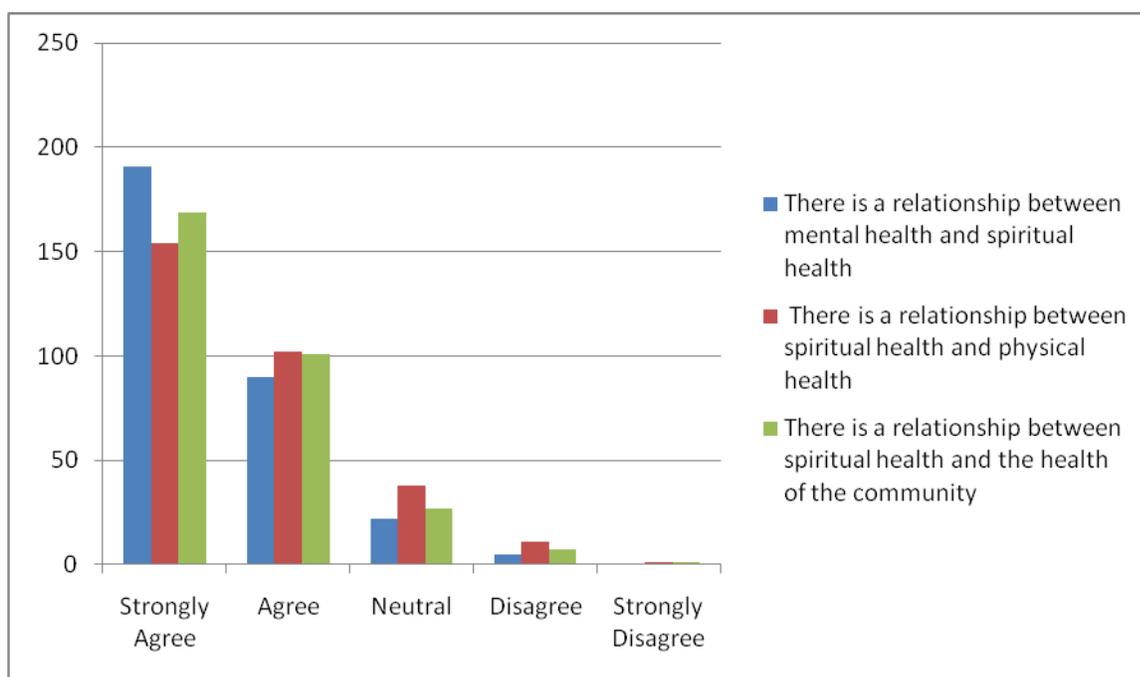
Some common themes that were represented in the 67 comments for this section were as follows:

- Relationship with God and Jesus as most important
- A spiritual path is not religion, spirit is everywhere
- Non-traditional organized religion for self-realization
- Spirituality and religion interchangeable
- Faith communities important for connection
- Organized religion as a manipulative tool
- Organized religion is unnecessary for practicing spirituality
- Spirituality is indefinable

The Importance of Spirituality for Wellness

The participants were instructed to respond to the following statements regarding the relationship of spirituality and wellness: 1) There is a relationship between spiritual health and mental health, 2) there is a relationship between spiritual health and physical health, and 3) there is a relationship between spiritual health and the health of the community. The number of participants that responded was 308, 306, and 305 respectively; 32 skipped the question, while 43 commented (see Figure 6).

Figure 6 The importance of spirituality for wellness



Some common themes that were represented in the 43 comments for this section were as follows:

- Physical, mental, emotional, social, occupational, and spiritual are interrelated
- Define 'spiritual health'

- Spiritual wellness as inner peace

Appropriateness of Religious and Spiritual Interventions

The Integration of Spirituality into Professional Practice

The number of participants that responded to this section ranged from 275 to 286 (see Table

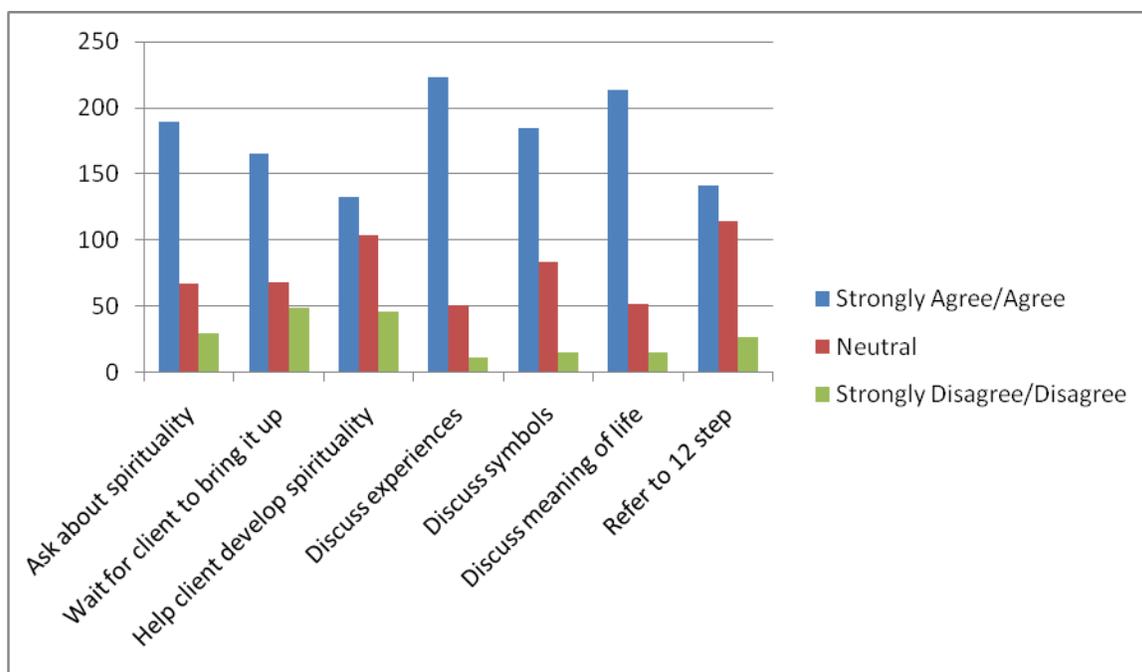
10). Items that were highly endorsed included: 1, 2, 3, 4, 6, 13, and 14 (see Figure 7).

Table 10

The integration of spirituality into professional practice

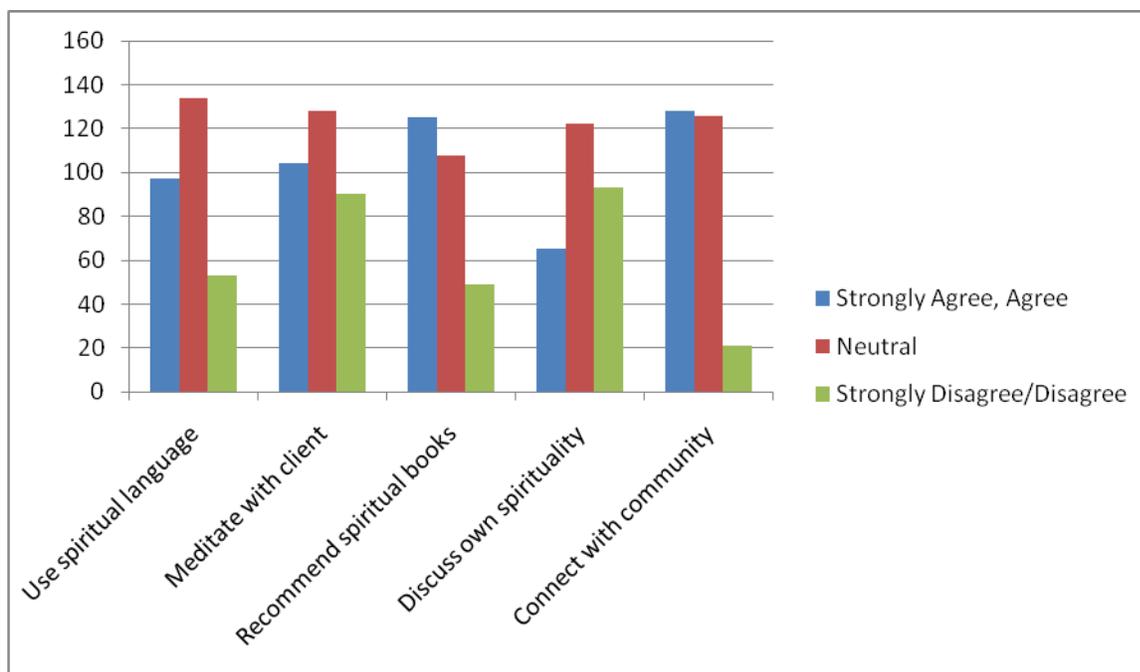
-
1. Ask a client about his/her spirituality
 2. Wait until the client brings up his/her spirituality
 3. Help client to develop spiritually
 4. Discuss client's spiritual experiences
 5. Use spiritual language
 6. Discuss client's spiritual symbols
 7. Recommend spiritual program
 8. Pray for client
 9. Pray with client
 10. Meditate with client
 11. Recommend spiritual books
 12. Discuss own spirituality
 13. Discuss meaning of life
 14. Refer to 12-step program
 15. Use spiritual issues to connect with community
- List the items that you are using in your work with clients
-

Figure 7 Items that were highly endorsed as appropriate interventions



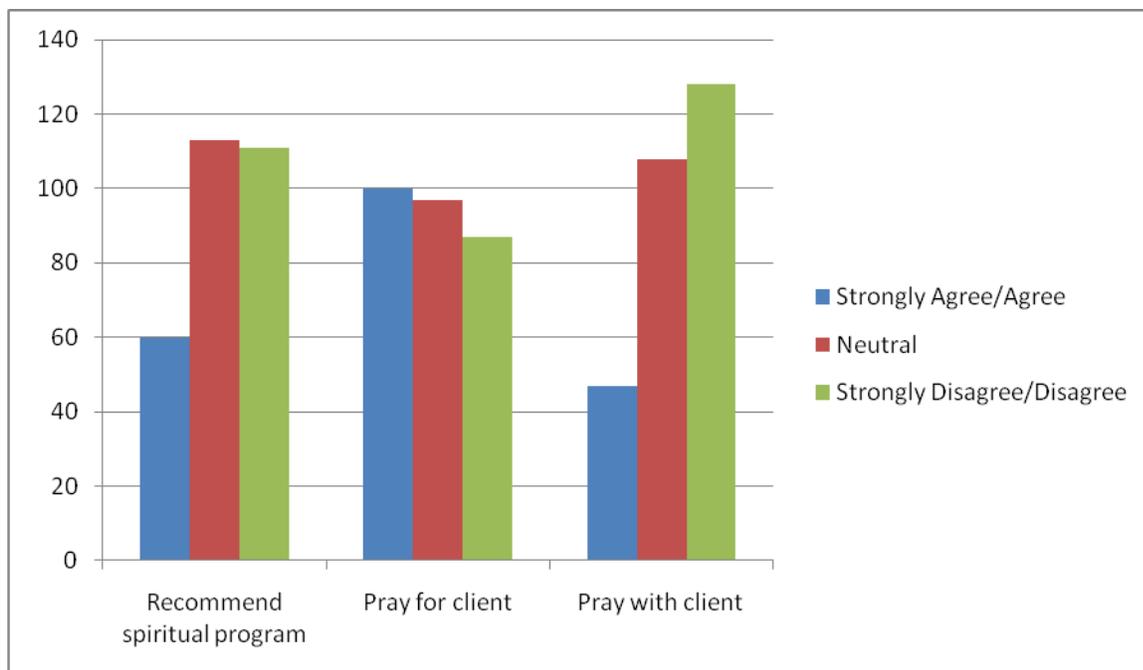
The items that were considered neutral included: 5, 10, 11, 12, and 15 (see Figure 8).

Figure 8 Items that were considered neutral/depends on client



The items that were considered, overall, inappropriate included: 7, 8, and 9 (see Figure 9).

Figure 9 Items that were considered inappropriate interventions



The participants were instructed to *list the items that you are using in your work with clients*, 158 responded. The 158 respondents disclosed themes about integrating spirituality into clinical practice.

Thematic Comments by Participants Regarding the Clinical Use of Spiritual Interventions

Neutrality.

- Neutral often means ‘I might’
- The better category for neutral here is that "it depends" upon the client

Spiritual leadership and guidance.

- It is the role of a Spiritual Director, Pastor, Rabbi, Imam, or other spiritual leaders to give spiritual leadership and support to clients
- Unless the therapist is a fully trained pastoral counsellor through the Canadian Association of Pastoral Practitioners and Educators, they are not competent to work with the topic

- It is not appropriate for every therapist to engage in spiritual formation/integration work. Professional training in contemplative theory and practice is as important to spiritual guidance as professional training is to the practice of psychotherapy

Ask/do not ask the client to engage in the subject of spirituality.

- Allowing them to lead when it comes to something as personal as spirituality/religion
- Only if clients bring up own spirituality and religious practices
- Ask clients about their beliefs and use whatever is supportive to them as a resource in clinical work
- I do sometimes ask a person about her/his spirituality
- Inquire as to how their faith has been a friend or an enemy to them in the present trouble
- Inquire about how clients' spiritual beliefs inform their life choices
- Ask client what they do to nurture their spirituality

Rogerian perspectives.

- Providing an accepting environment for whatever their beliefs might be
- Respect, support, non-judgement, and providing a safe space

Client and therapist epistemology.

- If both therapist and client are of same religion it may be appropriate to pray for and with client. If the client is not religious but therapist is, praying for/with would not be appropriate
- My own spirituality is irrelevant to the client
- Explore the spiritual concept of forgiveness

- No evangelizing of any belief system
- Caution regarding counsellors discussing their own spirituality
- Discussions that may include the negative impacts of religion, i.e. spiritual abuse

Spiritual language and prayer.

- Willingness to pray in-session, but only at clients' request
- I also pray with clients when they ask me to and pray for my clients on a regular basis
- Do not use own language but listen for their language. Use their language throughout therapy, i.e. Jehovah as the term for God
- Spiritual language and symbols arise frequently in my work

Framework, tools, and referrals.

- Include spirituality as part of the bio-psycho-social-spiritual framework for wellness
- Questions on intake covers religious background and any current beliefs
- Items that may be useful are verses from the Bible, books, spiritual gift assessments, life purpose materials
- Meditation, arts and culture as an expression of one's spirituality
- Breathing, meditation, body sensing, essence sensing, integration of spiritual experience, understanding the blocks to true nature/essence and how to access deeper levels of Self
- Caveat - it is only with the client's permission that we incorporate these practices
- Referrals to community groups like AA, NA, Divorce Care, and Griefshare

- I only refer clients to 12-step programs that have a clear concept of the ‘higher power’

Meaning of life.

- Explore the area of clients’ spirituality more in terms of their “Meaning of life” perceptions and beliefs
- Meaning of life discussions are vital to get to the values they choose to live by
- Ask about values related to the soul if person is dealing with grief and loss, etc.
- Existential resources
- Assist client with ethical or moral issues being influenced by their spiritual beliefs
- The client's expressed goals to guide actions in these regards

The Integration of Religion into Professional Practice

The number of participants that responded to this section ranged from 280 to 286 (see Table 11 & Figure 10).

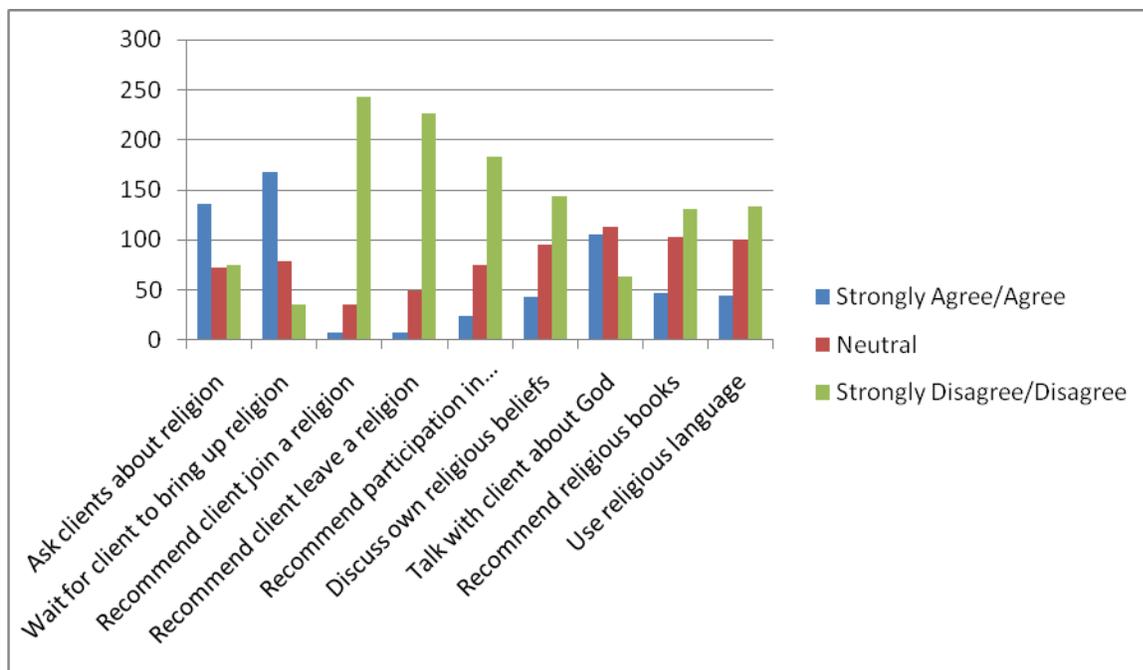
Table 11

The integration of religion into professional practice

1	Ask clients about their religion
2	Wait until the client brings up his/her religion first
3	Recommend client join a religion
4	Recommend client leave a religion
5	Recommend participation in a religious program
6	Discuss own religious beliefs
7	Talk with client about God
8	Recommend religious books
9	Use religious language

List the items that you are using in your work with clients

Figure 10 Views on the appropriateness of religious interventions



The participants were instructed to *list the items that you are using in your work with clients*, 132 responded. The 132 respondents disclosed themes about integrating religion into clinical practice.

Thematic Comments by Participants Regarding the Clinical Use of Religious Interventions

Ask/do not ask the client to engage in the subject of religion.

- Discuss God if clients bring this up but never initiate it out of context
- Wait until client brings up their religion first
- Caution when discussing religion with clients because of all the power/authority concerns
- Religion has no place in counselling; spirituality, on the other hand, is appropriate when the client wishes to pursue this
- Religion is political, not spiritual
- Understanding cultural influences of their religious beliefs

- It is helpful to understand the faith background of a client
- Discussion and resources depend on the client's religious beliefs and whether similar to my own
- Religion as a potential resource unless the client indicates otherwise
- I don't use the word religion as I find it's loaded and often misunderstood
- I have discussed God with clients, once they bring it up, and if appropriate, compare how strict their God is with the strictness of their parents and introduce the concept of unconditional love/acceptance
- All of these items are dependent on whether the client wants to talk about these issues
- I think that combining religion and professional practice can lack objectivity. Also, religious beliefs can produce a lot of unnecessary guilt
- I usually wait for the client to bring it up, but occasionally it seems a good idea to ask, if I get an inkling that it might be somehow important

Recommend client leave and/or join a religion.

- As for joining or leaving, I would not bring that up unless the client brought forward that concern as an issue for them
- Recommend client to leave religion or community if assessment indicates harm to client
- It is not the counsellor's place to make recommendations
- Within the context of therapy it is sometimes necessary to explore with a client aspects of their religious life though I would not encourage or dissuade the client from being part of any religious congregation

- May be appropriate to discuss the option of leaving a religion, particularly when the religion is presenting a barrier in the client's efforts in self-realization
- In my view a religious program, or religion, is just one of various contexts where someone can potentially identify spiritual meaning within a community of other like-minded/hearted people

Talk with client about God.

- I wouldn't discuss my views about god with clients, but this has to do with my own values and biases
- IF a client indicates that they have a religious connection, then I may use that as a way of talking about God or encouraging use of programs
- I ask clients about their religion as it relates to their spiritual beliefs and what they have come to believe about life and God. I talk to clients about their image of God
- If a client talks to me about God, why would I deny him/her the right to do so? But for me, as a practitioner, to start talking about God or encouraging someone to go to church would, again, be questionable and possibly unethical. It always depends on the individual circumstance
- I have discussed my own beliefs as part of a conversation in which the client has specifically asked me what I believe
- If they spoke of praying and God and sin then I would use these words as well to explore what they mean to the client and what aspect of this influences their current situation

- I do discuss God, but not related to religion, but more around spirituality and leave lots of room for their own definition of the divine and their own language around that
- As far as I interpret the Code of Professional Ethics for Psychological Practitioners (CPBC & CPA), it is and always was, against the Ethical code to discuss your own religion or religion per se, with a client

Spiritual leadership and guidance.

- Refer to religious leaders as an adjunctive to the healing process
- Counselling in terms of religious beliefs has always been and should remain the territory of ministers and priests
- Collaboration with pastors and ministers

Recommend religious books, programs, use religious language.

- I have given clients books to read that may contain spiritual and religious overtones, but nothing that I am advocating. I try to match reading to their experience so as to offer balance and perspective
- Currently I am recommending Jungian writer James Hillman (Soul's Code), James Hollis, who are actually existentialist. I have never recommended specifically Christian writers or Buddhist writers unless I thought the client could specifically benefit based on their own belief system
- If a client professes an interest in a certain religion, I'm OK about suggesting resources for further exploration

- Recommend religious books (if I am familiar enough with their faith that I can genuinely recommend something meaningful), use religious language (if I am familiar enough with the client's particular faith that I can use religious language that is meaningful to them in an appropriate way)
- Only use religious language presented by client
- I might use a clients religious language if it was appropriate and fit for me but only as a way of listening to really hear what they are saying
- “God” must be defined by the client; religious language must be led by the client
- I have recommended a religious program if it has been something which is in accord with the client's faith or an area they have expressed an interest in exploring

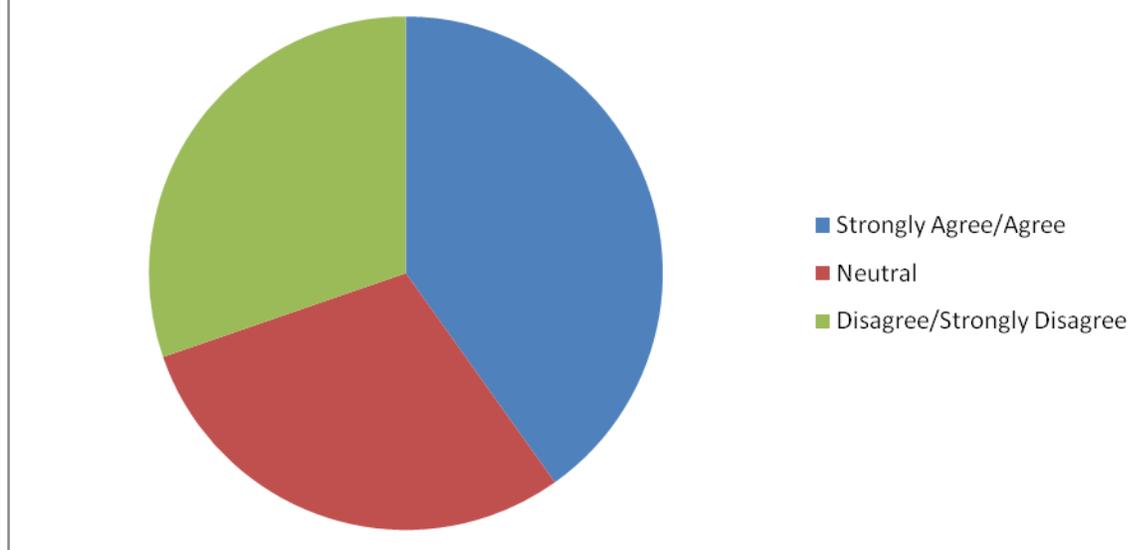
Education, Comfort, and Competency

Graduate Program Coursework Regarding Religion and Spirituality

The participants were instructed to respond to the following two statements: 1) I am satisfied with the content related to religion and/or spirituality presented in my graduate program, and 2) I want to learn more about integrating religion and spirituality with assessment and interventions.

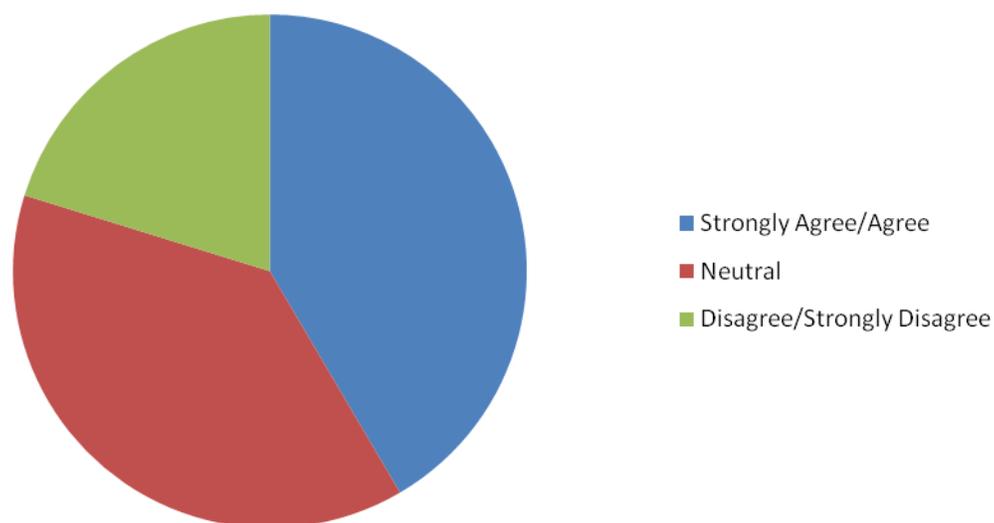
For the first statement, 110 (40.2%) participants chose strongly agree/agree, or were satisfied, while 81 (29.6%) were neutral or uncertain, and 83 (30.3%) participants chose disagree/strongly disagree, or were dissatisfied with the content related to religion and/or spirituality in their respective graduate programs (see Figure 11).

Figure 11 Statement 1. I am satisfied with the content related to religion and/or spirituality presented in my graduate program



For the second statement, 113 (41.5%) participants chose strongly agree/agree, while 104 (38.2%) were neutral or uncertain, and 55 (20.2%) participants chose disagree/strongly disagree, or did not want to learn more about integrating religion and spirituality with assessment and interventions (see Figure 12). When instructed to, *Please comment below on the types of education/training you would like to see included as either elective or core courses in your graduate program on religion and spirituality (i.e. courses and/or workshops) and the types of expertise regarding instruction on religion and spirituality that may interests you (i.e. professors trained in religious studies, theologians, clergy, spiritual leaders)*, 134 participants responded.

Figure 12 Statement 2. I want to learn more about integrating religion and spirituality with assessment and interventions



Participant themes related to past and future training and expertise

Comments on previous training in graduate programs.

- Very little training - the standard 1 minute here and there in an ethics or assessment course regarding respecting clients culture/religion
- nothing touched upon in my graduate degree in some way
- There was absolutely no content related to religion or spirituality
- NO content related to religion or spirituality in any coursework
- I have had no training whatsoever in religiosity and spirituality in any of my graduate programs. It is my personal belief that we have made religion and spirituality seem so negative in this society, that professors are loathe to bring it up. If they do so, it is merely in passing, perhaps a ten minute discussion tops. The message that one gets, as a student, is that these are issues that are either not to be brought up, either because they're taboo, or because they're deemed unimportant. The implication also is that if a

counsellor wants any training in these areas, he/she should be in a pastoral counselling program, not a mainstream one

- We need more courses or talks on how to properly address religion/spirituality with clients, the boundaries that should be respected, what to do/not do, and also some knowledge on what important aspects of a client's life story are missing or neglected if we, as counsellors, do NOT ask them about their religious/spiritual beliefs. In other words, if we don't bring this up with clients, are we silently implying that their religious/spiritual beliefs are NOT important? This could have important implications for everyone involved
- I think there is an increasing ignorance of religion among professionals and this gap ought to be bridged
- As part of my Masters program, I took a course entitled "Psychology and Religion" - very useful
- My Masters coursework had as one of its core elements the question of integration of faith into practice with each of its courses. It was offered from a Christian perspective
- Spirituality or religion should be optional for those students who are interested - it should not be a core part of any counselling program
- I would avoid graduate programs which involved such core courses
- I believe that spirituality and religion is something special but personal. University programs or Education in this area, doesn't have to do with them
- Spiritual teaching should be left to religion, it should not be a part of graduate counselling programs

Core courses wanted in graduate programs.

- A course on integrating spirituality into counselling practice would be helpful for any graduate program, as would a conscious integration of the spiritual aspects of all counselling approaches/issues
- Learn more about how to connect one's spiritual or religious beliefs to their quest for meaning in life or the goals that they present in counselling, especially for those clients that have strong religious or spiritual beliefs
- Opportunities to increase confidence in these kinds of discussions based on understanding one's own spiritual beliefs and how they have formed the individual
- Directly addressing the effect of religious or spiritual beliefs or non-beliefs on the clinical relationship and on counter transference would have been helpful
- A course in Pastoral Care
- A course on how to respectfully integrate and what the potential pitfalls might be
- As offered in degrees in Spiritual Psychology in The States
- Integration courses and meaning center therapy courses
- Course on working with clients within their own belief system, and teaching when it is helpful (not harmful!) to approach clients with spiritual issues
- Studies around various spiritual practices and religious beliefs and how they impact on an individual and family's daily functioning
- Just to openly talk about spirituality and religion and the impact on depression, anxiety, and relationships would be helpful. Experiential exercises would be most useful
- A core course on counselling and spirituality

- I think there should be courses in secular schools that address the issue of values and counselling
- Would like to see core courses in graduate programs on religion and spirituality that would include religious studies offered by theologians, clergy and spiritual leaders from several different religious aspects
- A broad survey course that touched on the ethics of clinical practise and the place of spirituality, religion and prayer in the healing process

Cultural effects and world religions.

- Information about other cultures would be valuable so all counsellors are aware of beliefs and customs that are of importance to their clients
- Have a better understanding of some of the more common religions that are encountered
- Lively group discussions that explore world religions promoting inclusivity, and understanding
- General info on religious/cultural/spiritual beliefs with emphasis on individual differences
- More information about religious/cultural beliefs as they may impact some of the issues addressed in graduate school (e.g. sexuality, addictions, family structure and functioning, dying & death) would have been helpful
- Contemporary theories and interpretations of the bible and other religious sacred writings
- More information on how a religion shapes the cultural reality of individuals would be helpful

- Courses on types of religion (eastern etc.) to enable a better understanding of beliefs, customs, expectations, traditions, roles etc.
- I would have liked to see a second course further along in the program that was more in depth regarding the spiritual practices of various cultures
- In a multi-cultural context, a world religions background would be helpful to understand some of the basic underlying values associated with various world religions as well as how to approach these clients without bias
- Comparative religions should be taught. Instead we are taught to be cautious about cultural ignorance. Being urged to have caution is not the same as developing competence
- I would like more education regarding different religions' view of God
- Survey course on major world religions
- Discussions on working with people of various spiritual and religious visions would have been useful
- A cross cultural class in counselling that included theologies would be useful
- A general overview of various religious perspectives may help therapist's gain insight into client's belief systems, especially those that are impediments to healing
- There needs to be content on world religions, spiritual movements and cultural influences including movements that involve spiritual practices that may be considered "pagan". Including what is the role of religion and spirituality in creating political and social control within a culture

Workshops, electives, theories, and techniques.

- Alternative stress reduction techniques, meditation

- I think that this requires more of a workshop/elective approach than a core course
- Courses on integrating spirituality into established counselling techniques (I recall reading an article on spiritual augmentation of CBT)
- Definitely workshops on meditation and the differences between prayer and meditation
- Exposure to research benefits of prayer/meditation
- Ethics guidelines further developed for practitioners by professional body
- Interfaith exposure through symposiums, etc. for clinicians
- Workshops from all of the above, just as we take survey courses in different schools of therapy
- Workshops with healers of other ideologies, diversity teaching about grief , after life, anything
- An elective and not part of the core curriculum... but it could come up in a discussion on ethical practice as it fits with moral and ethical practice
- I think this is an important dimension and a course on spirituality could be included as elective, however, the opportunity for a workshop (or series of) I think would be just as effective
- Teachings on forgiveness and models of forgiveness especially when working with trauma survivors would be useful
- Integration of Spirituality with various psychological theories, Understanding your personal spirituality with the role of a therapist
- Courses and workshops: taught by specialists in this field, people who have used this approach effectively, develop strategies to be used by counsellors

- Spirituality and Mental Health
- Effects of spiritual beliefs on ability to cope
- I think transpersonal psychology is important to be part of a psychological training
- Depth psychology perspectives
- I would like to see Applied Metapsychology as an integral part of all counsellor training
- elective courses workshops and courses, spiritual and religious issues may be useful for the counsellor's own development and personal growth
- Personally I find Jungian psychology an integrative approach to spirituality and I think it is important to learn as much as possible about all the main religions and spiritual traditions

Potential instructors.

- Having a variety of professors come to teach what works for them and their practice
- Clergy, professors and theologians
- Ideally, these courses would be taught by counsellors who have knowledge in several religions and successfully work with clients of diverse religious beliefs
- I would like to see more on religion and spirituality offered in graduate programs and this information needs to be presented from diverse perspectives by people who have in depth understanding and training
- Professors who can integrate their personal spiritual beliefs to their practice/teachings were great assets for my learning experience
- I'd like to see discussion leadership by educators who are themselves interested in integrating psychology, faith, and philosophy

- I would like to see instruction be given by individuals - lay and ordained and from different faith/contemplative backgrounds - who are developed both theologically and mythically; who have both a solid theology of spirituality and spiritual direction and who have a long period of personal contemplative practice and psychosocial awareness/integration
- Presentation by a representative of the major religions functioning today
- Experienced therapists who are spiritual/religious; religious studies profs who are also therapists, spiritual leaders of different faiths

Comfort and Competence Levels

A comparison was made of the participants' answers in the categories of *age* and *comfort and competence levels* of integrating religion and spirituality into counselling. Two hundred and seventy-seven participants completed the Likert-scale questions, while sixty-four skipped the questions.

In the younger age group category that included participants between 20 to 40 years, 18 (45%) respondents chose strongly agree and 19 (47.5%) agree, while three (7.5%) scored neutral on being *comfortable* working with religious and/or spiritual clients (see Figure 13). When asked about *competency and/or preparedness* to work with religious and/or spiritual clients, 14 (36.9%) respondents chose strongly agree, 17 (44.7%) agree, and seven (18.4%) scored neutral (see Figure 14).

In the middle- age group category that included participants between 41 to 60 years, 82 (46.3%) respondents chose strongly agree, 78 (44.1%) agree, 15 (8.5%) scored neutral, and two (1.1%) chose disagree on being *comfortable* working with religious and/or spiritual clients (see Figure 13). When asked about *competency and/or preparedness* to work with religious and/or

spiritual clients, 70 (39.5%) respondents chose strongly agree, 74 (41.8%) agree, 27 (15.3%) scored neutral, and six (13.4%) chose disagree (see Figure 14).

In the older-age group category that included participants over 60 years, 33 (55%) respondents chose strongly agree, 18 (30%) agree, 8 (13.3%) scored neutral, and one (1.7%) chose strongly disagree on being *comfortable* working with religious and/or spiritual clients (see Figure 13). When asked about *competency and/or preparedness* to work with religious and/or spiritual clients, 30 (50%) respondents chose strongly agree, 19 (31.6%) agree, seven (11.7%) scored neutral, three (5%) disagree, and one (1.7%) chose strongly disagree (see Figure 14).

One hundred and sixty-two participants qualified their answers on comfort and competence.

Figure 13 Comparison of Comfort level and Age, distributed by percentage of participants, when working with religious and/or spiritual clients

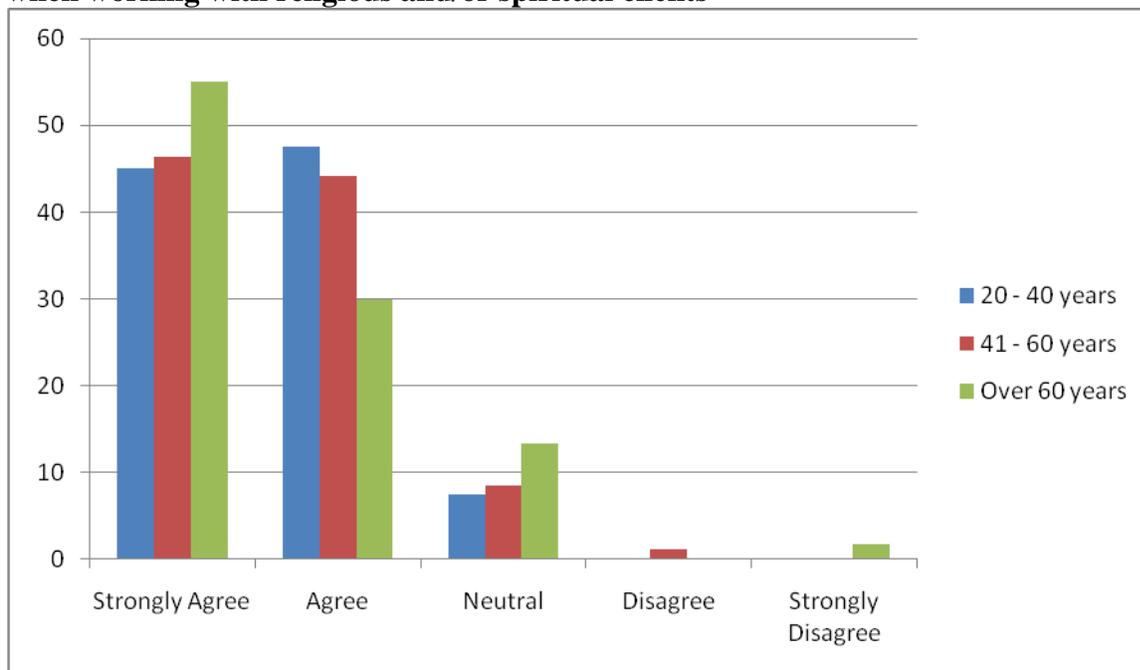
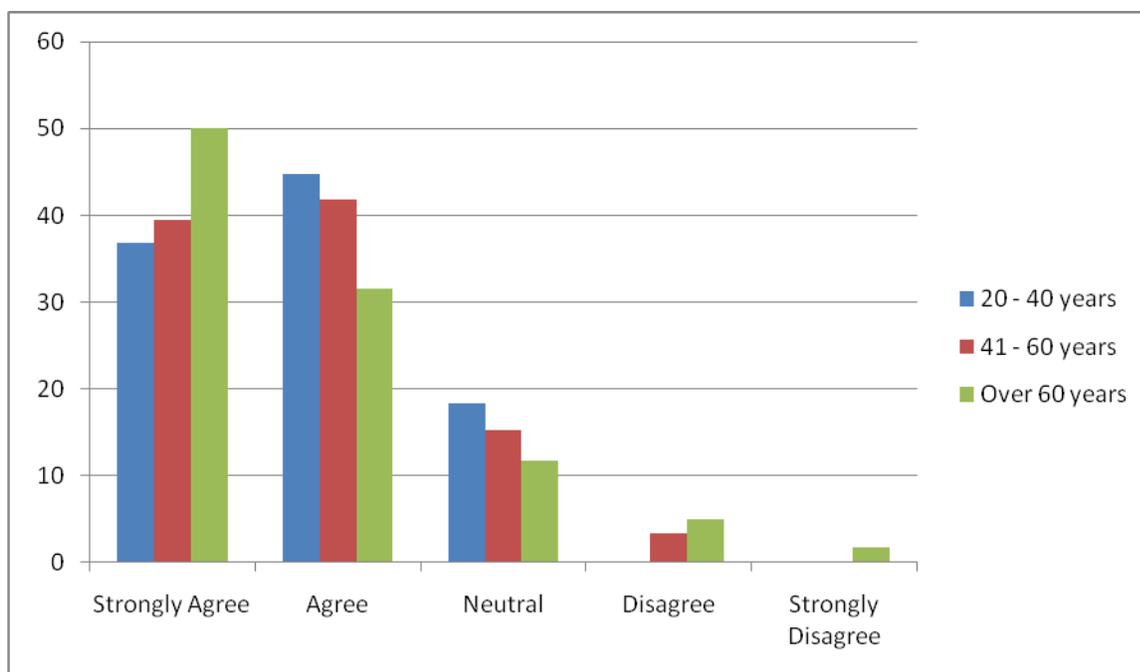


Figure 14 Comparison of Competence/Preparedness and Age, distributed by percentage of participants, when working with religious and/or spiritual clients



Comments on Comfort and Competence

Struggle.

- I do not think I am completely competent because I do not have information or understanding of many religions and I believe that some clients may be put off by my ignorance and it will affect the therapeutic alliance
- I wish I had more training and also a wider range of personal experience with different world religions
- I find it challenging to talk about or deal with Religious issues with clients since the culture in general seems to somewhat disregard Religion - so most times I feel I am walking on egg shells around what my religious beliefs are - not just in session but in life as well
- I'm comfortable with those in the Christian tradition but less so with other religions

- I have had clients in the past with alternative religious beliefs (i.e. Muslim, etc), I did not feel competent to work within or utilize their religious views as I simply did not know enough about them
- I am very comfortable in working with clients who have spiritual backgrounds that I am familiar with. I may be less comfortable in working with clients who have spiritual backgrounds that contradict my own values or what I view as imminent harm to client (i.e. cults and others)
- I would say I am comfortable discussing spirituality, comfortable with my own spirituality. Not as confident in discussing formal religious beliefs because I do not have in depth understanding of them
- I agree that I am both comfortable and competent to help clients with issues of a spiritual nature. I am not comfortable, nor am I competent to deal with issues of a religious nature - this is the realm of priests and ministers
- Lumping spirituality and religion together in these statements is problematic for me. I am quite comfortable with working with clients' spirituality and at times, I am not so comfortable working with clients who hold radical and fundamentalist religious beliefs

Anger.

- I HAVE SERVED AS A CLERGYMAN FOR OVER 25 YEARS PRIOR TO ENTERING COUNSELLING AS A CAREER.THE KEY ISSUE IS TO RESPECT THE CLIENT

- I do not interfere with anyone's beliefs. Social problems are social problems regardless of religion. Religion simply creates a fog in which the problems may be hidden, relabelled or vilified

Rejection.

- I am comfortable working with clients and respectful about their beliefs. I prefer not to work with very religious clients
- I don't have any competence in this area, I am a Counsellor not a Priest
- Because I consider myself a spiritual person but not a religious person then I could see running into some roadblocks working with a client who a fundamentalist and would probably refer them to their religious leader for further exploration of how their beliefs fit for them
- I would not want to work with highly traditional Christians, or for that matter highly fundamental, traditional in any religion

Integration.

- I feel extremely comfortable and prepared to work with religious and/or spiritual clients
- I feel that the program I was involved in equipped me well in this regard; however, I also feel that I have much to learn!
- I accept when I cannot know everything about other religions and I enjoy being educated by my clients about their particular faith path
- I find that in my general practice most people are more interested in talking about spirituality than religion

- As for competence, I believe that comes from experience, but also from the willingness to be open and learn
- I feel comfortable if the client introduces the concepts to the session
- I don't believe that I need to be educated in any specific religious or spiritual practices in order to help clients work through their issues
- Because I bring my personal, not professional, experience with spirituality to clients, I believe further professional studies in this area would be beneficial both to my clients and myself
- I am comfortable working with religious/spiritual clients in that I am curious about their belief systems and how they contribute to or detract from their emotional and mental well being
- I am competent in that I create the space and opportunity for discussion and integration of religion and spirituality in session. I am not competent or prepared to work in depth with clients around specific religious or spiritual issues (i.e. I have never taken formal training in this area)
- Life experience, training, personal study, etc. leave me feeling both comfortable and competent - it has all worked well so far!
- I think counselling therapists with a greater understanding of spirituality have a distinct advantage in bringing a more holistic understanding of the human condition than those without. I believe that as counsellors we need to be trained and have understanding in aspects of spirit, mind and body and understand that integration in the journey of life

- I am comfortable talking about meaning of life, spiritual beliefs and a client's congruency between their spiritual values and lifestyle, but don't feel entirely competent to address deeper, bigger spiritual questions or issues
- I have taken courses in world religions and done some cross cultural work that I believe helps me understand various spiritual disciplines that I may encounter with my clients. There is always room for more training as I continue my work
- I feel that I am quite comfortable with discussing spirituality with my clients as throughout my life, I have studied most religions and discovered the common threads between spiritual beliefs rather than focus on the differences
- Because I have a strong belief system I am able to respectfully help clients with their questions. It is not about pushing a particular belief as much as enabling them to find solace, affirm their value and give hope
- I feel that my comfort level is high in these areas as a result of my own extended training and research, as well as, personal work
- I'd feel comfortable having a referral from a Pastor, Priest, Imam, Guru, etc. to work with a member of his or her Church on personal, family, emotional, or behavioural issues. I would also feel comfortable referring the individual back to his/her Spiritual teachers for information unrelated to our topic of endeavour
- I have studied the integration of spirituality and psychology. I have also explored spiritual issues with clients and integrate this regularly into my work
- My openness to others' spiritual beliefs, despite my distaste for organized religion, allows me to honour their needs regardless of whether or not these needs include spiritual or religious issues

- I believe that spirituality is a core issue in my work with trauma and therefore feel confident in addressing it
- Being religious myself, I feel I can relate to some degree with people who identify as being spiritual/religious
- Trained in Religious studies
- I think that we neglect clients, and provide impoverished therapy, when we don't enlist the client's own belief system to help them interpret what is happening to them, give them comfort, and help them decide the best path to health & happiness
- My own world view and life process is centered on my own personal faith, which has been a life-time, active process. I think I've done the work also to recognize how to distinguish and respect other people's experiences and perspectives from my own, which is a critical competency for working with people on these themes
- I work in a Rogerian way with this topic
- To me this is just one aspect of understanding a client's culture and worldview. All counsellors should be competent in this area
- I took an internship which involved supervision related to how I used or didn't use religion/spirituality with clients. The supervision was very helpful
- When working with clients of the same religious background, I believe my experience and competence after years of experience is strong. I am also comfortable working with clients of other beliefs by accepting the differences and meeting with them where they are at

- I have at times referred a client to someone who has a more compatible belief system but much of the time I have just worked with them using basic counselling tools within the context of their belief system
- I have read many books (from Christianity to Eastern traditions) and have attended many seminars on the healing of spiritualism. I continually self-educate on these topics
- “Competence” is the right question, not “comfortable”
- I feel that for many people, their spiritual and religious beliefs are integrally tied to their emotional well being, so I must be able and willing to meet them on this issue and provide some guidance
- I work very hard to be multiculturally, and multifaith sensitive
- I am somewhat educated in religious language and concepts, and feel very comfortable moving to someone's point of view, and work from there
- You don't have to be homosexual to counsel homosexuals; or religious to counsel the religious; or an atheist to counsel the atheist; or battered to counsel the abused; or an addict to counsel the addicted. You need to be a competent counsellor that keeps a professional stance

Chapter 5: Discussion

Summary of Results

The main areas that this study explored included: counsellor spiritual and religious identity and practice; counsellor beliefs about the importance of spirituality for mental, physical, and community health; and, counsellor beliefs and practices regarding the appropriateness of addressing spirituality and religion within the context of therapy. Other areas that were explored were counsellors' education and training on these topics, and their perceived abilities regarding comfort and competence when working with religious and/or spiritual clientele. It is important to note that the majority of the participants were women (72%), were between the ages of 41 to 60 years (61%), while 35% indicated that they had been practicing in the field over 20 years (*versus* 16% for each of the remaining four categories). The results of this study showed that clinical counsellors believe that spirituality, but not necessarily religion, are important dimensions in their lives, and in their work with clients. The results also showed that although participants indicated that they support specific interventions, less than half indicated that they are using these interventions in their clinical practice.

Clinician Epistemology

The majority of the clinical counsellors in this study identified with two out of six epistemology positions; 38% of participants identified with position number four - *there is a transcendent or divine dimension found in all manifestations of nature*, while 34% of participants identified with position number one - *there is a personal God of transcendent existence and power whose purpose will ultimately be worked out in history*. When it came to reporting as spiritual and/or religious, the majority of the participants identified themselves as spiritual (94%) *versus* religious (24%). Of the 289 participants that identified themselves as spiritual, 248 (86%)

also reported that they *regularly get in touch with their spirituality*, while 60 (81%) of the 74 participants that identified themselves as religious reported that *participation in organized religion is the primary source of their spirituality*. The comment themes in this section of the survey aligned with the choices reported regarding the beliefs and practices of the participants; i.e. *organized religion is unnecessary for practicing spirituality; a spiritual path is not religion, spirit is everywhere; and, relationship with God and Jesus as most important*.

It is clear that the clinical counsellors in this study support the concept of a positive relationship of spirituality to mental health (91%), physical health (84%), and community health (89%). Comments in this section typically referred to the interrelatedness of the three components - mental, physical, and community health; i.e. *as humans we are a whole being ... mental, emotional, physical and spiritual. We are spiritual beings in a physical body. All parts of us must be nurtured for optimal health*. I think it is safe to conclude that the majority of participants support a bio-psycho-social-spiritual paradigm both personally and professionally. If this is so, then the results for the next section in the survey on the appropriateness of integrating spiritual and religious interventions should align with the support of this paradigm.

Spiritual Interventions

I was surprised to learn that of the 341 clinical counsellors of the BCACC that began this study, 81- 84% responded to the Likert-scale questions on the appropriateness of the integration of spiritual interventions listed, but only 46% responded to the question - *list the items that you are using in your work with clients*. Some of the comments referred to the dimension of spirituality to be the arena of spiritual leaders, and the necessity to refer spiritually minded clients, while others emphasized competence in this area as being associated with the necessity of pastoral counselling training. One might conclude that although the majority of participants

responded positively to integrating most of the spiritual interventions listed into counselling, less than half are actually using spiritual interventions in their work with clients. Most of the spiritual interventions were either highly endorsed (7 items) or rated as neutral (5), with the exception of *recommend spiritual program*, *pray for client*, and *pray with client*. There seems to be some ambivalence regarding recommending spiritual programs as depicted in participants' comments on this topic:

- It is not the counsellor's place to make recommendations
- Recommend spiritual program (if the client wishes to explore their spirituality in a different context)
- It would also not be appropriate for therapist to recommend a spiritual/religious program unless client expresses desire for same; even then it would be better for client to come to this realization on her/his own
- Recommend spiritual program. I do use this. I do not recommend any specific spiritual program. I encourage clients to develop their own program consisting of whatever helps them feel more in touch with their spiritual nature, whether it be simply listening to music that inspires them, or spiritual book, or walks in nature, yoga, or becoming involved in a religious institution

As praying is typically associated with religious behaviours, it would seem that the lack of support for *praying with client* and *praying for client*, or religious interventions in general, would also be apparent in the next section of the survey.

Religious Interventions

In the section of the survey that inquires on the appropriateness of integrating religious interventions, 82-84% responded to the Likert-scale questions, while only 39% responded to the

question – *list the items that you are using in your work with clients*. As in the previous section, comments by participants recommended referring clients to religious leaders as well as including collaboration with clergy. There were negative connotations about religion, and religious organizations as being unhelpful, and sometimes abusive in nature. Spirituality versus religion was also endorsed; i.e., *Religion has no place in counselling, spirituality, on the other hand, is appropriate if the client wishes to pursue this*.

Only three religious interventions were endorsed: *ask clients about their religion* (48%), *wait until client brings up his/her religion first* (60%), and *talk with client about God* (37% agreed, while 40% scored neutral/depends on client). The remaining six items were not endorsed. When comparing the two interventions regarding initiating discussion about religion with the results from the section on spirituality, participants identified as being more willing to be the initiator of a discussion on spirituality versus religion; *ask clients about their spirituality* (66%), and *wait until client brings up his/her spirituality first* (59%). As indicated in previous research, it would appear that the counsellors in this study are biased when it comes to discussing religious content within the therapeutic process of their clients. It would also appear that the issue of who should introduce these dimensions in therapy, counsellor or client, is divided. Participants made reference to the necessity of addressing these issues, including the implication that by not acknowledging or addressing spirituality and religion in the therapeutic process, the void could be harmful to the client:

- Working through this process and a clear understanding of it has been helpful and necessary for many of my clients in the past five years

- I think that we neglect clients, and provide impoverished therapy, when we don't enlist the client's own belief system to help them interpret what is happening to them, give them comfort, and help them decide the best path to health & happiness
- If we don't bring this up with clients, are we silently implying that their religious/spiritual beliefs are NOT important? This could have important implications for everyone involved

Graduate Coursework

For the questions on previous program coursework regarding integrating religion and spirituality into counselling, one-third of the counsellors that participated in this study expressed that they were satisfied with the content presented in their graduate programs, one-third were neutral or uncertain on the subject, and one-third were dissatisfied. When presented with the question on interest in continuing education on these themes, overall the participants appeared to be receptive... the split was approximately 40% for further education, 40% were neutral or uncertain, and 20% were not interested. Participants expressed an interest in core courses, electives, and/or workshops in their graduate programs. Comment themes included support for survey courses on world religions and cultural effects on populations. There was support for courses on application to counselling theories and techniques (i.e. CBT), and for in depth discussion regarding transference, countertransference, and other possible pitfalls that may be encountered when delving into these realms. Other comments included support for interfaith symposiums; a course on spirituality and mental health (i.e. depression and anxiety), and pastoral care. Lastly, there was reference to the importance of engaging in personal work on spirituality and religion (i.e. family history genogram).

Comfort and Competence

The majority of the clinical counsellors that participated in this study identified as being both comfortable and competent/prepared when working with spiritual and/or religious clients. Age was compared with comfort and competence/preparedness levels, and the results indicated that age was not a determining factor. For comfort level in the 20-40 year age group, 92.5% chose strongly agree/agree, while in the 41-60 year age group, 90.4% chose strongly agree/agree, and with the older age group, over 60 years, the results were slightly lower, as 85% chose strongly agree/agree that they were comfortable working with spiritual and/or religious clients. For competence/preparedness levels in the 20-40 year age group, 81.6% chose strongly agree/agree, while in the 41-60 year age group, 81.3% chose strongly agree/agree, and with the older age group, over 60 years, 81.6% identified as being competent/prepared to work with spiritual and/or religious clients. Overall, the results indicated that participants are feeling slightly more comfortable than competent when working with religious and/or spiritual clients (within a five to ten percent margin).

Of the 341 clinical counsellors that began this study, 81% responded to the Likert-scale questions for this section, while 48% qualified their answers in the comments section. The comments on comfort and competence when working with spiritual and/or religious clients were classified and sorted by this researcher as either under the category of struggle, anger, rejection, or integration. The responses given in the comments sections throughout this survey seemed to frequently depict an emotionally charged response, which this researcher believes is indicative of the importance of more research regarding the integration of religion and spirituality within the context of therapy.

Addressing Research Hypotheses and Questions

As described in the introduction of this paper, I proposed three hypotheses for this study.

Hypothesis One: Registered clinical counsellors are not feeling comfortable and competent to work within the context of the religious and spiritual dimensions of clients

The majority of participants indicated that, in general, they are comfortable and competent to work within the context of the spiritual dimensions of clients. Their responses indicated that they support spiritual dialogue and interventions, but not necessarily religious dialogue and interventions with clientele. The outcomes also show a discrepancy between the counsellors' beliefs *versus* their actual behaviour or practice regarding the appropriateness of incorporating religion and spirituality into counselling, as less than half listed the interventions that they are presently using in their work with clients. It is likely (based on the literature described in chapter one and two of this thesis) that the majority of the respondents are not competent to work within the spiritual and/or religious dimensions of clients.

Themes on impediments to competency.

Themes in the literature presented in this paper regarding impediments to achieving clinician competency in working within the religious and spiritual dimensions of clients include the lack of education and training, and the lack of skill *versus* personal experience.

There is a lack of education and training on the topic of the integration of religion and spirituality (or existential issues in general) into therapy in clinical graduate programs; research indicates a lack of or a paucity of coursework and training in existing programs (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Carlson, Kirkpatrick, Hecker, & Killmer, 2002; Frame, 2001; Griffith & Griffith, 2002; Griffith & Griggs, 2001). Although receiving training in all of the world religions may seem impractical, those trained in a particular faith tradition may

have the depth but not the breadth of the various religions and spiritual beliefs and practices as a whole (Gonsiorek, Richards, Pargament, and McMinn, 2009; Hodges, 2007). Some academics believe that working within the religious and spiritual dimensions of clients should be identified as a “specialized field” with its own regulatory body (Hathaway, 2008). Appropriate and competent supervision falls under the domain of education and training in this regard.

Supervisees need supervisors that are trained in not only multi-cultural counselling in general, but in supervising students and seasoned clinical counsellors that are working with religious and spiritual clientele. Aten and Hernandez (2004) offer important guidelines in this regard to help support supervisee competence in these domains.

It is important to highlight the difference between having skill *versus* intrapersonal experiences regarding clinicians working with clients in the realm of religious and/or spiritual beliefs and practices. Walker, Gorsuch, and Tan (2004) have found that counsellors are integrating religion and spirituality into counselling based on intrapersonal experiences and note that this creates risks for the clients through the intentional or unintentional imposition of values, and through inappropriate interventions. A study by Frazier and Hansen (2009) supports Walker et al., (2004) in that the psychologists who identified as religious/spiritual were more likely to report that they were engaging in “religious/spiritual psychotherapy behaviours”. As mentioned in the introduction of this paper, I have come to realize my own naivety regarding my own faith background and experiences in these realms as being a source of competency to work within the spiritual and religious dimensions of clients. As a Christian, I have come to recognize that the concept or term “Christian” can mean many different things to different people, and that not all Christians share the same beliefs and practices. In this regard, I may unintentionally cause harm to Christian clients based on my assumptions and/or biases about their belief system. This is

where in-depth dialogues, including assessments, can be helpful to counsellors with respect to fully understanding a client's worldview, and how their beliefs might be helpful and/or harmful regarding the presenting issue introduced in the counselling process. Chappellee (2000) offers a comprehensive ethical decision making template for Christian counsellors working with religious and/or spiritual clientele. I believe that this template can be useful for all counsellors (no matter what their religious or spiritual position) in working with clients presenting with not only Christian viewpoints regarding counselling goals, but for other world religions and epistemological positions as well.

Hypothesis Two: Counsellors will engage in discussions on clients' spiritual and/or religious dimensions, but only at the initiation of the client

As previously discussed in this chapter, the clinical counsellors that participated in this study are more comfortable initiating a discussion on spirituality *versus* religion. I agree with Souza (2002) in that counsellors need to take a position on this issue, and not just with spirituality, as ignoring one's religious and/or spiritual beliefs or existential issues in general, can inadvertently cause harm to the client. The lack of training in how to go about initiating and conducting discussions on these topics, including recognizing and understanding relevant transference and countertransference issues, were some of the sources of discomfort reported by Master level counselling students in the study conducted by Souza (2002). The results of a study by Griffith and Griffith (2002) showed that 60% of therapists were willing to initiate a discussion on spirituality, while only 42% were willing to initiate a discussion on the topic of God—similar results are reported in this paper. Barriers to integration noted included the therapists' fear of imposing religious and/or spiritual beliefs due to religious differences between themselves and their clients, and the belief that religion is “disempowering of people”. Historically, religious

and spiritual beliefs and practices have not only being viewed as being disempowering, but psychologically damaging as well (Entwistle, 2009; Hayes & Cowie, 2005; Plante, 1999).

Proponents of pastoral counselling dispute these ideas while recognizing that as humans we are psycho-spiritual-somatic beings, therefore, spirituality and psychology cannot be separated (Benner, 2002). Contrary to secular thinking, Bruinsma-de Beer (2006) emphasizes that the purpose of pastoral care is the empowerment of individuals. Tisdale, Doehring, and Lorainne-Poirier (2003) note that a therapist's personal history will influence his or her "theoretical and theological orientation", and thus the approach to client care.

Hypothesis Three: Participants believe that there should be more training on the inclusion of the dimensions of religion and spirituality in psychotherapy through their respective graduate programs and through continued education

It appears that in general, the majority of the participants are either happy with (40%), or undecided or neutral about (30%), the education and training they received in their respective graduate programs regarding the inclusion of religion and spirituality into the counselling process for clients. Two-thirds of the participants also reported being neutral or undecided about (39%) and uninterested in (20%) receiving continuing education on this topic.

Hoffman, Cox, Ervin-Cox, and Mitchell (2005) argue for a foundational approach as being necessary for counsellor competency regarding the integration of religion and spirituality that includes an understanding of the interrelationships between religion, spirituality, and mental health, as well as developmental issues in this regard. They also emphasize the importance of knowledge about diversity and ethical issues that counsellors will face in working with religious and/or spiritual clientele (Hoffman et al., 2005). Brawer, Handal, Fabricatore, Roberts, and Wajda-Johnston (2002) recommend that clinical psychologists not only need to be trained in

sensitivity to bias in these areas, but in competence in the use of assessment measures. The American Psychological Association stresses the need for sensitivity to, and respect of, the religious and spiritual beliefs of clients; this includes reference to the need for adequate training that will ensure competence in working with religious and/or spiritual clientele (Eck, 2002). A survey that included respondents from the American Counseling Association found that, overall; participants supported the nine competencies presented for effectively addressing spiritual and religious issues in counselling (Young, Wiggins-Frame, & Cashwell, 2007). Competency themes included the necessity for sensitivity, understanding, and acceptance on these issues, as well as knowledge about the relationship of religion and spirituality (i.e., similarities and differences). Language use, cultural differences, developmental issues, counsellor self-reflection and exploration of personal beliefs were also included (Young, Wiggins-Frame, & Cashwell, 2007).

Limitations of the Study

The first limitation of this study is that the recruitment of participants was limited to membership of the British Columbia Association of Clinical Counsellors (BCACC). To gain a broader Canadian perspective it would have been efficacious to include membership of the Canadian Counselling Association (CCA) as well. A second limitation was a possible sampling bias of counsellors from mixed samples—those that received their education and training through faith-based graduate programs and internships, and/or through secular programs. It would have been helpful to include a question in this regard in the demographics section of the survey as it would allow for discrimination of this kind. A third limitation was the ambiguity surrounding one of the questionnaire answer choices. Descriptive statistics were used to analyze the results of this study based on a five-point Likert-scale framework for the last three sections of

the questionnaire (self-administered survey). For the questions regarding beliefs about appropriate spiritual and religious interventions, respondents indicated that the Likert-scale choice labelled *neutral* should have been labelled *depends on client* or *I might*. It would have been helpful to ask for a qualifier if a respondent chose neutral for a question.

Implications for Further Research

The clinical counsellors represented in this study generally believe that spirituality is an important phenomenon in their lives, and that it is positively related to mental, physical, and community health. They also believe in the process of integrating spirituality, but not necessarily religion into counselling. As stated previously, although there is support for integration, the results showed that less than half of the participants in this study reported doing so in their practice. What does this mean... are clients or their counsellors that indicated they support initiating discussions on religion and/or spirituality actually doing so, and if not what may be the possible reasons? There is a lot of discussion in the literature as to what constitutes competency in this regard, and if by applying these pre-requisites to the counsellors' in this study existing skills and knowledge would they be considered competent. I will conclude by saying that I believe that most would not. What is needed is more research on this subject, specifically in the area of determining or understanding why counsellors are not feeling comfortable, confident, or competent regarding introducing or initiating the subject of religion and spirituality in the counselling process. I also believe that there needs to be more empirically-based research on the efficacy of existing and future multi-theoretical techniques and practices in the counselling field for integrating these dimensions. Lastly, if we as professional counsellors do not prepare ourselves personally and professionally to bring (or allow) the dimensions of religion

and spirituality as part of the therapeutic process, our clients may believe it is not safe to do so, and we would therefore be doing them a great disservice.

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Appendix A

Broadcast to BCACC Members

Dear Colleagues:

I am writing to ask you to participate in a brief survey about the place of religion and spirituality in clinical counselling. This research is part of my Master's work at City University of Seattle in Vancouver. The goal of this research is to get a picture of how practicing therapists view the place and limits of religion and spirituality in therapeutic work.

Clicking the link below will take you to a website where you will find an anonymous questionnaire that has been validated for this kind of inquiry. The questionnaire asks for only generic demographic information—age, sex, and years of practice—and results cannot be traced or attributed to any individual. Most people have found that five to ten minutes completes the task, and most users have found thinking through the questions to be a helpful review of this area of professional interest.

Results will be shared back to the BCACC for distribution.

Thank you for helping me with my education and for contributing to an effort that I feel certain will contribute to our profession.

With much appreciation,

Alison Plumb

http://www.surveymonkey.com/s.aspx?sm=ZsPo_2f69vywwyXhtXA8VGmw_3d_3d