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**PSYCHOTHERAPY WITH TROUBLED SPIRITS:
A CONSENSUAL QUALITATIVE INVESTIGATION
OF SPIRITUAL PROBLEMS IN THERAPY**

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by

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ABSTRACT

A consensual qualitative research strategy was used to examine data from interviews with 12 therapists. Therapists were asked to discuss their experiences working with spiritual problems in therapy. Analyses revealed 8 domains relevant to therapy with spiritual problems: client description, therapist religious/spiritual background and beliefs, therapist training, therapist approach/philosophy, assessment of spiritual problems, therapy process, therapy outcomes, and impact of therapy on therapist. Numerous categories within these domains are identified and discussed leading to proposed models for approaching, assessing, and intervening with spiritual problems. The frequency of categories within and across cases was classified. Implications for practice, training, and continued research are discussed.

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Chapter I. INTRODUCTION

Religion and spirituality have suffered from a history of neglect and misunderstanding in psychology (Bergin, 1980; Hood, Spilka, Hunsberger, & Gorsuch, 1996; Lukoff, Lu, & Turner, 1992; Miller, 1999b; Richard & Bergin, 1997; Wulff, 1996). Nowhere is this more evident than in the psychotherapy literature. For instance, Freud (1907/1959, 1966) viewed religion as “a universal obsessional neurosis” and characterized spiritual experiences as pathological. Albert Ellis (1980) conceptualized religious belief as irrational thinking and emotional disorder that results in poorer mental health and well-being. In recent years, however, the literature concerning psychotherapy with religious and spiritual clients and issues is burgeoning (e.g., Bragdon, 1993; Cortright, 1997; Griffith & Griffith, 2002; Krippner & Welch, 1992; Miller, 1999b; Pargament, 1997; Richards & Bergin, 1997, 2000; Shafranske, 1996) and the benefits of spirituality are being recognized (Koenig, 1998, 1999; Levin, 2001; Pargament, 1997; Plante & Sherman, 2001; Shafranske, 1996).

For decades, survey data have demonstrated that the overwhelming majority of the United States' and the world's population (estimates are usually around 90% or more) believe in the existence of God or a supreme being (Gallup & Castelli, 1989; Hoge, 1996; Shorto, 1997). A substantial proportion of the U.S. population has reported that religion plays a significant role in their daily lives, and a large percentage (79%) believe that religious values should be discussed in therapy when appropriate (Hoge, 1996; Quackenbos, Privette, & Klentz, 1985). In contrast, surveys have consistently demonstrated a significant lack of religiosity in mental health professionals (Bergin &

Jensen, 1990; Shafranske & Malony, 1990). This “religiosity gap” is reflected in the lack of training mental health professionals receive covering the nature and treatment of religious and spiritual issues (Lannert, 1991a; Lukoff et al., 1992; Shafranske & Malony, 1990). Despite the religiosity gap, there is evidence that mental health professionals value “spirituality,” as opposed to traditional “religion” (Bergin & Jensen, 1990; Shafranske & Malony, 1990), which may provide a basis for closing the religiosity gap in therapy (Lukoff et al., 1992).

In terms of psychotherapy with religious or spiritual *clients*, the literature indicates that religious clients prefer counselors who share similar views and values (Worthington & Gascoyne, 1985; Wyatt & Johnson, 1990); religious persons typically consult with friends, family, and clergy before seeking mental health professionals (Sell & Goldsmith, 1988); and strongly religious individuals have negative anticipations about counseling in general, but particularly with secular counselors (Keating & Fretz, 1990). Morrow, Worthington, and McCullough (1993) found that college students perceive that clients will improve more when counselors support their values rather than challenge them. The students also predicted that clients whose beliefs were challenged (regardless of religious persuasion of the counselor) would be less likely to return to counseling. Despite these reservations, clients do appear to view discussing religious concerns as appropriate and desirable (Rose, Westefeld, & Ansley, 2001).

Considering the relatively large proportion of people who report a belief in a supreme being, it is likely that religious and spiritual concerns will become salient for individuals as they encounter various trials during their lifespan for which they may seek

counseling or psychotherapy. In fact, religious and spiritual problems are frequently found in psychotherapy. Among a sample of university counseling center clients (N = 5,472), Johnson and Hayes (2003) found that 43% experienced at least some distress concerning religious or spiritual issues and 25% reported considerable distress. A survey of national internship training directors revealed that 72% of directors have addressed religious or spiritual concerns in psychotherapy (Lannert, 1991b). It is likely that virtually all clinicians will encounter clients with religious or spiritual problems (Anderson & Young, 1988; Lukoff, Lu, & Turner, 1998). Despite the prevalence of these concerns, there is little clinical research investigating the nature and treatment of religious and spiritual problems in psychotherapy (Lukoff et al., 1998; Turner, Lukoff, Barnhouse, & Lu, 1995).

Worthington (1989) delineated five reasons why therapists should understand spiritual issues. First, a high proportion of the population and clients consider themselves religious. Second, people often spontaneously consider spiritual matters when in the midst of emotional and psychological crises. Third, due to the sacred nature of spirituality and the perceived neglect of these issues in therapy, clients with spiritual issues may be reluctant to introduce them in secular therapy. Fourth, therapists are generally less religiously oriented (though not necessarily less spiritual) than their clients are (Bergin & Jensen, 1990; Shafranske & Malony, 1990). Finally, a lack of religious orientation may present difficulties when working with clients with religious and/or spiritual concerns. For example, some religious clients may find it difficult to establish trust in the therapeutic relationship if the therapist is not religiously affiliated.

The prevalence of religious and spiritual problems in psychotherapy raises the issue of therapists' competence to address these concerns (Lannert, 1991a; Lukoff et al., 1992, 1995, 1998; Lukoff & Lu, 1999). The American Psychological Association (1992) Code of Conduct states that "when differences of... religion...significantly affect psychologists' work concerning particular individuals or groups, psychologists obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals" (p. 1601). Moreover, Shafranske and Malony (1996) and Yarhouse (2003) maintained that psychologists have an ethical obligation to consider spirituality as they would any other cultural characteristic such as race, ethnicity, or sexual orientation in their assessment and treatment. Lukoff et al. (1992) stressed that historical and biological bias in psychology and psychiatry have precluded culturally sensitive treatment for religious and spiritual problems.

In conjunction with the call for greater religious and spiritual competency (Frame, 2000; Fukuyama & Sevig, 1999; Shafranske & Maloney, 1996), Richards and Bergin (2000) proposed four compelling reasons to develop this proficiency. First, religious diversity is a cultural fact, and most mental health professionals will encounter it in their practice. Second, psychotherapists will enjoy more credibility and trust with religious clients, leaders, and communities if they obtain training and competency in religious and spiritual diversity. Third, psychotherapists have an ethical obligation to obtain competency in religious and spiritual diversity (see above). Finally, competency in religious diversity may help psychotherapists understand how to access more fully the healing resources in religious communities to assist their clients in coping, healing, and

changing. Therefore, the mental health profession needs a more comprehensive view of religion and spirituality to ensure competency and culturally sensitive treatment (Frame, 2000; Fukuyama & Sevig, 1999; Lannert, 1991a; Lukoff et al., 1992, 1998; Lukoff & Lu, 1999; Richards & Bergin, 2000).

In response to these concerns, “religious or spiritual problem” was included as a V-code in the DSM-IV under Other Conditions That May Be a Focus of Clinical Attention (American Psychiatric Association, 1994). In the DSM-IV, the Religious or Spiritual Problem category states the following:

This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution (p.685).

Elaborating on the DSM-IV description, Lukoff, Lu, and Turner (1992) defined religious problems as “experiences that a person finds troubling or distressing and that involve the beliefs and practices of an organized church or religious institution” (p. 676). Lukoff et al. identified several types of problems in the clinical literature such as loss or questioning of faith, change in denomination or conversion to a new religion, intensification of adherence to the beliefs and practices of one’s own faith, and joining, participating in, or leaving an alternative religious movement or cult. These categories are by no means exhaustive, but represent problems found most frequently in the clinical literature.

Spiritual problems are defined as “experiences a person finds troubling or distressing and that involve that person’s reported relationship with a transcendent being or force” not necessarily related to a religious institution (Lukoff et al., 1992, p. 677). Types of spiritual problems include distress connected with near-death, meditative-related, and mystical experiences, questioning spiritual beliefs and values, and anguish following spiritual experiences such as a kundalini awakening (Lukoff et al., 1998). The inclusion of this category in the DSM-IV resulted from a proposal documenting the frequent occurrence of religious and spiritual issues in clinical practice (Lukoff et al. 1992).

Considering the prevalence of religious and spiritual problems and the ethical obligation to competently address these concerns, it appears timely to begin investigation into understanding and working with religious and spiritual problems in psychotherapy. Furthermore, the paucity of research on therapy for spiritual problems and psychologically complex nature of these concerns calls for a systematic research approach that provides depth and richness of understanding, involves inductive reasoning, and remains close to the lived experience of professionals in the field—i.e., a qualitative approach. Qualitative investigation allows other practitioners to evaluate and utilize the insights gleaned from experienced professionals with the intention of improving their clinical effectiveness and competence. It also generates models for therapy that can be applied and tested through empirical means.

This study attempted to increase the profession’s understanding of psychotherapy for spiritual problems through qualitative investigation. Specifically, the present study

generated substantive models for approaching, assessing, and conducting therapy for spiritual problems. In this vein, three questions were addressed: (a) how do therapists approach and conceptualize spiritual problems and their treatment, (b) how do therapists diagnose and assess spiritual problems in psychotherapy, and (c) what strategies and interventions do therapists use to work with spiritual problems?

Chapter II. REVIEW OF THE LITERATURE ON SPIRITUAL PROBLEMS

Defining religion and spirituality is a source of contention, debate, and disagreement throughout the psychological literature (Maher & Hunt, 1993; Zinnbauer, Pargament, & Scott, 1999). It is commonly conceded that religion and spirituality are complex and multifarious concepts, with no agreed upon definition (Batson, Schoenrade, & Ventis, 1992; Hood, Spilka, Hunsberger, & Gorsuch, 1996). Some authors consider religion a broader concept than spirituality (Emmons, 1999; Pargament, 1997), while others regard religious involvement as an aspect of spirituality (Gorsuch & Miller, 1999). Others question whether religion and spirituality are separable at all and suggest that extricating these constructs may result in unnecessary and harmful polarization (Helminiak, 2001a; Pargament, 1997; Zinnbauer et al., 1999). For example, contrasting spirituality with religion may disregard the fact that virtually every institutional religion is concerned with spiritual development. Furthermore, considering spirituality in only personal terms ignores the important cultural contexts in which spirituality is shaped and experienced (Zinnbauer et al., 1999). Helminiak (2001a) argues that religion and spirituality are probably not separable, but they are distinguishable. Moreover, therapists may be overstepping their bounds of competence when they address religious issues (e.g., theological doctrines, rituals) for which they lack training. Instead, Helminiak proposes delineating the underlying humanistic core of spirituality found in all religions and familiar to most people. In this way, therapists can address spirituality that includes religious issues but does not require theological expertise. In his view, spirituality is an inseparable part of the human mind and, therefore, under the purview of psychology.

Definitions for religion and spirituality should begin with a comment about their etymology. *Religion* originally comes from the Latin root *religare*, which means to bind together. While definitions vary, religion often refers to an organized system of doctrines, worship, and rituals (Worthington, 1989). Other definitions include “a search for significance in ways related to the sacred” (Pargament, 1997, p.32); “a system of beliefs in a divine or superhuman power, and practices of worship or other rituals directed towards such a power (Argyle & Beit-Hallahmi, 1975, p.1); and “the feelings, acts, and experiences of individual men (sic) in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider divine” (James, 1902/1961, p.42). *Spirituality* stems from the Latin root, *spiritus*, which connotes breath or the essence of life. Spirituality often refers to relationship with a higher power or transcendent being not necessarily related to an organized religion (Fukuyama & Sevig, 2001; Lukoff et al., 1992; Zinnbauer et al., 1999). It may also be considered in nontheistic terms and relate to human beings’ potential for self-transcendence—in other words, the *human spirit* (Helminiak, 2001a).

A Brief History of Spirituality and Psychotherapy

Jung is generally considered the first psychotherapist to embrace and encourage the exploration and integration of spiritual issues in psychotherapy (Lukoff et al., 1992). Jung considered the individuation process a spiritual journey through which a person develops a relationship with her center (the Self) and the unconscious that leads to integration, wholeness, and fulfillment (Jung, 1989). According to Jung, spirituality is inherent in psychotherapy and the pursuit of spiritual experience is vital for becoming a

complete human being. In other words, the process of individuation is not unlike a spiritual quest:

This path to the primordial religious experience is the right one, but how many can recognize it? It is like a still small voice, and it sounds from afar. It is ambiguous, questionable, dark, presaging danger and hazardous adventure; a razor-edged path, to be trodden for God's sake only, without assurance and without sanction (Jung, 1945/1968, p. 217).

For Jung, matters of the spirit and soul were inseparable from concerns of health and wholeness. It was no accident that Jung posted the following quote from the Delphi Oracle above the door of his house: "*Vocatus atque non vocatus, deus aderit*" (Bidden or not bidden, god is present) (Storr, 1983). When anxiety and depression emerge in a person's life, it is the result of straying from one's spiritual path. Therefore, almost every problem is considered a spiritual problem and psychotherapy's goal is to facilitate recognizing this departure and reorienting oneself to one's spiritual path.

Jung was virtually the lone voice for considering spiritual matters in psychotherapy until the last few decades. Currently, transpersonal approaches and institutes of training that integrate spirituality and psychotherapy (e.g., Hakomi Institute, Esalen Institute, Evam Institute, and Nuropa University) emphasize humanity's relationship with the transcendent and view life's concerns through a spiritual frame. It should also be recognized that addictions recovery models have emphasized the importance of the transcendent for decades (May, 1988; Miller, 1990). Secular psychotherapists recently have been expressing the previously neglected view that

psychotherapy of the whole person is a farce without due consideration for the spiritual aspects of human beings' nature (Benner, 1989; Helminiak, 2001a; Richards & Bergin, 1997). Consistent with Jung's view, many psychologists maintain that psychotherapy is a spiritual process because of its focus on healing, growth, and meaning, even if from nontheistic perspectives (Benner, 1989; Helminiak, 2001a; Peck, 1993; Vaughn, 1977).

Neglect of Spiritual in Psychology

Reasons for the neglect of religion and spirituality in psychology, discussed in detail elsewhere (e.g., Bergin, 1980; Richards & Bergin, 1997; Wulff, 1996), relate to the prevailing paradigms (e.g., philosophical naturalism, positivism, materialism) associated with psychoanalysis, behaviorism, and biologic bases of behavior that have excluded the role of the numinous (Lannert, 1991; Lukoff et al., 1992; Lukoff & Lu, 1999; Peck, 1993). Modern psychology developed during the Age of Science, i.e., the 19th and 20th centuries, when the scientific establishment was challenging religious authority. The materialistic (or mechanistic) worldview, arising from Newtonian theories, maintained that the world and all within it operate like a machine. Thus, there was no need for supernatural explanations or appeals to a higher being. The world was in motion and could be quantified and understood by the universal and discoverable laws of nature. Darwin's theory of evolution was gaining prominence at this time and supplemented the materialist's view with further evidence that God was unnecessary (Richards & Bergin, 1997).

The harbingers of modern psychology (e.g., Freud, Watson, Thorndike, etc.) adopted modern science's philosophy and eschewed religion. Early psychiatrists and

psychologists believed that in order to gain respectability as a fledgling discipline, they must apply the accepted principles of physical science, not the metaphysics of religion. Along with the materialist view, modern science accepted the following assumptions: naturalism, determinism, reductionism, and positivism. Naturalism is the metaphysical perspective that the universe is self-sufficient (i.e., a closed system) and can be understood without the need for supernatural explanation. Determinism means that all events are contingent on preceding events.

Reductionism maintains that all things can be understood by analyzing the parts. Positivism is the epistemological view that only observable events contribute to knowledge; thus, modernistic science is the only way to discover truth. What cannot be directly observed is “unscientific.” Each of these philosophical assumptions may have negative implications for religion and spirituality. In many ways, these assumptions relegate spirituality to the realm of fantasy and delusion, at worst, or to the realm of the ineffable, at best. In any event, most early psychologists with a few notable exceptions (e.g., Jung, James, and Allport) excluded religious phenomenon and thought from the “science” of psychology (Richards & Bergin, 1997).

Implications of Neglect for Psychotherapy

Neglect for spirituality in scientific psychology spilled over into professional psychology. Peteet (1985) offers four reasons for the neglect of spiritual issues in treatment. First, religion/spirituality is a highly personal and private domain that is generally considered more taboo than discussing other topics, even sexuality. Second, based on various presumptions and some fact, religion is considered a superstition and a

historical source of conflict and oppression. Third, religion is often viewed as an “opiate of the masses” or a “crutch” in times of suffering. Finally, ambivalence in treatment professionals about imposing their own views and crossing professional boundaries may prevent exploration of religious/spiritual issues. As spiritual issues have been ignored in therapy, professionals have also neglected them in theory development and research. The reasons for this disregard are varied and include the reasons discussed above, philosophical and cultural bias, overemphasis on biological basis of behavior, and lack of training and education (Bergin, 1980; Lukoff et al., 1992; Wulff, 1996).

The implications of this neglect on mental health are abundant and severe. Based on psychology’s history and philosophical assumptions that exclude the legitimacy of spirituality, Peck (1993) argued that the neglect of spirituality has resulted in most mental health professionals being unprepared to handle pathological or healthy spirituality. Furthermore, mental health’s disregard for religion and spirituality may lead to misdiagnosis, mistreatment, inadequate research and theory, and professionals’ own limited personal development (Bergin, 1980; Lukoff et al., 1992, 1998; Peck, 1993; Richards & Bergin, 1997).

Similarly, Lovinger (1984) pointed out that neglect of religion might result in various resistances and countertransference reactions that are harmful to clients. First, negative attitudes and biases towards religion or specific sects/denominations may inhibit openness and damage trust in the therapist. Second, because many therapists lack training in religious thought, they may mistakenly assume that they will be unable to facilitate a client’s exploration of conflict related to religious values and beliefs. Therapists may not

realize that many of the therapeutic skills used to explore other issues can effectively be used to help clients sort through religious conflict. Third, therapists may confront their own anxieties when exploring existential themes such as morality, responsibility, and suffering. Without proper understanding and management, these anxieties may result in untherapeutic behavior such as ignoring clients' concerns or rejecting aspects of clients' worldview. Fourth, therapists' limited religious or spiritual education and development may confine their effectiveness with spiritual clients. This may lead to misdiagnosis and mistreatment of religious or spiritual clients.

In response to this neglect and the recognition of the importance of religion and spirituality for well-being, mental health has increasingly turned its focus to spirituality. Research investigating psychotherapy with religious and spiritual *clients* is burgeoning (e.g., Bergin & Richards, 1997, 2000; Lovinger, 1984; Miller, 1999b; Propst, 1988; Shafranske, 1996) as is exploring the role of religion and spirituality in mental health (Emmons, 1999; Koenig, 1998, 1999; Pargament, 1999; Plante & Sherman, 2001). What remains to be fully explored are effective ways to approach, diagnose, and treat religious and spiritual *problems* in psychotherapy (Lukoff et al., 1998; Turner et al., 1995). Many clients present with or introduce spiritual concerns in therapy and yet research investigating the treatment of these concerns is virtually nonexistent (Johnson & Hayes, 2003; Lannert, 1991b; Lukoff et al., 1998). The recognition of this omission was the impetus for the recent V-code, *Religious or Spiritual Problem*, added to the DSM-IV. It is also the foundation for this study.

History and Rationale for DSM-IV “Religious or Spiritual Problem”

The proposal for the V-code Religious and Spiritual Problem (Lukoff et al., 1992) arose from increasing concern with “the mental health system’s pathologizing approach to intense spiritual crises” (Lukoff et al., 1998, p. 25). The authors of the proposal hoped to increase mental health professionals’ cultural sensitivity to spiritual issues through presenting a nonpathological diagnosis analogous to V62.82 Bereavement. The criteria for bereavement states that a person should not be diagnosed with major depression if they meet these conditions during a period of bereavement following the death of a loved one. In this way, a person is not pathologized for demonstrating culturally appropriate reactions to the loss of someone close to them. Similarly, a person experiencing distress related to a religious or spiritual experience or conflict should not be diagnosed with a mental disorder, unless it can be clearly demonstrated that a disorder is present independent from or in conjunction with the religious or spiritual problem (Lukoff et al., 1998). Unfortunately, there is little research investigating the differentiation of spiritual problems from psychopathology. For instance, how does a clinician differentiate spiritual visions from psychotic hallucinations with religious content? Or how does one distinguish a mystical experience, which may involve perceptual distortions and contact with the transcendent, from psychotic or manic episodes?

Lukoff et al. stressed three important reasons for including this new category in the DSM-IV. First, spiritual problems are frequently presented and discussed in psychotherapy. In a survey of APA-member clinical psychologists, Shafranske and Maloney (1990) found that 60% indicated that clients often use religious language to

express their concerns. Approximately half of the psychologists reported that at least 1 in 6 of their clients presented with religious or spiritual issues. A survey of internship training directors revealed that 72% had at least occasionally addressed spiritual issues in psychotherapy (Lannert, 1991b). Anderson and Young (1988) postulated that virtually every mental health professional will work with clients who present religious concerns during their careers.

Second, there is a lack of training for understanding the nature and treatment of religious/spiritual problems. Shafranske and Maloney (1990) reported that 85% of psychologists surveyed had rarely or never discussed religious or spiritual topics in their training. Lannert (1991b) found that 100% of training directors (94% of whom were also in private practice) received no education or training during internship. In a survey of practicing psychologists in Pennsylvania, 74% reported that religious/spiritual issues were not covered during their graduate and internship training programs (Rockey, 1995).

Third, there is an ethical mandate to provide training and develop competence when working with issues such as religion and spirituality (APA, 1992; Lannert, 1991a; Shafranske & Maloney, 1996). Spirituality, like other cultural characteristics such as race and ethnicity, should be given considerable attention in psychotherapy training. Lukoff et al. (1992) hoped the new DSM category would redress the existing cultural insensitivity in four ways:

Increase the accuracy of diagnostic assessments when religious and spiritual issues are involved.

Reduce the occurrence of iatrogenic harm from misdiagnosis of religious and spiritual problems.

Result in improved treatment of such problems by stimulating clinical research.

Encourage clinical training centers to address the religious and spiritual dimensions of human experience (p. 680).

Lack of Research on Spiritual Problems

According to Lukoff, Lu, and Turner (1995), the clinical and research literature has devoted considerably more attention to religious rather than spiritual problems.

There are many professional organizations and conferences devoted to religious issues and problems as well as more than a dozen journals and books dedicated to pastoral counseling and Christian psychology. In contrast, there are few organizations or journals dedicated to spiritual problems (Lukoff et al., 1995). Considering the breadth of literature focusing on religious problems, the following literature review and this study will primarily focus on the diagnosis and treatment of spiritual problems. However, there is often overlap between the two constructs, thus, some literature concerning religious problems will also be included. The following section will review the empirical and theoretical literature concerning the diagnosis and treatment of spiritual problems.

Review of the Literature on Spiritual Problems

As previously noted, the bias against religion and spirituality and the neglect of spiritual matters in psychology have significantly limited the amount and quality of research and theory that has been produced in this century (Hood et al., 1996; Lovinger,

1984; Lukoff et al., 1998; Peck, 1993). This is especially true in the realm of diagnosis and treatment of spiritual problems (Lukoff et al., 1992, 1996, 1998; Lukoff, Turner, & Lu, 1992, 1993; Turner et al., 1995). What follows is a review of literature regarding spiritual problems. The review will begin by examining empirical and case studies investigating the nature and prevalence of spiritual problems in various treatment settings. Next, the literature pertaining to the assessment and diagnosis of religious and spiritual problems will be reviewed. This will include a general overview of diagnostic decision making, empirical investigations of the diagnosis of religious and spiritual problems, and theoretical contributions examining principles for distinguishing between spiritual experiences and psychopathology. Finally, the literature on approaching and treating spiritual problems will be examined. There is virtually no empirical work in this area, but important theoretical models have been proposed.

Literature Examining the Nature and Prevalence of Religious and Spiritual Problems

Several studies have investigated the nature and prevalence of religious and spiritual concerns in different professional settings. The following studies were found in a search of PsychINFO from the years 1940-2002 using the parameters “religious OR spiritual problem,” “religious OR spiritual concern,” and “religious OR spiritual issue.” Other studies were found through references in articles related to religious and spiritual problems and unpublished manuscripts known to the author.

Lukoff et al. (1998) noted that “although there is limited psychological theory that is useful in understanding spiritual problems, there is an extensive knowledge base that has developed at the case level” (p. 29). Lukoff et al. argued that the case study method,

though seldom taught or respected, is still a principal method for transmitting knowledge within the profession. Furthermore, they maintained that case studies benefit the study of anomalies in treatment and guide the development of assessment and psychotherapy. Lukoff et al. searched the Medline bibliographic database from 1980 to 1996 for case reports and found that an astoundingly low .008% addressed religious and spiritual issues. They conducted multiple searches in PsycINFO and Medline databases and found over 100 cases that involved religious and spiritual problems. Lukoff et al. did not claim that these cases represent the prevalence of religious/spiritual problems found in psychotherapy, but rather characterize the types of problems most likely to be published. They also noted that the cases vary in quality and few used any checks for reliability or validity.

From this database, Lukoff et al. identified the following types of religious problems with the number of cases in parentheses: loss or questioning of faith (12), change in denomination/conversion (4), intensification of religious belief or practice (5), joining or leaving a new religious movement or cult (5), and “other” religious problem (5). They found eleven types of spiritual problems, many of which fall under the rubric, *spiritual emergency*. Spiritual emergency is a term from the transpersonal literature that signifies a “significant, abrupt disruption in psychological, social, and occupational functioning” that results from an intensified unfolding of spiritual potential and development (Lukoff et al., 1998, p. 38-39; see also Bragdon, 1993 and Grof & Grof, 1989, 1992). Examples include kundalini awakenings (i.e., a meditative experience characterized by violent tremors, shaking, and sensations of heat moving up the spine),

psychic openings (i.e., extrasensory perception and out of body experiences), near-death experiences, past-life experiences, possession states, and shamanic initiatory crises. Spiritual emergencies contrast with a gradual unfolding of spiritual potential leading to transcendent states and functioning called *spiritual emergence* (Bragdon, 1993; Grof & Grof, 1989). Spiritual emergence usually does not require the attention of mental health professionals.

In the database, the spiritual emergencies identified were kundalini awakenings (3), shamanistic initiatory crises (4), psychic openings (2), past lives (2), possession states (2), and near-death experiences (4). Other types of spiritual problems included distress related to mystical experiences (2), loss of faith (2), meditation-related (4), separating from a spiritual teacher (2), and “other” spiritual problems (2). Combined religious/spiritual problems included serious illness (17) and terminal illness (6). Furthermore, several religious/spiritual problems overlapped with other DSM-IV disorders. This included religious/spiritual problem concurrent with substance abuse (2), psychotic disorder (7), mood disorder (2), dissociative disorder (1), and obsessive-compulsive disorder (1).

Hartter (1995) investigated the prevalence of religious and spiritual problems in psychotherapy using a sample of doctoral graduates in professional psychology from The Union Institute in Ohio. She sampled 100 graduates, 60 women and 40 men, most of whom (63%) had been in clinical practice at least 16 years. Eighty-four percent of the sample were in private practice. Hartter used the DSM-IV category, Religious or Spiritual

Problem, and the types of problems identified in the literature to define these concerns (Grof & Grof, 1989, 1992; Lukoff et al., 1992).

Hartter found that a large percentage of psychologists had seen clients who presented with various types of religious and spiritual problems. The sample had encountered clients with the following types of concerns: religious problems (81%), spiritual problems (69%), near-death experiences (53%), spiritual emergencies (45%), past-life experiences (48%), and spiritual emergence (68%). During a typical year, therapists estimated seeing a number of clients present with the following issues: 24% with spiritual emergence, 24% with religious problems, 10% with spiritual problems, and 7% with spiritual emergencies. Respondents also reported seeing an increase in virtually all the categories over the course of their practices. Although limited to a select sample of therapists from a particular institution, these findings suggest that psychotherapists may encounter a high percentage of religious and spiritual problems in psychotherapy.

Using a national archival data set ($N = 5,472$ college students), Johnson and Hayes (2003) found that 25% of students reported currently experiencing a “moderate” to an “extreme” amount of distress related to religious and spiritual concerns. Among students who sought help from university counseling centers, 13% reported “a little bit” of current distress related to religious/spiritual concerns, 10% a “moderate” amount, 6% “quite a bit,” and 3% an “extreme” amount of distress related to religious/spiritual concerns. These findings suggest a high prevalence of religious and spiritual problems in college students in general and in those seeking counseling.

Johnson and Hayes (2003) also found that university students with considerable distress over religious/spiritual problems also tended to be distressed about the loss of a relationship, confusion about values, sexual assault, homesickness, and suicidal ideation. These students were especially likely to seek psychological help when they also had problematic relationships with peers. Among all students who sought help at a university counseling center, considerable distress about religious/spiritual concerns was predicted by confusion about values, problematic relationships with peers, sexual concerns, and thoughts of being punished for one's sins. These findings highlight associated concerns that may signal the presence of religious/spiritual problems in students. This information may help identify individuals who are likely to have religious/spiritual concerns, but are reluctant to disclose this information to counseling center staff.

Silber and Reilly (1985) examined the religious and spiritual concerns of 114 hospitalized adolescents (age range: 11-19 years). They developed the Spiritual and Religious Concerns Questionnaire (SRQ), which is an 18-item instrument designed to measure beliefs, attitudes, and needs related to religion and spirituality in a hospital population. Unfortunately, the authors provided no psychometric properties for the SRQ. They found that the large majority of hospitalized adolescents believe in God (Supreme Being) and that the more seriously ill demonstrated higher scores on the SRQ. African-American patients demonstrated higher SRQ scores than White patients, females had higher scores than males, Catholics had higher scores than Protestants, and parochial school students had higher scores than public school students. Caution should be used in interpreting these findings because of the lack of validation of their instrument.

Furthermore, the SRQ questions were specific to hospitalized populations and may not generalize to other groups. Despite these limitations, these findings suggest that there are significant cultural differences among hospitalized adolescents and their religious/spiritual concerns. As expected, the more seriously ill adolescents, regardless of race or sex, displayed the highest degree of spiritual concern. This suggests that severity of illness may increase one's contemplation and concern related to spiritual matters.

Carroll, McGinley, and Mack (2000) investigated the religious/spiritual needs and concerns of 200 male residents in inner-city substance abuse treatment programs. Carroll et al. were concerned that treatment staff may neglect assessing and addressing the spiritual needs of patients because of bias and misunderstanding. They hoped their study would provide support for the prevalence of spiritual concerns in treatment center residents. The purpose of their study was to examine the extent and types of religious/spiritual problems reported by substance abuse treatment center clients. They surveyed residents from New York City and Philadelphia chemical dependency treatment centers. The researchers used the Religious/Spirituality subsection of the Substance Abuse Problem Checklist (SAPC; Carroll, 1983) to assess the degree of religious/spiritual concerns. The SAPC is an instrument designed to assist chemical dependency treatment staff in assessing and treating substance abuse problems. The Religious/Spirituality subsection consists of 26 items that describe religious/spiritual issues encountered in life.

Items that specifically addressed religious/spiritual *problems* experienced by residents and their corresponding percentages of agreement given by the sample are listed below:

“I have fallen away or lost my religious faith.” (30%)

“I am confused about my religious beliefs.” (8%)

“I’ve had spiritual experiences which puzzled or frightened me.” (8%)

“I miss the comfort I once had from my religious faith and practices.” (30%)

“I feel very guilty about things I’ve done in the past which my present or former religion regards as sinful.” (31%)

“I feel as though I’ve committed unforgivable sins and crimes.” (18%)

“When I die, I will probably go to hell.” (15%)

“I fear the final judgment after death.” (22%)

“I would like to become active in my religion again, but I am anxious and fearful about trying.” (23%)

Overall, 83% of the sample reported at least one religious/spiritual concern. These results showed a high percentage of treatment center clients experienced distress about various religious/spiritual problems.

The types and frequency of problems endorsed indicated that many residents demonstrated a spiritual longing for something lost (e.g., connection with God) and anxiety related to judgment and condemnation, presumably connected with their substance abuse and associated behaviors. However, it is not clear what the nature of the participants’ spirituality was before treatment or before their substance abuse. It may be that participants felt spiritually empty and disconnected before abusing substances and used chemicals as a way to fill a void in their lives. The researchers did not include a control group to examine differences with a comparable sample of nonsubstance abusers.

Future longitudinal and qualitative research may shed light on the development of spiritual problems across the lifespan. In any event, this study reveals that many treatment center residents have spiritual concerns and provides examples of types of religious/spiritual problems encountered.

Daaleman and Nease (1994) examined patients' attitudes regarding physician inquiry into religious and spiritual issues. According to the investigators, most physicians do not address religious and spiritual issues with patients for fear of projecting their own beliefs onto patients, lack of awareness about the importance of spiritual issues, and their own discomfort with spiritual matters. The researchers proposed that if physicians could identify the receptivity of patients to spiritual inquiry, they might be more likely to approach the subject with patients. Furthermore, they hypothesized that physicians would be more likely to identify patients with religious/spiritual problems.

They designed and administered the Spiritual and Religious Inquiry (SRI) instrument to measure patients' attitudes regarding physician inquiry into their spiritual matters. The authors designed the SRI specifically for this study and it had not been previously validated or compared with other measures. It consists of two sections. The first section assesses personal information including prayer frequency, religious denomination, and frequency of attendance at religious services. The second section consisted of 11 statements about physician inquiry into spiritual issues. One hundred questionnaires were distributed over two months to patients in the waiting area of a university based family practice center. Eighty surveys were returned and used in the study.

Results indicated that patients disagreed with the statements regarding physician inquiry, with two exceptions. The respondents agreed that physician should refer patients to clergy for spiritual problems (90%) and that most patients will seek help for spiritual problems on their own. The participants strongly disagreed that physicians had the training or qualifications to discuss religious issues with patients. Finally, the more respondents attended church and prayed, the more agreeable they were to physicians' inquiry into their spiritual issues. The study is limited by its use of convenience sampling with predominately Christian patients and its reliance on a self-report measure. These limitations notwithstanding, the study suggests that patients prefer clergy when discussing spiritual concerns and they do not perceive physicians as competent to address these concerns.

Ellis, Vinson, and Ewigman (1999) conducted a survey of family physicians' attitudes and practices regarding patients' spiritual concerns. They mailed 231 questionnaires to family physicians in Missouri and had a 74% return rate overall. The questionnaire included the Ellison Spiritual Well-being Scale (ESWS) and questions concerning attitudes toward spiritual health in medical care, obstacles to discussing patients' spiritual concerns, and the frequency of discussing eight spiritual topics in three clinical settings. The eight spiritual topics included fear of death or dying, meditation or quiet reflection, prayer, attitudes about forgiveness, attitudes about giving and receiving love, religious views, role of God in illness, and meaning or purpose of illness. Overall, results indicated that the physicians in this sample demonstrated a high level of spiritual

well-being. Ninety-six percent of the respondents affirmed that spiritual well-being is an important component of good health.

Most physicians (86%) believed that inpatients with spiritual questions should be referred to a chaplain. Fifty-eight percent thought physicians should address spiritual concerns of patients while 37% were neutral on the issue. It is interesting to note that referral to a counselor or psychotherapist was not considered on the survey or in responses. While it is understandable to consider clergy in relation to spiritual issues, it also highlights the lack of association of psychotherapy and spirituality. Physicians reported discussing the fear of death or dying most frequently. Less than 20% discussed the remaining seven spiritual topics in more than 10% of patient encounters. The most frequently cited barriers to discussing spiritual issues with patients were lack of time (71%), lack of training in how to obtain a spiritual history (59%), difficulty in identifying patients who want to discuss spiritual issues (56%), concerns about projecting beliefs onto patients (53%), and uncertainty about how to manage spiritual issues raised by patients (49%). These results highlight the need for further training and research needed by medical personnel to better address spiritual concerns in patients. This study also implies the need for dialogue between medical and mental health professionals in terms of addressing spiritual concerns. Physicians could benefit from familiarity with the services psychotherapists can provide in terms of working with religious and spiritual problems.

Peteet (1985) investigated the frequency and types of religious problems presented by 50 cancer patients in psychiatric consultation. Peteet acknowledged that

religious issues are receiving more consideration in health care, but few researchers have paid attention to the form religious issues take with the seriously ill. Peteet interviewed 26 men and 24 women between the ages of 23 and 70 years old (mean age = 47) who were diagnosed with various forms of cancer such as breast and lung cancer and leukemia. Three criteria were used to determine if patients were experiencing a religious problem: (a) participation and support from a religious community while ill, (b) use of religious language to describe feelings, hopes, and questions about illness, and (c) explicitly concerned with problems related to their faith or religion. This criteria appears to unnecessarily limit the sample to people actively involved in a religious community. It is likely that people encountering life threatening illnesses may spontaneously consider spiritual issues and face spiritual problems regardless of their religious history or community, as this study later demonstrated.

Among the 50 cancer patients included in the study, 13 mentioned religion spontaneously and 21 patients identified as religious when asked. Thirty-two patients indicated that they had a religious problem or concern. Interestingly, nine of these patients did not identify themselves as unequivocally religious. This suggests that some people may encounter religious or spiritual problems who would not normally identify themselves as religious or spiritual. This is not surprising given the terminal nature of their illnesses. It seems likely that people might spontaneously struggle with existential and spiritual problems when encountering their own mortality (Worthington, 1989). Eighteen patients characterized themselves as actively struggling with religious problems in relation to their illness.

Peteet delineated five major forms of religious problems from the patients' concerns. These included loss of religious support, pressure to adopt a different religious position, unusual religious beliefs, conflict between religious views and view of the illness, and preoccupation with the meaning of life and illness. Unfortunately, Peteet does not explain how he delineated these forms in his analysis, and thus caution should be used in generalizing his findings. It should also be noted that Peteet's category, *unusual religious beliefs*, appears to be a problem from the perspective of the physician rather than the patient. In one case mentioned, a 21-year-old woman believed that she had been "born again" and insisted that she was the Virgin Mary. She was hospitalized for treatment of an acute psychotic episode. It is not clear from this case example, but her condition might have been explained and treated differently had someone assessed that she was experiencing a spiritual emergency rather than a psychotic episode.

A recent survey of psychologists from four exemplar mental health clinics and a national sample of 1,000 APA psychologists investigated how clinicians are addressing spiritual concerns and using the V-code (Hathaway, Scott, & Garver, 2004). In both samples, over 90% of the psychologists had never diagnosed a client using the V-code. Interestingly, about 75% of clinicians in military settings had used the V-code, while virtually none of the 35 psychologists from inpatient or medical settings had used it. A very small percentage of private practitioners (4.5%) had ever used the V-code as well. They emphasized the importance of addressing spiritual concerns for both therapeutic and ethical reasons.

In summary, preliminary attempts have been made to identify types of religious and spiritual problems seen in psychotherapy and medical settings, though most of the studies are limited by reliance on survey designs and self-report. A very high percentage of people in various settings reported spiritual concerns and some spontaneously experienced spiritual problems when in distress. It is significant that most of these studies were conducted in medical settings. It makes sense that many people struggling with serious and/or terminal illnesses would contemplate religious and spiritual issues. However, this also shows the relative neglect religious and spiritual problems have received in the psychological literature. Given the prevalence of religious and spiritual problems in a variety of settings, it is imperative that mental health professionals systematically investigate variables involved in the diagnosis and treatment of these concerns.

Review of Literature on Differential Diagnosis of Religious and Spiritual Problems

Diagnostic practice in psychology is far from objective. The subjective nature of the current diagnostic system and practice in psychology lends itself to potential bias and misuse. Perhaps this is no more evident than with religious and spiritual experiences that may appear to the uninformed or unsympathetic eye as pathological delusions or hallucinations. For example, claims that one encountered a vision of the Virgin Mary may be acceptable and appropriate in some predominately Catholic Latin American cultures. Moreover, transpersonal practitioners have identified spiritual emergencies that may meet the criteria for a psychotic episode but which should be approached and treated differently to ensure the fullest recovery and integration (Bragdon, 1993; Cortright, 1997;

Grof & Grof, 1989, 1992; Lukoff, 1985). For example, a woman who has had a mystical experience in which everything around her turned gold and she believed she directly experienced God may be distressed by this unusual experience. Based solely on DSM-IV criteria, she may qualify as having experienced a psychotic episode and referred for hospitalization. However, further understanding about her history and spiritual practices may reveal that she has had a transformative spiritual experience that may result in greater personal integration if given appropriate support and spiritual/psychological guidance.

The few existing studies on diagnostic practices suggest that the process is value laden, subjective, and influenced by clinicians' previous assumptions. For example, James and Haley (1995) found that therapists diagnosed clients in poor physical health as more pathological, evaluated them as less appropriate for psychotherapy, and rated them less capable of establishing a therapeutic relationship than clients in better physical health. Other studies on diagnosis and clinical judgment have found that client gender (Seem & Johnson, 1998), client age (James & Haley, 1995), therapist gender (Hansen & Reekie, 1990), therapists' theoretical orientation and years of clinical experience (Daleiden, Chorpita, Kollins & Drabman, 1999), and therapists' ethnicity (Atkinson, Brown, Parham, Matthews, Landrum-Brown & Kim, 1996) affect clinicians' ratings of severity of diagnosis, type of diagnosis, attribution of pathology, and prognosis. Taken as a whole, it is clear that diagnostic practice is lacking neutrality and objectivity and is subject to clinicians' values and assumptions.

Before beginning a review of the literature on diagnosing religious/spiritual problems, one may ask why it is important to assess spiritual issues in psychotherapy. Chirban (2001) offers several reasons why this is the case. First, the health-outcome research proposes compelling evidence that religion and spirituality have many beneficial effects on psychological, spiritual, and physical well-being (Koenig, 1998, 1999; Levin, 2001; Pargament, 1997; Plante & Sherman, 2001; Shafranske, 1996). Second, religion and spirituality express existential needs and concerns that may promote integration of one's goals and sense of self and provide guidance for coping. Third, religion and spirituality are often a source of central passion and concern for clients. Thus, by tapping this resource, therapists may discover important information about a client's values, beliefs, relationships, personality, and potential for healing. Fourth, a thorough assessment of clients' spirituality enables clinicians to make important diagnostic decisions about the idiosyncratic or collective nature of their concerns. Finally, spirituality is a living, thriving reality in the lives of most people. The real question is not whether we should assess spirituality, but why the profession does not consider it more often.

Differentiating Among Three Categories

The recent DSM-IV category Religious or Spiritual Problem has increased the options and, potentially, the cultural sensitivity for diagnosing religious/spiritual concerns. Now that the field has a legitimate option for categorizing religious/spiritual problems, how do mental health professionals make this diagnosis and distinguish it from mental disorders or pathology with religious content? This is an important question

considering the iatrogenic harm that may occur from inappropriate diagnoses such as increasing isolation felt by clients/patients and blocking future attempts at help-seeking (Bragdon, 1993; Greyson & Harris, 1987; Lukoff, 1985; Lukoff, Lu, & Turner, 1996). Lukoff et al. (1992) suggested that the inclusion of this new category requires differentiating among three types of problems: (a) purely religious or spiritual problems, (b) mental disorders with religious or spiritual content, and (c) religious or spiritual problems not attributable to a mental disorder.

According to Lukoff et al., *purely religious problems* consist of concern over faith and doctrinal matters and should be treated by appropriate clergy. For example, a religious woman experiencing distress related to her religion's view on salvation should probably consult with her clergy. Lukoff et al. defined *purely spiritual problems* as "conflicts about a person's relationship to the transcendent or arise from a spiritual practice" (p. 677). For example, a person who experiences perceptual changes during meditation may be distressed by the experience. Walsh and Roche (1979) suggested that such experiences reflect increased sensitivity to perceptual distortions common to all people. Often spiritual teachers and mentors address these types of problems as well as psychotherapists.

Mental disorders with religious and spiritual content are identifiable axis I disorders that manifest religious or spiritual symbols and expressions. These include obsessive-compulsive disorder, manic episodes, and psychotic episodes with religious or spiritual content. It is often helpful to address the religious and spiritual ideation even when directly related to a mental disorder (Bradford, 1985; Hoffman, Lob, & Sim, 1990).

What is vital in these instances is to differentiate whether these distressful experiences are “true” expressions of spirituality or the result of the underlying pathology (discussed in more detail in the following sections). Lukoff et al. (1996) created an additional classification called *religious or spiritual problem concurrent with mental disorder*. This involves religious or spiritual problems that are addressed in conjunction with an existing mental disorder. For example, if a therapist addresses excessive religious rituals associated with obsessive-compulsive disorder then both OCD and Religious or Spiritual Problem should be coded. This classification increases the use of the new category and accentuates the importance of addressing important religious/spiritual issues. This should alert mental health professionals to the existence of spiritual issues and help focus treatment to address these concerns.

Religious or spiritual problems not attributable to mental disorder are conflicts and experiences directly related to spirituality and not pathology. Questioning one’s religious/spiritual beliefs and values or distress related to changing one’s religious/spiritual community fall under this category. This might also include near-death and mystical experiences, and other spiritual emergencies. Mystical experiences are among the most frequently encountered spiritual events in the clinical and research literature. A high percentage of the population (30-40%) report having mystical experiences (Hood et al., 1996). Allman, De La Roche, Elkins, and Weathers (1992) surveyed 286 APA psychologists’ attitudes towards clients who report mystical experiences. Interestingly, they found that 50% of these psychologists reported having had a mystical experience themselves. Although frequently less religious than clients,

psychologists appear to be open to spiritual experiences as much or perhaps more than the general population. Psychologists in full-time practice estimated that 4.5% of their clients in the past 12 months presented as having had a mystical experience. They also measured therapists' judgments about clients' mystical experiences rated on a scale from *possibly psychotic* to *probably not psychotic*. Humanistic/existential psychologists were less likely to consider clients with mystical experiences as psychotic than behavioral, cognitive, and psychodynamic therapists. Moreover, psychologists who rated spirituality as important were less likely to regard clients' mystical experiences as pathological. These findings suggest that spiritual experiences are typical of human experience rather than inherently pathological.

At the current time, only two empirical studies have attempted to validate the DSM-IV category, Religious or Spiritual Problem, and examine the differential diagnosis of religious/spiritual problems using the concepts listed above. Milstein, Midlarsky, Link, Raue, and Bruce (2000) compared clergy and mental health professionals on their ability to distinguish among the three categories of presenting problems with religious/spiritual content. A national, random sample of 111 rabbis and 90 clinical psychologists were provided three clinical vignettes representing a mental disorder (schizophrenia with spiritual content), a spiritual problem without a mental disorder (mystical experience), and a pure religious problem (client unclear about religious rituals for mourning a parent). They were asked to rate the vignettes as to the likelihood that the situation was caused by a religious/spiritual problem, utility of psychiatric medication for the problem, and severity of the problem.

Concerning the first question, both the clergy and psychologists evaluated the religious etiology of schizophrenia as less religious than the mystical experience, which was less religious than mourning a parent. Furthermore, rabbis considered the etiology of schizophrenia as significantly more religious than psychologists did. In regards to the utility of psychiatric medication, rabbis viewed medication as more useful for schizophrenia than the mystical experience and more helpful for the mystical experience than mourning. Psychologists rated medication as more useful for schizophrenia than both mystical experience and mourning. Psychologists considered medication as significantly more helpful for schizophrenia as the rabbis did. In terms of severity, rabbis rated schizophrenia as more serious than mourning and mourning was considered more serious than the mystical experience was. Moreover, rabbis considered mourning a parent as more severe than psychologists did.

The validity of the results is limited somewhat by a methodological flaw. That is, the vignette for mystical experience did not describe someone who was experiencing distress—a vital criterion for diagnosing a religious or spiritual problem. Despite this shortcoming, this study showed that both psychologists and clergy could distinguish among problems with spiritual content. Furthermore, it provided preliminary support for the utility and validity of this distinct category.

A second study by Hartter (1995) (discussed in more detail above) demonstrated that psychologists consider the new DSM-IV category a necessary and valuable contribution to their practices. Sixty-five percent indicated that they would use the V-code Religious or Spiritual Problem if finances or third party reimbursement were not an

issue. Furthermore, 92% agreed that there was a qualitative difference between a psychotic episode and spiritual emergency or spiritual problems. Further research is needed to validate this new category and provide support for its utility, but these studies are a promising start.

Differential Diagnosis of Religious Problems from Psychopathology

As previously noted, there is an extensive literature base examining the role of religion and religious issues in psychology. Several authors have identified criteria for distinguishing between religious experience and pathology. Barnhouse (1986) indicated that when differentiating between psychotic disorders and other phenomena the content of religious language alone rarely determines its pathological significance. She recommended that an extensive religious history should be included in every psychological evaluation.

Greenberg and Witztum (1991) stressed that therapists must be thoroughly familiar with the basic tenets and beliefs of a client's religion or identifying pathology will be extremely difficult. Based on clinical experience with an ultra-orthodox Jewish sect in Israel, they proposed the following criteria for differentiating between obsessive-compulsive behaviors and religious practices: (a) compulsive behaviors exceed the religious injunctions; (b) compulsive behaviors overemphasize one specific behavior to the neglect of other important religious practices; (c) the focus of obsessive-compulsive behavior is reflective of the disorder (e.g., intrusive thoughts of blasphemy, repeated behaviors such as checking and counting); and (d) the person neglects many important aspects of the religious life.

Greenberg and Witztum (1991) also proposed criteria for distinguishing between normal religious experiences and psychotic symptoms. Compared with other religious experiences, psychotic episodes are more intense, terrifying, and consuming. Psychotic episodes are associated with decompensation in social skills and personal hygiene and involve particular messages from religious figures. It should be noted that nonpsychotic religious or spiritual experiences (such as mystical experiences) may also involve perceived direct communication with religious figures (Lukoff, 1991). These criteria have yet to be empirically supported, but they offer helpful guidelines for making clinical decisions. However, some would argue that *spiritual emergencies*, a type of spiritual problem, reflect some of the criteria listed by Greenberg and Witztum and, thus, should be approached differently to avoid further decompensation or mistreatment (Bragdon, 1993; Grof & Grof, 1989; Lukoff et al., 1998). For example, a person in a spiritual emergency would benefit from active social support, “grounding” techniques, and spiritual guidance/psychotherapy rather than hospitalization and heavy medication (Grof & Grof, 1992; discussed in more detail below).

Lovinger (1984) also offered guidelines for assessing religious problems and distinguishing them from pathology. First, he suggested determining if the religious issue is “idiosyncratic or is rather an expression of group attitudes, ideas, or practices” (p. 177). For instance, speaking in tongues (glossolalia) should probably not be considered pathological for someone from a Pentecostal or charismatic church community, but may be considered a problem for someone who is nonreligious. Clinical judgment and a thorough understanding of a client’s background are required to make this type of

distinction. One problem with this criterion is that atypical spiritual experiences for a particular cultural group may occur and still not be pathological. For instance, it is generally not considered “normal” in mainstream United States culture to have directly heard the voice of God or to have witnessed spiritual beings. Yet, many people have claimed to have had similar unusual spiritual experiences who are not actively affiliated with a religious or spiritual movement (Bragdon, 1993; Grof & Grof, 1992; Hood et al., 1996). Though these experiences differ significantly from one’s cultural group, they may not necessarily indicate pathology or psychological decompensation. The determination of psychopathology depends on the worldview of the clinician and his or her openness to nonpathological altered states of consciousness. It may also depend on several other factors including psychological history and amount of stress a person is currently experiencing.

Second, Lovinger considered hallucinations and delusions with religious content as indicative of pathology, in contrast to more recent transpersonal perspectives that might consider them spiritual emergencies (Bragdon, 1993; Grof & Grof, 1989; Lukoff, 1985, 1991; Lukoff et al., 1998). Lovinger failed to explain what he means by hallucinations or delusions and seems to include all such phenomena as inherently pathological. However, Lovinger believed that hallucinations were similar in structure to dreams and could be treated as such. That is, hallucinations can be treated as complex imagery and symbols from the mind and interpreted in this way. Third, Lovinger emphasized assessing the quality of the religious orientation. Although great strides have

been made in shedding the “obsessional neurosis” stigma championed by Freud (1907/1959), there may be pathological features in the expression of one’s religious life.

Lovinger summarized the work of Rubins (1955), Salzman (1953), and Pruyser (1971, 1977) who all proposed ways to identify neurotic and pathological expressions of religious faith. For example, Rubins characterized neurotic religious attitudes as involving shallowness, narcissistic displays of piety, inappropriate efforts to keep parental approval, bargaining with God, and over-dependence on external authority.

Based on many years of clinical experience, Lovinger (1996) recently updated his diagnostic criteria and delineated the following 10 markers of pathology. The first marker is *Self-Oriented Display*, characterized by narcissistic displays of being religious. The second marker, *Religion as Reward*, is marked by people who use religion to explain assistance with ordinary difficulties in life (e.g., God helping one find a parking space). Third, *Scrupulosity* is intense focus on avoiding sin or error. *Relinquishing Responsibility* is characterized by feeling responsible for events beyond one’s control and neglecting responsibility for things for which one is accountable. Fifth, *Ecstatic Frenzy* is intense, erratic emotional expression often containing religious content or occurs in religious contexts that may signal impending decompensation. Sixth, changing church affiliation every few months, *Persistent Church-Shopping*, may suggest difficulties in maintaining stable relationships. The seventh marker, *Indiscriminate Enthusiasm*, involves enthusiasm frequently expressed to people who do not welcome it. Eighth, *Hurtful Love in Religious Practice*, involves expressions of love that unnecessarily cause harm to oneself or others. *The Bible as Moment-to-Moment Guide to Life* is characterized by

applying scripture in concrete ways to direct one's daily experiences. Finally, *Possession*, may reflect underlying pathology such as hysteria, dissociative reactions, paranoia, psychosis, and borderline disorders.

Lovinger's markers are insightful and interesting but caution should be used in their application. A client's religious and psychological history are needed to determine whether patterns of pathology manifest themselves in other areas. That is, a person's ability to function at work, home, recreation, or in social settings should be considered. Are a person's pathological religious expressions affecting other psychosocial areas? If so, then psychopathology is likely. Furthermore, informed clinical judgment is required to determine when the markers are, in fact, pathological and when they are acceptable religious expressions. As previously noted, the diagnostic process is subjective and influenced by the clinician's prior assumptions and worldview. How does one determine when *Ecstatic Frenzy* or the *Bible as Guide* is a symptom of pathology rather than a value difference between the clinician and patient?

Like Lovinger, Spero (1985) proposed a dynamically oriented diagnostic approach. Relying on the insights of psychodynamic theory such as object-relations models, Spero developed eight diagnostic criteria based on his clinical experience and theoretical orientation:

The individual expresses religious behaviors and beliefs that are somehow related to overall lifestyle. This characteristic is itself not necessarily pathologic, but is necessary as a basic criterion.

The individual's total religious affiliation, or the current intensity or sense of religious meaning and conviction, is of relatively recent and rapid onset and has involved the individual in severing one or more significant family, social, or professional ties and roles.

The individual's past history includes numerous religious "crises" or episodes of changing religious affiliations or levels of belief.

The individual's religious behaviors and beliefs evince fixation at or regression to specific clusters of object-relational pathology, typified by (a) the predominance of primitive object-relational thematic material in dream, fantasy, or thought productions which are unarticulated with developmentally appropriate psychosexual or object-relational themes, (b) lack of integration between the individual's mode of religious expression and adaptive ego functioning, and (c) failure to successfully accomplish appropriate psychosocial tasks.

The religious individual is preoccupied either with a directly acknowledged or intellectually masked fear of back-sliding and the reactive adoption of rigidity, scrupulosity, and punctiliousness in the attempt to deal with such fears. This is sometimes manifest in the adoption of strict interpretations of religious law when the prevailing custom follows a lenient interpretation and where there is obvious discomfort with adopting lenient interpretations.

Continued unhappiness and improductivity (sic) following religious conversion or awakening.

Excessive idealization of a religious movement or leader, and the use of such idealization to resolve problems of autonomy, identity, impulse control, and so forth.

Occasionally, the cautiously interpreted countertransference reaction of a well-analyzed and experienced worker can also serve as a minimal indicator of the patient's attempt to use religion as a tool to satisfy neurotic needs (pp. 20-22).

Spero intended these criteria to help determine when a person's religious beliefs or behaviors reflect underlying intrapsychic needs and conflicts rather than purely religious phenomena. Therefore, the utility of Spero's diagnostic scheme is limited to those who accept and understand psychodynamic language and theory. Like most of the diagnostic suggestions reviewed, Spero's criteria lack empirical support.

In summary, diagnosing a religious problem requires a substantial understanding of the client's religious history and background (see Richards & Bergin, 1997, and Spero, 1985, for sample clinical interviews). Criteria are described which may help clinicians distinguish religious problems from mental disorders such as OCD and psychotic episodes. Assessing clients' overall quality of religious orientation may help determine whether there is a pathological nature to their religious expression and concerns. None of the criteria proposed has been empirically investigated. The next section will examine the literature on differentiating spiritual problems from psychopathology.

Differential Diagnosis of Spiritual Problems from Psychopathology

According to Lukoff et al. (1996), "the clinician's initial assessment of powerful spiritual experiences can significantly influence the eventual outcome" (p. 243).

Inappropriate reactions to and diagnoses of spiritual experiences by mental health

professionals may intensify feelings of isolation and prevent understanding and assimilation of the experience, and future help-seeking (Lukoff et al., 1996). However, it is also important that clinicians accurately diagnose psychopathology. Even transpersonal psychotherapists agree that medication and hospitalization are required in some instances for severe decompensation (Grof & Grof, 1989; Lukoff et al., 1998; Wilbur, 1984). Differentiating spiritual experiences from psychopathology can be extremely difficult because of similarities between pathological symptom expression and unusual behaviors and perceptual characteristics in spiritual experiences (Lukoff et al., 1996, 1998). For example, Bragdon (1993) noted that visions associated with near-death experiences might be seen as hallucinations. Several authors have proposed methods for distinguishing spiritual experiences from psychopathology, which will be reviewed in this section.

Transpersonal psychology has significantly contributed to expanding our understanding of diagnosis and treatment for spiritual problems. In fact, transpersonal psychologists and psychiatrists proposed the Religious or Spiritual Problem category for the DSM-IV. The existence of this category has provided a way to signify the presence of a religious/spiritual problem with or without concurrent mental disorders. In this way, clients' religious and spiritual issues may be addressed without necessarily being pathologized or stigmatized. Furthermore, falling within the domain of "spiritual problem" are spiritual emergencies. The identification and understanding of spiritual emergencies will help clinicians differentiate psychopathology and provide a framework for helping patients cope and heal with these unusual experiences.

Bragdon (1993) indicated three primary ways people respond to spiritual experiences: (a) gracefully integrate them into their lives and further develop spiritually and psychologically; (b) become temporarily overwhelmed and experience a spiritual emergency, but eventually accept the experience as part of their reality; and (c) fail to integrate the experience eventually resulting in a chronic state of fragmentation. Bragdon argued that classically trained clinicians might diagnose all three responses as pathological based on the *content* of their experiences. For example, a person might encounter a vision of light accompanied by a voice calling her to pursue a particular vocation. She may integrate the experience as a sign from God and seek the vocation to the best of her ability without decompensation in her social and emotional functioning. Nevertheless, if for some reason, she consulted a mental health professional about the experience who was insensitive to events of this kind, she might be categorized as delusional or psychotic.

The DSM-IV does not differentiate between psychotic hallucinations and delusions and religious/spiritual phenomena such as visions and intense meditative experiences (Bragdon, 1993). The DSM-IV also does not distinguish between the disorganized and incoherent speech of the psychotic from the “noetic quality of spiritual experience” (p. 84). Nor does it differentiate psychotic disorganized behavior from the unusual behaviors of a kundalini awakening. For instance, during a kundalini awakening a person may feel intense feelings of heat pulsating up the spine, experience overwhelming waves of emotions, find it difficult to control behavior, and become extremely disoriented. All of which may appear as disorganized psychotic behavior.

Bragdon admitted that distinguishing spiritual emergencies from psychopathology could be extremely difficult in people who are highly dissociative. Bragdon recommended clinical expertise and an open-minded stance that considers experiences of this kind potentially representing spiritual emergencies rather than pathology.

Grof and Grof (1992) argued that clinicians must “accept the fact that spirituality is a legitimate dimension of existence and that its awakening and development are desirable” (p. 252). Along these lines, Wilbur (2000) conceptualized human development consisting of three realms: Prepersonal, Personal, and Transpersonal. The *prepersonal* realm is characterized by the infant beginning to individuate and develop a sense of self. Psychological functioning in this realm is considered prerational. The *personal* realm, considered as *rational* psychological functioning, involves strengthening and developing a coherent, autonomous self. The *transpersonal* realm (*transrational* psychological functioning) usually requires intentional contemplative practices that put one in touch with higher states of conscious awareness. In differentiating between spiritual experiences and psychopathology, Wilbur (1993) admonished mental health professionals to identify the *pretrans fallacy*. This involves confusing prepersonal states with transpersonal states, which is admittedly understandable because each is, in a sense, *nonpersonal*. Regression to prepersonal states is characteristic of psychotic episodes while progression to transpersonal states may result in a number of different spiritual experiences that occasionally resemble psychotic features.

Distinguishing between spiritual experiences and psychopathology requires a thorough understanding of what characterizes a *spiritual emergence* and *emergency*

(Bragdon, 1993; Grof & Grof, 1992). The first criterion includes the intensity of the process and degree of functioning in daily life. Those whose daily functioning is significantly impaired by extremely intense experiences are probably encountering a spiritual emergency. Second, people experiencing a spiritual emergence usually display an attitude of excitement contrasted with the frightening and overwhelming stance found in a spiritual emergency. Finally, a clinician should consider how the person copes with society's reactions to their experience. In a spiritual emergency, the person might lack discrimination concerning who would be receptive to their experience and share their experience with people who are not interested or uncomfortable.

Once it is determined that a person is experiencing a spiritual emergency, it becomes paramount to distinguish it from psychopathology. Grof and Grof (1992) recommended beginning with a complete medical evaluation to rule out contributing physical conditions. The Spiritual Emergence Network, a specialized facility in California for treating spiritual emergencies, begins with a physical and blood test. If the results are negative, they proceed with diagnosing a spiritual emergency and treating it as such. If the psychological and spiritual interventions help, they continue with the transpersonal treatment. If, however, physical symptoms persist, they refer the person for a more complete medical evaluation.

If the medical evaluation excludes organic causes, then clinicians should attempt to determine if the experience meets the criteria for a spiritual emergency or psychiatric disorder (Grof & Grof, 1992). Many authors stress the importance of pre-episodic functioning (Bragdon, 1993; Cortright, 1997; Grof & Grof, 1992; Lukoff, 1991). If a

person's history evidences generally healthy functioning in social, psychological, spiritual, and sexual adjustment, then it is likely that the person's current experience originated within their psyche. This determination usually suggests a positive prognosis. In contrast, disruptions in a person's history, strong indications of manic features, poorly organized content of experiences, self-destructive tendencies, and the presence of persecutory delusions or hallucinations are indicative of psychopathology. In this case, traditional approaches to treatment may result in better outcomes (Grof & Grof, 1992).

Similar to the features Grof and Grof offered, Lukoff (1985) proposed several positive prognostic indicators that help differentiate between spiritual experiences and psychopathology, two of which are usually required to predict positive outcomes if treated effectively. The first indicator is good pre-episode functioning demonstrated by a healthy social network, intimacy with romantic partners, and an absence of psychotic episodes. The second is acute onset of symptoms occurs during a 3 month period or less. The third indicator included stressful precipitants to the psychotic episode such as trauma, divorce, loss of job, or death of a loved one. Finally, evidencing a positive exploratory attitude to the experience is often predictive of positive outcomes. Lukoff et al. (1996) maintained that individuals who meet the criteria for a spiritual emergency should not be hospitalized and medication should be minimal. They also recommended transpersonal psychotherapy.

Drawing on the existing literature and clinical experience, Lukoff (1985) proposed diagnostic criteria for distinguishing mystical experiences with psychotic features from psychotic episodes. Though specific to mystical experiences, his criteria

appear to apply to other spiritual problems as well. The first criterion involves determining if a psychotic state is present according to the DSM-IV. This includes the following features: delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior (American Psychiatric Association, 1994). Clinicians should not rely solely on the content of an experience to determine whether someone is psychotic. The content often looks similar, but someone who is psychotic may be unaware of the bizarre nature of their experience and/or speak in a monotone, detached voice. In contrast, in spiritual experiences a person is often able to recognize the incredulity of others concerning their experience and discusses the experience in an affectively alive manner (Lukoff, 1985).

Clinicians should also assess the person's level of daily functioning and adaptability. Typically, a psychotic episode leaves the person severely incapacitated. Completing daily tasks is difficult and the individual may threaten to harm themselves or others. During intense spiritual experiences, a person may experience temporary disruptions completing daily tasks, but usually resumes previous levels of daily functioning in a short time. In addition, there is usually not the threat of harm to self or others following spiritual experiences. Determining the presence of a mystical experience is the second criterion. Lukoff proposed the following five criteria, all of which must be present: ecstatic mood, sense of newly-gained knowledge, perceptual alterations, delusions (if present) have themes related to mythology, and no conceptual disorganization.

In one of the few empirical studies investigating spiritual experience and psychopathology, Hartter (1995) found that 92% of psychologists believed there was a difference between a psychotic episode and a spiritual emergency. In response to an open-ended survey question asking how they differentiate between the two, the psychologists identified the following eight criteria listed in descending order by prevalence: (a) Ability of client to function in reality; ability to carry out activities of daily living; (b) previous history of mental stability; (c) content of thought processes; conceptual organization or disorganization; (d) outcome that leads to wholeness or integration; transformative; (e) content and organization of hallucinations and delusions; (f) neurochemical imbalances; (g) intact “religious belief system;” and (h) duration of crisis. These findings closely resemble the recommendations found in the literature (e.g., Bragdon, 1993; Grof & Grof, 1992; Lukoff, 1985). Considering that these suggestions were given spontaneously in an open-ended format provides some validity to the criteria previously discussed.

In another study, Jackson (1991) compared five “undiagnosed” and five “diagnosed” subjects all of whom interpreted their experiences in spiritual terms. The undiagnosed group met the following criteria: they reported an intense experience explained in religious or paranormal terms; the experiences were assessed as possibly involving delusions or hallucinations; apparent absence of functional deficits and evidence of positive social adjustment; and geographical proximity to the research center (i.e., Alister Hardy Research Center in Oxford). The diagnosed group was individuals

who had recovered from major psychoses and interpreted their experiences in strongly spiritual terms.

Results indicated significant phenomenological similarities between the two groups. Each group manifested grandiose beliefs about their status, positive and negative emotional experiences, true and pseudo hallucinations, visual and auditory hallucinations (visual hallucinations reported more often in diagnosed group), firm conviction of “delusional” beliefs, and a lack of insight into the possibility that their experiences could be explained psychologically rather than spiritually. The degree of symptom severity tended to separate the two groups. For example, the diagnosed group reported being completely overwhelmed by their experiences, during which they lost contact with consensual reality and acted out their delusions in bizarre behavior, in contrast to less severe manifestations in the undiagnosed group. The diagnosed group also differed in that they unanimously indicated intensely negative experiences.

Jackson and Fulford (1997) intensively interviewed nine participants from a database of over 5,000 accounts of spiritual experience. They strategically selected cases in which there appeared significant overlap between spiritual experience and psychotic illness. The semi-structured interviews covered the participants’ background and history, the context, phenomenology and effects of their spiritual experiences, and the interpretations that they and others placed on them. The purpose of the study was to determine whether benign spiritual experiences could manifest psychotic phenomena. The second goal was to explain the significance of this finding, if it occurs.

Traditional psychopathology defines mental illness by the form, content, duration, and intensity of symptoms and a lack of insight into their psychological origin (Jackson & Fulford, 1997). The researchers found that the participants' spiritual experiences resembled the general form of psychotic phenomenon. For example, some of the participants demonstrated delusions and first person auditory hallucinations (voices addressing the person). In terms of content, participants demonstrated benign symptomology that differs from malignant symptoms such as delusions of persecution. In addition, the subjects described their experiences as intense and enduring. Overall, the phenomena were broadly defined as psychotic and likely to receive a diagnosis of psychoses in a traditional psychiatric setting. However, in many cases the experiences resulted in healthy and adaptive outcomes as interpreted by the participants and external observers.

Jackson and Fulford (1997) concluded that the psychological profession needs to reconceptualize its notions of mental illness. They proposed a more balanced model that considers the evaluative nature of medical concepts and defines pathology as the patient's experience of *incapacity*, i.e., failures of ordinary intentional action. Jackson and Fulford emphasized that pathology should be understood as "essentially embedded within the framework of values and beliefs of the individuals concerned" (p. 53). They also argued that the mental health profession must recognize that it is a value-laden profession.

In a comment on Jackson and Fulford's study, Littlewood (1997) stressed that mental illness and spirituality are always social or cultural phenomenon—neither are objectively "real." These concepts are "experienced through cultural meanings' not

‘influenced by’ culture” (p. 67). Storr (1997) criticized Jackson and Fulford’s distinction between good and bad psychotic experiences. For Storr, whether an experience is spiritual or pathological depends on the nature of the experience and the social setting. For instance, most everyone has had at least one psychotic episode—i.e., falling in love. Storr concluded his critique with the following thoughts:

My own feeling is that the distinction ‘spiritual’ versus ‘pathological’ should be dropped. Everyone is liable to have deeply irrational experiences or hold deeply irrational beliefs that may be destructive or may be life-enhancing. Psychiatric diagnosis must include reference to the subject’s personal relationships and his place in society as well as taking cognizance of his beliefs and mental experience as an isolated individual. Otherwise, we may condemn saints as psychotic, while treating serial killers as sane (p. 84).

In all attempts at evaluating another human being’s experience, the subjective and cultural aspects of the evaluation process should be considered.

In summary, the preceding discussion has highlighted many attempts at establishing criteria for the differential diagnosis between spiritual experiences and psychopathology. Empirical and exploratory research into the diagnosis of spiritual problems is sorely lacking. A few studies have highlighted the difficulties inherent in assessment and diagnosis, but even fewer have investigated the actual diagnostic practices of mental health professionals. One of the purposes of this study is to explore how psychologists make these complicated decisions.

Review of Literature on Psychotherapy with Spiritual Problems

With the inclusion of Religious or Spiritual Problem in the DSM-IV, addressing spiritual concerns is now a legitimate focus of attention within mental health. After years of neglect, psychotherapists and researchers are finally devoting considerably more attention to spirituality in treatment. However, there is a severe dearth of research and literature examining the treatment of spiritual *problems*, as opposed to that with religious or spiritual *clients* (Johnson & Hayes, 2003; Lukoff et al., 1992, 1998). The following review will discuss general approaches to the treatment of spiritual issues found in clinical practice and highlight three important conceptual frameworks for treating spiritual problems.

Reasons For and Against Therapy with Spiritual Problems

Koenig (1998) offered five reasons why addressing spiritual issues is beneficial to psychotherapy. First, understanding a person's spiritual life can shed light on their psychological conflicts. For instance, a client may appear resistant to following through on recommendations made in psychotherapy. Upon further inspection of her religious history, the therapist discovers that her religious group expresses suspicion towards secular psychotherapy. This understanding may help explain resistances encountered in therapy and encourage exploring her suspicion and lack of trust in a nondefensive manner. It may also suggest referring to a religious therapist or clergy member or collaborating with her minister, if possible. Second, knowing clients' spiritual worldviews can assist in developing and implementing interventions that are consistent with their values and, thus, more likely to ensure compliance. Third, addressing spiritual

issues may help identify resources that provide additional comfort and support for clients concomitant with psychotherapy. Fourth, clients may have had negative religious/spiritual experiences that prevent them from utilizing healthy spiritual resources for their current concerns. Working through these negative experiences may open previously closed avenues for healing and growth. Lastly, addressing spiritual concerns demonstrates sensitivity and respect on behalf of the therapist, thus strengthening the therapeutic alliance.

Addressing spiritual issues in psychotherapy is not without its critics, however. Chirban (2001) summarized the most common criticisms of treating spirituality in secular psychotherapy. First, including “nonscientific” phenomena may confuse treatment. Psychologists adhering to a narrow definition of empirical science (e.g., strict behavioral paradigms) may not believe that spiritual phenomena have a place in psychology. Second, conflicts may be created between client and therapist by focusing on spiritual beliefs, even when they are similar. Focusing on spirituality may encourage clients to assume therapists are more similar to them in worldview than they actually are. Furthermore, attending to clients’ spirituality may thrust the therapist in unfamiliar territory that may result in impeding treatment. Third, the inclusion of spirituality may introduce different goals and criteria from that of “scientific” psychology, thus confounding treatment. For example, some psychologists may insist that psychotherapy should focus on observable behavior and circumstances, not the inner spiritual life of individuals. Finally, according to critics, spirituality may introduce phenomena that fall

outside the purview of the scientific method, which should establish the goals of psychology.

Theoretical Approaches to Spiritual Problems

With the inclusion of Religious or Spiritual Problem in the DSM-IV, clinicians can legitimately focus on spiritual concerns in psychotherapy. Subsequently, Peteet (1994) recognized that clinicians need a conceptual framework for deciding how to approach spiritual problems in therapy. He proposed four approaches. The first is to avoid discussing moral or spiritual issues and instead focus on the psychological aspects of the problem. Therapists may acknowledge the importance of spiritual problems for clients, but direct attention to the emotional components involved. This approach intends to encourage clients to resolve spiritual problems from a psychological perspective. This approach is similar to that taken by Freud and Ellis. Although this strategy supposedly acknowledges the importance of the spiritual problem, it implicitly discounts clients' spiritual reality and may disrupt the therapeutic alliance. There are indeed psychological problems disguised in religious language. Therapists must make careful and thorough assessments of clients' spiritual lives to differentiate psychopathology from spiritual concerns (see above).

A second approach recognizes the importance of spiritual problems and their need for attention, but does not address them in secular psychotherapy. In this case, clinicians may refer the client to clergy or spiritual directors to address the spiritual problem. Therapists who lack training and competence in treating spiritual concerns may take this approach. Once again, this approach may be perceived by the client as dismissive and

damage the therapeutic relationship. If the client is at the beginning of therapy or seeking treatment this may be a simple procedure. However, if spiritual problems arise during the course of longer-term therapy, the costs of referring the client must be weighed against the potential harm of abandonment.

The third approach proposed attempts to distinguish between the psychological and spiritual aspects of the problem, but considers how these aspects influence each other. Using a client's spirituality as a resource, the therapist addresses the problem indirectly through integrating psychological and spiritual perspectives. For example, a cognitive-behavioral approach combined with religious imagery may be used to treat depression or prayer and meditation may be used to alleviate anxiety. Much of the literature involves this kind of approach (e.g., Miller 1999b; Propst, 1988; Shafranske, 1996).

In a fourth approach, therapists may use a shared religious or spiritual orientation to directly address spiritual problems that are considered the primary concern. This might involve incorporating scripture to help clarify problems and offer solutions or praying with clients. Several precautions should be taken with this approach. Disclosing one's spiritual orientation to clients may engender complicated transference and countertransference dynamics. For example, a client may come to view the therapist as a spiritual mentor rather than a therapist, which may preclude serious attention to a client's interpersonal and characterological issues. Furthermore, clients may assume similarity in values and worldview because of a shared spiritual orientation. This may become problematic when value conflicts arise. In addition, a therapist may need to possess

significant training and education in theological matters before utilizing religious scripture, rituals, or practices. Richards and Bergin (1997) provide one of the best examples of this type of approach (discussed in more detail below).

The conceptual frameworks offered by Peteet are a helpful beginning to understanding the treatment of spiritual problems, but they lack a firm empirical and philosophical foundation. Zinnbauer and Pargament (2000) proposed their own four philosophical orientations for addressing spiritual issues in therapy. They begin by describing two extreme positions (Freud vs. Jung) frequently taken with respect to religious and spiritual problems. On the one hand, Freud reduced spirituality to prerational, infantile states. This position denies legitimacy for spiritual experience and considers spirituality as pathological. In contrast, the position taken by Jung elevates spiritual problems to transpersonal status. Considering all problems as spiritual may inhibit discrimination between healthy and unhealthy spirituality and fail to identify some problems as truly pathological.

Among the four approaches proposed, the first is termed the *rejectionist* orientation. This approach is similar to that taken by Freud and denies sacred realities (e.g., existence of God, presence of miracles) fundamental to most religious and spiritual traditions. The major theoretical models of psychotherapy possess rejectionist elements. For example, classic psychoanalysis reduced religion to a primitive defense mechanism and religious altruism to defensive undoing of past sins (McWilliams, 1994). Traditional rational-emotive therapy likened religion to irrational beliefs and emotional disturbance (Ellis, 1980). Existential psychotherapy reduced belief in God to defenses against death

anxiety and adherence to religious prescriptions as avoidance of responsibility (Yalom, 1980).

This orientation has several disadvantages when working with spiritual issues. First, the inherent hostility toward religious and spiritual beliefs may prohibit the formation of a strong therapeutic alliance with spiritually committed clients. This approach may also engender understandable suspicion and skepticism toward mental health in religious and spiritual clients. Second, the assumption that religiosity or spirituality is inherently harmful is not consistent with the research data (see Koenig, 1998; Plante & Sherman, 2001; Shafranske, 1996). Third, the rejectionist orientation is culturally insensitive and ethically reprehensible.

The second orientation, *the exclusivist*, maintains “a fundamental belief in the ontological reality of a religious or spiritual dimension of existence” (Zinnbauer & Pargament, 2000, p. 165). This view purports that there is one “true” religious or spiritual reality. Exclusivists respect clients’ spiritual beliefs only when they coincide with the therapists’ views. Examples of this approach are found in the fundamentalist “biblical counseling” models proposed by Adams (1970) and Bobgan and Bobgan (1987). From these perspectives, all that is needed for psychological health and healing can only be found in religious scripture. Understandably, the exclusivist orientation is viewed suspiciously by mainstream psychology. Problems with this orientation include being overly restrictive concerning clients’ religious views, being intolerant of different religions or religious beliefs, and contradicting research that shows the effectiveness of both religious and nonreligious coping (e.g., Pargament, 1997). This orientation may

work well with religiously similar clients, but it presents a very inflexible approach for the multitude of spiritual practices presented in psychotherapy (Zinnbauer & Pargament, 2000).

The *constructivist* orientation represents the third approach to treating spiritual issues. This approach “denies the existence of an absolute reality but recognizes the ability of individuals to construct their own personal meanings and realities” (Zinnbauer & Pargament, 2000, p. 166). Constructivists view all worldviews, theistic or atheistic, as human constructions developed from the various contexts and experiences of the individual and society. This orientation attends to the quality or coherence of a person’s constructions, rather than its correspondence to some objective reality or truth. Therapy is seen as an attempt to restore coherence to conflicted and disturbed constructions of the world. Zinnbauer and Pargament stated that “the willingness to enter different worldviews, to help people understand their problems from the perspective of their own constructions, and to find solutions to suffering with the methods and metaphors of the client’s orienting system are the keys to religious constructivism” (p. 167).

The constructivist orientation is an advance over the first two approaches. It allows for greater flexibility and adaptiveness with clients’ spiritual beliefs and experiences. It also expresses more appreciation for the religious and spiritual beliefs and values of clients. However, it is not without its shortcomings. Some question whether respecting clients’ spiritual beliefs is enough without truly holding similar views about reality (e.g., Spero, 1985). It is questionable whether clients will perceive constructivist therapists’ spiritual interventions as sincere when there are discernable differences

between their personal beliefs about reality. Another problem is the ethical relativism expressed in the constructivist approach. How will a constructivist clinician make distinctions between healthy and unhealthy spiritual practices if he is supposed to *always* respect the client's worldview? If our worldviews are socially constructed, what standard does one use as a basis for pathology or health? Other approaches face this dilemma as well but it is especially salient within this approach. A constructivist view is not value-free. Constructivists must be mindful of their own assumptions and views concerning religion and how they might influence therapy (Zinnbauer & Pargament, 2000).

The final approach for treating spiritual issues is the *pluralist* orientation. This approach emphasizes the existence of a spiritual reality but maintains that there are multiple paths towards it. Human beings and human experience are recognized as infinitely complex; thus, it is highly doubtful that any one human belief system holds the absolute truth. Cultural, interpersonal, intrapersonal, and political forces shape our spiritual beliefs and experiences and, therefore, spirituality is expressed in innumerable ways. The different religions and spiritual paths can offer invaluable insights and directions for human experience. The pluralistic orientation enables the counselor to hold personal spiritual beliefs while respecting different beliefs and values of clients. This perspective also recognizes that value differences are inevitable, but not inherently destructive to therapy. Examples of this approach are found in cross-cultural (Tyler, Brome, & Williams, 1991) and multicultural (Fukuyama & Sevig, 1999) therapy.

Zinnbauer and Pargament mentioned two important cautions to the pluralistic approach. First, therapists must be keenly aware of their own beliefs, values, and

assumptions and the impact they may have on therapy. A mindful, respectful, and collaborative stance is required on the part of the therapist. Second, and this applies to the exclusivist orientation as well, if the spiritual worldviews are similar between the therapists and client, then there is potential to mistakenly assume that other spiritual beliefs and values are shared. This may prevent further discussion about spiritual issues because counselor and client may assume the other understands more than they actually do. A final caution about the pluralistic orientation is that conflict may still occur for clients with an exclusivist view. Clients' views concerning absolute spiritual reality may entail rejecting other means to God. Thus, they may not trust therapists who claim to appreciate and value their worldview as "one" legitimate approach to spirituality.

Zinnbauer and Pargament admitted that their categorization simplifies matters and that orientations can be combined or fall in between one another. For example, Richards and Bergin (1997) proposed a "theistic realism" approach that combines exclusivist and pluralistic elements (see below). Zinnbauer and Pargament argued that the constructivist and pluralistic approaches are best suited for addressing spiritual issues in psychotherapy. They provide the most flexibility to respectfully and effectively address the multitude of spiritual beliefs and experiences found in therapy. The main difference between them is their position on the existence of an absolute spiritual reality. The constructivist denies absolute spiritual reality while the pluralistic approach maintains its existence. The remainder of this section will summarize specific approaches to the treatment of spiritual problems. While most spiritually informed models of treatment focus on therapy with spiritual clients rather than treating spiritual problems specifically, there is a great deal of

overlap between addressing spirituality and spiritual problems in psychotherapy.

Therefore, the following summaries will focus on the elements within these approaches that apply to the treatment of spiritual problems.

A Spiritual Strategy for Counseling and Psychotherapy

Scott Richards and Allen Bergin have been among the most productive and vocal researchers and clinicians advocating for the inclusion of spirituality in mainstream psychology. Richards and Bergin (1997) attempted to synthesize the past 15 years of Bergin's work in this area with Richards' original contributions and provide a strategy for integrating spirituality into mainstream psychotherapy. From the outset, they identify their major assumptions. Adhering to a Judeo-Christian framework, Richards and Bergin assume that God exists, human beings are God's creation, and unseen spiritual processes connect humanity with God. Furthermore, they define *spirituality* as "attunement with God, the Spirit of Truth, or the Divine Intelligence that governs or harmonizes the universe" (p. 77). By Spirit of Truth, they mean that human nature inherently possesses spiritual capacities for transcendence and contact with the transcendent. This includes ideas such as *revelation, conscience, inspiration, and intuition*. They defend their theistic worldview by asserting that theism has profound implications for psychology, most clients hold theistic worldviews, and they are most familiar with this view.

Moreover, they maintain that a viable spiritual strategy for psychotherapy must be empirical, eclectic, and ecumenical. By *empirical*, they argue that rigorous research should be used to evaluate a spiritual strategy's claims concerning human nature, therapeutic change, and treatment effectiveness. In this vein, they support both

quantitative and qualitative investigations for understanding human personality and psychotherapy. By *eclectic*, Richards and Bergin believe that a spiritual strategy should be integrated into existing therapeutic approaches. They propose that a spiritual strategy should complement approaches found in psychodynamic, behavioral, humanistic, and systemic therapies.

By *ecumenical*, they mean that “*as much as possible*, the philosophical and spiritual assumptions of the strategy need to be *reasonably* accommodating to the worldviews of the major religious and spiritual traditions that modern therapists are likely to encounter” (italics mine, p. 15). From this statement, it is clear that Richards and Bergin hold fast to their theological perspective and use it to evaluate other spiritual worldviews. It also reflects some elements of the exclusivist and pluralistic orientations proposed by Zinnbauer and Pargament (1997). To their credit, they make their values explicit and leave it to their audience to evaluate the validity and applicability of their approach. Thus, the question remains as to how effective their approach will be for clinicians and clients who do not share their worldview. They also suggest that a spiritual strategy for mainstream psychotherapy must be ecumenical to avoid a multiplicity of denominationally specific approaches (e.g., for Catholics, Jews, Muslims, etc.). While approaches for specific groups are necessary, they argue a comprehensive unifying approach is required to avoid the “fragmentation and incoherence that currently characterizes this domain of psychotherapy” (p. 15). However, they believe a comprehensive approach should have denominationally specific *applications*.

While not a strategy for specifically treating spiritual problems, Richards and Bergin's approach is certainly applicable in this regard. They begin by delineating five general spiritual goals for psychotherapy with the caveat that they be applied in the framework of a multidimensional, integrative approach and based on the needs of the client. They also maintain that therapists need not be religious or spiritual themselves to pursue these goals with clients. Goal 1: *Help clients experience and affirm their eternal spiritual identity and live in harmony with the Spirit of Truth* (p. 116). This can be applied to all clients, but does not require discussing religious or spiritual issues with all clients. Richards and Bergin believe that achieving this goal will result in healing, growth, and change for clients; assist clients with listening to their consciences (Spirit of Truth); and encourage therapists' valuing of clients.

Goal 2: Help clients examine and better understand what if any impact their religious and spiritual beliefs have on their presenting problems and their lives in general (p. 117). Without a thorough understanding of clients' cultural, personal, and spiritual backgrounds, it is unlikely that therapists will adequately understand clients' worldviews. Because spiritual beliefs are so significant for some clients, it is vital to explore their impact on presenting problems and other areas in clients' lives.

Goal 3: Help clients identify and use the religious or spiritual resources in their lives to assist them in their efforts to cope, heal, and change (p. 117). This suggestion is frequently made in the literature (e.g., Koenig, 1998) and makes intuitive sense. Richards and Bergin warn that this goal is most appropriate for clients who view their spirituality

as a source of strength and caution its use with those who have unresolved spiritual issues (e.g., anger at God or clergy).

Goal 4: Help clients examine and resolve religious and spiritual concerns that are pertinent to their disorders and make choices about what role religion and spirituality will play in their lives (p. 117). This goal is particularly relevant for the treatment of spiritual problems. Richards and Bergin suggest that some clients may want to pursue these concerns with religious leaders and such requests should be respected. Unfortunately, they provide little guidance for specifically addressing and treating spiritual problems.

Goal 5: Help clients examine how they feel about their spiritual growth and well-being and, if they desire, help them determine how they can continue their quest for spiritual growth and well-being (p. 118). This goal is appropriate for clients who explicitly express interest in pursuing spiritual growth in therapy. Clients may feel more comfortable exploring spiritual growth with religious leaders and therapists should respect such requests.

After establishing goals for therapy, Richards and Bergin propose components for their spiritual strategy. First, therapists should adopt an ecumenical stance. This involves an attitude of respect and acceptance of clients' diverse religious and spiritual beliefs and affiliations. An ecumenical stance requires multicultural competencies (Sue, Arredondo, & McDavis, 1992) that include increasing sensitivity and understanding of clients' spiritual issues, religious traditions, resources, and worldviews. It also involves deepening awareness regarding one's own spiritual worldview, background, assumptions, and biases. Second, Richards and Bergin recommend adopting a denominational

therapeutic stance. This means tailoring one's therapeutic approach to the needs and demands of clients' religious or spiritual denominations. While an ecumenical stance is often implicit in therapy, a denominational stance is typically explicit. They do not insist that all therapists should at times adopt a denominational stance (e.g., nonreligious or atheistic therapists), but emphasize the benefits for those who can. Richards and Bergin believe a denominational stance gives added leverage with clients and allows therapists to appreciate and utilize more fully their religious and spiritual resources.

Third, therapists should build a spiritually open and safe therapeutic relationship. Spiritual and religious beliefs are often a sacred and private matter for people. Thus, therapists need to establish an atmosphere of mutual trust, caring, and respect for the client and their beliefs. Taking a spiritual history, informing clients of one's openness to spiritual issues and potential use of spiritual interventions, avoiding religious symbols or dress that advertises one's religious persuasion, and carefully considering the costs and benefits of disclosing one's spiritual beliefs help establish a safe therapeutic alliance.

Fourth, assess the religious and spiritual dimensions of clients to facilitate increased understanding of clients' problems and ways to assist them. They developed a spiritual history questionnaire to assist with this goal. Fifth, Richards and Bergin propose implementing religious and spiritual interventions such as prayer, meditation, or spiritual imagery. This should only be done after careful assessment of clients' spiritual beliefs and with their explicit consent. Richards and Bergin suggest that spiritual intervention can be more readily applied with less disturbed clients. More severely disordered clients

may need traditional means of therapeutic intervention (e.g., hospitalization, medication) before spiritual issues can be effectively discussed.

Sixth, their spiritual strategy offers ways to manage values in therapy. They assert that psychotherapy is value-laden and it is important for therapists to be cognizant of their values and respectful of clients' values. They disagree with proponents of ethical relativism (i.e., all values are equally valid and good) and maintain that there are values that promote health and well-being more than others. Richards and Bergin advocate for therapists to model and teach healthy values, help clients clarify values and understand the influences on their values, and assist clients in making reasonable choices for which values they want to internalize. Finally, Richard and Bergin's spiritual strategy proposes that therapists may seek and obtain spiritual growth for themselves through intervening in their clients' lives. They believe therapists can benefit from belief in God and spiritual development. Subsequently, they recommend that therapists practice spiritual disciplines (e.g., prayer, meditation, etc.) to receive spiritual guidance and direction for therapy. For example, therapists may gain spiritual insights and inspirations during meditation or spontaneously which guide therapy and increase therapeutic effectiveness.

In summary, Richards and Bergin propose a multidimensional, integrative approach for addressing spirituality in treatment. Their recommendations have much to offer mainstream psychotherapy. They encourage mindful and intentional consideration of spiritual issues in psychotherapy and propose ways to integrate spirituality in therapy. They view the integration of spirituality as being complimentary with multicultural competence and benefiting therapeutic outcomes with religious/spiritual clients. Finally,

they emphasize the importance of rigorous study and validation for attempts at integrating spirituality into psychology.

Consideration of spiritual problems is implied in their approach, but they fail to address this issue at length. In fact, they seem to support referring clients to appropriate clergy or spiritual directors for such concerns. They are not clear when spiritual problems are appropriate for secular psychotherapy and when they are not. In some ways, they seem to advocate for the exclusion of spiritual matters in secular psychotherapy when they are at odds with the therapists' views despite their emphasis on an ecumenical stance. This view may severely limit the application of their spiritual strategy to issues that are consistent with the therapists' theological understanding. Furthermore, their approach advocates for a particular theological position (Western Protestant theism) that may be incompatible for many therapists and clients. It is not clear that therapists who are sensitive to spiritual issues but hold different theological views from Richards and Bergin could truly apply their approach.

Finally, Richards and Bergin strongly emphasize the importance of understanding clients' denominational beliefs. While it is helpful and important for therapists to be familiar with clients' religious/spiritual framework, it seems at times that they are expecting therapists to become accomplished theologians. This may be an unrealistic expectation for most psychotherapists. Is it possible to understand common elements in healthy spirituality and human experience without knowing all the details of a particular religious persuasion? Or is it necessary for all secular psychotherapists to become pastoral counselors as well? In other words, is there a human core to spirituality that

could be a legitimate focus of secular psychotherapy regardless of therapists or clients' religious persuasion (see discussion on Helminiak below)?

Transpersonal Approaches to Spiritual Problems

Transpersonal psychology is credited with introducing the category Religious or Spiritual Problem into the DSM-IV. This is understandable given that spirituality constitutes the core of transpersonal theory and practice. While there are several models for transpersonal therapy (Cortright, 1997; Grof & Grof, 1992; Vaughn, 1977; Wilbur, 1999), they each share basic assumptions and principles that may facilitate the treatment of spiritual problems. Transpersonal psychology may be defined as an attempt to synthesize the world's spiritual traditions with modern psychology. Transpersonal psychology is concerned with coming to a fuller understanding of the self and then moving beyond the self to the numinous. Transpersonal theorists emphasize the need to look beyond the confines of the natural world to the spiritual dimension to fully understand human beings (Cortright, 1997). Transpersonal psychology is not only concerned with experiences "beyond" the personal, but also with how spirituality is expressed in everyday living. Cortright stressed that "transpersonal psychology studies how the spiritual is expressed in and through the personal, as well as the transcendence of the self" (p. 10).

Transpersonal approaches to psychotherapy provide a natural framework for understanding and treating spiritual concerns. Cortright (1997) listed eight basic assumptions that unite transpersonal therapy and facilitate the treatment of spiritual issues. First, transpersonal psychology emphasizes that human beings' essential nature is

spiritual. They affirm our psychological nature and the contributions of modern psychology, but give precedence to our spiritual nature. Moreover, the transpersonal understanding of spirituality generally views human beings as actual participants with the divine. That is, “man’s (sic) innermost consciousness is identical to the absolute and ultimate reality of the universe” (Wilbur, 1980, p. 75). Second, transpersonal psychology views consciousness as multidimensional. Transpersonal theorists have researched the effects of psychedelic compounds and spiritual practices on states of consciousness. These studies have suggested that normal consciousness is only a small part of total consciousness and human beings can tap into expanded states of consciousness. Third, human beings possess a natural inclination toward spiritual seeking, which is a drive for actualization and wholeness.

Fourth, transpersonal approaches accentuate the benefits of contacting deeper sources of wisdom and guidance for growth and healing. These sources of wisdom include those found in modern psychology as well as that gleaned from spiritual traditions such as Christianity or Buddhism. Transpersonal psychology particularly emphasizes the inward search for wisdom. Fifth, transpersonal therapists affirm the uniting of the conscious will with spiritual impulses toward growth and healing. Transpersonal psychology holds a pluralistic orientation (Zinnbauer & Pargament, 2001) that emphasizes multiple ways to the divine or spiritual dimension. Sixth, altered states of consciousness are viewed as legitimate ways to access transpersonal experiences that assist with personal development. Seventh, transpersonal psychology views all of life and human actions as meaningful, including suffering and joy. This perspective aids in coping

with a multitude of concerns. As Victor Frankl showed, human beings can cope with tremendous suffering if it is viewed as meaningful. Finally, transpersonal perspectives on human nature shape views of clients. Transpersonal theory views people as spiritual beings and fellow seekers. Thus, clients should be approached with compassion and respect as the therapist aims to facilitate their movement toward spiritual and psychological wholeness.

Psychotherapy for spiritual problems. Transpersonal approaches have been applied to a multitude of spiritual concerns including psychotic disorders and spiritual emergencies with psychotic features (Lukoff, 1996) and other spiritual emergencies (Bragdon, 1993; Cortright, 1997; Grof & Grof, 1989, 1992; Lukoff et al., 1998). These approaches have several features in common. First, therapists should express sensitivity and understanding toward clients' spiritual lives and experiences. If a therapist finds it difficult to accept a client's spirituality, he or she should consider referring the client to someone more experienced with spiritual issues. Second, education is viewed as one of the most powerful interventions. Providing a client with a spiritual and conceptual framework for understanding his or her problem may help alleviate distress. Cortright (1997) stated that education offers a cognitive understanding of the problem and changes the person's relationship to the experience. When the experience is framed as positive and growthful, the person may shift from viewing himself or herself as sick and evil to wounded, but healing. Third, transpersonal approaches emphasize the need for providing a sanctuary or container for people experiencing spiritual problems or emergencies. This can be as simple as evidencing an attitude of acceptance and sensitivity toward their

experiences in the therapy room or it may involve a short stay in a spiritual treatment or retreat center.

Fourth, often people experiencing spiritual crises are in need of *grounding*. This may involve changing one's diet to include heavier foods such as grains, meats, and potatoes and avoiding "light" foods such as raw fruit and vegetables. Grounding may also consist of exercises intended to reestablish connection to oneself and the world. This may include yoga, meditation, or long walks in nature. Other grounding methods include bodywork (massage, acupuncture, or body therapy), sleep, listening to music, and, occasionally, medication. Grof and Grof (1992) recommend that people experiencing intense spiritual emergencies temporarily discontinue active inner exploration and spiritual practices until they have regained a solid sense of themselves and being in the world. Finally, transpersonal approaches stress that therapy should be experiential. Therapy should provide a safe place for creative expression and exploration. This may include painting, drawing, dancing, breathing, or screaming. The use of symbol and metaphor can be useful in helping clients become centered and facilitate further growth.

As with most approaches to spiritual problems, transpersonal therapy lacks a substantive empirical basis for its treatment of spiritual concerns. In fact, some transpersonal theorists eschew empirical attempts at understanding spirituality. Most of the support for transpersonal approaches is found in case studies and anecdotal accounts. Intuitively, however, transpersonal approaches appear well suited for treating spiritual problems. Its strengths include recognizing and affirming spiritual experience and the role of spirituality in personal growth and healing. Moreover, transpersonal approaches

benefit from integrating wisdom found in religious and spiritual traditions. However, transpersonal approaches have their disadvantages as well. Framing spirituality in ineffable and transcendent ways may preclude rigorous and reasonable attempts at understanding the human spirit (Helminiak, 1996, 1998, 2001b). This may open the door for contradictory and whimsical views about life or psychotherapy that lack reasonable, empirical support. Great atrocities have been done in the name of religious and spiritual inspiration. What criteria should be used to evaluate spiritual truth claims if spirituality is based on supposed individual inner revelation and transcendent experience?

Furthermore, transpersonal approaches tend to emphasize Eastern spiritual traditions more than Western (Helminiak, 2001b). In other words, transpersonal theory is not purely pluralistic, but often submits its own view of spiritual reality. For example, transpersonal theory emphasizes that human beings are divine and there are many pathways to discovering this divinity within. This may be a problem for clients grounded within Western spiritual traditions who view human beings as creations of the Godhead, not gods themselves. For example, orthodox Muslims or Christians may be troubled by transpersonal therapists' view that there are many roads to the divine and that they are themselves gods. This may inhibit their openness about spiritual matters and/or their trust in the therapist. Furthermore, it may reflect insensitivity to the religious/spiritual beliefs and values of the client.

Helminiak's Human Core Approach to Spiritual Problems

In contrast to approaches that may overemphasize theological understanding (Richards & Bergin, 1997) or appeal to esoteric spiritual insight (transpersonal theories),

Helminiak (1996, 1998, 2001a) proposes a *nontheistic* approach that frames spirituality as an essential aspect inherent in the consciousness of human beings. Helminiak (2001a) acknowledges that secular psychotherapists risk overstepping the bounds of their professional competence if they address matters of religion (e.g., God, doctrinal concerns). Most psychotherapists are not accredited clergy or pastoral counselors who have knowledge and expertise in religious matters. Helminiak (2001a) argues that delineating the psychological aspects of spirituality from the religious or theological is required:

The solution proposed here is to understand spirituality as an inherent human phenomenon and, thus, proper to psychology, but a phenomenon, nonetheless, that may naturally open onto religious elaboration and questions about God. That is, spirituality is understood to be a common human core that runs through all religions and cultures and might be expressed in theist terms. A coherent understanding of this spiritual core can help psychotherapists discern, respect, nurture, and purify it in any of its many religious and theist expressions or apart from institutionalized religion and belief in God...At stake is the attempt to propose a coherent psychology of spirituality (pp. 165-166).

In Helminiak's view, spirituality is a legitimate focus for psychology and allows psychotherapists to address this core underlying the multitude of religious expressions. Helminiak begins by assuming that there exists a self-transcending dimension inherent in the human mind called the "human spirit." This dimension is an innate propulsion to become most fully oneself, the best one can be, and to transcend our current ways of being. It is characterized by our capacity for awe, wonder, inspiration, and marvel.

Furthermore, this view of spirituality is dynamically structured in the human mind (Lonergan, 1957, 1972). According to extensive analysis by Lonergan, spirituality is structured according to four foci—the *empirical* (awareness, openness to experience), *intelligent* (question our understanding, experience insight, formulate ideas and theories), *rational* (assess validity of arguments, make judgments, know reality), and *existential* (make choices, establish meanings, embrace values).

Based on this structure, Helminiak proposes “transcendental precepts” that govern the unfolding process of human spiritual development and dictate authentic living. The transcendental precepts include being attentive or aware, intelligent, reasonable, and responsible. Helminiak (2001a) contends that these precepts are inherent in the human mind and guide “what is true, right, good, and wholesome” (p. 168). Violating these precepts will result in becoming less human and self-destructive. By *authenticity*, Helminiak means living as much as possible according to these precepts and, thus, becoming a more complete human being. Helminiak admits that his view advocates for inherent normativity in human values that may conflict with current attempts at “neutrality” or “value-free” psychology. However, he claims that treatment of spirituality requires an appeal to what is truly good and wholesome for human development: “Until psychology addresses the big questions about the meaning of life and about the nature of the true and the good (not necessarily answers the questions but faces them openly and honestly as an unavoidable facet of human experience), psychology cannot pretend to deal with whole human beings, let alone with spirituality” (p. 171).

Following the approach outlined above, Helminiak (2001a) proposes three responses to clients' spiritual issues in psychotherapy. First, therapists may validate various aspects of clients' spirituality. Many religious precepts and practices encourage healthy living and spiritual development. For Helminiak, as long as beliefs and practices coincide with furthering authenticity (i.e., living according to the transcendental precepts) they should be supported and encouraged. Second, therapists may reinterpret aspects of clients' spirituality. For example, if a client uses prayer of petitions as a way of avoiding responsibility (one of the transcendental precepts), then it should be reinterpreted in a way that facilitates more authentic spiritual living. Reinterpretation can often be done using the religious framework of the individual. Third, and most controversial, Helminiak suggests that therapists may reject aspects of clients' spirituality. According to Helminiak (2001a), spiritual beliefs and practices that inhibit personal growth and integration and oppose the transcendental precepts should be rejected. Examples include satanic control and hexes to the extent they hinder personal responsibility, prohibitions against being angry with God which often reflects anger with life in general, and prohibitions against questioning which may prevent challenging religious authority or exploring inner experiences.

In defense of his approach, Helminiak (2001a) asserts that "once the core of spirituality is discerned and formulated normatively, a powerful tool is available. It not only allows the competent treatment of spiritual matters in secular psychotherapy, it also allows incisive criticism of spiritual matters that are attached to religion" (p. 180). As stated previously, Helminiak's approach is complex and nuanced and a review of his

writings would provide a fuller picture than is possible in this summary (see Helminiak 1996, 1998). However, his perspective provides a bold attempt at delineating the essential human core of spirituality that should be a legitimate focus in psychology and psychotherapy.

As can be expected, Helminiak's view is not without its criticisms. Slife & Richards (2001) challenge Helminiak's normative approach and claim that his values may conflict with those of many religious clients. They advocate for therapists becoming knowledgeable about the various systems of religious beliefs that clients present and treating problems within that framework. Watts (2001) interpreted Helminiak's position as rejecting the inclusion of clients' spiritual beliefs as a cultural variable, as one would consider racial issues. He advocates for increasing therapists' competency in working with clients from within their spiritual perspective and worldview. Finally, Marquis, Holden, and Warren (2001) criticize Helminiak's view as limited to the existential realm and not addressing the transpersonal.

Rationale for Present Study

The purpose of the present study was to generate substantive models for approaching, assessing, and conducting therapy with spiritual problems in psychotherapy. In other words, to explore the process of diagnosing and assessing spiritual problems, develop a philosophical approach and conceptualization strategy for working with spiritual issues, and delineate interventions and techniques used to work with spiritual problems. Considering the prevalence of religious and spiritual problems and the ethical obligation to competently address these concerns, it appears timely to begin investigation

into understanding and treating religious and spiritual problems in psychotherapy. Furthermore, the paucity of research on the treatment of spiritual problems and the complexity of psychological treatment for these concerns calls for a systematic research approach that provides depth and richness of understanding, involves inductive reasoning, and remains close to the lived experience of professionals in the field—i.e., a qualitative approach.

Psychotherapy is a particularly complex and dynamic phenomenon that is especially suited for qualitative investigation. Counseling psychologists have advocated for the legitimization and increased application of qualitative methodology for decades (Borgen, 1992; Hill & Gronsky, 1984; Polkinghorne, 1984). Given that spirituality is sacred, private, and complex as well, a qualitative approach is an important strategy for exploring these phenomena. The following were other considerations for using a qualitative approach for this study: to present a detailed view of diagnosis and treatment, to present an in-depth understanding of this topic, to examine the process of psychotherapy with religious/spiritual problems, and my desire to be an active learner rather than an “expert” on this topic (Creswell, 1998; Marshall & Rossman, 1999; Maxwell, 1996). Qualitative investigation allows other practitioners to evaluate and utilize the insights gleaned from experienced professionals with the intention of improving their clinical effectiveness and competence. It also provides theoretical models that can be applied and tested through empirical means.

Primary and Supporting Research Questions

Primary Research Questions: How do therapists philosophically approach and conceptualize spiritual problems and their treatment? How do therapists diagnose and assess spiritual problems in psychotherapy? What strategies and interventions do therapists use to work with spiritual problems in therapy?

Supporting Research Questions: How do therapists differentiate spiritual problems from psychopathology? What types of spiritual problems are typically encountered? How do therapists establish and maintain the therapeutic alliance when treating spiritual problems? What outcomes or results did they see from their work with spiritual problems? How do therapists' spiritual views and/or philosophy influence their work with spiritual problems? What have therapists learned about therapy from working with spiritual problems? What types of training have they received?

Chapter III. METHOD

Conceptual Map of the Study

Figure 1 (Appendix A) presents a conceptual map that provides an overview of the research questions and design for this study. The arrows illustrate that this study is a process in which each component influences the corresponding components. For example, in selecting the participants and conducting interviews, questions may arise about their experiences that were not previously considered. These new questions may modify the central research question, the subquestions, data analysis, and the research purpose. It is essential that the researcher remain flexible throughout the process allowing for such changes and insights as they occur (Marshall & Rossman, 1999).

Participants

Therapists

A purposeful sample of 12 psychotherapists experienced in working with religious/spiritual problems in psychotherapy was recruited. To obtain this sample, all therapists listed in the yellow pages of a large southeastern city (N = 90) were mailed a nomination form (Appendix B). On this form, each therapist was asked to identify five professionals with at least five years post-licensure experience to whom they would refer a client with religious or spiritual problems or who might be considered experienced in this area. Thirty-six therapists were nominated using this procedure of which 8 agreed to participate (3 women, 5 men). Four additional therapists (2 women, 2 men) were recruited in a mid-sized Midwestern town through a similar nomination procedure.

However, not all therapists in this community were mailed a nomination form. Instead, a convenience sample of 15 therapists in the community was asked to nominate therapists believed to be experienced in working with spiritual issues in therapy. From this procedure 11 therapists were nominated of whom 4 agreed to participate.

All nominated therapists were sent a letter (Appendix C) announcing that they had been nominated by colleagues, explaining the nature of the study, and requesting their participation. The letter also indicated that the interviewer may contact them by phone to inquire about their decision to participate. The letter emphasized the important nature of this study and the value that their experience and insight would provide in increasing our profession's understanding of religious/spiritual problems in psychotherapy. This includes providing other professionals who may be less experienced in this area with knowledge, understanding, and techniques whereby they may improve their treatment of religious/spiritual problems. All the therapists who participated expressed enthusiasm for the research topic and valued the importance of addressing spiritual concerns in psychotherapy.

The therapists ranged in age from 38 to 62 years ($M = 49.58$, $SD = 7.08$) with 12 to 30 years of clinical experience ($M = 21.25$, $SD = 6.12$). Ten of the therapists were White, one was Latino, one identified as Cajun as well as White, and one did not reveal this information. Eight of the therapists listed their partnership status as married or in a committed cohabitating relationship, three as single (two of whom identified as being gay), and one did not list this information. The therapists belonged to several different professions including eight psychologists, two clinical social workers, one licensed

professional counselor, and one licensed marriage and family therapist. In terms of theoretical orientation the therapists identified the following nonmutually exclusive influences: five therapists identified as psychodynamic, five as family systems, five as eclectic, two as holistic, three as phenomenological, one as constructive-developmental, and one as cognitive. Religious and spiritual affiliations included Buddhist, Unitarian, Episcopal, Presbyterian, Disciples of Christ, Christian, evangelical Christian, and Mennonite “with New Age, Pagan, and other added sensibilities.” Several therapists noted that they were inclusive of other religions regardless of their own religious affiliation. One participant described himself as a “refugee from fundamentalism” who is open to many forms of spiritual expression.

Judges, auditor, and interviewer

The role of the judges involved individually reading interview transcripts, coding domains and core ideas for emerging themes, cross analyzing cases, and collaborating with one another to reach consensus on each aspect of the process. The judges read transcripts, made margin notes, formed initial codes, and noted comments about the process of analysis. Then the judges conferred together to reach consensus about the emerging themes. The auditor’s role was to review the work of the judges, ensure that the team’s conclusions are explicit in the data, and provide constructive feedback.

For the vast majority of the time, the research team was able to reach consensus on the data. Care was taken to ensure that each team member’s voice and perspective was being represented. This was done through periodically checking in with the team to discuss how the analysis was being experienced by each member. Also, the team would

vary which member would initiate sharing their findings to minimize the tendency to avoid disagreement and give consent too easily. On very few occasions, consensus could not be reached on particular data units. Members expressed their frustration with the impasse and eventually agreed to suspend these data from further analysis.

Three members composed the judges and an additional member (the dissertation chair) served as the auditor. The judges consisted of the author, a Caucasian male doctoral candidate in counseling psychology; the second member, an African American female doctoral student in clinical psychology; and the third member, a Caucasian male clinical psychologist in private practice. Every attempt was made to recruit judges consisting of the following characteristics: diverse theoretical orientations and cultural and religious backgrounds, shared interest in religious and spiritual issues in psychotherapy, clinical experience, and the ability to collaborate and effectively resolve interpersonal conflicts. Judges were recruited through postings on university list serves and inquiries with personal acquaintances of the primary researcher who might take interest in this subject area. The primary researcher met to discuss the study with potential research members, explained the procedure, and the expected time commitment. All team members agreed to the guidelines and expressed interest in the topic and methodology. The auditor was a Caucasian male faculty member in counseling psychology at a large Mid-Atlantic university. The 4 members possessed 2-18 years of clinical experience. In terms of theoretical orientation, the primary author described himself as existential-humanistic and interpersonal, one member was cognitive-behavioral, another member was transpersonal and psychodynamic, and the auditor was

humanistic, interpersonal, and feminist. All the judges except the primary researcher were unfamiliar with the identity of the participants.

The primary researcher conducted the interviews to ensure consistency and depth in the interview process. Allowing the participants to construe their own meanings during interviews and following the interview protocol (Appendix E) was believed to limit subjective bias in the interview process.

Bracketing biases

Each judge recorded his or her familiarity, biases and expectations at the outset of the study with the intent of minimizing the influence of biases on the data analysis (a procedure known as *bracketing*). While acknowledging biases does not eliminate undue influence from occurring, it allows for increased consciousness and intentionality in managing bias. The research team spent the first meeting discussing these biases and expectations and agreeing together about ways to monitor their influence and hold one another accountable. At various points during the analysis, it would become evident that a member was arguing for agreement in ways obviously consistent with his or her point of view. If this viewpoint conflicted with the perspective of others, it would be acknowledged by the team and brought to the attention of the member. In almost every case, the member agreed that his or her perspective was influencing the process and would reevaluate his or her point of view based on this awareness. In some cases, a member would own his bias but maintain their perspective. Members consulted the data to resolve the disagreement. If this failed to bring consensus, then the data was suspended from further analysis. Fortunately for the team and the study, this happened very rarely.

In terms of familiarity with the literature, the primary researcher has published a study in the area as well as prepared an extensive literature review for this study. The second member had little familiarity with literature addressing spiritual problems prior to the study, but she had moderate knowledge of the spirituality and health literature. The third member was very familiar with literature pertaining to spirituality and psychotherapy, but unfamiliar with spiritual problems literature until this study. The auditor has published studies pertaining to spirituality and reviewed the literature review for this study in depth.

The researchers expressed both similar and dissimilar expectations and beliefs concerning therapy with spiritual problems. At the outset of the study, the primary researcher believed that work with spiritual problems will be more successful when the therapist is attuned to spirituality in him- or herself and others. He believed that work with spiritual problems requires an ecumenical stance and openness to mystical and transpersonal phenomenon (or at least the ability to suspend disbelief). He viewed the therapy process as spiritual in nature in that it is aimed at the healing and growth of another person and influenced by invisible, but nonetheless effectual processes that occur in the therapist, client, and in the space between them. He believed the pathologizing of spirituality was unnecessary and harmful. He also viewed many psychological problems as spiritual in nature. That is, many problems result from a lack of spiritual center to one's being or a wavering from one's spiritual path or calling. Spiritual problems also arise from rigidification of one's identity or way of being that does not recognize that human beings are a process of becoming and that life is a flow of constant change. It is

significant to note that during the course of this study the primary author encountered a spiritual crisis of his own. He experienced a complete collapse of his previously held spiritual beliefs and found himself in a state of perpetual doubt and disillusionment from which he has not fully recovered. While still valuing the power and effectiveness of spirituality in human experience, the author has significant doubts about the validity of supernatural phenomenon, an afterlife, or the necessity of a transcendent being or force guiding or participating in the universe. The author maintains an attitude of openness and acceptance of spiritual beliefs and phenomenon that is balanced by a more severe skepticism than he had previously known. In terms of this study, the author has struggled with his own spiritual problem, the abandonment of belief and severe doubt and despair, and yet maintains more than ever the belief that spirituality is a great asset, a powerful source of healing and growth, and can provide relief from existential despair.

In terms of expectations for this particular study, the primary researcher expected a high degree of sympathy for spiritual issues among the therapists selected for this study. He expected the therapists to value spirituality and be devoted to their personal spiritual development and open to transpersonal or supernatural explanation for human experiences and growth. He expected these therapists to possess a higher degree of professional development in working with spiritual issues in therapy compared with other professionals. He believed that most of the therapists would view therapy as a spiritual endeavor, guided by a transcendent force, and aimed at transforming the spiritual lives of clients. He also assumed that the therapists would generally refrain from pathologizing spiritual issues and rather view them as a natural part of human experience that could, in

fact, lead to further personal and spiritual development. He expected that the therapists' philosophical approach would be informed by their personal religious or spiritual beliefs. And that therapy would often consist of explicit religious/spiritual interventions such as prayer, meditation, or scripture.

The second judge believed that the treatment of spiritual problems by therapists will depend on two things: 1) personal beliefs or biases of the individual therapist and the 2) severity of the presenting spiritual problem. She expected that the personal beliefs of the therapists will determine whether they view spiritual experience as authentic. She believed that therapists who are open to spiritual reality will more likely refrain from pathologizing religious experience. Conversely, a therapist without personal spiritual experiences might be more prone to pathologizing spirituality. She also believed that even if one controlled for therapist bias, there would be differences in the treatment of spiritual problems depending on how severe and maladaptive the spiritual problems are as perceived to by the therapist. Thus, she assumed that even therapists who are sympathetic towards spirituality would view spiritual problems that cause severe social/behavioral or affective problems as more of a psychopathological and less of a spiritual condition.

The third judge adheres to a transpersonal perspective and thus believes that all therapeutic endeavors are spiritual in nature. He assumes that human beings are in different stages of spiritual development. Problems in living occur when people become stuck at a particular stage. Therapy can help provide insight, creativity and imagination to life's problems and lead to further spiritual development. He expected that therapists'

personal spiritual orientations would influence their approach, conceptualization, and interventions with spiritual problems. He believed the therapists in this sample would abhor the pathologizing of religion/spirituality, and if anything, err on the side of spiritualizing issues that may indeed be pathological. He anticipated conceptualization would include the transpersonal or spiritual nature of human beings and that interventions might include techniques of an explicitly spiritual character.

The auditor believes that many therapists are skeptical about spiritual phenomena because they are not readily explained within therapists' cognitive schemas, knowledge bases, and worldviews. He also believes that many therapists possess negative attitudes toward religion. He further asserts that a good number of therapists are not well educated about working with religious/spiritual issues in therapy, and have a bias toward interpreting religious/spiritual phenomena as indicative of pathology. Finally, he did not expect the therapists who participated in this study to reflect this widespread bias by virtue of the recruitment procedure that was used.

Measures

Demographic Form

Those who agreed to participate completed a demographic form that asked for some basic information: degree and year received, years of pre- and post-licensure experience, age, sex, partnership status, race/ethnicity, theoretical orientation, and religious/spiritual orientation. (Appendix D). The form also asked participants to indicate name, address, phone number, email, and convenient times to be contacted by phone.

Interview Protocol Development and Procedure

Based on the recommendation from Hill et al. (1997), the interview questions were provided in advance to encourage thoughtfulness and recollection of a significant case or cases. Once consent was obtained, those who have agreed to participate were mailed the interview questions (Appendix E). The questions were developed through conscious consideration of the empirical and theoretical literature and every effort was made to avoid implying a theoretical bias in the wording. The questions were reviewed and approved by the auditor and the dissertation committee. The interview protocol defined religious and spiritual problems and included the DSM-IV description.

The interview questions were sent to participants one to two weeks in advance of their interview date, and were presented as a cue to help participants construct a narrative account of the treatment of a religious/spiritual problem. The primary researcher conducted all the interviews in person. The purpose of the interviews was to gather information about therapists' experience working with spiritual problems in therapy including assessment, philosophical approach, interventions and strategies used, and training received. The interviews consisted of one face-to-face 45-60 minute interview followed by an optional 15-30 minute phone or in-person interview to clarify responses and seek elaboration, if needed. During each interview, information was recorded through audiotape recorders, information protocols, post-interview notes, and memoing. As well, the interviewer recorded thoughts, reactions, and important points discussed. Immediately following each interview, the interviewer recorded reactions, comments, and future questions for follow up interviews.

Participants were given opportunities in the follow-up interview or through reviewing transcripts to modify or elaborate information they have provided. However, none of the participants responded or asked to modify any of the material. The primary researcher transcribed two interviews to gain the experience of transcribing and to obtain a more comprehensive “feel” for the data. Professional transcriptionists transcribed the remaining interviews verbatim from the audio recordings.

Given the sensitive and personal nature of the topic and method of study, several data collection issues were considered. First, the interviewer respected the participants’ time. Interviews took place at a time and location that was convenient for the participants (e.g., office, home, etc.). The interviewer also respected the time limits set for the interview. Second, the primary researcher conducted a pilot interview with the information protocol designed for this study to promote efficient and effective interviewing. Third, confidentiality of the participants was protected through the use of code numbers in place of names on transcripts, audiotapes, and memos. The participants were professionals and took precautions themselves to protect the confidentiality of any clients they discussed. If clients’ or therapists’ names were mentioned they were deleted from the transcripts. Participants were also informed that they can withdraw from the study at any time and for any reason.

Procedures for Analyzing Data

A Consensual Qualitative Research (CQR; Hill, Thompson, & Nutt Williams, 1997) method was utilized to address the research questions raised in the previous chapter. In CQR, Hill et al. developed a qualitative methodology that combines features

found in other approaches in a unique way. For example, Hill et al. use *grounded theory* (Strauss & Corbin, 1998) as the basis for developing substantive models from the data. In this approach, researchers frequently compare the emerging themes and categories with the original data until core ideas are established. They combine this with phenomenological and feminist approaches that emphasize an understanding of the context from which data emerges and reaching consensus on emerging themes through open and collaborative dialogue.

The central features of CQR include using a team of researchers to analyze the data, the process of reaching consensus, and systematically examining the representativeness of results across cases. Qualitative research emphasizes in-depth exploration and description of complex phenomenon, which can be particularly useful in the study of relatively unexplored areas (Hill et al., 1997; Maxwell, 1996; Miles & Huberman, 1994; Strauss & Corbin, 1998). Qualitative research is well suited for understanding the meaning, process, and context of phenomenon, identifying unexpected phenomenon, generating theory, and developing causal explanations (Maxwell, 1996). Essentially, qualitative research seeks to understand the nature of phenomena in its natural setting through active, collaborative, and inductive investigation.

The following eight key components constitute the CQR method (Hill et al., pp. 522-523):

1. Data are gathered using open-ended questions in order not to constrain the responses of the participants.
2. The method relies on words to describe phenomena rather than using numbers.

3. A small number of cases are studied intensively.
4. The context of the whole case is used to understand the specific parts of the experience.
5. The process is inductive, with conclusions being built from the data rather than imposing and testing an a priori structure or theory.
6. All judgments are made by a primary team of three to five researchers so that a variety of opinions are available about each decision. Consensus is used so that the best possible construction is developed for all the data.
7. One or two auditors are used to check the consensus judgments to ensure that the primary team does not overlook important data.
8. The primary team continually goes back to the raw data to make sure that their results and conclusions are accurate and based on the data.

The CQR method consists of three general steps (Hill et al., p. 523):

1. Responses to open-ended questions from questionnaires or interviews for each individual case are divided into domains (i.e., topic areas).
2. Core ideas (i.e., abstracts or brief summaries) are constructed for all the material within each domain for each individual case.
3. A cross analysis, which involves developing categories to describe consistencies in the core ideas within domains across cases, is conducted.

The CQR method used for this study allowed the participants' experiences to inform and guide the development of a substantive theory for psychotherapy with religious and spiritual problems in psychotherapy. CQR falls within the traditions of Strauss and

Corbin's (1998) grounded theory, comprehensive process analysis (Elliot, 1993), phenomenological approaches (Giorgi, 1985), and feminist theories (e.g., Fine, 1992). Therefore, the method places a premium on allowing themes to emerge from the data through the use of an iterative approach; using consensus teams and comparing data across cases; attending to the context of the participants and researchers; and reaching consensus through open dialogue and shared power (Hill et al., 1997).

Data Management

Data managing consisted of creating and organizing files for the data. This included transcripts, index cards, memos, and computer files (Microsoft Word). Data were frequently backed up using photocopies, multiple hard copies, zip drives, and floppy disks.

Data Analysis

The overall process of data analysis in CQR is most influenced by *grounded theory* (Strauss & Corbin, 1998). Grounded theory is a qualitative approach that attempts to generate or discover a theory that is "grounded" in the data. In other words, general themes emerge within an inductive, dialectic process with data that is systematically gathered and analyzed throughout the research process. This is accomplished through collecting interview data, attempting to develop and interrelate categories of information, and writing a substantive or context-specific theory or set of theories.

Coding of Domains

Each judge read the first five transcripts in their entirety. The remaining seven transcripts were split between the judges. The primary researcher read through and coded all the transcripts while the remaining two members coded approximately 6 a piece. After reading through the transcripts each member independently generated overarching domains that comprised all the data they had read. Each block of data (phrase, sentence, or paragraph related to same topic area) was assigned at least one domain. The members were initially given the option of using a “start list” of domains rationally developed from the content of the interview questions as recommended by Miles and Huberman (1994) and Hill et al. (1997). The start list for this study included the following domains: Client Description/Background, Spiritual Problem/Concern, Assessment/Diagnosis, Conceptualization, Approach, Treatment, Therapist Development, and Training.

Domains evolved through several revisions during the process of data analysis and team discussions about emerging themes. Once the domains were established, the cases that had been initially coded were reexamined and modified to be consistent with the final domain list. After individually coding the first transcript, the judges met to discuss and arrive at consensus regarding the coding of domains. Following the achievement of domain consensus for the first transcript, the entire team coded four more transcripts in the same manner. This was to ensure clarity on the range of the domains. The remaining cases were split between team members with the primary researcher coding every transcript. The primary researcher created a consensus version of the transcripts from the domain titles and excerpts from interviews. This consisted of

integrating the findings from the judges into an abstract or summary version. The following eight domains were identified (see Table 1 for description): Client Description, Assessment of Spiritual Problem, Therapist Approach/Philosophy, Therapy Process, Therapy Outcomes, Therapy Impact on Therapist, Therapist Religious/Spiritual Background, and Therapist Training.

Coding of Core Ideas

The judges individually summarized the content of each domain for each transcript. This involved abstracting the *core ideas* or essence from the meaning units in each domain. Hill et al. (1997) made several recommendations for constructing core ideas. First, members need to consider the overall context of the case when developing the core ideas for each domain. The context is instrumental in shaping individual domains and, thus, the core ideas within domains. Second, members should summarize the content of each domain with the focus of that domain in mind. Core ideas should not be constructed in a vacuum removed from the overall context of the case or the specific domain. Third, the judges should attempt to remain as close as possible to the participant's meaning. Inferences and theoretical concepts were to be kept to a minimum and only the explicit meaning should be gleaned. The judges should remain especially vigilant to the influence of their expectations and biases at this point in the process. To minimize the role of personal bias, team members recorded their expectations and reactions during the process of constructing core ideas.

The entire team met to discuss the first two cases and reach consensus about the core ideas. After the first two transcripts, teams of two, with the primary researcher

coding every case, coded the transcripts. In the event of disagreements, the judges returned to the transcripts to discuss their ideas until they reached consensus. The primary researcher created a consensus version of the core ideas in the form of a short abstract. The team gave the cases to the auditor who provided feedback about domains and core ideas.

Cross Analysis

After analysis of the individual cases, the team moved into *cross analysis*. In this discovery oriented process, the team examined the core ideas for each domain across cases to determine *categories*—i.e., similar themes among the cases in the sample. This involves each member examining all the cases and abstracting larger themes. For each domain, the primary researcher grouped all of the core ideas from each case together. Team members then independently developed categories into which the core ideas fit. The team discussed the wording and content of categories until consensus was reached. Every effort was made to develop categories that are consistent with the data. Core ideas were assigned to multiple categories within and across cases and were revised in the process. Categories and domains were continually revised until the judges agreed that the data were well represented.

Auditing

Although the consensual process helps minimize individual bias, the team remains susceptible to the influence of individual members and lapses in the level of scrutiny given to individual cases. Therefore, an auditor serves the important role of

validity check and alternative perspective for the team. The auditor read through all the raw data in each domain and determined whether (a) the raw data fit the domain, (b) the core ideas comprehensively included important material from the domains, and (c) the core ideas were worded succinctly and accurately (Hill et al., 1997). The auditor's comments were returned to the team, who met to consider whether to accept or reject any changes. This revised consensus version and the original feedback were returned to the auditor. The auditor then had the opportunity to argue for any recommended changes that were rejected. After completion of the cross-analysis, the auditor reviewed the findings and provided feedback on the wording and level of abstraction of the categories. The team considered the auditor's suggestions and discussed these ideas with the auditor until consensus was achieved. The final version of categories and corresponding core ideas can be found in Appendix F.

Stability Check

After the initial cross-analysis was complete, the remaining two cases (temporarily omitted in the initial cross-analysis) were added back in to determine whether the designations of "general," "typical," and "variant" had changed. The team also used the cases to decide whether new categories were warranted to accommodate the new cases. The remaining cases did not alter the results substantially, thus the analysis results were considered stable. In all eight domains, only three domains had changes. Among these three domains only six total changes were made (out of 104 categories) in terms of their representativeness. No categories were added, altered, or deleted based on the two additional cases. The team attempted to determine the representativeness of the

sample through examining the frequency of categories across cases. Categories were labeled *general* if they applied to all cases, *typical* if they applied to half or more, and *variant* if they applied to fewer than half but at least two cases. Tables 2 through 7 contain summaries of findings from the cross analysis.

Chapter IV. RESULTS

Results are structured on a domain by domain basis beginning with pre-therapy variables (Client Description, Therapist Religious/Spiritual Background and Beliefs, Therapist Training, Therapist Approach/Philosophy), moving to therapy variables (Assessment of Spiritual Problems, Therapy Process), and finally post-therapy variables (Therapy Outcomes, Therapy Impact on Therapist). Within each domain, the themes that emerged (i.e., categories) are presented beginning with those categories that are general or typical of the sample followed by those categories that are variant. In the last section, narrative summaries are presented for each of the cases.

Client Description

We identified four primary categories within the client description domain, which are presented in the following order: demographics, therapy concerns, personal attributes, and background. All of the categories and subcategories are listed in Table 2. All the categories and corresponding core ideas are listed in Appendix F.

Demographics

We divided this primary category into four subcategories: age, ethnicity, and sex; educational experience; family characteristics; and employment and/or professional experience. Typically, therapists reported the age, ethnicity, and/or sex of the clients. Clients ranged in age from 20 to mid-40s. Most therapists did not identify the ethnicity of clients, but the ones that were reported were White. There were an approximately equal number of male and female clients reported.

The second category, educational experience, entailed the education and training clients had received. Eight clinicians indicated their clients' educational experience. One therapist worked with a client who was mentally challenged and had completed high school. "She is mentally challenged, not too bad but she is on disability for it... She says it's a learning disability but she is a little slow. Just a little bit slow. Can be easily taken advantage of..." Other educational experiences reported included college educations, graduate degrees in seminary and psychology, and personal training in theology and ministry by the client's local bishop. For example, one therapist reported a client who "has a master's degree from a seminary...also has a PhD in Religion and Psychology."

Typically, therapists indicated their clients' family characteristics. We divided this category into two subcategories: relationship status and children. Six therapists reported that their clients were married. A few therapists indicated that their clients were involved in extramarital relationships and a few were involved with same-sex relationships. Five therapists reported that their clients had children, from one to three children. The fourth category of demographics entailed employment and/or professional experience. Practitioners typically reported their clients' professional experience. For example, a few clients were teachers or instructors, one worked in the arts, one was a minister, one a surgeon, one was in sales, and another belonged to a religious order.

Therapy Concerns

We grouped therapy concerns into three categories: relationship conflict, sexual orientation or gender, and other mental health concerns. Therapists typically reported that

their clients had concomitant relationship conflicts. We divided this category into three subcategories: general conflict, sex, and anger. Several therapists indicated that their clients presented with general conflict with marital or romantic partners. One client felt abandoned by her husband and wanted a divorce. Another client had been recently shunned by her female lover. Therapists variantly indicated that the relationship conflict centered on sexual issues. For instance, one client suffered from a sexual dysfunction that required surgery and created tension between her and her husband: "Sex was very painful when they began to introduce that into the relationship because of some physical problem. I don't remember what it was, but it was a problem that required an operation. And every time she had sex it was just excruciatingly painful to her. So it made her incompetent as a sexual partner and it was very frustrating to him. Years and years of his impatience with that and not understanding that, being put upon by that...her feeling abandoned by him and not understood...how hard she was trying with him and how much this hurt." Another client reported having a harmful sexual relationship with her pastoral counselor. Finally, two clinicians reported that their clients experienced debilitating anger toward their partners.

Variantly, therapists reported that clients had concerns around sexual orientation or gender. For example, one client, who was Baha'i, began to discover that she was a lesbian when she was 28-years-old and faced expulsion from her church: "But the major issue that has recently taken place is that she's decided that she, well first she said that she was bi-sexual. And now, she's deciding that she's not bi-sexual, she's lesbian. And so has been experimenting with a lot of different relationships...But that is really against

the Baha'i religion." Another client experienced ambivalence, shame, and confusion about his sexual attraction to men: "Well he was raised in the Baptist Church, Southern Baptist, and thought he was going to hell and he really wrestled with this for, oh, eight or ten months, I guess. 'Am I gay? No, I don't want to be that!' he knew it was wrong and bad wicked and sinful and wanting to change, praying to God that he be shown a way to change from being - from having homosexual impulses and attractions." A third client had experienced confusion since childhood about her gender preferences.

Therapists typically noted a variety of other concerns reported by their clients. We divided this category into four subcategories: substance abuse, depression/anxiety, social status or respectability, and miscellaneous. Two clients received treatment for substance abuse. Four clients experienced significant depression or anxiety during the course of therapy. Three clients worried how they might suffer shame or humiliation in view of their peers or social groups because of their problems. Clients also reported such concerns as abandonment, identity, self-esteem, unexpected pregnancy, overwhelming expectations from family, and autonomy.

Personal Attributes

We grouped this primary category into two subcategories: personal characteristics and religious/spiritual beliefs or practices. We divided the first category, personal characteristics into two subcategories: positive and negative. Therapists noted several impressions and observations about clients' personalities. On the positive side, therapists found clients bright, attractive, mentally stable, amicable, powerful, vulnerable, strong,

creative, caring, and fun. On the negative side, therapists variantly noted that some clients were mistrustful, antisocial, hostile, mentally challenged, and naïve.

Clinicians typically reported clients' religious/spiritual beliefs or practices. This category referred to clients' religious involvement. One therapist stated that his client was deeply religious and active in her church. Another therapist's client found support in a gay affirming church. Two therapists noted that their clients were uninvolved in their religious faith when they entered therapy. One client was active in a religious order: "She was living separately [from her husband]...she was part of an order in New York and would visit the Mother House periodically, but kept her disciplines. She was in seminary across from the church..."

Background

We grouped this category into two subcategories: family background and religious/spiritual background. Therapists typically indicated information about the client's family background. We divided this category into two subcategories: family members and childhood. Family members included information about client's parents and siblings. Some therapists noted the relationship clients had with their parents. For example, one client's mother did not realize the pressure she was placing on her daughter. Another client constantly sought the approval of his parents. Another client's mother died during the course of therapy. Practitioners variantly reported information about clients' childhood. For instance, one therapist noted that his client was raised in a secular family that rarely emphasized spirituality. Another client experienced repeated abandonment and was sexually abused as a child.

Therapists typically indicated information about clients' religious/spiritual background or history. This included religious education, religious affiliation, spiritual journeys, and other characteristics of the client's early religious life. For example, one client was Baha'i and received a very strong moral foundation as a child: "...But what I'm seeing in her is that she's a pretty spiritual person. She is understanding her values and I'm sure it's because she's been a Baha'i all her life... She had a good foundation so when she sees somebody that swears or smokes or drinks, she knows that those values are not her values and she really doesn't want to have a relationship [with them.]" Other clients were raised in various churches such as Christian Science, Catholic, Baptist, and evangelical. Some clients were raised with very little religious influence at all.

Therapist Religious/Spiritual Background and Beliefs

We divided this domain into six categories: religious affiliation (general), spiritual worldview (typical), religious/spiritual background (typical), spiritual journey/change in beliefs (variant), beliefs about people (variant), and how spirituality affects therapy process (variant). All of the categories and subcategories are listed in Table 3. All the categories and corresponding core ideas are listed in Appendix F.

The first category, religious affiliation, was derived from the interviews and the demographic form filled out by the participants (see Methods section). Some therapists identified with multiple spiritual orientations. Nine therapists identified as Christian, two as Unitarian, three were influenced by Buddhism, three were evangelical Christian, one was Episcopal, two were Presbyterian, one was Mennonite, and one was a "refugee from fundamentalism." One therapist, for example, found that being Unitarian provided a

helpful perspective in appreciating the good and truth found in all religions and spiritual paths. Another noted that he was a Christian who could think and conceptualize theologically. A third considered himself a Christian, but not of the “born again” variety.

Therapists typically reported aspects of their spiritual worldview during the interview. As an example, one clinician commented on the messages he learned from spiritual hymns: “I think also from my religious background there is, I’m not even sure where this comes from. It almost like came from the singing instead of the preaching, you know, a sense of wonder and a sense of joy and a sense of benevolence and grace and community and the possibility of growth and change, love and paradise and joy.”

Another therapist shared that life is about the presence of God. A third therapist believed that following God’s plan for one’s life leads to joy and peace, while disobedience leads to discontentment.

The third typical category, religious/spiritual background, involved a brief history of some of the therapists’ religious lives. For instance, one therapist was raised in a fundamentalist church where he learned about how powerful and all-encompassing religion can be. Another therapist’s parents were missionaries. He remembered having many positive early religious experiences: “I mean I grew up in a Christian home and my grandfather was a missionary. My father is a minister and so I grew up with that. I grew up thinking that we were about helping people.” A third therapist was raised Catholic, but learned from her mother that religion is an internal and personal affair. She took solace in this belief after she divorced and could no longer participate in the sacraments.

Therapists variantly described their spiritual journeys. For example, one therapist recalled how he moved from conservative Protestantism to Buddhism and the Unitarian fellowship later in his life. He remembered beginning to question his religious beliefs while in college and eventually traveled all over the world learning from spiritual sages. Another therapist described how he grew up a devout Christian, but became an atheist later in life: "I've gone through my own developmental history how it's changed and my own beliefs in God have changed a great deal...I've gone through my own questioning about whether God exists and whether I even believe in God and in Christianity and those sorts of things, and periods of time where I took a very much more agnostic view of things. And I remember how that was a crisis in my life, me saying that you know questioning things I believed when I was younger and saying that may not be true was an emotional and spiritual crisis for me." A third practitioner began her life as a nonbeliever. Later in life, she discovered religion and joined a Pentecostal church, then she pursued Catholicism, and finally, she became an evangelical Christian.

The fifth category, beliefs about people, entailed therapists' views on human beings and other therapists. As an example, one therapist believes that most master therapists are highly spiritually developed and informed people. Another clinician believes that many secular (non-Christian) therapists lack moral integrity. A third therapist views all people as possessing inherent worth and value. Two therapists noted that all people are wounded and in need of healing and this healing takes place through our woundedness.

The sixth category, how spirituality affects therapy process, was divided into two subcategories: helpful and harmful. Four therapists viewed spirituality as a help to therapy. For instance, one therapist believed his spiritual experiences helped him understand and empathize with his client's struggle with leaving the pastorate. He also believed his spirituality allowed him to appreciate and respect client's spiritual beliefs. Another therapist attributed her ability to be empathic, confident, and patient with her client to their similar spiritual beliefs. Clinicians also recognized how spirituality might be harmful to therapy. One therapist noted that the boundary between pathology and religious faith was very thin for her client. Another therapist viewed spiritual beliefs outside of Christianity as foundationless and potentially harmful to clients. Finally, a third therapist viewed the often religiously-backed reparative therapy for sexual orientation as harmful.

Therapist Training

We grouped this domain into six categories: spiritual influences (typical), graduate programs or courses (typical), personal experiences and religious background (variant), professional or work experiences (variant), relationships (variant), and attitudes about training (variant). All of the categories and subcategories are listed in Table 3. All the categories and corresponding core ideas are listed in Appendix F.

Therapists typically reported spiritual influences that developed their work with spiritual problems. We divided this category into two subcategories: personal (typical) and workshops/institutes (variant). As an example, one therapist included his personal study of Jung and Buddhism as significant influences. Another therapist noted her

personal study of the Bible as a rich source of truth, peace, and guidance for working with spiritual problems. She noted, “The Bible is a life-changing book, and life-sustaining. I have never read anything else that had the potential to bring peace and change my heart like the Bible can.” Practitioners also mentioned the personal study of James Fowler, Kohlberg, M. Scott Peck, Carlos Castenada, and Thich Nhat Hanh as influences. Five therapists indicated attending workshops or institutes such as through the American Academy of Psychotherapy, American Marriage and Family Therapy conferences, and Unitarian general assembly.

Therapists also typically indicated being trained through graduate programs and coursework, though most of these did not occur in psychology training programs. For example, several therapists reported attending seminary or religious colleges where they gained a solid foundation in spiritual issues. One therapist reported, “When I went to graduate school I got a masters degree in theology and so I had a great course on the psychology of religion that’s still the foundation now that I think about it.” Another therapist received training in spiritual issues as an intern and postdoctorate fellow at Biola University’s graduate program in psychology, which emphasizes the integration of spirituality and psychology. He commented, “I went to Rosemead and I remember thinking of, ‘why am I going here? [God has] prepared me all my life to be in secular places...’ but, those were four years of being immersed with people who had a lifetime career of integrating psychology and theology. And, you know, it was four years of incredible training, workshops, so to speak...in vivo kind of things...” A third clinician reported taking courses in Jungian therapy while in graduate school: “In graduate school I

took several courses in Jungian psychology and went into my own psychotherapy, with several different therapists, one of whom was a Jungian, and would tape record my dreams and go to her and talk about my dreams.”

Variantly, therapists felt prepared for work with spiritual problems through their personal experiences and religious background. As an example, one therapist felt his spiritual journey from conservative Christianity to Buddhism and Unitarianism prepared him well for working with many different spiritual problems. Another clinician believed her experience in Bible study groups through her church trained her to work with spiritual issues. A third therapist indicated that her training in the Unitarian church about understanding spirituality helped equip her for working with spiritual problems. She reported, “And then when I became a Unitarian, the first thing I did is they offered understanding a program of like say 6 weeks or something. ‘Understanding your own spirituality.’ So I went there and it was like the best experience that I ever had because I sat there in a room full of, say 20 people, and we all discussed our spirituality. And it wasn’t a secret, everybody was open and [our spiritualities] were all different. You’re not supposed to talk about that kind of stuff but here we are in this room and we did this for like 6 weeks or so. It was a great experience and it like solidified my spiritual program.”

Therapists also variantly reported being trained through their relationships with certain people in their lives. For example, one therapist credited his relationship with a Trappist monk as helpful to his work with spiritual problems. He also stressed the importance of his ongoing supervision and consultation with fellow therapists. As he put it, “I’ve had some wonderful personal therapists—I’ve been seeing _____ now for 10

years, it's just wonderful. And I've just seen a lot of other psychotherapists in the last 28 years. Also, the supervision that I've gotten. And so both that kind of supervision (and there has been lots of peer supervision groups that have gone on for 6, 7, 8 years) where every week we meet for an hour and a half or two hours and we take turns talking about cases. And so I think that one learns the discipline through the combination of personal psychotherapy and supervision of peers." Another therapist benefited from his spouse's theological training. He learned about the numerous issues that confront theological students as they progress through their programs. He also learned about a number of significant theological issues that clients often struggle with.

A fifth category of therapist training involved therapists' professional or work experiences. Several clinicians reported the training they received through preparing for and presenting on spiritual issues to colleagues and students. Others noted they gained experience in working with spiritual problems from their clients over their years of practice. Finally, therapists variably reported their attitudes about training on spiritual problems. One therapist, for instance, proclaimed that it is not graduate school's role or responsibility to teach faith to students. He felt that belonged in the jurisdiction of religious organizations and institutions. Another therapist expressed surprise by the lack of knowledge many therapists have about their clients' spiritual lives.

Therapist Approach/Philosophy

One of the major questions for this study was how do therapists approach spiritual problems in therapy philosophically or conceptually. Within this domain, two primary categories emerged which encompassed the whole of the data: religious/spiritual

approaches (included 13 categories) and general approaches (included 6 categories). The former referred to an approach or philosophy that contained reference to spirituality. The latter referred to general approaches used by therapists that did not inherently possess religious/spiritual dimensions. Findings within the religious/spiritual approach category are reported first followed by the nonreligious/spiritual approach category. All of the categories and subcategories are listed in Table 4. All the categories and corresponding core ideas are listed in Appendix F.

Religious/Spiritual Approaches

Among the clinicians, three categories were typical. First, therapists typically described their therapeutic approach as having emphasized spiritual and personal transformation within their clients. For example, several therapists attempted to ally with clients' growth impulses and focus on stimulating spiritual development. As one therapist stated, "Generally, I think of people's religious beliefs as originating in and sustained by a yearning and longing for something that is better than what they presently have. And in that sense, I really want to enlist that yearning and longing." Another therapist desired to help clients expand their way of being in the world when their current life patterns are limiting. A third practitioner reported attempting to help clients develop a "nonjudging muscle" through assimilating the Buddhist concepts of nonjudgment and mindfulness into their daily lives.

Secondly, therapists typically reported a fundamental valuing of spirituality and human experience. Therapists approached therapy with the attitude that spirituality is important, indeed, essential for growth and healing. As one therapist put it, "what helps

me is the perception that...pretty much we are spiritual beings and, therefore, everything we do impacts and is impacted by our spiritual identity or spiritual sense of who we are, what we are, and where we are going.” Another therapist emphasized his curiosity in clients’ spirituality and his belief that life contained wonder, joy, love, and possibility for change. Several therapists viewed religious faith and spirituality as an asset for clients. One in particular commented that he thoroughly enjoyed working with clients who possessed a strong faith.

Therapists typically indicated adhering to a pluralist or ecumenical spiritual perspective. This referred to an appreciation for many paths to truth and/or God and that no path is necessarily more valid than another is. It also referred to therapists who appreciated multiple spiritualities and worked not to impose their beliefs onto their clients. An ecumenical approach identifies the common ground among spiritualities and utilizes those factors which contribute to the health and well-being of their clients. For example, one therapist indicated that his current religious affiliation (i.e., Unitarian) provided a helpful perspective in appreciating the good and truth found in all religions and spiritual paths. A second clinician stressed that his approach was nonjudgmental. He did not try to convert others to his particular religion, thus, many people from various religious groups sought out his services. A third therapist, also a Unitarian, attempted to discover where her client was spiritually and work from there. She made every effort not to impose her own beliefs, even inclusivist ones, onto her client.

The remaining themes found within the overarching religious/spiritual approach category occurred variably. In contrast to the primary author’s expectations, only four

therapists described their approach to therapy as a spiritual or divine encounter. Each of these therapists expressed sensing or believing that God or a spiritual force was working through them in their therapeutic relationships. One therapist reported believing that there is a divine reason for each encounter he has with clients. Another therapist believed that God was working through him to love and help his clients. A third therapist believed he was a channel for God's love to flow through to clients.

A fifth category of religious/spiritual approaches involved therapists' personal spiritual experiences informing their approach to therapy. Clinicians explicitly acknowledged their own spiritual experiences as having significant influence on their work with spiritual problems in these instances. One therapist, for example, stated, "I think I have more confidence around the spiritual issues because they're so familiar to me personally. I think I've been more patient because of...just knowing that my own process took so long and it's ongoing and [the client's] will be too." Another therapist recognized that his personal experiences with his own spiritual development greatly influenced his adherence to a developmental perspective.

In a sixth category, therapists variably reported that they viewed many problems encountered in therapy as spiritual problems. As an example, one therapist viewed concerns such as hope, trust, acceptance, and values as implicitly spiritual issues. Another therapist used the common therapeutic issue of depression as an example. He maintained that depression is a way for the body or soul to preserve energy and cope with the demands of life. Thus, depression is as much a spiritual problem as a physical or chemical one.

Therapists variantly adhered to a Buddhist, Eastern, or New Age philosophy in regards to therapy. A couple of therapists reported emphasizing the Buddhist concepts of nonjudgment and mindfulness, while another described being influenced by Carlos Castaneda, early Christian mystics, Eastern religions, Thich Nhat Hanh, and Dorothy Beck. Therapists also variantly acknowledged taking a Christian theological or philosophical position when approaching spiritual problems. One therapist, for instance, believed that all people are spiritual beings in need of a relationship with God. He viewed the figure of Jesus as the bridge between humanity and God. A second therapist believed that human beings needed to accept God's grace and forgiveness and to follow God's will for their lives to find peace. Another therapist expressed resonance with the Christian view that all people are wounded and in need of healing through God.

In a ninth category, a few therapists acknowledged being influenced by Jungian or other spiritually informed psychologists such as M. Scott Peck, Fowler, and Kohlberg in their approach to working with spiritual problems. Therapists variantly reported that they approached spiritual problems in therapy through working within clients' religious/spiritual beliefs or traditions. One therapist indicated using a client's own religious tradition to facilitate change. In this case, he used the client's own theology about grace and forgiveness to help her accept her frailty and humanity. Another therapist reported using more specifically religious terminology when working with Christians.

An eleventh category of religious/spiritual approaches involved therapists' emphasis on the creation of meaning or search for truth. As one therapist put it, "Spirituality I see more as how does a person value themselves, how do they value

others, how they make meaning out of their own experience which is really what psychotherapy is about—which is to me that spiritual issue, you know it's spirituality, it's how do you make meaning, basically.”

Another variant religious/spiritual approach taken was to define spirituality as relationship. For instance, one therapist believed that because we are spiritual beings we are necessarily relational beings as God is in relationship with creation and the created are in relationship with one another. A final variant category of religious/spiritual approach involved adherence to the wounded healer conception of therapy. In this approach, all human beings are viewed as wounded or damaged in some way, yet it is precisely these wounds that empower one to heal, grow, and help others. One therapist succinctly described this approach as follows, “...by His wounds we are healed, by our wounds we heal others.”

General Approaches

Within this primary category, there were six categories—three typical and three variant among the therapists. Therapists typically approached spiritual problems from a phenomenological perspective. A phenomenological approach emphasizes the suspension of preconceived theories and assumptions about the client and a reliance on the inner, subjective, or lived experience of the client. In this approach, clinicians place a premium on trusting the client's organismic growth impulses and following their process in therapy. It has its roots in the philosophies of Husserl, Heidegger, and Gadamer and in the psychologies of Carl Rogers, Rollo May, and Fritz Perls. One therapist, for example, gave a poignant description:

I think that conceptual frameworks are in the back seat and the front seat is my felt experience of this person, and that guides my interventions more than conceptual frameworks. I don't want to travel without conceptual frameworks because there are times when I can be sort of inducted into an emotional space with my client where I am of no good. I can be sort of inducted into their world and now I've gone too far into the emotions and I need to get back out, and that's where conceptual frameworks can be really useful. They are like a safety net, or more like a belay rope, where if I get in too far, I'm anchored up above and I can pull myself back out and say, "What am I doing here?" "Why am I doing this?" "What's needed to be done?" and "What's the next step?" But I don't mainly go by that. I mean, I don't mainly have something like that in my mind when I start a session or start working with somebody. I'm trying more to pay attention to the phenomenology of their internal world and then the interpersonal world between the two of them and my internal world.

As seen from this example, the therapist relies on his internal experience and intuition to understand the internal experience of the client. Another therapist maintained that the exploration and description of one's experience is, in itself, healing. In his words, exploring one's experience of the world opens up a new perspective or "the image that comes is of a nice spring day...so we raise the blinds and raise all the windows and open the doors and let some fresh air in."

Typically, therapists also approached spiritual problems from a developmental perspective. This involves viewing spiritual and psychological development as occurring

in stages or as unfolding across the lifespan. Often this includes the view that problems occur when one's development is arrested or stuck at a particular stage along life's way. For instance, one therapist reported believing that people are in a process of becoming and pain is an invitation to grow. A couple of therapists utilized an object relations perspective which views psychological development occurring through phases as we relate initially to early caregivers and later to other significant people in our lives. These therapists viewed therapy as an attempt to "reparent" or reprocess harmful object representations through a healthier relationship with the therapist; thus, resulting in further psychological and spiritual development.

In a third category, therapists typically emphasized therapeutic presence or the therapeutic relationship in their work with spiritual problems. This constituted focused attention on the quality of the relationship between therapist and client. This also implies a premium placed on being genuine, open, respectful, and accepting of clients. One therapist, for example, described his approach as moving into feelings and connection with clients. He believed his role is to develop a genuine relationship with clients and maintain that relationship throughout the therapy. A second practitioner attempted to use the relationship to allow clients to experience their own feelings through reflection and to experience not being alone on their journey. A couple of therapists emphasized the necessity of developing a relationship that felt safe; thus, paving the way for painful introspection and self-discovery.

The remaining three nonreligious/spiritual approaches identified varied in frequency among the therapists. Three therapists emphasized taking a holistic or systemic

view of therapy and clients. The consensus among the three therapists was that human beings are far too complex for linear models of understanding or simple rational explanations. A comprehensive account of people and their problems will consider the various levels at which human being interact and are influenced (e.g., cultural, political, personal, spiritual, interpersonal, etc.).

The second variant category of nonreligious/spiritual approaches involved working with emotions to facilitate work with spiritual problems. For instance, one therapist stated, “I would focus on his feelings, his affect and I think that’s what I would really try to focus on to help him, to draw him out about this spiritual issue.” Finally, therapists variantly approached spiritual problems as they would other types of nonreligious problems. These therapists approaches tended not to vary based on what problems the client presented with. For example, whether the client was questioning her faith or afraid of speaking in public, the therapist would approach therapy from a consistent perspective (e.g., phenomenological, developmental, etc.).

Assessment of Spiritual Problems

We identified four primary categories within the assessment of spiritual problems domain. The categories are presented in the following order: types of spiritual problems, conceptualization of spiritual problem, diagnosis, and client’s desires, needs, or goals. All of the categories and subcategories are listed in Table 5. All the categories and corresponding core ideas are listed in Appendix F.

Types of Spiritual Problems

Within this primary category, we identified 10 types of spiritual problems (6 typical, 4 variant). The first category, questioning or changing religious/spiritual beliefs, involved clients who were experiencing doubt, skepticism, or conflict over their currently held religious/spiritual beliefs and values. One clinician, for instance, described a client who was struggling with the narrowness of her religious beliefs and their ability to sustain her. Another therapist described a client who wondered whether the religious faith he had as a child could be relevant to him as an adult. A third therapist described a client who was experiencing tremendous anger and pain as she questioned the existence of God.

Typically, therapists reported clients whose spirituality was underdeveloped or arrested. This involved clients who appeared stuck in various phases within their spiritual development. As an example, one therapist described a client who was grieving the loss of past spiritual experiences and unable to move forward into new spiritual experiences. Another clinician worked with a client who had lost the personal connection with his spirituality, it had become mere prescribed ritual; thus, his faith had grown stagnate and dry. In some cases, this category included clients who were spiritually empty or lacking in a spiritual life. For example, one therapist described a client in the following words: “I might say the person had no spiritual life. There was a vacuum in this man’s life in regards to the transcendent, in regards to the sort of things that are values regarding spirituality. Just not awake. That’s actually, really the way to describe it...the word ‘awake’ is a good word.”

A third category of spiritual problem was problematic religious/spiritual beliefs which included two typical subcategories: unhealthy religious/spiritual beliefs and scrupulosity or rigid religious/spiritual beliefs. This category involved therapist believing that clients' currently held religious/spiritual beliefs were a source of problems or greatly contributed to troubles in the clients' lives. One therapist, for example, determined that a client's fundamental religious beliefs about sexuality hindered her psychological and spiritual development. Another therapist described a client who internalized messages about self-denial and submissiveness in such a way that she had frequent problems in relationships and in her self-concept. A third therapist worked with a client whose primary spiritual problem was conflict between a rigid rules focused perspective on God versus a larger more expansive view.

Therapists typically reported conflict in relationship with God as a primary spiritual problem. This included clients who felt prohibited by God from pursuing something they felt entitled to and/or experienced painful emotions in regards to their relationship with God. For example, one therapist worked with a client who was withdrawing from and rejecting God because she felt unable to divorce her husband. Similarly, another therapist described a client who felt his divorce had cost him his relationship with God. A couple of therapists had clients who felt they were betraying God and hurting their relationship with God because of their choices of career or romantic partner. For example, one client proclaimed, "So can I be loved by God if I am gay, can I even be a Christian if I'm gay, will I have a spiritual community if I'm gay, do I deserve a spiritual community if I'm gay? You know bottom-line—will God love me if

I am gay and, if I am gay, then can I ever participate in a relationship with someone or do I have to be celibate in order to be okay with God?"

A fifth category of spiritual problems entailed clients' feeling guilty, sinful, or as if they were being punished by God. This category included clients viewing themselves as damaged, judged, and deserving of punishment. One therapist described a female client who considered herself heterosexual, yet had an affair with another woman. She felt guilty for both having an affair and having a homosexual encounter. She felt confused by the experience and concerned that God might judge and punish her. A second therapist discussed a client who was experiencing tremendous guilt because she did not feel she was living up to God's expectations for her. She felt she had to live up to certain standards of performance and behavior or God would be gravely disappointed in her.

The therapists in the study variably reported the remaining five categories. The first variant category of spiritual problems, spiritual distress associated with career or calling, involved clients who struggled with whether they were on the right spiritual path or encountered spiritual distress because of their particular vocation. As an illustration, one practitioner described a client who struggled with the demands and expectations of being a minister. She was planning to leave the ministry and expected many of her congregation to be disappointed and displeased. Another example involved a client who felt he was called to be in the music ministry but failed to secure a job in that field. He felt he was failing God and encountered conflict with his wife who he saw as somewhat

responsible for his failures. A third therapist worked with a client who was confused about her calling and wanted to find what her true passion was.

The second variant category involved client's being angry with God or the church. One client expressed being angry with God because she felt her situation was unfair. Another client felt abandoned by the church and, subsequently, used this perceived abandonment as a rationale for living recklessly. A third client grew up in a devout Catholic family. She expressed tremendous anger about her uncertainty and doubt, and about questioning God's existence later in life.

Therapists variantly reported clients who were in spiritual distress concerning their sexuality. This entailed sexual infidelity and sexual orientation issues. For instance, one therapist worked with a client who viewed being gay as wicked and sinful. He prayed that God would change his sexual orientation; otherwise, he felt he must abandon the faith he knew and loved. Another therapist described a client who worried she would be rejected by her family and God if she were to identify as a lesbian. A third clinician worked with a female client (mentioned previously) who was conflicted about both having an affair and having the affair with another woman.

A fourth variant category of spiritual problem involved clients' fear of rejection or isolation from God or their community. One client feared God, her family, and her church might reject her because she is a lesbian. Another client worried that his church community would shun him after his divorce. A third experienced rejection and isolation because of marital infidelity. A final variant category involved therapists' determination that a client's grief or loss was a primary spiritual problem. For example, one therapist

assessed that a client's grief over the loss of his dream to be a music minister was complicating his enjoyment of life and relationship with his spouse. A second clinician identified grief as a major issue for his client. He found it necessary to "go through the ashes of her life" and reprocess the grief over many different losses throughout her life.

Conceptualization of Spiritual Problems

We divided the primary category, conceptualization of spiritual problems, into four categories: viewed as developmental issues (typical); intertwined with psychological issues (typical); intertwined with relationship issues (typical); and viewed as opportunity for growth and healing (variant). Therapists typically conceptualized spiritual problems as developmental issues. This means that problems were usually seen as normal conflicts or impasses one might encounter along life's journey. For example, one therapist indicated thinking of "maladaptive religious beliefs as developmental arrests" which helped him avoid pathologizing spirituality. Another therapist described her conceptualization process along developmental lines as follows:

I really think more from a developmental framework so when I'm looking at someone and where they are in terms of spirituality I am thinking...sort of Fowler stuff in terms of faith development stages and then Kohlberg (and I love Kohlberg)...I'm thinking about okay where are they in terms of how they're processing their faith or how they're processing kind of moral/ethical issues...I think about how does that fit with...psychodynamic development in terms of object relation stuff and their concept of themselves. Because...where my bent is

is that our relationship with God is really an object relations issue...but the first thing I do...is think about, in terms...of development...what stage are you in.

A third therapist holds that people are in a process of becoming and spiritual problems are an invitation to develop oneself. Thus, when his client encountered distress concerning her identity and passion in life, he viewed this as a window of opportunity for her to progress to a greater stage of personal and spiritual development.

The second category of conceptualization, spiritual problems intertwined with psychological issues, contained three subcategories: depression or anxiety, self-concept or loneliness, and miscellaneous. This category revealed that clinicians often recognized other comorbid psychological issues that accompanied the spiritual problems. For instance, four therapists diagnosed clinical depression along with the spiritual problem. In one case, the depression resulted from the dissolution of his family because of his divorce. In another instance, the client experienced depression in response to feeling lost, confused, and without a solid identity. A few therapists also recognized self-concept and loneliness issues in their clients. Typically, therapists identified some form of pathology or mental health concern that was comorbid with the spiritual problem. However, it was seldom clear as to which problem occurred first or how the problems influenced one another.

The third typical category involved spiritual problems being intertwined with relationship issues. We divided this category into two subcategories: partner or spouse and other relationships. Nine of the 12 therapists reported relationship issues alongside the spiritual problems with their clients. As an example, several therapists noted that their

clients initially presented in therapy with relationship problems. Occasionally, the spiritual problems emerged only after meeting with the therapist for many sessions. Even then the spiritual problems were usually closely connected with the relationship issues. A couple of therapists indicated that their clients experienced early childhood abandonment issues that contributed to current relationship problems. One practitioner reported that his client's pursuit of God directly related to her experience of neglect and abandonment by her father.

Finally, therapists variably approached spiritual problems as an opportunity for growth and healing. One therapist, for example, viewed the client's current spiritual crisis as beneficial because she surrendered her quixotic pursuit of perfection and was embracing her own humanity. Another therapist, mentioned above, reported that people are in a process of becoming and pain is an invitation to grow. A third therapist acknowledged that her client's experiences in Alcoholics Anonymous and in graduate school helped the client move away from a rigid religiosity to a more open spirituality.

Diagnosis

We divided the broad category, diagnosis, into six categories (2 typical, 4 variant). Typically, therapists assessed the client's religious background or history when making a diagnosis. Eight of the therapists indicated taking a religious/spiritual history when clients reported a spiritual problem. One therapist expressed his dismay at the lack of knowledge therapists might have about their client's religious background:

I've been struck by how uninformed many therapists are about religious issues...

For example, here in supervision when talking about a client they mention church

or something and I'll say, "Oh, what church?" Well they don't know and I think, "What do you mean you don't know?" I mean there's a world of information here. Is this person a Catholic, a Hindu, Baptist? And it says a lot about their family, you know, really enriches our understanding of this person's world. It's not only what kind of faith community they are a part of or fleeing from or whatever."

As indicated above and in other therapists' responses, an assessment of a client's religious background might involve gaining an understanding for what religious affiliation the client had, what type of church the client was raised in, if any, and how important the client's faith is to them.

Therapists also typically indicated assessing the health of the client's spirituality. This involved assessing how mature and flexible a client's faith was as opposed to rigid and inflexible. Five therapists described clients who held rigid or problematic religious beliefs that contributed to their spiritual problems. For example, one therapist assessed that his client's theological perspective that she was of less value than others contributed to her being taken advantage of and abused. Another therapist found that her client's insistence on righteousness and perfectionism resulted in excessive guilt and anxiety. A third therapist assessed that his client was spiritually anemic, that is, lacking a spiritual center though she desperately wanted one.

Variantly, clinicians reported that they assessed the client's psychological or developmental history when working with spiritual problems. This included assessing such areas as object relations, sexual history, family relationships, and identity issues. As

an illustration, one therapist noted taking a thorough assessment of how her client developed a sense of self and other and maintained healthy relationships so that she could determine the presence of psychopathology. Another therapist recognized how his client's spiritual problem (and other problems) resulted from long standing pathology throughout her family history.

A fourth category of diagnosis involved therapists assessing their clients' characterological or personality traits. This entailed looking at interpersonal issues such as hostility or suspiciousness with others. It also included noting positive traits such as the ability to be empathic and compassionate. In the fifth category, therapists variantly indicated intending to avoid pathologizing their client or their client's issues. One therapist, for example, explicitly informed the client that he used diagnostic labels for insurance purposes only, but chose to think about his client and her issues from a more holistic and humanistic perspective.

A final category of diagnosis consisted of differentiating spiritual difficulties from secular or psychological problems. For instance, one therapist differentiated a client's deep spiritual conflict about his sexual orientation from his secular concerns such as adjusting to professional stressors, his efforts to reduce alcohol consumption, and lingering anxiety and depression. Another therapist determined that her client was suffering from severe depression and anxiety apart from his distress about his spiritual problem. She recognized that the severity of his symptoms, his psychological history, and current circumstances all were contributing to a major depressive disorder that required medical attention in addition to therapy for his spiritual problem.

Client's Desires, Needs, or Goals

We divided this final major category within the Assessment of Spiritual Problems domain into two categories. These categories involved therapists' assessment of what the clients presented with and what their expectations and goals were for therapy. Variantly, therapists reported that clients' initial therapy goals were not explicitly spiritual. As an example, a couple of clients presented with marital conflict with no mention initially about spiritual problems. Another therapist prefers to begin a therapy relationship examining the main concern of the client rather than beginning assessment with specific religious or spiritual questions.

Therapists also variantly indicated having assessed that their clients were striving for authenticity or relatedness with others. Several therapists noted that their clients wanted to make changes in their lives that were consistent with how they experienced themselves to be. Two therapists mentioned that their clients were seeking increased intimacy in their relationships with others and a stronger community of support.

Therapy Process

The bulk of the data applied to what actually occurred in therapy between the therapist and the client. This is often referred to as therapy process and involves such things as the strategies and interventions used by a therapist, the relationship between client and therapist, and the course of therapy. We grouped the therapy process domain into four primary categories: therapist strategies, therapist interventions, reactions in therapy, and course of therapy. All of the categories and subcategories are listed in Table 6. All the categories and corresponding core ideas are listed in Appendix F.

Therapist Strategies

This primary category was defined as general strategies or objectives that therapists attempted to achieve with their clients. We divided therapist strategies into seven categories: promoted spiritual development or change (general); promoted new experience of self (typical); personal spiritual experiences facilitated understanding client and spiritual problem (typical); addressed psychological issues to facilitate work with the spiritual problem (typical); openness towards client's spirituality (typical); recognized client obstacles to healing or growth (typical); and monitored client's reactions to therapy interventions (variant).

Therapists generally promoted spiritual development or change in their clients. This entailed an active attempts at helping clients move through their current impasses to a more mature and developed spirituality. One practitioner, for example, presented specific questions for exploration and introduced mindfulness to his clients as a way to entice him to develop spiritually. A second therapist challenged his client's current religious beliefs, which were wrought with fear, with opposing religious beliefs that promoted love and compassion for oneself. Another therapist directly challenged her client's beliefs about guilt and sin, which the therapist saw as debilitating. The therapist examined how her client prayed and found that she could not move past confessing sin and apologizing to God. The therapist responded, "Yes, you need to confess sin...But then move on because then you're in the fellowship of God and God wants to fellowship with you.' I just felt so bad for her...I wanted her to experience the peace that passes our

own understanding, which is really what we have if we really understand what is to be in Christ.”

The second category, promoted new experience of self, contained three subcategories: self-acceptance, self-awareness, and authenticity. This category involved therapists’ attempts at providing clients with a new and better experience of themselves in therapy and in their lives. That is, therapists wanted their clients to come to accept themselves for who they are and for where they are at in their lives, to develop increased awareness about themselves and their being-in-the-world, and to be more genuine with themselves and others. For instance, one therapist encouraged his client to accept her flaws as a pathway to personal growth. A second therapist used “depth mirroring” to help his client recognize how she interacts with the world and how she was angry with God and others. As a third therapist eloquently put it, “[his client] wants to be true to himself and wants to be happy. That was a powerful thing for him. And he was miserable, miserable—and so for him to think that somehow being more congruent would help him feel more content with himself that was important.”

Typically, clinicians reported that their personal spiritual experiences facilitated understanding of the client’s experience and spiritual problems. Six therapists noted that their own spiritual background and experiences helped them connect with clients and empathize effectively; thus, contributing to the overall progress of therapy. For example, one therapist indicated that his spiritual journey from fundamentalism to Buddhism and Unitarianism, and his close relationships with ministers over the years helped him deeply empathize with his client’s struggle as a pastor who was leaving the ministry.

A fourth typical category of therapist strategies entailed therapists addressing psychological or emotional issues to facilitate work with the spiritual problem. This category, also found within the assessment domain, is included here as an acknowledgment of the importance of distinguishing other factors that may be contributing to the spiritual problem. For instance, one therapist discovered that his client's conflictual feelings about being gay were not solely about religious prohibitions, but early abusive sexual relationships as well. This facilitated therapy in that the client could recognize psychological and historical reasons (i.e., abuse) for his current conflict with being gay and more readily resolve his spiritual issues with it. Similarly, another therapist helped his client change the punitive spiritual perspective she possessed through processing the ways childhood abuse contributed to her penchant for seeing herself as damaged and guilty. A third practitioner first addressed his client's depression, anxiety, and drinking behavior which then helped the client focus more clearly on his spiritual problems.

The fifth category of therapist strategies involved an attitude and communication of openness toward the client's spirituality. Presumably, all the therapists who were nominated for this study and volunteered to participate maintain at least a minimum amount of openness, but not all of the participants explicitly referred to this attitude. As an example of this category, one therapist stressed vigilance toward client's beliefs. Another therapist reported demonstrating curiosity and interest in his clients' spiritual lives which resulted in further exploration of spiritual issues in therapy. A third therapist noted that he asks about spirituality on his intake form. A fourth therapist believed that

clients often picked up on his openness toward spirituality through the artwork and décor that adorned his office.

The sixth category of therapist strategies, recognizing obstacles to clients' healing and growth, involved therapists being attuned to clients' issues that were circumventing therapeutic progress. As an example, two therapists attributed impasses in therapy to the client's projections and unresolved issues onto the clinician. In one instance, the therapist recognized that the client had many harmful experiences with men that contributed to mistrust in current relationships, including the client's relationship with the therapist.

Finally, therapists variably indicated monitoring client's reactions to therapist interventions. For instance, one therapist was vigilant to the client's reactions around interventions of a spiritual nature. He wanted to ensure he was not imposing his own spiritual views on the client and not assume where the client was at spiritually. Another therapist reported that he intuitively and empathically feels whether particular interventions are appropriate for clients. A third therapist expressed being thoughtful and cautious about how he communicated about spirituality with the client.

Therapist Interventions

This category involved specific therapeutic techniques used by therapists to work with spiritual problems. Within this overarching category, we created two broad categories, spiritually themed interventions and general therapist interventions. Each of these broad categories has numerous subcategories, which will be discussed below.

Spiritually themed interventions included eight categories, four were typical and four were variant among the therapists.

We divided the first category, explicitly religious/spiritual interventions, into three subcategories: meditation/mindfulness, use of scripture, and “other.” As an example of the first subcategory, one therapist indicated routinely introducing loving-kindness meditation to clients dealing with shame. Another practitioner referred to his work with a client as “mindfulness training” as he tried to help his client respond more attentively and lovingly toward his partner. Several therapists found the second subcategory, use of scripture, facilitative in connecting, consoling, and challenging clients. For example, one therapist challenged his client’s scripture-based self-criticism by countering with passages that emphasized grace and forgiveness. Another therapist indicated often using scriptures about grace and forgiveness with clients struggling with guilt. Finally, the “other” category included interventions such as lighting candles during therapy to signify hope, reciting religious poetry, working with charkas (i.e., energy centers in the body), and using spiritual gardens.

Typically, therapists used the religious or spiritual language of the client to facilitate work with spiritual problems. One therapist, for example, found that using the client’s spiritual language helped him avoid impinging his own beliefs onto his client. A few therapists noted that using religious terminology that the client is familiar with helped them connect with clients, maintain the therapeutic alliance, and achieve therapeutic goals.

A third category of therapist interventions, therapist self-disclosure, was divided into two subcategories: self-disclosure about personal religious/spiritual beliefs and self-disclosure about their experience working with religious/spiritual issues. For instance,

one therapist found disclosing her interest and experience in theology helpful in building and maintaining the therapeutic alliance. However, she also found that not gratifying all the client's desires to know the details of her spiritual life therapeutic. The clinician was wary that the client might adopt the therapist's spiritual beliefs rather than develop her own individual theology. Another therapist stated that he is usually explicit about both his sexual orientation and his general spiritual beliefs with clients. He felt that therapists have an ethical responsibility to be aware and explicit about their values with clients. Therapists variably disclosed to clients their previous work and experience with spiritual issues in therapy. For example, one therapist found that disclosing her therapy experience with other people with similar religious views helped establish the therapeutic alliance.

A fourth typical category of therapist interventions involved showing and communicating respect for clients' religious/spiritual beliefs and values. Several therapists found it important to inform client that they genuinely respected their faith and viewed it as an asset. One therapist, for example, proclaimed, "And so I respect her [the client's] goals and told her that I like working with people who have a strong faith. I do think that their [clients] faith is a real asset." Sometimes that respect for a client's beliefs comes in the form of not infringing your own beliefs and experiences on the client. As one therapist explained, "Well I would say at times I was aware of sort of walking softly in terms of my own spiritual belief system and sort of maintaining my position as a therapist...And there was times I was aware of walking very carefully in terms of

continuing to try to talk within her framework and not intrude too much with my framework.”

Variantly, therapists encouraged their clients to confront God. This involved helping clients acknowledge and express painful feelings in their relationship with God with the intent of improving their connection and communion with God. For example, one therapist worked with a woman who felt trapped in her current relationship and blamed God for her infidelity and unfair situation. In the therapist’s words, “She and God need to wrestle like Jacob and the angel. I thought that if she was mad at God...she and God needed to have this conversation...Of course, God will win the conversation, but nonetheless, it would be a really good thing to sort of tell God. God’s big enough to...handle it. You can be mad at God and cuss God out, God will still be there.” Another therapist found that healing in his client did not truly begin until the client was able to acknowledge and express his anger at God for the way his life had turned out.

Therapists variantly reported recommending religious/spiritual books or tapes. For instance, one therapist loaned books on spirituality and sexuality to his clients struggling with sexual issues. He realized he needed to be thoughtful and careful about what books he recommended, as some religious clients may not be open to certain approaches to spirituality such as Buddhism. Another therapist loaned audiotapes on mindfulness by Thich Nhat Hahn. He believed many of his clients have benefited from this approach to developing mindfulness practice into their daily lives. Finally, a third therapist recommended a book he had written on marriage to a client dealing with infidelity.

The third variant category of spiritually themed interventions, reframing client problems with a religious/spiritual perspective, involved therapists providing a theological or spiritual reinterpretation on the current problems they were facing. In one case, the therapist encouraged his client to recognize her affair was partially the result of her own attempts to “play God” in her life and not own her humanity. He also believed bringing her secret about the affair into the open would break the power the secret was having over her life and marriage. A second therapist deeply examined her client’s beliefs and early religious messages he had grown up with. Through this process, the client was able to explore his religious beliefs and values and understand the implications for violating them.

A fourth variant category of spiritually themed interventions entailed being guided by a divine or spiritual force. In these cases, therapist relied on their inner experience, or guidance from a spiritual source to help understand and work with spiritual problems. For example, one therapist expressed it this way:

...I have often had the feeling when I am with someone that there’s more than me here. I sometimes don’t think I would be able to say the things I say or to connect in the way that I do if I didn’t, it’s like there’s something flowing through me and it’s not like mystic or anything like that but there’s something more and I think that that really does inform my practice a good bit. It’s not that I use scripture all the time or pray before I see clients or anything like that, it’s not that direct – I don’t know it’s weird to say, it just feels like I channel the love somehow.

From this perspective, the therapist feels like a conduit through which a greater power or mysterious dynamic is affecting the client, the therapist, and their process.

General therapist interventions were techniques used in work with spiritual problems that are not explicitly related to spirituality and among the common techniques found in therapy across theoretical orientations. We grouped this category of therapist interventions into eight subcategories, four typical and four variant. The first typical category of general therapist interventions involved the therapist's use of empathy and understanding. Empathy is usually defined as feeling into and with another person's experience and articulating that understanding to the client. When done well, this usually leads to further understanding of and openness to clients' experience, a change in clients' feelings, and the generation of new solutions. Several therapists explicitly reported using and expressing empathy. For example, one clinician used empathy to remain nondefensive and unintimidated with his client when she was hostile towards him. This led to a new relational experience for the client which allowed her to lower her defenses, be vulnerable with the therapist, and effectively address her interpersonal and spiritual concerns. Another therapist invited his client to help him with the empathic process. He encouraged his client to point out when he was misunderstanding his perspective and spirituality.

Typically, therapists attempted to form a strong therapeutic alliance with clients. We divided this category into two subcategories: established initial rapport and built and maintained the therapeutic alliance. As an example, one therapist facilitated rapport through allowing the client to discuss issues in his own time. The client initially wanted

to discuss his anger at his wife, but after sufficient rapport was established he began discussing problems in his relationship with God. Another therapist used the spiritual language of the client to build and maintain the therapeutic alliance. A third therapist noted several factors that helped develop the therapeutic relationship. First, the client was referred to the therapist by his pastor so there was some initial confidence in her skills and openness to spirituality. Second, the counseling took place away from the client's hometown which allowed him privacy and safety. Third, the client identified with Tony Soprano, a character from a popular television series who also saw a therapist. Fourth, the practitioner disclosed her experience working with clients with similar religious views. Finally, the therapist strengthened the alliance through following the client's process and needs in therapy. That is, she utilized a behavioral and problem focused approach early on in therapy that fit the client's style and needs. After sufficient trust was developed, she utilized more psychodynamic and experiential interventions that facilitated further changes and growth in the client.

Another important finding was the use of intuition for understanding and working with client's spiritual problems. This typical category included two subcategories: guided by intuition or inner experience and conceptual frameworks viewed as secondary to intuition. Several clinicians mentioned relying on their clinical judgment, intuition, or felt sense of a client to facilitate therapy. For instance, one therapist explained that based on several years of clinical experience she was able to intuitively sense what a client's spiritual issue is and what might be the best course of action. Another therapist trusted his intuition to help him manage countertransference reactions and to determine the

appropriateness of particular interventions for his client. A third therapist decried the reliance on conceptual frameworks as a guide for therapy, but preferred to trust his intuition and inner experience of the client.

The final typical category involved therapist use of exploration techniques in therapy. These techniques include experiential questions and empathic reflections aimed at moving a client into fuller exploration of their problems and experiences. For example, one therapist reflected the client's way of being to him (i.e., failing to "stop and smell the roses") in a way that helped the client become conscious of his overactive style. Another therapist used what he called "depth mirroring." In this approach, the therapist reflects the implied messages in the client's narrative in a way that can be received and encourages further exploration. His client began to recognize the anger and hostility she held towards men, the world, and God.

We divided the first variant category, managed client transference, into two subcategories: recognition of transference and use of transference to facilitate therapeutic work. The therapist cited in the previous paragraph recognized that his client experienced hostility and anger towards men. Through creating a container for her anger and hostility and remaining nondefensive and empathic, his client gained several new experiences such as having her feelings validated, expressing vulnerability, and learning to trust the therapist. A second therapist helped her client sort through the meanings of the client's projections onto the therapist. The clinician accomplished this without revealing her own thoughts, feelings, or spiritual beliefs so that the client could come to her conclusions about herself and her experience autonomously. A third therapist stated, "I think what

really happens over the years of working with someone...is that every week there's another little piece of experiencing consistent presence and caring in the therapeutic relationship. There's another possibility of being heard, being reflected, being mirrored, being cared for, being gently challenged, basically reparenting.”

The second variant category of general interventions, validated client's strengths, involved recognizing the client's personal resources and abilities. For instance, one therapist made the effort to recognize and validate the healthy aspects of the client's current stage of spiritual development before enticing them with further development. Another therapist noted several strengths in his client including high motivation for change, personal responsibility, and the ability to state what he needed and whether he could obtain it. A third therapist utilized his client's strengths in art and creativity to propel her forward in her spiritual development.

Clinicians variably focused on and processed emotion to facilitate work with the spiritual problem. For example, one therapist explained, “I would focus on his feelings, his affect. And I think that's what I would really try to focus on to help him, to draw him out about this spiritual issue.” In this case, the client had unresolved grief and anger. After addressing these feelings, the spiritual problems became the central focus. Another therapist pursued areas of emotional intensity in clients. He tracked the client's emotional expressiveness and focused on whatever feeling or experience was most alive in the moment.

The third variant category of general therapist interventions involved therapists referring clients to external resources to promote healing and growth. For example, two

therapists reported introducing their clients to new church communities or religious organizations such as those that may be gay affirming. Another therapist invited his client to join a men's therapy group. The client found acceptance and affirmation that complemented the work he was doing in individual therapy. A fourth therapist encouraged her client to consult with his pastor for additional support and confirmation about theological issues discussed in therapy.

Reactions in therapy

The third primary category in the therapy process domain, reactions in therapy, entails the emotions and internal experiences that therapists and clients experienced in their work together. We divided this category into three primary subcategories: therapist reactions to client or therapy (typical), countertransference or therapist bias (typical), and client reactions in therapy (typical).

The first subcategory, therapist reactions to client or therapy, was divided into four additional subcategories: positive reactions (typical), negative reactions (variant), difficulty witnessing client's suffering (variant), and "other" reactions (variant). Therapists typically indicated having positive reactions to clients and therapy. For example, several therapists noted enjoying their work with the client. Several therapists also observed positive attributes in their clients such as insight, intelligence, creativity, kindness, talent, and attractiveness. One practitioner stated that he felt honored by the client's willingness to express her anger and hurt with him and towards him. Therapists variably admitted to having negative reactions toward their clients. For instance, one therapist shared that he initially felt intimidated by his client's hostility and sensed that

their work together would require a great deal of energy. A few therapists stated that they found it difficult to witness their client's affliction. One therapist, for example, struggled to watch and not intervene while his client suffered within the strict rules set up by her religious beliefs.

Therapists typically reported experiencing countertransference or bias towards their clients or their clients' issues. We divided this category into two subcategories: manifestations and management strategies. Clinicians variably reported manifesting countertransference reactions in their work with spiritual problems. One therapist noted being sexually attracted to his client. A couple of therapists found it difficult to withhold their own feelings or beliefs when working with clients who held different beliefs. A fourth therapist initially felt some discomfort with his client related to his own feelings around inadequacy, inferiority, and aging. In his own words, "When she came to me, I had some real sense of discomfort about her. It triggered some of my self-judgment issues. It's like 'am I going to be smart enough or am I going to be sophisticated enough, am I going to be whatever' that kind of thing."

Therapists typically indicated using management strategies to resolve countertransference or biased reactions. We divided this subcategory into two further subcategories: behavioral strategies (variant) and cognitive or internal strategies (typical). Two therapists noted using self-discipline or withholding certain behaviors or interventions so as not to gratify their own personal needs. Three therapists reported explicitly discussing belief and value differences with their clients. Therapists indicated several cognitive or internal strategies for managing countertransference or bias. For

example, one therapist stated that he relied on self-awareness and intuition to avoid gratifying his own needs at the expense of the client's well being. Another therapist explained her management strategy as "strictly just cognitively, and just sitting on myself and saying 'you're not going to do this, you can't do this, you don't want to do this.' So I'm just using some rules...and, you know, that I don't live in his world and his skin, but it was hard." A third therapist indicated listening to his bodily reactions or internal sensations of discomfort to inform him of countertransference reactions.

The third subcategory of reactions in therapy, client reactions in therapy, was divided into two additional subcategories: positive reactions and negative reactions. Therapists reported several types of positive client reactions such as enjoyment of the work, increased motivation, improved trust, and relief. Clients also expressed negative reactions in therapy such as contempt, confusion, incredulity, mistrust, and anger.

Course of Therapy

The fourth primary category of therapy process involved issues surrounding the course of therapy. We divided this category into three subcategories: context, spiritual problem emerged over course of therapy, and therapeutic issues during the course of therapy. Context referred to the type, frequency, and length of treatment. For instance, therapists reported therapy taking place over several months or years, in individual or group settings, and usually on a weekly basis.

Typically, clinicians reported that spiritual problems emerged over the course of therapy, rather than as the presenting issue. Several therapists worked with clients who initially presented with marital concerns. For example, one therapist worked for four

months on the client's anger and conflict with his wife before the spiritual problem emerged. Another therapist addressed his client's depression, anxiety, and drinking behavior which then allowed the spiritual problem to emerge more clearly.

The final subcategory of the course of therapy involved therapeutic issues that arose over the course of therapy. For example, one therapist observed that his client experienced oscillating periods of resolution and conflict with his spiritual problem. This client would feel content for a time serving in the ministry, but circumstances would change and he would question his calling again. Another therapist felt that his client's issues required a gradual pace; he did not want to rush therapy. A third therapist reported that his client had rejected her previous therapist, an intern, because she considered the intern her intellectual inferior.

Therapy Outcomes

The therapy results domain referred to the results of therapy with spiritual problems. All of the categories and subcategories are listed in Table 7. All the categories and corresponding core ideas are listed in Appendix F. We grouped this domain into four categories: religious/spiritual change (typical), self-improvement (typical), improved relationships (typical), and made decision to start new life (variant). Therapists typically reported religious/spiritual change in clients after therapy with their spiritual problems. We divided this category into three subcategories: spirituality or views of God changed (typical), found resolution with spiritual conflict (typical), and changed spiritual community or environment (variant). For example, after struggling with his sexual orientation, one client broadened his spiritual beliefs about being gay and religious. The

therapist reported, “I think one thing I did was to try to help move away from black and white thinking because he was at first thinking that it’s not possible to be a gay man and to have a viable faith...and so he gradually began broadening his thinking, I guess, about what is possible and at the same time I didn’t have any attachment to him coming out or not or being a Baptist or not.” Another client began to practice mindfulness and meditation in his daily life; thus, altering his previous frantic and impatient way of being. Several clinicians noted that their clients broadened their understanding of God. They no longer viewed God in a limited way, but adopted a view of God that included grace, compassion, and openness. For example, one therapist commented that “[his client] was finally able to focus on the loving aspect of God as well as on the judging, and I think that that’s as far as we got.” Typically, therapists indicated that clients resolved their spiritual problems. Several therapists proclaimed that their clients found resolution, peace, and growth with their spiritual issues. Finally, three therapists reported that their clients found new and more inclusive and accepting religious communities, leaving their previous churches behind.

The second category of therapy results, self-improvement, contained two subcategories: gained new understanding of self (typical) and increased self-worth (variant). As an example, one therapist reported that his client discovered that she was valuable and worthy of appreciation. He explained, “[the client] allowed herself to be flawed. She allowed herself to be, both to recognize simultaneously, say “abused” and of utmost value. And then that was possible because of God.” Another therapist indicated that his client discovered how his early sexual experiences were abusive and contributed

to his current sexual confusion. A third therapist stated that her client became more independent, learned to make better decisions, and was more aware of her values. A fourth therapist helped his client come to view herself as both damaged, and yet, valuable and accepted by God at the same time.

We divided the third category of therapy results, improved relationships, into three subcategories: spouse or partner (variant), family (variant), and “other” (variant). This category involved improvement in relationships with significant others as a result of therapy with their spiritual problems. For instance, one client learned to relate more effectively with his wife after incorporating mindfulness into the relationship: “It went on long enough for his marriage to get a lot better. I think they were separated. They moved back in together and his sort of newly acquired skills in mindfulness—he was by no means a guru or anything like that—but he had enough going that it helped him. Even though they moved back in together they were able to sustain a good vibe towards one another.” Another client established a committed gay relationship and introduced his partner to his family. This same client disclosed his sexual orientation to his family and eventually developed a closer relationship with them. A third client opened up to her mother’s love and compassion after she developed compassion for herself. A fourth client became more open and vulnerable with her therapist, whom she initially did not trust.

Practitioners variably reported that their clients made decisions to begin a new life. For example, one client left an uncomfortable job situation, in which he was being taken advantage of, and started his own medical practice. After divorcing her husband, suffering an emotional collapse, and rediscovering her strength and spirituality in

therapy, one client began a whole new life including a new house, new clothes, and a new hair style.

Therapy Impact on Therapist

This domain referred to the effects that working with clients' spiritual problems had on the therapists. All of the categories and subcategories are listed in Table 7. All the categories and corresponding core ideas are listed in Appendix F. We divided this domain into three categories: learned new approaches or gained knowledge (typical), self-growth (typical), and reexamined or reinforced previous knowledge (variant). In the first category, therapists typically reported having learned new skills or approaches for working with spiritual problems. One therapist, for example, learned the importance of creating a space for clients to self-heal. Another therapist found that he worked with his client's spiritual problem much like he would other types of problems seen in therapy. A third therapist shared how she learned to avoid interpreting clients' spirituality: "I was talking about [how]...we project onto God the same kind of qualities as we have with our parents...people don't want to hear that. It's very threatening, it's very unnerving, and it makes them very anxious. So that's one thing I've learned that's been important." A fourth therapist learned about the Baha'i faith and the importance of mentors and small, supportive community groups.

The second category, self-growth, involved therapists growing and gaining self-understanding. One therapist, for instance, realized his own lack of mindfulness and failure to be attuned to his client's needs. Another clinician increased her awareness of how she tended to react negatively toward her client's family in session. A third therapist

learned the value of his internal strength and patience with clients. A fourth therapist grew in his appreciation for what is possible in terms of human growth and healing: “I can remember the first several times I saw him thinking, ‘this is dismal, this guy is in hell already, never mind about later on and how can he get out of this marriage, how can he pass his boards, how can he be at peace with himself.’ None of that seemed possible or I didn’t see how he could get from here to there. So it was nice to watch.”

Therapists variantly noted reexamining or reinforcing previous beliefs and values. For instance, after watching his client develop mindfulness skills and flourish, he was reminded of the benefits of practicing mindfulness in his own life. A second therapist, relearned his need for God and reliance on God for being effective as a therapist. A third therapist was reminded of the freedom and forgiveness that comes from God’s grace.

Narrative Case Summaries

The remainder of this chapter includes summaries of each of the participants’ therapeutic cases. They are presented in the order in which the interviews were conducted. Each case was given a descriptive title followed by a brief summary of the therapist’s work. The purpose for these case summaries is to illustrate the various themes for approaching, assessing, and intervening with spiritual problems in therapy. It is also hoped that these case summaries will provide the reader with a feel for the participants and their work. These narrative summaries are also included for comparison purposes with the proposed models for working with spiritual problems presented in the next chapter.

Case One: Leaving the Ministry

At the time she entered therapy, this client was a minister in a local church in a large city in the southeastern United States. She had graduate degrees in psychology and theology and taught courses part-time at a local college. She presented with distress related to the demands of being a minister and being constantly under public scrutiny. Eventually, she decided to leave the ministry and sought help from her therapist for this endeavor. Her decision to leave the ministry was precipitated by her primary spiritual problem: she had begun to question her faith and the narrowness of her religious beliefs, but faced difficulty in leaving because she was a minister and had recently published a book on spiritual devotions.

The therapist approached his client and her spiritual issues from a Buddhist and pluralistic perspective. He was conscious of his own spiritual experiences and journey from conservative Christianity to Buddhism and Unitarianism. He found that his own spiritual experiences helped him empathize with his client, but he was cautious not to impinge his own beliefs and experiences on her. He discovered that no formal assessment was necessary to diagnose the spiritual problem; it gradually unfolded over time. The therapist also felt he approached her spiritual problem as he did most other problems; that is, he attempted to help her develop a nonjudgmental attitude toward her experiences and practice mindfulness meditation. He also occasionally recommended spiritual books related to her conflict. The therapist felt therapy was successful. His client learned that she was valuable and worthwhile even if she left her previous faith. For the therapist, he

learned the importance of meeting clients where they are developmentally, being careful not to impinge his own beliefs and experiences onto them.

Case Two: Learning to Be

The client was a married man in his 30s who presented in therapy with marital problems; i.e., he was unsure he wanted to remain in the marriage. The therapist described him as a successful businessman in the art world who had a well-developed “doing side,” but an underdeveloped “being side.” They worked together for approximately 6-8 months. The therapist relied on his intuition and experience with the client to assess that the client lacked spiritual depth and development. He recognized that the client was perceived by others as insensitive and aggressive, but wanted to be softer and more at peace. The therapist also sensed that the client had potential for spiritual maturity. From the therapist’s perspective, most spiritual problems are developmental problems, as was the case for this man. The therapist assessed that the client’s main issue was developing the capacity to be mindful about himself and his life.

The therapist approached the client from a phenomenological and Buddhist-informed perspective. He relied on his inner experience, intuition, and relationship with the client rather than on explicit conceptual frameworks. The therapist intuitively and empathically felt whether particular interventions were appropriate for client. He views people’s religious beliefs as originating from their longing to find something better in life. Thus, he attempted to utilize the client’s longings and growth impulses to facilitate his spiritual development. Furthermore, the therapist had faith in the client’s process and inner experience without the need to impinge his own beliefs onto him.

Therapy shifted from focus on his marriage to his spiritual development. The therapist recommended a series of audiotapes on mindfulness, which the client thoroughly devoured. Therapy became “mindfulness training” for the client and with great success. His marriage and relationship with his child improved and he enjoyed developing mindfulness skills. The therapist was reminded of his need to practice mindfulness in his own life. He also became aware of ways he failed to be mindful in therapy with his client.

Case Three: And the Truth Shall Make You Free

The client was a married woman and a teacher in her early 30s. She presented in therapy with marital problems complicated by an extramarital affair. She initially asked the therapist to help her end the affair and improve her relationship with her husband. The client had a long history of sexual dysfunction which improved after surgery. However, after years of conflict with her husband she became sexually involved with another man. She was a deeply religious woman and recognized the immorality of her situation in the eyes of her faith. She had always hoped that her husband would become more religious. Ironically, as he began to grow in his faith, she began to lose hers. The therapist assessed the woman’s religious background, beliefs, and practice. He determined that she had problematic religious beliefs that were preventing her from admitting her faults and finding forgiveness and healing. She viewed herself as a paragon and felt she had been unfairly treated by God and the world. He believed she needed to embrace her frailty and humanity, confess her infidelity to her husband, and confront God with her feelings.

The therapist approached this client from a phenomenological and relational perspective. He believed his connection with the client was of utmost importance. He also viewed therapy as a truth seeking and illuminating venture and religious faith as an asset. He attempted to free the client from her self-limiting views by confronting her with the “reality” of her experience. He encouraged her to confront God openly and honestly with her anger and pain. He stressed that she would only be healed through bringing her secret affair into the light of truth. He acknowledged that there was risk involved, but believed she would not find healing unless she took the chance. He attempted to help her accept her flaws and bring an end to the affair. He worked within her religious faith to alter her views on perfectionism and self-righteousness. He also recommended a spiritual book on marriage that he wrote. Therapy was still in progress at the time of the interview. The therapist was hopeful, but unsure about how things would turn out.

Case Four: Can I be Gay and Christian?

The client was a successful surgeon in his mid-40s who presented in counseling with marital problems. About 10 sessions into therapy, the client separated from his partner and therapy shifted focus to emerging sexual orientation concerns. The client was raised in a conservatively religious church and felt great shame and ambivalence over identifying as gay. The client believed he had two choices: extinguish his gay inclinations to stay in the auspices of his faith or reject his religious beliefs and become a full fledged gay man. The therapist experienced the client as someone who was outwardly powerful, both physically and professionally, and yet inwardly vulnerable and childish. He assessed the spiritual problem as it emerged over the course of therapy and through the

development of the therapeutic relationship. Therapist viewed client as struggling with fear of failing as a son, a man, and a Christian. He determined that the client wanted to find self-acceptance, love, and community while being true to himself.

The therapist typically addresses spiritual issues as he would any other issue. He approached the client with a strong curiosity about his spiritual life. The therapist described his approach as phenomenological in nature and believes that the exploration and description of one's experience is, in itself, healing. He also emphasized the importance of developing safe relationship with client. Ultimately, the therapist viewed therapy as bringing light and refreshment to his client.

Before delving into the spiritual problem in earnest, the therapist addressed the client's other concerns (e.g., drinking, depression, anxiety). The therapist attempted to move the client away from thinking dichotomously about his faith. He challenged dichotomous thinking about sexual orientation and religious faith by introducing client to gay affirming churches. Therapist also challenged some of client's scripture-based self-criticism by countering with scripture passages that might be interpreted less harshly. Additionally, use of religious language and texts facilitated connection with client and achievement of therapeutic goals. The client achieved several positive results including the following: broadening his thinking about God and his options for being gay and religious; disclosing sexual orientation to his family and eventually developing closer relationships with them; developing a successful romantic relationship; maintaining a cordial relationship with his ex-wife and children; and finding new supportive church and religious community.

The therapist was affected as well. He learned the importance of creating a space for clients to discover their own ways to grow and heal. He also grew in appreciation for what is possible in terms of human growth and healing.

Case Five: Finding God's Will

The client was a 34-year-old male who sought therapy for marital problems. He was angry and resentful toward his spouse for failing to complete her graduate degree in a timely manner. They had moved for his spouse's education and he had been unable to procure a job in the music ministry—which he felt was his spiritual calling. The client felt guilty and confused and as if he were disappointing and betraying God. The therapy took place over five years. The therapist found the client intelligent, insightful, and likeable. Assessment took place informally throughout the therapy relationship. In fact, the client's spiritual issues surfaced after four months of working together. The therapist determined that the client was attempting to recapture emotional connection and experience of God that he had in high school. He conceptualized the client's spiritual problem as developmental—i.e., he was learning to adjust to changes in his spiritual experience and come to a more mature spiritual perspective. The therapist also assessed that the client was experiencing tremendous grief over the loss of his dream to become a minister and loss of his earlier spiritual experiences. The therapist believed the anger and resentment at spouse was a result of unprocessed grief over his loss of calling and early spiritual experiences.

In terms of his approach, the therapist addressed the client's problem as he would other similar nonreligious issue, i.e., from a developmental perspective. This perspective,

shaped by his own spiritual experiences and development, meant that he sought to find where the client was stuck and how he could move the client to the next developmental stage. The therapist focused on emotion and meaning of emotion related to the spiritual problem. He also attempted to help client discover whether he was following God's will and express anger toward God. The client began to see his changing circumstances and his responses to them as opportunities to develop his faith. He also experienced recurring bouts of conflict with his calling and resolution. Each time he would recognize feelings and needs that needed to be expressed. The therapist relearned the developmental aspect of spiritual problems, i.e., how they can resurface in a different form over time. He also was reminded that working with spiritual issues is similar to working with other emotional issues.

Case Six: Sexual Orientation and Individuation

The client was a 28-year-old Caucasian female in graduate school studying human development and counseling. She was in therapy for four years with the therapist. She was the youngest of five children and was raised in Mississippi. She did not have a clear presenting issue when she first entered therapy. She felt that if she were to be a counselor, she needed to participate in counseling herself. As therapy progressed, the therapist assessed that the client's current spiritual beliefs were conflicting with beliefs she inherited from her family of origin. The client was experiencing conflict about her sexual orientation. She felt that if she identified as lesbian, then she was betraying God. She also feared her parents would reject her if they discovered she was a lesbian. The therapist conceptualized the spiritual problem as conflict between a rigid rules

perspective of spirituality and a more open and accepting one. The therapist assessed the client's object relations of God and sexual history to determine presence of pathology. She also looked for evidence of defensiveness and anxiety in the client's spirituality. The therapist determined that fundamental religious beliefs inherited from her family of origin hindered her psychological and spiritual development.

The therapist approached the client's spiritual concern from a developmental perspective. Thus, she considered the psychological, moral, and spiritual development of her client. She believed it would have been problematic to separate the spiritual from the psychological or emotional. She also believed her own spiritual experiences made her more empathic and confident in working with client's spiritual problem. Therapy progressed slowly at first because of the client's many projections onto the therapist. She patiently worked through these projections without revealing much of her own beliefs so the client could develop her own independent beliefs and values. It was as if the client was looking to the therapist to replace her family as her moral and spiritual guide. Additional interventions included use of scripture and books on spirituality and sexuality. Eventually, the client began to trust herself and developed her own views on her faith and her sexuality. She became estranged from her family as a result of coming out, but she found support in a gay-affirming church.

Case Seven: Down the Slippery Slope

The client was a 42-year-old Caucasian male who was referred to therapy by his pastor. He remained in therapy for approximately three years on a weekly basis. He belonged to a conservative Christian church in the southeastern United States. He

presented with distress concerning the dissolution of his marriage. He was worried that having a divorce would denigrate him in the eyes of his church and God. Ultimately, he feared that he would lose his salvation. The therapist determined that he displayed classic signs of depression and anxiety, some of which was distinct from his current spiritual problems. He also had begun acting irresponsibly and self-destructively after his divorce. He felt that he had crossed the line with his divorce; he was condemned. Thus, his soul was lost and he was sliding down the slippery slope into perdition. He began drinking heavily, missing work, and engaging in hostile behavior toward others.

The therapist initially approached the client from a behavioral perspective. She felt he needed to regain control of his life and his choices and decrease his depressive and anxious symptoms. Once that was accomplished, the therapist sought to help him appropriate forgiveness for his divorce and subsequent behavior using more humanistic and interpersonal approaches. The client was not interested in changing his religious beliefs. He saw his actions as sinful and did not want them reinterpreted. Instead, the therapist helped him face up to his mistakes and accept the grace and forgiveness that was available in his religion. The therapist found it difficult to withhold her own spiritual beliefs and work within the client's faith. But she determined that therapy would not be successful otherwise. Eventually, the client got his life in order. He eliminated self-destructive behaviors and returned to adhering to previous religious beliefs and values. He also incorporated ideas of forgiveness into his religious beliefs/values. He was even able to consider remarrying someone and not fear losing his faith or salvation. For her

part, the therapist felt she successfully respected his beliefs and kept her own from interfering with his therapy.

Case Eight: Doormat Theology

After 28 years of marriage, the client's husband demanded a divorce. The client, a middle-aged woman from a small town in the south, was devastated. She immediately fell into a major depression and was hospitalized. She responded poorly to medication and was given 11 ECT treatments which resulted in mild memory loss and some improvement in her mood. At this point she entered therapy. The therapist discovered that the client had struggled through most of her life. She was raised in a fundamentally religious church, was sexually abused as a child, and frequently verbally and emotionally abused by her father and husband.

Despite all of this, she paid her own way through college and became a teacher. The therapist found her a strong, creative, and amazing person. Therapist determined that the client was extremely depressed (non-psychotic type) and looking for a father-figure. He did not use formal assessment to test for the presence of pathology, but determined through sessions that source of distress was connected with her relationships with God and men. Therapist conceptualized the spiritual problem as distress resulting from overemphasis on her role as servant in contrast to need to care for herself. Everything the client was taught about spirituality was oriented toward self-denial and submission to others. This subservient role was encouraged by the client's husband, whose father also shared her "doormat theology."

Therapy took place over four years. The therapist described his approach as foundationally person-centered. He is inclined to connect to clients through unconditional positive regard, congruence, and empathy. He is additionally influenced by training in constructive developmental theory; thus, he views spiritual and personal development as occurring in stages. The therapist also has awareness of some sort of divine influence in his therapy practice. He feels that he is a channel for a loving force for his clients. In this case, the therapist viewed the long term course of therapy as providing reparenting opportunity for the client, that is, providing new experiences of being heard, mirrored, cared for, and learning that she is a person of value and strength. There was additional use of scripture and metaphor to support the notion that self-love is essential to loving others. Therapist helped client move from “either/or” thinking to a more sophisticated and comprehensive perspective on herself, life, and spirituality.

Case Nine: Finding God

The client was a female graduate student in her mid-20s. She was attending graduate school at a large Midwestern university where she was studying biology. She was raised Catholic but was not practicing religion at the time she entered therapy. She presented in counseling with self-esteem and inferiority concerns. She initially wreaked havoc in the counseling center she attended: yelling at the front desk staff, demanding not to have to wait in the waiting room, dismissing her first counselor for being intellectually inferior, and generally displaying hostile behavior to those she encountered. The therapist recalled being intimidated by her initial presentation, but working really hard not to show it. Through the course of therapy, he realized she had developed a tough exterior to

survive the nightmarish demands she faced as a child, abandoned by her father and family. He also assessed that her general existential hopelessness and lack of a clear sense of identity, purpose, and self-esteem involved a great pursuit to find, in a sense, a “God” – a spiritual or existential foundation for her life. The client’s specific experience involved tremendous anger about being abandoned by her father and God. She attempted to fill spiritual void with substance use and with a passion for school and the sciences, which she used to attack God.

After his initial intimidation, the therapist was able to develop compassion and understanding for his client. This was aided by his belief that all people are spiritual beings in need of a connection with the divine. He also holds the perspective that all his therapeutic encounters are divine encounters, that is, God has a purpose in bringing them together. He believes that being spiritual beings implies being relational beings. Thus, the therapist approached therapy from a relational perspective which opened up to questioning the client’s relationship with God. He allowed his client the freedom to question and be angry with him. He used the therapeutic relationship to allow her to experience both her own feelings as well as an experience of not being alone on her journey. Eventually, his client developed trust and vulnerability with him. She recognized her yearning to have an intimate relationship with God and others. She also developed compassion for herself and realized she could be simultaneously damaged and whole through her relationship with God. As for the therapist, he learned the tremendous value of allowing clients the freedom to experience where they are at emotionally and spiritually and express it with him.

Case Ten: Finding One's Self

The client was a woman, recently estranged from her husband, who belonged to a religious order in New York. The estrangement occurred after years of marital conflict and because the client had an affair with another woman. She presented in therapy with depression after being shunned by her lover, which the therapist viewed as a cover for deeper spiritual concerns. She belonged to high society but worked with the poor in her community. She felt pressure to maintain her social status and respectability. She was also conflicted about the morality of her affair and her sexual orientation. The client had always identified as heterosexual and struggled to integrate her new sexual experiences with her identity. Subsequently, the client was confused about her calling to the ministry. The therapist assessed her primary spiritual problems as finding her identity and following her passions.

The therapist approached his client's spiritual problems from a holistic and systemic perspective. He views people as complex and sophisticated spiritual beings. He also believed that his client's crisis was an opportunity for spiritual growth and healing. A strong proponent of the 'wounded healer' concept, the therapist felt his client would grow through her woundedness and help others heal as well. In terms of interventions, he initially became a compassionate listener to help her know she was understood and establish hope. He then helped her sort through the "ashes of her life" to find the source of her grief and pain. The therapist examined her daily struggles and how these related to questions of her identity and spiritual beliefs. He helped her explore her sense of self and reexamine her concept of God. Further, he helped her examine oppression and

gender oppression and its spiritual and emotional effects. The therapist also used the client's natural propensity for art and creativity as a source of healing and growth. He would often focus on the body to identify sensations related to grief and anger. Other techniques included the use of charkas (energy centers), psychodrama, meditation and spiritual gardens to access and explore her experience. In the end, the client began seeing God outside of her limiting figurative box. She was able to expand her spiritual views to include femininity. She also left previous denomination and found a new, more inclusive denomination. Finally, the client connected more fully with her artistic and spiritual nature.

Case Eleven: Cruise Ship Christianity

The client was a 20-year-old college student who was raised in an affluent evangelical Christian family in the Midwest. She entered therapy at the request of her parents after she began to struggle with her grades. She reported tremendous anxiety, which the therapist attributed to great pressure she experienced internally and externally. She internalized her parent's social values and felt she had to attain high levels of success to be loved and accepted. This carried over into her spiritual life where she placed a high premium on moral and social perfectionism. At the time she entered therapy, she presented with deep spiritual doubt and questioning. She thought, "Am I condemned to always feeling like a failure because I cannot live up to the standards God has established?" The therapist compared her current spiritual life to a cruise ship with a life boat attached by a rope floating behind it. The client was in the life boat wanting something different in her life, wanting to discover new places, but still attached to the

life of privilege and social expectations. Cruise ship religion was no longer satisfying to her, but she was afraid to cut the rope and discover something new. She was spiritually lost and confused. The therapist also recognized the client was paralyzed by high levels of guilt and condemnation. She felt that she constantly failed God and her family.

The therapist approached the client's spiritual problem from a relational Christian perspective. She believed her client needed to appropriate the grace and forgiveness that was available to her through God. She needed to recalibrate her focus on performance and righteousness to one of compassion, freedom, and grace. In a sense, she needed to discover a new religion within her old one. The therapist also relies on the experience gained from her own spiritual journey and her clinical work. This experience informs her intuition, which is her chief guide in therapy. During therapy, the therapist explored the client's problem in depth. She used the metaphor of the cruise ship to describe client's current situation and faith. She attempted to change the client's beliefs about guilt and sin through use of scripture, reframing techniques, and the therapy relationship. The client initially rejected the concept of grace. Her worldview did not allow for such a concept. However, through patience and persistence, the client gradually began to integrate concept of grace into her religious beliefs.

Case Twelve: Coming Into Her Own

The client was a 28-year-old female who entered therapy to become more independent and improve her decision making. She was diagnosed with a cognitive impairment and lagged behind most of her peers academically and socially. When she entered therapy, she was living with her parents, but wanted to move out and live on her

own. She also had a 2-year-old daughter who was the result of a sexual assault. The first spiritual problem was whether to attend secular therapy. She and her family belonged to the Baha'i faith. The custom was to resolve family problems through a spiritual advisor in the religious community. However, the client's parents felt she needed an advocate and would benefit from counseling. The therapist assessed that her primary spiritual problem, which arose over the course of therapy, was questions about her sexual orientation. She had a history of negative relationships with men and had begun to explore intimate relationships with women. Through this process she came to identify as lesbian. The client was afraid she would be rejected by her family and her faith. She also wanted her daughter to have a Baha'i education.

For the therapist, the basis of therapy is the relationship between client and therapist. Thus, she sought to establish a strong relationship with her client through focusing on and understanding the client's feelings. She believes spirituality is very important and she relies on spirituality to guide and direct her in therapy. For example, she might pray before sessions or before making difficult decisions with clients. Furthermore, she tries to avoid imposing her spiritual beliefs on clients. Instead, she wants to understand her clients' spirituality as fully as possible. She was particularly challenged by this client because she was unfamiliar with Baha'i. Therefore, she read material on the religion and listened to her client's understanding of her faith.

During therapy, the therapist helped her client clarify her spiritual conflict with being lesbian and consider the implications. She supported her client as she disclosed to her mother that she was lesbian. The therapist recognized that part of the client's

individuation from her family was developing a faith of her own. The client struggled with whether to find a different religious community or deny her identity and remain in her current one. The client realized how much her faith meant to her and how grateful she was for the moral and spiritual development she had received. Currently, she continues to participate in a limited fashion in her previous faith, while having developed a greater sense of her spiritual and personal identity.

Chapter V: DISCUSSION

Based on the therapists' methods and practice, an overarching model for therapy with spiritual problems is proposed (Figure 2). This model contains four primary domains (Philosophy, Assessment, Therapy Process, and Outcomes) which logically flow from and influence each other. For example, how therapists conceptualize spiritual problems and select ways to intervene logically follows from their philosophical approach and assumptions about spirituality, human experience, and therapy. Further, therapists approaches may be modified through working with specific spiritual problems and change their future orientation. Therapists may also modify their conceptualizations or diagnoses as therapeutic work progresses. In this model, the antecedents to therapists' philosophical approach and subsequent work with spiritual problems are their religious/spiritual background and beliefs and training. It is assumed that the way therapists think about spirituality and psychotherapy with spiritual problems has been influenced by their own spiritual backgrounds and psychological and theological training—as was noted by several therapists in this study.

Within the proposed model, therapists hold both general and spiritual philosophical approaches for working with spiritual problems. These approaches may directly influence how they conceptualize spiritual problems, what strategies they use, and how they intervene with spiritual problems. For example, consistent with their philosophical approaches, therapists demonstrated both spiritual and general interventions with spiritual problems. Finally, outcomes that affect both the client and therapist are proposed to follow from the preceding assessment and interventions. Within

the Assessment domain, therapists use specific diagnostic and conceptualization strategies for determining and understanding the types of spiritual problems encountered. Within the Therapy Process domain, specific interventions follow from the various strategies held by the therapist. Further, therapists' management of their biases and countertransference reactions is involved in the therapy process and believed to contribute to positive therapeutic outcomes.

In the following discussion, a summary description of the therapists who participated in this study will be provided. The author will then elaborate on the major themes that emerged for philosophically approaching, assessing, and treating spiritual problems in therapy. Next, the author will expand on findings related to outcomes from the work in therapy with spiritual issues. Finally, the limitations of this study and the implications for future research and practice will be discussed.

Summary Description of Participating Therapists

All of the therapists in this study were highly experienced and considered authorities by their peers in working with spiritual problems in therapy. All of them also indicated possessing a spiritual belief system, which no doubt influenced their approach, assessment, and interventions with spiritual problems in therapy. Most of the clinicians expressed deeply held beliefs in God, a divine order to the world, the goodness of life, and the power of faith and spirituality, even if they did not belong to a traditional religious institution—a finding echoed in the literature on therapists' spirituality (Bergin & Jensen, 1990; Shafranske & Malony, 1990). Most of the therapists also described a religious background that contributed to their present understanding of spirituality and

therapy with spiritual problems. Not unexpectedly, given their perception as experts in the field, most of the practitioners had received specialized training or education in religion and spirituality. This finding sets them apart from most therapists in the field today. Miller (1999a), for example, noted that the vast majority of psychologists receive no training regarding religious/spiritual issues in therapy. Training for therapists in this study included undergraduate degrees in religion, seminary degrees, coursework in graduate school, personal study in religion, and preparing presentations and workshops for other practitioners.

Approaching Spiritual Problems

Therapists discussed their philosophical approaches or overarching strategies for working with spiritual problems in therapy, which included theoretical orientations, worldviews, and goals for working with clients' spiritual concerns. Furthermore, it can be reasonably assumed that therapists' philosophical approaches influence their assessment and therapeutic interventions with clients and their spiritual problems (Figure 2).

Overall, the therapists manifested two general approaches. One involved a focus on spirituality, while the second entailed common approaches found in most clinicians' theoretical repertoire. In the latter case, therapists typically approached spiritual problems from a phenomenological and developmental perspective while emphasizing the therapeutic relationship. Given that spirituality is such a subjective experience and deeply connected with one's inner life, it makes sense that therapists would approach spiritual problems through inward searching, subjective exploration, and experiential or phenomenological methods. A phenomenological perspective enforces the view that only

the individual is an expert on her or his experience. It also provides a stance of respect and openness to whatever arises in the client's experience and a willingness to follow that experience to the construction of a more coherent and beneficial awareness of oneself and life. This perspective is also consistent with other literature endorsing a phenomenological approach to spirituality in therapy (Griffith & Griffith, 2002; Lines, 2002; Mahrer, 1996). For instance, Mahrer (1996) proposed an existential-humanistic approach to clients' spirituality that emphasized accessing clients' "inner deeper potential" through letting go of preconceived notions and ideas and following clients' experiencing in the moment.

Often combined with a phenomenological perspective, therapists typically approached spiritual problems from a developmental perspective. In this approach, therapists viewed clients' problems as obstacles or rites of passage into further spiritual and psychological development. As one therapist explained, "I guess in some ways it's kind of a developmental issue...where I think in terms of a spiritual development issue in a person's spiritual life...Like in their emotional life things change over time and to be able to deal with the changes and that experience that you're having, understand why it's changing and put some meaning on it." Like much of psychological theory, theories of spirituality are often viewed as unfolding in stages or phases of development (Fowler, 1981, 1996; Wilbur, 1984, 1999). A developmental perspective also generally refrains from pathologizing crises or symptoms, but rather views them as signals that one is under developmental arrest. These crises or problems are understood to be normal developmental occurrences throughout the life span. Further, most people must negotiate

these stages to attain greater awareness and maturity. Through spiritual awakening, therapy, significant relationships, and/or other life experiences a person may successfully navigate a particular phase of development and progress to the next. Two caveats should be mentioned. Namely, viewing spiritual problems as developmental issues assumes a value judgment on the therapist's part as to what constitutes mature or developed spirituality. Therapists should be vigilant about how their own values and assumptions might influence or impede their work with clients' spiritual problems and their understanding of spiritual development. Secondly, overemphasizing spiritual problems as developmental conflicts may result in minimizing actual pathology, thus resulting in iatrogenic harm for clients. It is conceivable that certain clients may require psychopharmacology or other medical treatments to manage spiritual crises that might otherwise be missed by a therapist over-normalizing spiritual conflicts.

The third general approach emphasized the importance of establishing a strong therapeutic relationship. From this perspective, therapists are expected to be fully present, that is, open and accessible to their own and their clients' experiencing in the moment. Further, they must establish a solid foundation of trust and safety between themselves and their clients. Seven of the 12 therapists reported endorsing a relational perspective in their work. One therapist, for example, emphasized that no significant change will take place without a solid therapeutic relationship, especially when working with spiritual issues. As the general psychotherapy literature has solidly established, there is perhaps no more important factor in therapy than a healthy working relationship between therapist and client (Bordin, 1994; Gelso & Hayes, 1998; Whiston & Sexton, 1993). This is especially

important when working with the spiritual lives and concerns of clients (Richards & Bergin, 1997). The literature cites the negative anticipation and suspiciousness that religious clients' often manifest toward secular therapy (Keating & Fretz, 1990; Worthington & Gascoyne, 1985; Wyatt & Johnson, 1990). Thus, it is imperative that clients with spiritual problems feel a strong sense of connection and trust with their therapists.

In terms of religious/spiritual approaches, the therapists typically used three orientations for addressing spiritual problems in therapy. First, six clinicians reported adhering to a pluralistic or ecumenical philosophical approach to clients' spirituality, even if their personal spiritual beliefs were more exclusive (e.g. evangelical Christianity). This supports Zinnbauer and Pargament's (2000) contention that a *pluralistic orientation* is probably most preferable for working with spiritual issues in therapy. As one therapist put it, "there's no one path to the truth, [but] a thousand paths." This approach is also consistent with Richards and Bergin's (1997) assertion that an *ecumenical* stance is required when working with spiritual clients. This philosophical perspective enables therapists to hold personal spiritual beliefs while respecting and appreciating the different beliefs and values of their clients. This perspective also recognizes that value differences are inevitable, but not inherently destructive to therapy. This raises the question, "Can therapy with spiritual problems be successful if the therapist holds an exclusivist perspective?" The answer, of course, is "it depends." If the client holds the same exclusivist position, then therapy might be successful (as was the case for one therapist).

However, imposing one's beliefs about truth and spirituality are not likely to be well received by most clients, especially those with differing views.

Secondly, most of the practitioners fundamentally valued spirituality. This makes sense given the recruiting procedure used, but it is important to emphasize nonetheless. An attitude of openness, respect, and appreciation for religion and spirituality is probably essential to working successfully with spiritual concerns. Even espousing a pluralistic perspective, most therapists admitted to struggling with imposing their own beliefs and values onto their clients. If they did not fundamentally value spirituality and its various expressions, they would probably be more inclined to intervene from their own distortions and biases and likely harm their clients. As one therapist who was conscious of her desire to impose her own beliefs put it, "I had to metaphorically sit on my hands, so as not to put my beliefs on him." There is also a matter of faith involved. Valuing spirituality and recognizing it as an asset, allowed the therapists to trust clients' organismic propulsion toward healing, growth, and wholeness. Most of the literature on spirituality supports the notion of openness and valuing of clients' religions and spirituality (e.g., Shafranske, 1996; Miller, 1999a; Richards & Bergin, 1997). Furthermore, there is recognition that "value-free therapy" is a myth and that therapists must be mindful of their clients' values, their values, and the interaction of these values in therapy (Bergin, Payne, & Richards, 1996; Richards & Bergin, 1997).

Finally, eight therapists indicated emphasizing the spiritual and personal transformation of their clients. Spiritual problems were viewed as an opportunity for healing and pain as an invitation to grow. Therapists sought to help clients change their

beliefs, understandings, awareness, and perceptions of themselves and God. These practitioners, although pluralistic or ecumenical in orientation, were not ethical relativists. They perceived some forms of spirituality as healthier than others. They recognized when their clients' beliefs and values were preventing them from achieving higher order goals such as wholeness, peace, love, and self-acceptance. In contrast, they noted when spiritual beliefs led to constricted living, interpersonal conflict, or general distress. For example, one therapist observed how his client's religious beliefs reinforced excessive self-denial and self-denigration. These beliefs resulted in depression, lack of self-respect, and being abused and taken advantage of by those around her. Many therapists witnessed their clients suffering from self-imposed bondage—living lives held hostage by constricting and harmful beliefs and behaviors. These therapists sought to awaken their clients to nothing less than fuller and freer ways of being. Both transpersonal (Wilbur, 1999) and other spiritual approaches (Cortright, 1997; Griffith & Griffith, 2002; Richards & Bergin, 1997) emphasize leading clients to greater awareness, awakening, and spiritual maturity.

In sum, the model proposed for approaching spiritual problems is multifaceted. In this model, therapists would value spirituality in all its complexity and forms of expression. They would understand the common ground among the various religions and spiritualities, appreciate their value, and distinguish between that which is helpful and harmful. They would approach spiritual concerns with an attitude of openness, curiosity, and wonder. From within a safe and trusting relationship, therapists would address both the subjective, inner world of their clients' spiritual lives and their place along the

developmental spectrum. Finally, they would emphasize spiritual transformation in their clients whether from one stage to another or from unhealthy patterns to healthy ones.

Assessment of Spiritual Problems

The second major question for this study involved how therapists assess spiritual problems in therapy. Included in this investigation were the types of spiritual problems encountered and how therapists conceptualized and diagnosed spiritual concerns. We found a large amount of consistency among the spiritual problems found in this study with those identified in the literature (Hartter, 1995; Lukoff et al., 1998). The most typical types of spiritual problems included: questioning one's faith; underdeveloped spirituality; problematic spiritual beliefs (e.g., scrupulosity); conflict in relationship with God; and feeling guilty, sinful, or being punished by God. Other types of spiritual problems seen less frequently included: career or calling issues (i.e., "what is God's will for my life?"), anger at God or the church, sexual concerns (e.g., sexual orientation), fear of rejection by God or religious community, and grief.

It is noteworthy that virtually all the therapists observed multiple spiritual problems with their clients. It appears to be a rare occurrence that someone suffers from only one problem. For instance, if someone is questioning their faith, they may also have feelings of guilt and betrayal. Additionally, a client questioning the morality of his sexual orientation may also suffer from conflict in his relationship with God, fear of rejection from his religious community, feelings of guilt, problematic spiritual beliefs, and so on. Though based on a small sample, this list can serve as a guide for clinicians of typical

spiritual problems encountered in psychotherapy. This list is by no means exhaustive and further research examining the nature of spiritual problems seen in psychotherapy on a larger scale is needed.

In terms of conceptualization of spiritual concerns, nine therapists applied a developmental framework (consistent with their philosophical approaches) to understand the nature of clients' problems. In many cases, clients were viewed as in developmental arrest and in need of spiritual maturation. Often, it was not that what their clients were struggling with was pathological, but that they were caught up in applying patterns of thinking and behavior that were no longer appropriate for their current phase in life. For instance, one therapist worked with a client who was continually seeking to reexperience the "emotional and spiritual highs" he had as an adolescent in religious youth camps. The therapist recognized the client needed to mature in his development and learn to appreciate the growth that occurs from encountering arid spiritual periods.

Furthermore, therapists typically conceptualized spiritual problems as intertwined with other psychological and relational issues. This finding recalls Lukoff et al's (1992) discussion concerning the differentiation of pure spiritual problems, mental disorders with religious/spiritual content, and spiritual problems not attributable to a mental disorder. In these cases, seldom was a spiritual problem not comorbid with other issues. This study also supports the use of the DSM-IV V-code to acknowledge the existence of spiritual problems. This practice is performed far too infrequently in therapy mostly due to lack of awareness of the V-code or conscious attention to spiritual issues (Hathaway, Scott, & Garver, 2004).

For nine of the practitioners, spiritual problems contributed to and were affected by other types of psychological concerns such as marital conflict, family of origin concerns, substance abuse, anxiety, and depression. These types of issues were related to the clients' spirituality in complex and circular ways. Therapists were understandably reluctant to address them in an isolated fashion. These results support the contention that human experience is more complex and sophisticated than simple diagnostic systems allow. Therefore, therapists must fully consider both the manifestation of spiritual problems and other types of concerns in clients, and how they interface with one another. However, several therapists attempted to distinguish psychological concerns from spiritual ones at times. This included an examination of external stressors, abuse and sexual history, how defensive they were concerning their spirituality, foundational religious beliefs, and factors related to shame.

In terms of diagnosis, eight of the therapists relied on a thorough religious/spiritual history and an investigation of the relative health of the clients' spirituality. The existing literature stresses both of these procedures (Barnhouse, 1986; Bragdon, 1993; Gorsuch & Miller, 1999; Lukoff, Lu, & Turner, 1996). One of the most effective interventions therapists used was simply to ask about clients' spiritual lives. Given the reluctance to discuss spirituality by many clients (Worthington, 1989), directly inquiring about and showing interest in spirituality may pave the road for effective therapy and outcomes with spiritual problems. Furthermore, conducting a comprehensive religious/spiritual history offers several other advantages. It illuminates aspects of their family life, childhood, openness to experience, coping strategies, morals, values,

flexibility, and resilience to name a few. As Gorsuch and Miller (1999) explain, a thorough assessment of spirituality is also predictive of health outcomes, provides a fuller understanding of clients' worldviews and life contexts, can help track client outcomes, and facilitate the use of appropriate interventions. Richards and Bergin (1997) add that assessment can help therapists determine if the clients' spirituality and spiritual community can serve as an additional resource for healing.

Consistent with the literature, the clinicians found it particularly important to diagnose the relative health of clients' spirituality (Gorsuch & Miller, 1999; Hathaway, Scott, & Garver, 2004; Richards & Bergin, 1997). This included assessing its developmental aspects or maturity and whether current spiritual values and beliefs contribute to well-being or to discord. Not all religious or spiritual expressions are equal in their benefits. Some practices and beliefs promote love, wholeness, self-awareness, and healing, while others promote fear, conflict, fragmentation, and harm. As with many problems, it is usually not a case of either/or. Some aspects of a clients' spirituality may be salutary and others maladaptive. Therapists accomplished this assessment through exploring clients' beliefs, values, and behaviors, and their consequences in terms of relationships, life satisfaction, and inner experiencing. This is an area where therapists must be particularly careful. Therapists must be aware of how their own assumptions and biases about what constitutes spiritual health affect their judgment. It is inevitable that therapists' values influence the therapy process (Bergin, Payne, Richards, 1996). What is important is to be aware of how this is so and acknowledge value differences when they occur—also known as a *values-informed perspective* (Bergin, 1991). Some clients may

not want to change their moral beliefs (such as with sexual orientation), and it is the therapist's task to respect clients' values while examining the consequences of such beliefs. It is also essential for multiculturally competent practice that therapists remain cognizant of their own reactions, biases, and assumptions (Sue, Arredondo, & McDavis, 1992). The practitioners in this study excelled in that regard, as will be discussed below.

In summary, the assessment of spiritual problems begins with recognition of the types of spiritual problems clients present. Determining the nature of the problem is essential for establishing strong therapeutic alliances and producing positive therapeutic outcomes. It is also important to recognize that clients often present with multiple spiritual concerns. In this proposed model, therapists would conceptualize clients' spiritual concerns from a developmental perspective; considering the quality, maturity, and depth of clients' spirituality. They would initiate discussion of spirituality through direct inquiry and an attitude of openness. They would also recognize how spiritual problems are often intermingled with psychological issues such as relationship conflicts, trauma, and other mental disorders. Finally, diagnosis would include a thorough assessment of clients' religious/spiritual background and history and the relative health of their spirituality. The literature presents some interview protocols and instruments that could be helpful in this regard (for a review see Gorsuch & Miller, 1999; Richards & Bergin, 1997).

Therapy with Spiritual Problems

The third major question proposed by this study entailed how therapists intervene with spiritual problems in therapy. That is, what strategies, interventions, and techniques

did therapists use to help clients resolve their spiritual concerns? Further, we examined therapists' reactions in therapy and how they managed them. One of the first important findings was that for half the therapists spiritual problems emerged over the course of therapy, sometimes taking as long as four months to be introduced. This might occur for any number of reasons. First, it is often the case that new problems emerge over time when in therapy, thus spiritual concerns arose after therapy began. Another reason might be that clients initially feel uncomfortable discussing their spirituality and only after sufficient trust in the therapist has been established do they reveal this significant aspect of their lives. Given the possibility that spiritual problems may be present but unacknowledged, it is essential that therapists explore this vital area with clients.

Therapist Strategies

Therapists utilized several strategies for working with spiritual problems. To begin with, seven therapists demonstrated openness towards clients' spirituality to facilitate therapy. Given clients' reluctance to discuss spiritual issues and the sacredness of spirituality, an attitude of openness and acceptance is critical. Therapists demonstrated this through showing interest and curiosity, office décor, conducting religious histories, advertising, and sharing some of their own spiritual beliefs. Consistent with the philosophical approach of eliciting spiritual transformation and assuming a developmental perspective, all the therapists sought to promote spiritual maturity in their clients. This involved using various interventions to facilitate movement and change in clients' current phase of development (see below).

A third common strategy (utilized by ten therapists) entailed promoting new experiences of the self in clients. This included increasing self-acceptance, self-awareness, and authenticity. For many clients, personal distress is associated with poor self-image, feelings of shame and guilt, a lack of awareness, and pressure to live up to others' expectations. Therapists focused on addressing these issues and helping clients experience themselves in new ways. For example, therapists might help their clients come to see themselves as "children of God," and thus, forgiven, blameless, loved and accepted. Clients might also experience themselves in new ways through receiving unconditional regard, intimate connection, and compassion from their therapists.

A fourth strategy involved therapists using their own spiritual experiences to understand clients and their spiritual problems. Six therapists drew upon their own spiritual background and journeys to express empathy and provide a framework for helping clients heal and grow. This finding emphasizes the need for therapists to be spiritually informed and aware of their own spiritual lives. How did they arrive at their current beliefs and values? Where have they been religiously and spiritually? What influences have guided them in their journey? Questions such as these and others should be a regular part of a therapist's self-examination and preparation for working with spiritual problems. This type of self-examination would help prevent the imposition of their own beliefs and values, and provide valuable information for facilitating empathy and healing for clients.

A fifth strategy, which occurred with nine therapists, involved addressing psychological issues to facilitate work with spiritual problems. As therapists recognized

the interconnection of other concerns with spiritual problems, they often found it useful to address these issues as an avenue for resolving spiritual crises. For instance, one therapist helped his client examine early abusive sexual experiences and their contribution to his current spiritual crisis regarding his sexual orientation. Furthermore, spiritual problems were viewed in context with other issues. Spiritual problems do not exist in a vacuum. At times, resolving interpersonal issues, healing wounds from trauma, or facilitating emotional catharsis may be pathways for understanding and healing spiritual concerns.

In a final strategy, six therapists recognized obstacles to healing or growth in their clients. Like analysis of resistance in psychoanalytic approaches, recognizing, understanding, and appreciating impediments to growth are essential for substantive transformation to occur. If such obstacles are not identified, therapy may become stalled. Therefore, therapists need to be vigilant for obstacles such as negative attitudes toward therapy, significant projections onto the therapist, or sources of mistrust. Once identified, they can be processed in therapy, hopefully leading to closer connection and therapy that is more effective. As an example, one therapist believed progress with her client was slowed by the distorted perceptions the client had toward the therapist. The client failed to see the therapist as a real person and instead attempted to maintain an idealized view of the therapist. Only after the client could see the therapist as a fallible human being struggling with similar existential questions as the client, could substantial progress be made.

In sum, therapists tended to have several objectives or strategies in mind when working with spiritual problems. In this model, therapists would seek to promote spiritual development and new experiences of the self in clients. They would also draw upon their own spiritual experiences to understand and guide clients toward further development, healing, and growth. Further, effective therapists would address other psychological issues to facilitate work with the spiritual concern. Finally, therapists would maintain an attitude of openness to clients' spirituality while simultaneously identifying obstacles to their therapy progress.

Therapist Interventions

We found that therapists applied a number of different techniques and interventions for working with spiritual problems. These interventions included both spiritually themed and general psychotherapeutic techniques. As an example of the former, nine therapists commonly applied explicitly religious/spiritual interventions such as meditation, use of scripture, and prayer. Moreover, seven therapists used clients' religious/spiritual language in therapy. This likely aided with establishing rapport, building trust, and communicating understanding. It is not known whether therapy would have been as effective without these types of interventions, but it suggests that therapists should become comfortable with the religious language of clients and typical spiritual practices that might promote insight and healing. The existing literature offers suggestions for integrating these types of spiritual practices into therapy (Marlatt & Kristeller, 1999; McCullough & Larson, 1999; Richards & Bergin, 1997; Wade & Worthington, 2004). For example, Wade and Worthington (2004) found that congruence

between client and therapist on religious commitment was an important precursor to using spiritual interventions effectively. Further, when matched with religious commitment, spiritual interventions promoted the therapy relationship and positive outcomes.

Therapists also typically demonstrated respect for clients' religious and spiritual beliefs (9 participants). Clinicians showed respect through not imposing their values on clients, adhering to clients' spiritual goals rather than their own agenda, refraining from judgment, and acknowledging the value of faith. Therapists also communicate respect through disclosing their own spiritual beliefs and experiences to the client, which is another common intervention. Often a controversial topic among practitioners, the therapists found self-disclosure of personal religious/spiritual beliefs instrumental in establishing rapport, building trust, and facilitating change in clients. For example, one therapist reported, "One thing that I did reveal to her was my own interest in work in a more kind of a theological sense. I mean I don't have a theological degree but I went to a biblical school, and minored in biblical studies, and have done some work on feminist theology. And so I think that was helpful to her because it gave her a sense that I wasn't just some liberal psychotherapist who didn't have any idea about the text."

This finding suggests that therapists may want to examine their own comfort level with discussing personal spiritual beliefs, and thoughtfully consider appropriate ways to introduce them into therapy. Virtually all the therapists in this study expressed concern about imposing their beliefs or overly influencing clients. In fact, several therapists took active measures to prevent this occurrence (see discussion on managing reactions below).

Other less frequently used spiritually themed interventions included recommending spiritual books or tapes, reframing clients' other concerns from a spiritual perspective, encouraging clients to confront God, and relying on felt spiritual guidance in therapy.

Among the general types of therapeutic interventions, therapists often employed experiential techniques (six participants) and expressed deep empathy with clients (seven participants). Experiential techniques included such things as Gestalt empty chair, experiential questions, mirroring, evocative empathy, and metaphors. Through deeper experiencing and a fuller sense of being understood by therapists, clients are likely to gain new insight into themselves, feel a strong sense of connection with the therapist, and discover new solutions for their concerns (Martin, 1999). Adhering to a philosophical approach that emphasized therapist presence and a strong working alliance, therapists frequently intervened through establishing and maintaining the therapy relationship. Consistent with the literature, therapists believed that the therapy relationship was the cornerstone to client change and healing (Gelso & Hayes, 1998). As one therapist put it, "...that's why the therapeutic alliance is incredibly important. And if that doesn't develop, I can't do my job." Therapists often accomplished this through using religious language and disclosing information about one's spiritual beliefs.

Six therapists used intuition to understand and intervene with spiritual problems. Often considered a mystical or spiritual type of experience, intuition was included under general therapist interventions because it is discussed in secular literature and believed to be available to everyone, regardless of religious/spiritual persuasion (Rea, 2001). Jung (1921/1976), for example, included intuition in his well-known typology of human

experience and personality. Intuition served as a guide for therapists in connecting with clients, comprehending the depth of clients' concerns, and making decisions about interventions. One therapist, for example, emphasized his use of intuition as his primary guide in therapy. He attributed therapeutic errors to moments of disconnection from his internal process and intuition. Of course, for these therapists their use of intuition was founded on years of spiritual practice and therapeutic experience. Finally, therapists infrequently used several other general techniques such as managing client transference, validating client strengths, processing emotion, and introducing clients to external resources for support. This last example is especially important as it may be helpful to collaborate with pastors, religious communities, or other mental health agencies to effectively address the spiritual needs of clients (Bragdon, 1993; Grof & Grof, 1992; Richards & Bergin, 1997).

In sum, therapists applied a wide arsenal of interventions for working with spiritual problems. Some were specifically spiritual in theme and focus, while others were among common techniques used by therapists in general. Unfortunately, it was not possible from this data to determine if spiritual interventions were necessary for effective therapy or if a therapist could suffice with commonly used interventions. It seems likely that some familiarity with spiritual interventions would greatly benefit a therapists' ability to establish rapport and work with spiritual problems. However, it is also encouraging that many of the common interventions among a therapists' repertoire can be used to treat spiritual concerns.

Managing Therapist Reactions

Therapists quite frequently reported having reactions to clients' spiritual crises and experienced their own biases being triggered—a common phenomenon in therapy often referred to as countertransference (Gelso & Hayes, 1998). Typically, their reactions were positive and endearing. But occasionally, therapists encountered situations in which their own assumptions, values, or issues threatened to interfere with the therapeutic process. As many therapists can testify, it is difficult to watch clients suffer, especially when it appears the suffering is avoidable. Therapists found it difficult, at times, to withhold their own spiritual beliefs when they witnessed clients struggling with beliefs that appeared to contribute to their pain. One therapist also noted having erotic countertransference reactions to his client—a risk inherent in his approach: “I believe that psychotherapy is telling the truth in love. So loving somebody is the first thing you've got to do. And love is a dangerous thing and luckily so far, I've not transformed the transference relationship into something that's benefiting me. Obviously, it would benefit me if I have sex with my client, but I have not done that, thank goodness. But just because it's dangerous, this tool, and it is very dangerous, doesn't mean that I'm not obligated as a therapist, to love.” In all of the cases, therapists made a conscious effort to recognize, identify, and manage their reactions.

The current literature is growing as to how to recognize and manage countertransference (Gelso & Hayes, 2002; Hayes, 2004). This study offers some suggestions for managing these reactions when working with spiritual problems, many of which are consistent with this literature. First, therapists valued allowing clients to have

their own experiences and develop their own views. They respected clients' spirituality and beliefs and viewed them as assets. Second, they recognized and identified reactions that might distort or interfere with the therapy process. This included identifying value and spiritual differences between clients and themselves and recognizing emotional reactions triggered by their personal issues or wounds. One therapist, for instance, recognized that he "had some real sense of discomfort about her. It triggered some of my self judgment issues. It's like 'am I going to be smart enough or am I going to be sophisticated enough, am I going to be whatever?'"—that kind of thing."

Third, therapists applied management strategies for preventing reactions from interfering with therapy. These included behavioral strategies such as using self-discipline, making differences explicit, analyzing transference, and collaborating with clients by discussing differences and reactions and how to manage them. Clinicians also used cognitive or internal strategies for managing countertransference and bias. These included using intuition, self-awareness, conscious inhibition, trust in self and therapy process, and attending to inner experiencing and bodily reactions. It is likely that therapists will encounter clients and clients' issues that trigger reactions in the therapist, especially when addressing spirituality. Therapists have a great responsibility to "sharpen their instrument," that is, keep themselves emotionally and spiritually aware and healthy so they do not unduly affect the therapy process. The therapists in this study appeared to excel in this regard.

Outcomes in Therapy with Spiritual Problems

A number of important consequences occurred from therapy with spiritual problems for both therapist and client. Ten of the therapists indicated that their clients experienced religious or spiritual change as a result of therapy. This included changing their views of God and spirituality, resolving spiritual conflicts, and changing religious communities. Another important result was that clients increased their self-awareness, self-understanding, and self-esteem. Furthermore, six therapists observed that clients improved their relationships with significant others in their lives such as romantic partners, family members, or their therapist. One implication of these findings is that therapy with spiritual problems is effective. Furthermore, the proposed models for approaching, assessing, and intervening with spiritual problems have proven successful.

Another important consequence of therapy with spiritual problems was its impact on the therapists. Seven of the therapists reported having learned new approaches or gained new knowledge for working with spiritual problems, which will likely benefit their work in the future. One therapist learned the importance of creating a psychological space for clients to discover their own ways to grow and heal. Another therapist learned to minimize interpretations of clients' spiritual beliefs. Six therapists indicated experiencing self-growth from their work with spiritual problems. For example, one therapist learned the value of his internal strength, his genuine patience with clients. Less frequently, therapists acknowledged reexamining and reinforcing previous beliefs and values and experiencing self-growth. Thus, therapy with spiritual problems benefits both client and therapist in significant ways.

Limitations

My intent was to propose substantive models for approaching, assessing, and treating spiritual problems in therapy. These results are limited to this sample of 12 highly experienced therapists who volunteered to participate in this study. Thus, these results may not be representative of those who were invited to participate but declined. However, the size of our final sample is within the methodology's established guidelines (Hill et al., 1997). We were able to balance therapist sex, but we had more White heterosexual therapists, than non-White and non-heterosexual therapists. Moreover, the therapists were primarily from Christian religious traditions, although there were a variety of denominations represented and experiences with other spiritualities. Thus, therapists from other religious traditions (e.g., Judaism or Islam) may approach spiritual problems in different ways from those mentioned in this study.

We also recognize that only therapists' perspectives were investigated in this study. We lack the clients' view on their experiences with addressing spiritual problems in therapy. Thus, we have only the therapists' self-report about perceived outcomes and experiences of clients. However, at least one qualitative study is in the process of examining clients' experiences with therapy for spiritual concerns (S. Knox, personal communication, August, 2001). Further, few therapists reported on the race or ethnicity of their clients. Therefore, it is unclear whether these findings are limited to a particular racial or ethnic group of clients. Another issue was that this study primarily focused on successful cases. It could be that the proposed models for therapy with spiritual problems

would be unsuccessful with some clients or that different models were used in unsuccessful cases.

It was initially hoped that therapists would present challenges differentiating between severe pathology and spiritual experiences such as with mystical experiences vs. psychotic episodes. However, this was not the type of experience commonly encountered by the participating therapists. In future studies on assessment with spiritual problems, investigation in medical, psychiatric, or private treatment settings might better address how practitioners distinguish between pathology and spirituality in severe symptomology. Finally, we provided the participants with the interview protocol prior to the interview meeting so that therapists could provide fully informed consent, and have the opportunity to think about their experiences before the interview. We recognized that providing interview questions beforehand may have allowed participants to present their comments in socially desirable ways. On the other hand, it may facilitate richer responses as well (Hill et al., 1997).

Implications for Research and Practice

When taken as a whole, the models presented provide a suggested framework for addressing spiritual problems that may be beneficial for therapists and educators.

Therapists can apply the whole framework as a system for treating spiritual problems or select those features which would benefit their practice. Supervisors and educators may find the model helpful in teaching trainees a model for approaching, assessing, and intervening with spiritual concerns. Therapists can also use the framework to examine their own approach to spiritual problems and, if necessary, supplement missing elements

with additional training or study. For example, therapists might recognize the need to strengthen their developmental understanding of spirituality. Thus, they could attend trainings or study the spiritual and moral development theories of James, Fowler, or Kohlberg. Clinicians might also invest time and energy, if not already doing so, examining their own personal spiritual development and experiences and how they might be relevant to their clients' spiritual issues. Along these lines, therapists should examine their own spiritual assumptions and biases and how they might impact therapy. Therapists might also be encouraged that some of the common theories and interventions they adhere to are applicable with spiritual concerns.

In terms of assessment, therapists can anticipate what some of the most common types of spiritual problems may be for their clients. Further, they could regularly conduct a comprehensive assessment of clients' religious/spiritual history and the health of their spirituality (Gorsuch & Miller, 1999; Hathaway, Scott, & Garver, 2004; Richards & Bergin, 1997). In conceptualizing these problems, practitioners can apply a developmental framework with the understanding that other psychological and interpersonal issues interact with spiritual problems in complex ways. In terms of interventions, this framework provides therapists with numerous strategies and techniques which have proven useful in the successful treatment of spiritual problems (Miller, 1999b; Shafranske, 1996; Wade & Worthington, 2004). Moreover, therapists can select interventions which seem most appropriate for their clients. Clinicians could also pursue additional training or education in interventions with which they are less familiar such as the use of meditation or mindfulness (Marlatt & Kristeller, 1999).

The findings in this study may also be useful in future research on spiritual problems. First, these findings could be substantiated through empirical investigation. For example, the models presented here could be used in controlled effectiveness studies comparing them with other approaches and in different populations. Based on this study, it appears that both general and spiritual interventions were important for client improvement. Future empirical investigation could examine whether it is necessary to use spiritual interventions, or do clients' general symptoms and specific spiritual concerns improve with general psychotherapeutic interventions. In addition, these findings may help in shaping future measurement of spiritual problems. Based on the findings in this study and others (Carroll et al., 2000; Johnson & Hayes, 2003; Lukoff et al., 1998), an inventory of spiritual problems could be developed and used to address the nature and prevalence of spiritual problems in different populations. Knowing this information may help in identifying and addressing spiritual problems more quickly in treatment settings. Diagnostic and assessment protocols could also be developed and validated in various treatment settings.

The field may also benefit from future research that examines approaches from pastoral counselors or spiritual directors. How do these professionals, with specific training in spirituality, address the spiritual concerns of their clients? What differences occur between these professionals and secular therapists? As mentioned above, it would also be beneficial to capture clients' experience of presenting spiritual concerns in therapy. What is their experience like? From clients' perspective, what helped them admit the problem and find resolution? What factors slowed progress or hindered their

discussion of spiritual problems? Clients' voices need to be heard to have a more comprehensive understanding of this phenomenon. Further, research could investigate what training programs and educational centers can do to better prepare therapists for working with spiritual issues. It is clear that spirituality falls under the rubric of multicultural competence (Lukoff & Lu, 1999; Miller, 1999a; Shafranske & Malony, 1996; Yarhouse, 2003), therefore, research could address how trainees and professionals can better improve their knowledge and skills in this area.

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Appendix A: Tables and Figures

Table 1

Descriptive Summary of Domains

Therapist Approach/Philosophy:

The conceptual framework, philosophy, or approach used to work with spiritual problem(s).

Assessment of Spiritual Problem:

Types of spiritual problems presented; assessment and diagnosis of spiritual problem; and description, explanation, or conceptualization of spiritual problems the client presented

Therapy Process:

Techniques/interventions used to work with spiritual problems, therapeutic relationship or alliance, the course of therapy, and the client/therapist experience

Client Description:

Client information (e.g., demographics, family of origin, presenting concerns), client background

Therapist Religious/Spiritual Background and Beliefs:

The therapist's spiritual/religious background, beliefs and values

Therapy Outcomes:

Any treatment outcome or change in the client that is in the therapist's view a result of working with the spiritual issue

Therapy Impact on Therapist:

How the therapist was changed by the client, issue, and/or work; what the therapist learned from the experience

Therapist Training:

Training, education, or experiences that assist the therapist with working with spiritual issues in therapy (e.g., peer supervision/consultation, institutes of training).

Table 2

Categories and Frequencies for Client Description Domain

Primary Category	Category	Frequency
Demographics	Age, ethnicity, and sex	Typical
	Educational experience	Typical
	Family characteristics	Typical
	Relationship status	Typical
	Children	Variant
Presenting Issues	Employment or professional experience	Typical
	Relationship conflict	Typical
	General conflict	Typical
	Sex	Variant
	Anger	Variant
	Sexual orientation or gender concerns	Variant
	Other mental health concerns	Typical
	Substance abuse	Variant
	Depression/anxiety	Variant
	Social status or respectability	Variant
	Miscellaneous	Variant
	Personal attributes	Personal characteristics
Positive		Typical
Negative		Variant
Background	Religious/spiritual beliefs or practices	Typical
	Family background	Typical
	Family members	Typical
	Childhood	Variant
	Religious/spiritual background	Typical

Note: To determine representativeness of the sample, the following criteria were used: general = all 12 cases represented, typical = 6-11 cases represented, variant = 2-5 cases represented.

Table 3

Domains, Categories and Frequencies for Therapist R/S Background or Beliefs and Training

Domain	Category	Frequency
Therapist R/S Background	Religious affiliation	General
	Spiritual worldview	Typical
	Religious/spiritual background	Typical
	Spiritual journey/changes in beliefs	Variant
	Beliefs about people	Variant
	Spirituality's affect on therapy process	Variant
	Helpful	Variant
	Harmful	Variant
Training	Spiritual influences	Typical
	Personal	Typical
	Workshops/institutes	Variant
	Graduate programs/courses	Typical
	Personal experiences and religious background	Variant
	Relationships	Variant
	Professional and work experiences	Variant

Note: To determine representativeness of the sample, the following criteria were used: general = all 12 cases represented, typical = 6-11 cases represented, variant = 2-5 cases represented.

Table 4

Categories and Frequencies for Therapist Approach/Philosophy Domain

Primary Category	Category	Frequency	
Religious/Spiritual Approaches	Emphasized spiritual and personal transformation	Typical	
	Fundamental valuing of spirituality and human experience	Typical	
	Pluralist/ecumenical spiritual perspective	Typical	
	Therapy viewed as spiritual or divine encounter	Variant	
	Personal spiritual experiences inform approach	Variant	
	Typical problems encountered in therapy viewed as spiritual problems	Variant	
	Buddhist, Eastern, or New Age philosophy	Variant	
	Christian philosophy	Variant	
	Informed by Jungian or other spiritually informed psychologists	Variant	
	Worked within clients' religious/spiritual beliefs or traditions	Variant	
	Emphasized creation of meaning or search for truth	Variant	
	Spirituality defined as relationship	Variant	
	Adhered to wounded healer concept	Variant	
	General Approaches	Phenomenological approach	Typical
		Developmental approach	Typical
Emphasized therapeutic relationship or therapist presence		Typical	
Holistic or systemic view of therapy and person		Variant	
Worked with emotions to address spiritual problem		Variant	
	Approached spiritual problems in similar fashion as other problems	Variant	

Note: To determine representativeness of the sample, the following criteria were used: general = all 12 cases represented, typical = 6-11 cases represented, variant = 2-5 cases represented.

Table 5

Categories and Frequencies for Assessment of Spiritual Problems Domain

Primary Category	Category	Frequency
Types of spiritual problems	Questioning or changing religious/spiritual beliefs	Typical
	Underdeveloped spirituality or arrested development	Typical
	Problematic religious/spiritual beliefs	Typical
	Unhealthy religious/spiritual beliefs	Typical
	Scrupulosity or rigid spiritual beliefs	Typical
	Conflict in relationship with God	Typical
	Client feels guilty, sinful, or being punished by God	Typical
	Career or calling	Variant
	Angry at God or church	Variant
	Sexuality	Variant
	Fear of rejection by God or community	Variant
	Grief/Loss	Variant
	Conceptualization of spiritual problem	Viewed as developmental issue
Intertwined with psychological issues		Typical
Depression or anxiety		Variant
Self-concept or loneliness		Variant
Miscellaneous		Typical
Intertwined with relationship issues		Typical
Partner or spouse		Typical
Other		Typical
Viewed as opportunity for growth and healing		Variant
Diagnosis		Religious background/history
	Health of client's spirituality	Typical
	Psychological/developmental history	Variant
	Characterological or personality traits	Variant
	Therapist avoids pathologizing client	Variant
	Differentiated spiritual difficulties from secular/psychological problems	Variant
	Client's desires, needs, goals	Initial therapy or assessment goals not explicitly spiritual
Client striving for authenticity or relatedness		Variant

Note: To determine representativeness of the sample, the following criteria were used: general = all 12 cases represented, typical = 6-11 cases represented, variant = 2-5 cases represented.

Table 6

Categories and Frequencies for Therapy Process Domain

Primary Category	Category	Frequency
Therapist strategies	Promoted spiritual development or change	General
	Promoted new experience of self	Typical
	Self-acceptance	Variant
	Self-awareness	Variant
	Authenticity	Variant
	Personal spiritual experiences facilitated	Typical
	understanding client and spiritual problem	
	Addressed psychological issues to facilitate work with the spiritual problem	Typical
	Openness towards client's spirituality	Typical
Therapist interventions	Recognized client obstacles to healing or growth	Typical
	Monitored client's reactions to therapy interventions	Variant
	Spiritually-themed interventions	
	Explicitly religious/spiritual (R/S) intervention	Typical
	Meditation/Mindfulness	Variant
	Use of scripture	Variant
	Other	Variant
	Used R/S language of client	Typical
	Therapist self-disclosure	Typical
About personal R/S beliefs	Typical	
About therapist's work with R/S issues	Variant	
Respected client's R/S beliefs or values	Typical	
Encouraged client to confront God	Variant	
Recommended R/S books or tapes	Variant	
Reframed client's problem with R/S perspective	Variant	
Guided by divine or spiritual force	Variant	
General therapist interventions	Empathy and understanding	Typical
	Formed therapeutic alliance	Typical
	Established initial rapport	Variant
	Built and maintained alliance	Typical
	Intuition	Typical
	Guided by intuition or inner experience	Variant
	Conceptual frameworks secondary to intuition	Variant
	Exploration techniques	Typical
	Managed client transference	Variant
	Recognition	Variant
	Used to facilitate therapeutic work	Variant
	Validated client's strengths	Variant
	Focused on and processed client's emotion	Variant
Introduced client to external resources	Variant	
Reactions in therapy	Therapist reactions to client or therapy	Typical
	Positive reactions	Typical
	Negative reactions	Variant
	Countertransference or therapist bias	Typical
	Manifestations	Variant
	Management strategies	Typical

	Behavioral strategies	Variant
	Cognitive or internal strategies	Typical
	Client reactions in therapy	Typical
	Positive reactions	Typical
	Negative reactions	Variant
Course of therapy	Context	Typical
	Spiritual problem emerged over course of therapy	Typical
	Therapeutic issues during course of therapy	Variant

Note: To determine representativeness of the sample, the following criteria were used: general = all 12 cases represented, typical = 6-11 cases represented, variant = 2-5 cases represented.

Table 7

Domains, Categories and Frequencies for Therapy Outcomes and Therapy Impact on Therapist

Domain	Category	Frequency
Therapy Outcomes	Religious/spiritual change	Typical
	Changed views of God or spirituality	Typical
	Resolved spiritual conflict	Typical
	Changed religious/spiritual community or environment	Variant
	Self-improvement	Typical
	Gained new understanding of self	Typical
	Increased self-worth	Variant
	Improved relationships	Typical
	Spouse or partner	Variant
	Family	Variant
	Other	Variant
Therapy Impact on Therapist	Made decision to start new life	Variant
	Learned new approaches or gained knowledge	Typical
	Self-growth	Typical
	Reexamined or reinforced previous beliefs/values	Variant

Note: To determine representativeness of the sample, the following criteria were used: general = all 12 cases represented, typical = 6-11 cases represented, variant = 2-5 cases represented.

Figure 1: Conceptual Map of Study

Tradition of Inquiry

Consensual Qualitative Research

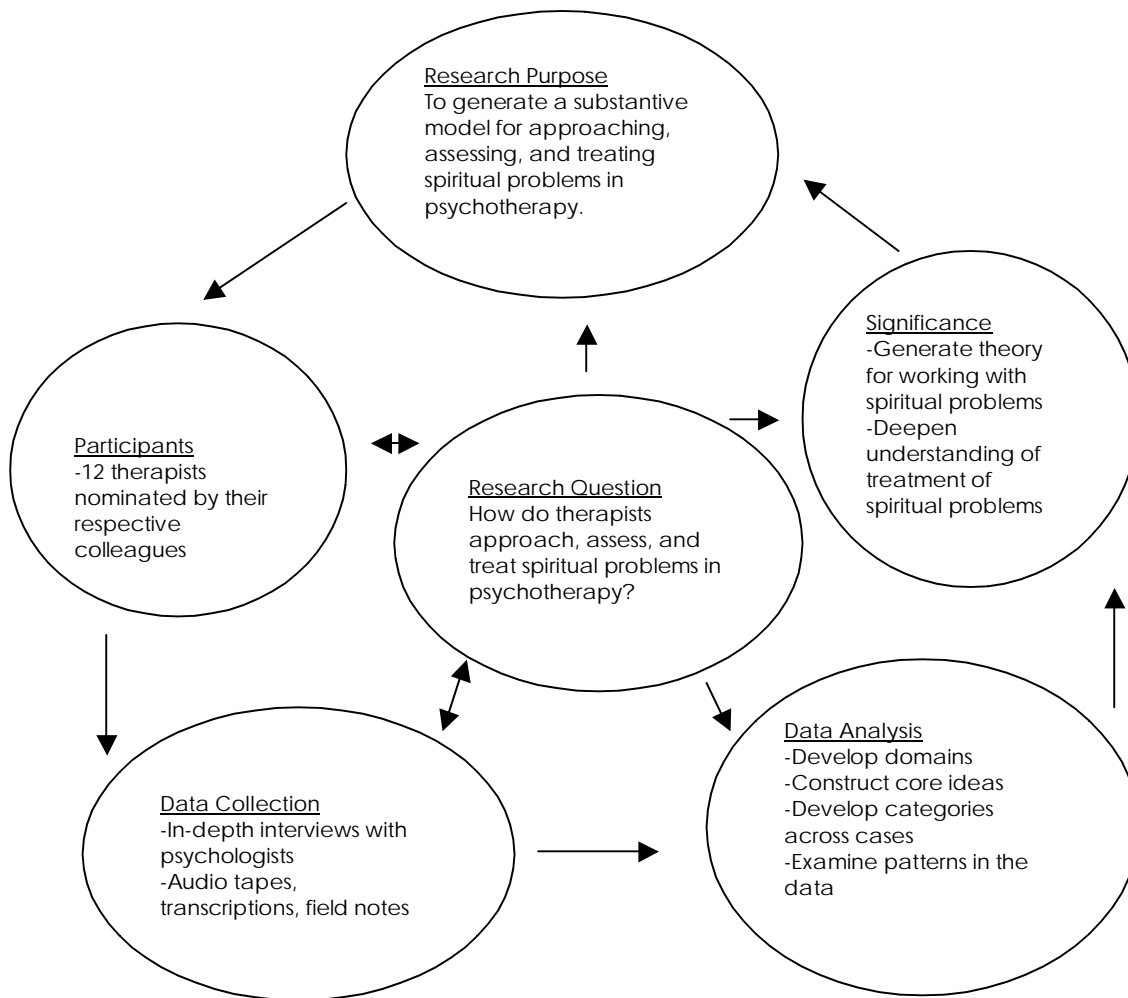
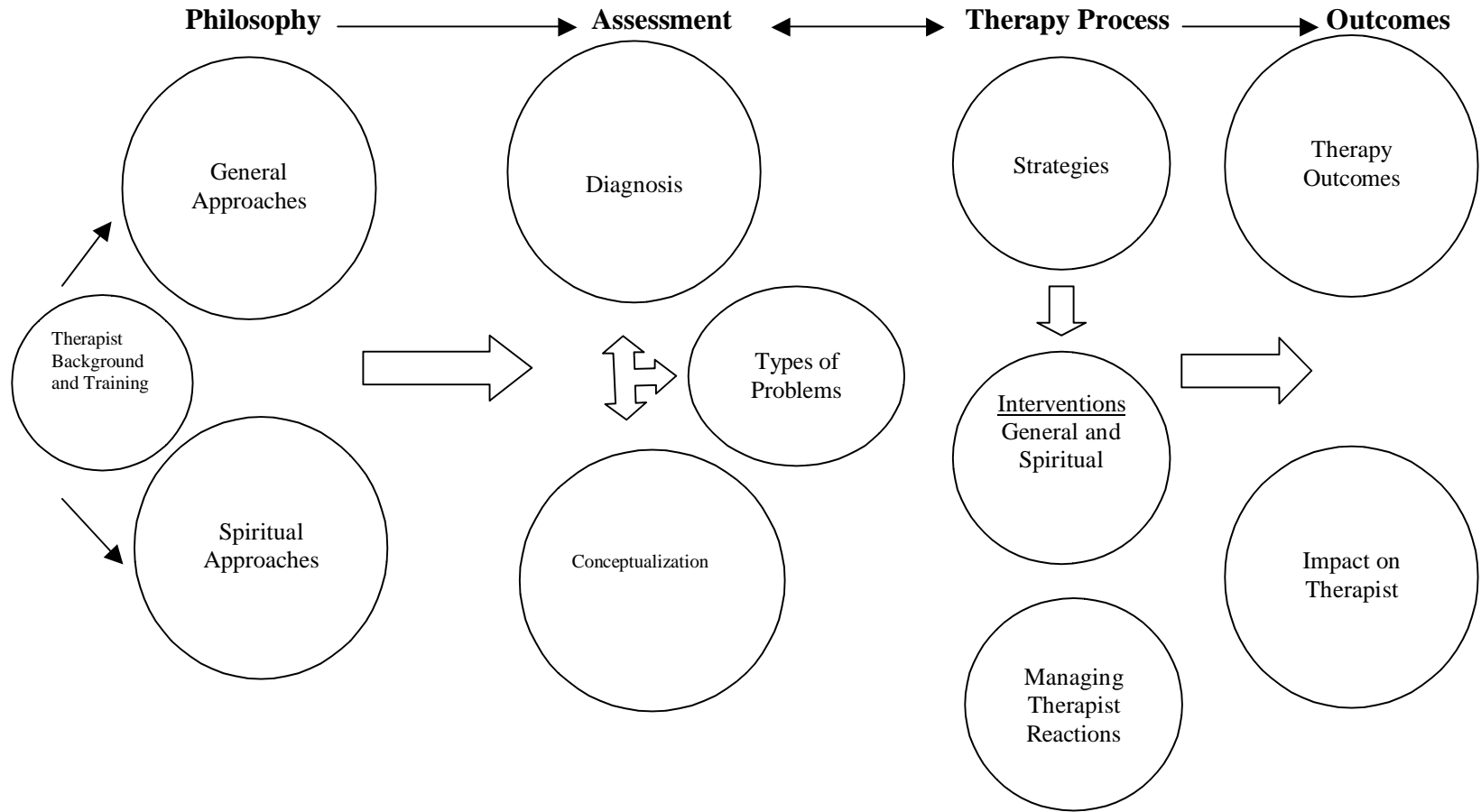


Figure 2: Proposed Model for Therapy with Spiritual Problems



Appendix B: Nomination Letter

«Date»

Chad V. Johnson

«Street»

«Town»

«Email»

«Name»

«Street»

«Town»

Dear «LastName»,

I am a graduate student in the doctoral program in Counseling Psychology at Penn State University and currently an intern at the Vanderbilt University Psychological and Counseling Center. I would like to request five minutes of your valuable time to nominate three to five fellow psychotherapists for participation in my dissertation research. I am planning to interview 12 to 15 psychologists about their experiences in treating **spiritual problems**, for a total of up to 60 minutes, plus a brief follow-up phone interview. Spiritual problems include but are not limited to distress associated with questioning or losing one's faith, mystical experiences, near-death experiences, or other spiritual experiences (e.g., meditation). Several colleagues and I will interpret the interview data according to the Consensual Qualitative Research strategy. My advisor is Jeffrey Hayes, Ph.D.

In order to be nominated, a therapist must:

1. Be a licensed or certified therapist practicing outpatient therapy with adult clients within a three-hour drive of «Town».
2. Have a minimum of five years' post-licensure experience.
3. Be, in your estimation, a highly effective therapist.
4. Be, in your opinion, open to discussing personal and aspects of her or his work.
5. Be, in your estimation, experienced in treating spiritual issues in psychotherapy.

In order to be considered for the study, your nomination form must be postmarked by Monday, (Date). Simply fill out the enclosed nomination form and mail in the prestamped return envelope. Please be advised that your nominations cannot be associated with you. Return envelopes are coded in the event that a second mailing is required, but the envelopes will be separated from the nomination forms when opened.

I deeply appreciate your help in this matter. Your knowledge of your colleagues will help to assure the quality of this research into an important topic.

Sincerely,

Chad V. Johnson

Appendix C: Invitation to Participate

«Date»

Chad V. Johnson

«Street»

«Town»

«Email»

«Name»

«Street»

«Town»

Dear «LastName»,

You have been nominated by your colleagues as an experienced therapist who is likely to be open to discussing your approach to working with clients' spiritual problems in psychotherapy. I am writing to ask whether you would be interested in participating in a qualitative, interview-based study on the diagnosis and treatment of spiritual problems. For this study, *spiritual problems* are defined as spiritual issues that cause distress for clients. *Spiritual* in this context refers to one's relationship to the transcendent (e.g., Allah, Supreme Being, the Cosmos, Brahman, the Godhead, etc.) not necessarily related to formal religious institutions. Examples of spiritual problems include, but are not limited to, loss or questioning of one's faith or spiritual values, leaving a cult or religious group, and distress related to near-death, mystical, meditative, or other types of spiritual experiences. I am particularly interested in work you have done that presented challenges to diagnosis and treatment (e.g., determining a psychotic episode vs. mystical experience). This study will complete my thesis requirement for the doctoral program in Counseling Psychology at Penn State University. My advisor is Dr. Jeffrey Hayes.

Participation would take a total of one to two hours of your time, including a 45 to 60 minute interview, a possible follow-up phone interview, and/or an optional second face-to face interview. You will also be invited (but not required) to revise a narrative account of your personal experience and to contribute to the model of treatment for spiritual problems developed in response to all of the interviews. I believe that your participation would greatly enhance this research, and may be an enriching experience for you as well.

I would appreciate your prompt response whether or not you are interested in participating. If you are interested, please carefully read and sign the informed consent form, complete the enclosed demographic form, and return these to me in the enclosed, stamped envelope. I will call you to ensure that we have the same idea of what the study entails, and to schedule an interview if we agree on your participation. I will send you the interview questions one week in advance of the interview. If you are not interested, simply return the demographic form with your name on it and the "not interested" box checked, or email me at **cvj2@psu.edu**.

If you have any questions regarding this study that you would like answered before agreeing to participate, please call me at (***) ***-****, or email me with your concerns before returning the informed consent form. I sincerely hope that you will take this opportunity to contribute your expertise to a clinically and theoretically important area of psychotherapy research.

Sincerely,

Chad V. Johnson

Appendix D: Demographic Form

Research on Treatment of Spiritual Problems

Not interested in participating (please write name below)

Name: _____

Degree: _____ Yr Received: _____

Address: _____

Yr of Licensure: _____

Yrs of Clinical Experience *Pre-*
Licensure: _____

Phone #s:(hm): _____ (wk): _____

Yrs of Clinical Experience *Post-*
Licensure: _____

Best times to reach you:

Age: _____ Sex: _____

(hm) _____ (wk) _____

Email: _____

Racial/Ethnic Identification(s): _____

Partnership Status: _____

Theoretical Orientation(s): _____

Religious Affiliation(s) and/or Spiritual
Orientation(s): _____

Appendix E: Interview Protocol

Interview Protocol

In preparation for the interview, choose a client of yours who meets the following criteria:

- A. Completed therapy within the past 12 months (the more recent the better).
- B. Presented with distress associated with a spiritual problem and sought remediation for this problem. It is not necessary that this problem be the primary presenting concern for treatment or main focus of treatment. It is only necessary that a spiritual problem became the focus of treatment for a period of time.
- C. The client presented with a “pure” religious/spiritual problem or one that was comorbid with other problems, but was not the result of pathology (e.g., schizophrenia, psychotic episode, etc.) from your perspective.

Interview Questions

The following questions will be asked in the course of the interview. Please allow yourself time to think about these questions before the interview. You may wish to express your thoughts in writing if you find this helpful.

1. How would you describe this client (demographic information, presenting complaints, family background, case conceptualization) and the presenting spiritual problem? Please omit (rather than change) any information that could reveal the identity of the client.
2. What was it like working with this client? What did you find helpful/not helpful in working with this client? What would you do differently? How would you describe the outcome?
3. How did you establish/maintain the therapeutic alliance when working with this spiritual problem? What did you find helpful/not helpful in this regard?
4. What process did you go through to assess and/or diagnose the spiritual problem?
5. How did you differentiate a spiritual problem versus psychopathology? (e.g., client functioning, previous psychological history, content of thoughts/delusions/hallucinations, duration of crisis)
6. How do you conceptualize the client and the client’s spiritual problem? (e.g., what did you see as the source(s) of the client’s problem? What were the predisposing intrapsychic, systemic, and/or spiritual factors?)

7. How did you approach this client's spiritual problem philosophically? What was your conceptual frame of reference?
8. What techniques and strategies did you use?
9. How do you approach this spiritual problem differently than other types of problems?
10. How do your own religious/spiritual views influence your work with this client or clients in general with spiritual problems?
11. What have you learned about the treatment of spiritual problems from working with this client?
12. How did you grow as a therapist and/or person from working with this spiritual problem?
13. What types of training (e.g., graduate school, workshops, institutes) have you had in working with spiritual problems?

Appendix F: Categories and Core Ideas

Categories Client Description (a = Therapist 1, b = Therapist 2, etc.)

Demographics

A) Educational experience

- Client has graduate degrees in seminary (a)
- Client has graduate degree in psychology (a)
- Client was a professional with graduate degrees (b).
- Client attended seminary to be a music minister (e).
- Client is a 28-year-old white female in graduate school studying human development and counseling (f).
- Client paid her own way through college and became a teacher (h).
- Client is a graduate student (i).
- Client was under the guidance and tutelage of her local bishop upon entering therapy (j).
- Client is a college student (k).

B) Employment and/or professional experience

- Client does part-time college teaching (a).
- Client teaches a course on sexuality (a).
- At the beginning of treatment the client was working as a minister in the church (a).
- Client wrote book of devotions before leaving Christian faith (a).
- Client worked in the arts (b).
- Client was a professional with graduate degrees (b).
- Client is a teacher (c).
- The client is a successful surgeon in his early to mid-40s (d).
- Client obtained sales job because he could not find a music ministry position and was successful at it (e).
- Client paid her own way through college and became a teacher (h).
- She was part of a religious order in New York (j).

C) Family characteristics

1) Relationship status

- Client was single (a).
- The client was married with one child (b).
- Client has been married for 8 years (c).
- Client married for 11 years (e).
- Client is married with three children (g).
- Client had been married for 26 years (h).
- Client was estranged from her husband (j).
- Client had recently been shunned by her female lover (j).
- Client was in an unfulfilling marital relationship (j).
- Client was having an affair with a woman (j).

2) Children

- The client was married with one child (b).
- Client had one child (e).
- Client had one child (e).
- Client is married with three children (g).
- Client had 3 adult sons (j).
- Client has a 4-year-old daughter (l).

D) Age, ethnicity, and sex

- Client is in his 30s (b).
- Client is a teacher in her early 30's (c).
- The client is a successful surgeon in his early to mid-40s (d).
- Client is a 34-year-old male (e).
- Client is a 28-year-old white female in graduate school studying human development and counseling (f).
- Client a 42-year-old White male (g).
- Client is female (i).
- Client is female (k).
- Client is 20 years old (k).
- Client is a 28-year-old female (l).

Therapy Concerns

A) Relationship conflict

1) General conflict

- Client presented with marital conflict (b).
- Client experienced ambivalence about whether to stay in marriage (b).
- Client felt abandoned by husband (c).
- Client felt blamed by husband (c).
- Client's husband lacked patience and understanding (c).
- The client presented with concerns about his marriage and their lack of a sexual relationship (d).
- Client sought therapy for help with marital problems (e).
- Client presented with distress concerning his marriage (g).
- Client presented for therapy after husband demanded a divorce (h).
- Client experienced frequent criticism from her husband which affected her self-worth (h).
- Client received no compensation from divorce (h).
- Client was estranged from her husband (j).
- Client had recently been shunned by her female lover (j).
- Client was experiencing intense grief from loss of relationship (j).
- Client was in an unfulfilling marital relationship (j).

2) Sex

- Client developed sexual relationship with previous pastoral counselor that was destructive for her (a).
- Client's marriage complicated because of sexual dysfunction (c).
- Client's husband did not understand how painful sex was (c).

- Client's marriage complicated because of sexual dysfunction (c).
- Client's husband did not understand how painful sex was (c).
- Client felt sexually inadequate (c).
- After surgery, client discovered her sexuality and had pleasurable sexual experiences (c).
- Client anger at husband prevented her from exploring her sexuality with him (c).
- The client presented with concerns about his marriage and their lack of a sexual relationship (d).
- Her dream was challenged by unexpected pregnancy (i).
- Client was having an affair with a woman (j).
- Client felt conflicted about morality of her affair and sexuality (j).

3) Anger

- Client anger at husband prevented her from exploring her sexuality with him (c).
- Client's husband was frequently angry with her (c).
- Client was angry and resentful towards spouse (e).
- Client was angry at wife for not completing her doctoral degree sooner (e).
- Client angry at wife because they moved for her schooling and he was unable to find a job that he wanted (e).

B) Sexual orientation or gender

- In individual therapy, the client addressed emerging questions about his sexual orientation (d).
- In individual therapy, the client addressed his ambivalence about attracting attention as a gay man (d).
- In therapy, the client addressed his tremendous shame and confusion over his feelings and wish to be heterosexual (d).
- Client experiences ambivalence about morality of sexual orientation (f).
- Client grew up with sense that she was different from others around her in terms of her gender preference (f).
- Client had questions and conflict about her sexual orientation (j).
- Client felt conflicted about morality of her affair and sexual orientation (j).
- Client had questions and conflicts concerning her gender and her religion (j).
- Major problem was sexual orientation issues (l).

C) Other mental health concerns

1) Substance Abuse

- Client received treatment for alcohol abuse which included her family (f).
- Client had recently stopped drinking alcohol (i).
- Client had recently stopped consuming caffeine (i).
- Client had recently stopped smoking marijuana (i).

2) Depression/anxiety

- Client displayed classic signs of depression including disrupted sleep, eating problems, worry, and frequent crying (g).
- Client received hospital treatment for depression following divorce (h).
- Client responded poorly to medication and was given 11 ECT treatments for depression (h).
- Client presented in counseling with enormous anxiety (k).
- Client reported feeling agitated and unable to concentrate on schoolwork (k).

- Client took antidepressant medication for some time (l).
- Client decided to discontinue antidepressant (l).
- Client is functioning well off of antidepressant (l).

3) Social status or respectability

- Client worried how divorce might affect relationship with church community (g).
- Client struggled with demands to maintain social respectability (j).
- Client felt great pressure to belong to certain groups (k).
- Client felt great pressure to be successful in school (k).
- Client's church emphasized evangelical message, but also stressed importance of social status and appearances (k).

4) Miscellaneous

- Client experienced repeated abandonment as a child (h).
- Client was sexually abused by family member (h).
- Client's lifelong ambition was to complete her PhD, but her dream was challenged by unexpected pregnancy (i).
- Client felt oppressed by expectations from church and family (k).
- Client is on mental health disability (l).
- Client's presenting concern was to move out of parent's home (l).
- Client presented wanting to work on low self-esteem and sense of inferiority (i).
- Client had personal identity issues in addition to spiritual and psychological (j).

Personal attributes

A) Personal characteristics

1) Positive

- Client is incredibly bright (a).
- Therapist considered client bright (b).
- Therapist considered the client as fairly mentally healthy (b).
- Client was respected in the community (b).
- Therapist finds client likeable (c).
- Therapist finds client attractive (c).
- Therapist finds client easy to connect with (c).
- The therapist experienced the client as someone who was outwardly powerful, both physically and professionally, and yet inwardly vulnerable and boyish (d).
- Therapist viewed client as intelligent, insightful, and likeable (e).
- Client evidenced stereotypical small town masculine traits (g).
- Client and husband were reputable members of their community (h).
- Therapist viewed client as strong, creative, and amazing person (h).
- Therapist viewed client as a person with a sweet nature (h).
- Therapist viewed client as sweet, caring, bright and fun (k).

2) Negative

- Client experienced memory loss from ECT (h).
- She had little trust in others, especially men (i).
- Client had a strong anti-social/anti-establishment mentality (e.g., easily offended, demanding exceptions to nearly all rules, quick to find others condescending) (i).

- This anti-establishment mentality made her highly challenging to work with for therapist and staff (i).
- Client is mentally challenged, that is, she is intellectually slow (l).
- Client is easily taken advantage of (l).
- Client viewed herself as being wild and rebellious (l).
- Therapist viewed her as being naïve and gullible (l).
- Therapist viewed her as desperately wanting acceptance from peers (l).

B) Religious/Spiritual beliefs or practices

- Client's religious beliefs and practices are very important for her (c).
- Client was deeply religious (c).
- Client was very active in her church (c).
- At beginning of treatment, client had not yet found a church to attend regularly (d).
- Client attending protestant church with a lesbian pastor (f).
- Client found support in gay affirming church (f).
- Client is an active member in a conservative religious group (g).
- Client and husband were very involved in their church (h).
- Client uninvolved in church or religion at time of treatment (i).
- She was part of a religious order in New York (j).
- Client was under the guidance and tutelage of her local bishop upon entering therapy (j).
- Client was loosely clinging to previous beliefs, yet not prepared to let them go (k).
- Client could not move past confessing sins in her prayer life (k).
- Client received strong moral foundation from religious faith (l).
- Therapist views client as spiritual person with strong sense of values (l).

Background

A) Family background

1) Family members

- The client sought the approval of his religious parents (d).
- Client had a loving relationship with his mother (d).
- Client had a complicated relationship with his father, to whom he struggled with a lasting drive to prove his manhood (d).
- Her father is an entrepreneur (f).
- She is the youngest of five children from a wealthy family (f).
- Client's mother died during course of treatment (h).
- Client's parents were divorced when she was young (i).
- Client had one younger sister and no other siblings (i).
- Client's mother did not recognize pressure she was placing on daughter to succeed (k-Assessment).
- Client was living with her parents at beginning of therapy (l).
- Mother very open and tolerant person (l-Assessment).
- Father is on dialysis and not expected to live long (l-Assessment).

2) Childhood

- Client was raised in a secular family with little emphasis on religion and spirituality (b).
- Client moved frequently as a child and often felt like an outsider (e).

- Client's family converted to more conservative church when he was 10 or 11 years old (g).
- Client experienced repeated abandonment as a child (h).
- Client was sexually abused by family member (h).
- Her social toughness was at one time highly adaptive and helped her survive a difficult childhood (i).
- Client had terrible experience in high school (l).
- Client only happy memory is participating in Special Olympics (l).

B) Religious/Spiritual background

- Client has graduate degrees in seminary (a).
- At the beginning of treatment the client was working as a minister in the church (a).
- Client wrote book of devotions before leaving Christian faith (a).
- Client was raised in a secular family with little emphasis on religion and spirituality (b).
- Client belonged to the Church of Christian Science (b).
- The client was raised in the Baptist church (d).
- Client attended seminary to be a music minister (e).
- Client is child of Baptist missionaries (e).
- Client became a Christian in high school after intense spiritual experience (e).
- Client was raised in a less conservative church until he was 10 or 11 years old (g).
- Client's family converted to more conservative church when he was 10 or 11 years old (g).
- Client was raised Catholic (i).
- Client's religious background is evangelical Christian (k).
- Client's family belonged to an affluent church (k).
- Client felt pressure from family and church to be successful (k).
- Client's upbringing was faith-based or evangelical Christian (k).
- Client's church emphasized evangelical message, but also stressed importance of social status and appearances (k).
- Client and client's family belong to Baha'i religion (l).
- Therapist compares Baha'i to American Indian religious systems (l).
- Baha'i faith a closed system—problems are settled from within (l).
- Client does not value smoking or drinking (l).
- Client has a good moral foundation (l).
- Client is a spiritual person (l).

Categories Therapist R/S Background/Beliefs

A) Religious Affiliation

- Therapist finds his current religious affiliation (Unitarian) provides a helpful perspective in appreciating the good and truth found in all religions and spiritual paths. (a)
- Therapist is a Christian who can think and conceptualize theologically (c).
- The therapist is Christian by background (h).
- Therapist considers himself a Christian but not “born again.” (j)
- Therapist is a Christian who adheres to Biblical principles in counseling and life (k).
- Therapist became and is Unitarian (l).

B) Spiritual Worldview

- Therapist holds belief that life is full of wonder, joy, grace, and possibility of growth from early religious experiences (d).
- In contrast to the client, the therapist relates to her spirituality as a grounding influence more than a guiding or rule-governed experience (g).
- She feels little need to define her spirituality in terms of labels and doctrine (g).
- Therapist sees life as a gift, not a given (h).
- Therapist believes life is about the presence of God more than the importance of using intercessory prayer to make life different from what it is (h).
- Therapist believes in a universe of intelligent design (i).
- Therapist has a deep belief in God (i).
- Therapist believes that because God loves him, he is able to love others (i).
- Therapist has thorough understanding and belief in God’s grace (k).
- Therapist believes God’s love is unconditional (k).
- Therapist believes God loves everyone (k).
- Therapist believes God has a wonderful plan for people’s lives if they trust Him (k).
- Following God’s plan leads to contentment, not following His will leads to discontentment (k).
- Therapist learned that spirituality is a personal and internal experience (l).

C) Beliefs about people

- Therapist believes hope is difficult for people without faith (c).
- Therapist believes that Christian view that all people are wounded and in need of help is a healthy perspective (c).
- Therapist believes counselors should develop as people so we can be more helpful to clients (c).
- Therapist believes that most master therapists are spiritually developed and informed people (f).
- Therapist believes people have inherent worth and value (i).
- Therapist believes that all people are fundamentally spiritual beings, come from a divine being, and are meant to live in relationship with God (i).
- Therapist believes people find healing through their wounds and are able to help others through their wounds (j).
- Therapist believes some secular therapists lack moral integrity (k).
- Therapist believes all people are sinners in need of God’s grace and forgiveness (k).

D) Spiritual Journey/Changes in beliefs

- Therapist's spiritual journey from conservative Protestantism to more Eastern and Unitarian perspectives informs his approach to therapy (a).
- Therapist recounted how his own spiritual views changed over time (e).
- Therapist recounted questioning God's existence and his belief in God (e).
- Therapist has had experience of working through spiritual crisis and achieving a sense of peace and spiritual growth (e).
- Therapist considered times of questioning as a spiritual crisis (e).
- Therapist described spiritual journey as having grown up in a church, moving away from religion in his 20s and 30s, and then experiencing a renewed desire for spirituality in his late 30s (h).
- Spiritual journey began as a non-Christian who went to a liberal church, then to a Pentecostal church, later attended Catholic services and finally became more evangelical (k).
- Therapist grew spiritually through exposure to AA (l).

E) Spiritual/Religious Background

- Therapist learned about roles, pressures, and responsibilities of minister from his previous and current religious affiliations (a).
- Therapist was raised in a fundamentalist religious church (d).
- Therapist gained belief that life is full of wonder, joy, grace, and possibility of growth from early religious experiences (d).
- Therapist gained belief that self-acceptance and self-love are possible from his early religious experiences (d).
- Therapist's parents were missionaries (e).
- Therapist had positive religious experiences when younger (e).
- Therapist was raised in Christian home with a father who was a minister (i).
- Therapist's grandfather was a missionary (i).
- Spiritual journey began as a non-Christian who went to a liberal church, then to a Pentecostal church, later attended Catholic services and finally became more evangelical (k).
- Therapist raised Catholic (l).
- Therapist's mother valued spirituality (l).

F) How spirituality affects therapy process**1) Helpful**

- Therapist's life and spiritual experiences helped him understand the client's issues (a).
- Therapist finds his current religious affiliation provides a helpful perspective in appreciating the good and truth found in all religions and spiritual paths. (a)
- Therapist religious background similar to client's beliefs (f).
- Therapist believed her religious beliefs both helped and hindered her work with the client (f).
- Therapist believed having a similar religious background facilitated empathy, confidence, and patience with her client (f).
- Therapist believes that genuine intimacy only happens through deep trust born out from yielding and sacrifice (i).
- Therapist believes there is a divine reason for the clients that come to work with him (i).

- Spirituality viewed as a strength (l).
- Spirituality viewed as a way to bring peace (l).
- **2) Harmful**
- Therapist believes boundary between pathology and religious faith very small in her religious tradition (f).
- Therapist believed her religious beliefs both helped and hindered her work with the client (f).
- Therapist believes client would have been harmed by a clinician who was not comfortable addressing spiritual issues (f).
- Therapist believes much of the information on spirituality and psychotherapy is foundationless and potentially harmful for therapy (i).
- Therapist does not believe reparative therapy is an ethical or valid therapeutic approach (j).
- Therapist fears client might view therapist's spiritual beliefs as "correct beliefs." (l).

Categories Therapist Training

A) Spiritual Influences

1) Personal

- Therapist has read a number of Jungian books (a).
- Therapist has read a number of Buddhist books (a).
- Therapist learned about spiritual issues from studying the Bible (f).
- Therapist informed on spirituality through reading M. Scott Peck, Fowler, and Kohlberg (f).
- The therapist sees her interest in Jung as an important contribution to this therapy treatment (g).
- Therapist influenced by reading Fowler's writings on faith development while in graduate school (h).
- Therapist tries to stay current with the literature on integrating spirituality and psychotherapy (i).
- Therapist explored a lot of treatments and spiritual issues through personal study and experience (j).
- Carlos Castaneda, the Christian mystics, Eastern religions, Thich Nhat Hanh, and Dorothy Beck were influential sources on the therapist (j).
- Therapist finds Bible a rich source of truth, peace, and life-changing material (k).

2) Workshops/Institutes

- Therapist received training in meditation (a).
- Therapist received training in the Buddhist principle of nonjudgment (a).
- Therapist received training in psychotherapy with spiritual issues from membership in the American Academy of Psychotherapy. (a)
- Therapist attended one presentation on working with religious fundamentalists (e).
- Therapist's internship and postdoctoral experience immersed him in an environment of theoretical integration of psychological and spiritual principles (i).
- Therapist has attended AMFT conferences in which innovative and alternative spiritual approaches were taught (j).
- Therapist learned from a group of spiritual healers at various conferences (j).
- Therapist has attended many trainings on spiritual issues (l).
- Therapist attending annual general assemble with Unitarian church (l).
- Therapist attended trainings on spirituality and grieving, dance as coping (l).
- Therapist received lots of training on death and dying at VA (l).

B) Graduate programs and courses.

- The therapist's graduate degree in theology, and in particular in a course on the psychology of religion, serves as a foundation for his work with spiritual issues.(b)
- In addition to graduate training, the therapist has an undergraduate degree in religion that informs his work and sensitivity to the difference in world view that comes with different religious faiths (d).
- Therapist learned about spiritual issues from attending religious college (f).
- Therapist learned about spiritual issues from examining feminist and conservative theological views on spousal abuse while in graduate school (f).
- Therapist's advisor was open to religious faith and encouraged him to pursue a dissertation topic that was spiritual in nature (i).
- Therapist's internship and postdoctoral experience immersed him in an environment of theoretical integration of psychological and spiritual principles (i).

- Therapist did not receive training on spiritual issues in grad school (l).
- Therapist has taken courses in Jungian psychology (a).
- Therapist was trained through Rogerian influence in graduate school to normalize and have clients' experiences (c).
- Therapist learned approach from humanistic psychology emphasis clinical training (j).

C) Relationships

- Therapist considered experience with a close friend who was formerly a Trappist monk as helpful to his work with spiritual issues (a).
- Therapist learned how to work with spiritual issues through receiving supervision (a).
- Therapist learned how to work with spiritual issues through consultation with other therapists (a).
- Therapist received training in psychotherapy with spiritual issues from a peer consultation group (a).
- Therapist influenced by theological training of his former spouse (c).
- Therapist's grandfather was a missionary, his father was a minister, and he grew up with Christianity (i).

D) Attitudes about training

- Therapist believes it is not graduate school's role or responsibility to teach faith or grace (c).
- Therapist surprised by lack of knowledge many therapists have about their clients' spiritual lives (d).
- Therapist reported that graduate training in psychology did not address spiritual issues (e).

E) Personal experiences and religious background

- Therapist learned about roles, pressures, and responsibilities of minister from his previous and current religious affiliations (a).
- Therapist's life and spiritual experiences helped him understand the client's issues (a).
- Therapist reported that graduate training in psychology did not address spiritual issues (e).
- Therapist trained through participation in Bible study groups (k).
- Therapist trained through Unitarian church (l).
- Therapist took course through church about understanding your spirituality (l).
- Therapist grew through open discussion about spirituality in her fellowship (l).

F) Professional or work experiences

- Therapist has conducted training on spirituality at psychotherapy conventions (b).
- Therapist has had many clients for whom religion is important (e).
- Therapist believes most of his training has come through clinical and personal experience (e).
- Therapist has taught courses on religious development (h).
- Therapist trained through preparing seminars and workshops for others (k).
- Therapist trains others on diversity issues including tolerance for different faiths (l).

Categories Therapy Approach/Philosophy

Religious/Spiritual Approaches

A) Personal spiritual experiences inform approach

- Therapist brings his own beliefs and history to treatment of spiritual problem (a).
- Therapist's empathy toward client's shame was aided by his own upbringing in a narcissistic family (a).
- Therapist utilizes liberal Quaker beliefs in his approach (a).
- Therapist approached client as he has himself, that is, recognizing the need to accept rejected parts of himself (d).
- Therapist's developmental perspective influenced by his personal experiences with spiritual development (e).
- Therapist believes her spiritual experiences made her more empathic and confident in working with client's spiritual problems (f).
- Therapist's approach informed by her spiritual journey (k).
- Therapist uses personal spiritual and life experience to understand client's problem and empathize (k).

B) Pluralist/ecumenical spiritual perspective

- Therapist's spiritual journey from conservative Protestantism to more Eastern and Unitarian perspectives informs his approach to therapy (a-Background).
- Therapist finds his current religious affiliation provides a helpful perspective in appreciating the good and truth found in all religions and spiritual paths. (a)
- Therapist finds it helpful to therapy to embrace the belief that there are multiple paths to truth (a).
- Therapist believes his approach is nonjudgmental—as evidenced by many people from pagan community seeking his services (h).
- Therapist recognizes different spiritual practices hold differing views on personal relationship with God (i).
- Therapist draws from many different religions and spiritual practices in his work (j-training).
- Therapist makes it clear that clients do not have to share her spiritual worldview (k).
- Therapist makes effort not to judge where people are in their journey (k).
- Therapist avoids imposing her spiritual beliefs on clients (l).
- Therapist checks for where people are spiritually (l).

C) Buddhist, Eastern, or New Age philosophy

- Therapist's spiritual journey from conservative Protestantism to more Eastern and Unitarian perspectives informs his approach to therapy (a-Background).
- Therapist introduces Buddhist practices of nonjudgment and loving kindness meditation with many clients (a).
- Therapist emphasizes development of “nonjudging muscle” to reduce shame and change negative self-talk (a).
- Therapist utilizes Buddhist philosophy, but not religion, in his therapeutic approach (a).
- Therapist considers himself a Buddhist psychotherapist meaning he utilizes Buddhist philosophy in his practice (a).
- Therapist recommended Buddhist tapes on mindfulness to client (b-Process).

- Carlos Castaneda, the Christian mystics, Eastern religions, Thich Nhat Hanh, and Dorothy Beck were influential sources on the therapist's approach (j-Training).

D) Christian philosophy

- Therapist believes that Christian view that all people are wounded and in need of help is a healthy perspective (c-Background).
- Therapist views figure of Jesus as bridging relationships between person and God (i).
- Therapist believes that all people are fundamentally spiritual beings, come from a divine being, and are meant to live in relationship with God (i--Background).
- Therapist believes people can experience peace through a relationship with Jesus (k).
- Therapist views all people as sinners—fallen from God (k).
- Therapist's approach emphasizes understanding and accepting God's grace (k).
- Therapist believes God intends for people to be free from sin and guilt (k).
- People will not be content unless they understand their place in the world (k).
- People will be content in life when they fulfill God's will for them (k).
- God will bless those who trust him and seek him (k).
- God will bless those who break patterns of sin and live righteously (k).
- Contentment comes from being God-focused rather than self-focused (k).
- God loves everyone and wants the best for them (k).
- God asks for certain ways of living because they benefit people (k).
- When people live according to the life God has designed for them they will be content and joyful (k).

E) Informed by Jungian or other spiritually informed psychologists

- Therapist's utilizes Jungian philosophy in his approach (a).
- Therapist informed on spirituality through reading M. Scott Peck, Fowler, and Kohlberg (f-Training).
- The therapist sees her interest in Jung as an important contribution to this therapy treatment (g-Training).
- Therapist utilizes spirituality component of AA to assist counseling (l).

F) Adhered to wounded healer concept

- Therapist believes that Christian view that all people are wounded and in need of help is a healthy perspective (c-Background).
- Therapist believes in "wounded healer" concept—that is, we are healed by our wounds and help heal others through our wounds (j).
- Therapist believes people find healing through their wounds and are able to help others through their wounds (j-Background).

G) Worked within client's religious/spiritual beliefs or traditions

- Therapist finds it easy to work within Christian framework because of shared language and values (c).
- Therapist uses client's own religious tradition to facilitate change (c).
- Approach was balanced with awareness that the therapist could not introduce her own spiritual perspective for fear of alienating the client (g).
- Therapist struggles with question of how much to disclose about her own spiritual beliefs and usually chooses not to share her views (g).

- With Christians, therapist uses more specifically religious terminology (i).
- Therapist attempts to understand each individual's spirituality (l).
- Therapist checks for where people are spiritually (l).
- Therapist patiently explores where people are in their faith or spirituality (l).
- Therapist respectful of where clients are spiritually (l).

H) Emphasized spiritual and personal transformation

- Therapist introduces Buddhist practices of nonjudgment and loving kindness meditation with many clients (a).
- Therapist emphasizes development of "nonjudging muscle" to reduce shame and change negative self-talk (a).
- Therapist views people's religious beliefs as originating from their longing to find something better in life (b).
- Therapist attempts to utilize clients' longings and growth impulse to facilitate spiritual development (b).
- Therapist attempts to free client from her self-limiting views, thus moving her to living more autonomously (c).
- Therapist desires to help clients expand way of being if current life patterns are constricting (d).
- Therapist viewed long term course of therapy as providing reparenting opportunity for client, that is, providing new experiences of being heard, mirrored, cared for, etc (h).
- Therapist believes that people are in a process of becoming and pain is an invitation to grow (j).
- Therapist believes people can experience peace through a relationship with Jesus (k).
- Therapist believes God intends for people to be free from sin and guilt (k).
- Therapist attempts to change faulty core beliefs and internalizations in clients (k-Process).
- Spirituality viewed as a way to bring peace (l).

I) Emphasized creation of meaning or search for truth

- Therapist believes job of counselor is to understand, clarify, and assist client in developing personal myth (c).
- Therapist views "truth" as very important for client (c).
- Therapist views psychotherapy as telling the truth in love (c).
- Therapist's general philosophy is that therapy should be a truth seeking and illuminating venture (c).
- Therapist defines spirituality as how a person connects with a larger system of meaning and creates meaning in life (d).
- Therapist views spirituality as valuing of self and other and making meaning in life (f).
- Therapist views spirituality as valuing and meaning-making (f).
- Therapist seeks to explore meaning of client's spirituality (k).
- Therapist encourages client to talk about her faith and what it means to her (l).

J) Therapy viewed as spiritual or divine encounter

- Therapist prefers to believe there is a divine purpose for the client and him to be working together, even if this is not so (c).
- Therapist views therapy as bringing light and refreshment to clients (d).
- Therapist has awareness of some sort of spiritual force in his therapy practice (h).

- Therapist feels that he is a channel for a loving force for his clients (h).
- Therapist approaches therapy with the belief that people are fundamentally spiritual beings (i).
- Therapist views all therapeutic encounters are spiritual encounters (i).
- Therapist believes there is a divine reason or purpose for each encounter he has with clients (i).
- Therapist believes God helps him be helpful with others (i).
- Therapist believes that God loves him and this helps him care for his clients (i).
- Therapist believes that because God loves him, he is able to love others (i-Background).
- Therapist believes there is a divine reason for the clients that come to work with him (i-Background).

K) Fundamental valuing of spirituality and human experience

- Therapist enjoys working with clients who have a strong faith (c).
- Therapist views faith as an asset for clients (c).
- Therapist believes truth and love are important for healing and change in therapy (c).
- Therapist views truth as force that ignites passion and love in relationships (c).
- Therapist views grace and redemption as point of therapy (c).
- Therapist believes faith provides sense of direction in therapy to complement therapist's presence (c).
- Therapist believes faith provides framework for making meaning and finding hope (c).
- Therapist is curious about spirituality of clients (d).
- Therapist believes life contains wonder, joy, love, and possibility for change (d).
- Therapist believes that life is basically good (d).
- Therapist believes that self-acceptance and self-love are possible (d).
- Therapist believes knowing spiritual background of client enriches understanding of client (d).
- Therapist is transparent and straightforward about his religious beliefs with clients who are concerned about their views being respected (e).
- Therapist considers spirituality an important aspect of the client's background (h).
- Therapist approaches therapy with the belief that people are fundamentally spiritual beings (i).
- Therapist attempts to value clients and show unconditional positive regard (i).
- Therapist assumes that human beings have inherent value (i).
- Therapist believes people have inherent worth and value (i-Background).
- Clients usually pick up on therapist's openness to spirituality by observing artwork, sayings and symbols within the therapist's office environment (j-Process).
- Approach is nonjudgmental as she has experienced problems and sin as well (k).
- Spirituality viewed as a strength (l).
- Therapist respectful of where clients are spiritually (l).
- Spirituality viewed as strength and asset (l).

L) Typical problems encountered in therapy viewed as spiritual problems

- Therapist views most issues seen in therapy as spiritual issues (d).
- Therapist believes it is not possible to separate the spiritual from the psychological or emotional (f).

- Everything people do is believed to impact and be impacted by one's spiritual identity and spiritual sense where one is going (i).
- Therapist views all therapeutic encounters are spiritual encounters (i).
- Sometimes, spiritual material is addressed directly by therapist (i).
- Therapist views issues like hope, trust, acceptance, value as implicitly spiritual issues (i).
- Therapist approaches depression as a spiritual problem as much as physical (j).
- Therapist believes depression is a way of preserving energy and dealing with life (j).
- Therapist believes that addiction is a spiritual issue as much as mind or body issue (j).
- Therapist believes that addiction is about shame (j).
- Therapist views shame as a problem with a spiritual nature (j).

M) Spirituality defined as relationship

- Therapist viewed client's spiritual problem as a relationship problem, which was complicated because it involved his relationship with God (e).
- Therapist views spirituality as valuing of self and other and making meaning in life (f).
- Therapist believes that therapeutic relationship is central because we are meant to be in relationship with God and are therefore relational beings (i).
- Therapist approaches therapy from a relational perspective which opens up to questioning the client's relationship with God (i).
- Therapist believes that being spiritual beings implies being relational beings (i).
- Therapist believes spiritual development affected by one's relationship with God, self, and others (i).
- Therapist believes relationships are of utmost importance to health and thus attempts to have a genuine and sincere relationship with clients (i).
- Therapist believes that all people are fundamentally spiritual beings, come from a divine being, and are meant to live in relationship with God (i--Background).

General Approaches

A) Approached spiritual problems in similar fashion as other problems

- Therapist approached spiritual problem as he would any other problem encountered in therapy (a).
- Therapist approaches spiritual issues as he would any other issue (d).
- Therapist approached client's problem as he would other similar nonreligious issues (e).

B) Phenomenological or person-centered approach

- Treatment approach emphasizes the therapist's personal, inner experience of the client and their interpersonal relationship rather than a theoretical framework (b).
- Therapist relies on faith in his inner experience and therapy process rather than forcing preconceived theories onto someone's experience (b).
- Therapist considers directive, "expert" interventions as somehow less spiritual than a phenomenological approach (b).
- Therapist values having faith in the client's process and inner experience without impinging his own beliefs on them. (b)
- Therapist believes he must balance showing acceptance and understanding with providing guidance and structure (c).

- The therapist describes his approach as phenomenological in nature and believes that the exploration and description of one's experience is, in itself, healing (d).
- Therapy was approached from a reflective Humanistic style, that is, being interpersonally authentic (g).
- The therapist describes himself as foundationally person-centered in approach (h).
- Therapist is inclined to connect to client through unconditional positive regard, congruence, and empathy (h).
- Therapist attempts to value clients and show unconditional positive regard (i).
- Therapist listens for clue in client's story that will help them get unstuck (k).
- Therapist believes understanding current situation and beliefs is key to moving forward and changing (k).
- Therapist focuses on clients' experience and obstacles (l).

C) Developmental approach

- Therapist views many religious/spiritual problems as arrested spiritual development (b).
- Therapist attempts to utilize clients' longings and growth impulse to facilitate spiritual development (b).
- Therapist approached client's spiritual problem from a developmental perspective (e).
- Therapist's developmental perspective influenced by his personal experiences with spiritual development (e).
- Therapist approaches spiritual concerns from a developmental perspective (f).
- Therapist considers moral and spiritual development in clients concerns (f).
- Therapist views God-concept as originating from object-relations with parents (f).
- He is additionally influenced by training in constructive developmental theory (h).
- Therapist views spiritual development as occurring in stages (h).
- Therapist viewed long term course of therapy as providing reparenting opportunity for client, that is, providing new experiences of being heard, mirrored, cared for, etc (h).
- Therapist believes spiritual development affected by one's relationship with God, self, and others (i).
- Therapist believes that people are in a process of becoming and pain is an invitation to grow (j).
- Spirituality often contingent on where people are developmentally in life (l).
- Therapist patiently explores where people are in their faith or spirituality (l).
- Therapist respectful of where clients are spiritually (l).
- Therapist considers where clients are in life development (l).

E) Holistic or systemic view of therapy and person

- Therapist believes it is not possible to separate the spiritual from the psychological or emotional (f).
- Everything people do is believed to impact and be impacted by one's spiritual identity and spiritual sense where one is going (i).
- Therapist finds it just as detrimental as helpful to separate sex, spirit and body (j).
- Therapist looks at the intersection and relationship of sex, spirit, body and psychological spirit (j).
- Therapist emphasizes the complexity of people (j).
- Therapist emphasizes the multiple levels of relationships between people and their world (j).
- Therapist believes a broader, systemic approach is often helpful (j).

F) Emphasized therapeutic relationship or therapist presence

- Treatment approach emphasizes the therapist's personal, inner experience of the client and their interpersonal relationship rather than a theoretical framework (b).
- Therapist views "presence" as one of the main jobs of the therapist (c).
- Therapist believes faith provides sense of direction in therapy to complement therapist's presence (c).
- Therapist describes his approach to therapy as moving into feelings and connection with clients (c).
- Therapist believes his role is to develop a real relationship and manage the relationship (c).
- Therapist emphasizes importance of developing safe relationship with client (d).
- Therapy was approached from a reflective Humanistic style, that is, being interpersonally authentic (g).
- Therapist sees self as instrumental in helping clients identify the pieces present in their puzzle, what's missing, what they're forcing together, and what fits (i).
- Therapist believes that therapeutic relationship is central because we are meant to be in relationship with God and are therefore relational beings (i).
- Therapist allows clients freedom to question and be angry with him (i).
- Uses the therapeutic relationship to allow clients to experience both their own feelings as well as an experience of not being alone on their journey (i).
- Therapist approaches therapy from a relational perspective which opens up to questioning the client's relationship with God (i).
- Therapist believes relationships are of utmost importance to health and thus attempts to have a genuine and sincere relationship with clients (i).
- Therapist believes that genuine intimacy only happens through deep trust born out from yielding and sacrifice (i-Background).
- Therapist views therapeutic alliance as central to change (k-Process).
- Therapist cannot help client change without strong therapeutic alliance (k-Process).
- Basis of therapy is relationship (l).
- Therapist establishes strong relationship (l).

G) Work with emotions to address spiritual problems

- Therapist describes his approach to therapy as moving into feelings and connection with clients (c).
- Therapist focused on affect and meaning of affect related to spiritual problem (e).
- Therapist examines the various aspects of pain that are present (j).
- Therapist focuses on understanding clients' feelings (l).

Categories Assessment

Types of Spiritual Problems

A) Questioning or changing religious/spiritual beliefs

- Primary spiritual problem is leaving her faith and church after being devoted and deeply involved (a).
- Her spiritual problem consisted of struggling with the narrowness of Christian beliefs and ideals and their ability to be sustaining for her (a).
- Client struggled with how to respond to public inquiry about her faith because it had changed (a).
- Client began losing her faith as husband began strengthening his (c).
- Client questioned whether religious faith he had as a child would fit him as an adult (d).
- Client questioned his original calling and commitment to God (e).
- Therapist assessed that client's spiritual beliefs were conflicting with beliefs she inherited from her family of origin (f).
- Therapist conceptualized that client's experiences with AA and her academic environment affected her previous spiritual beliefs and view of herself (f).
- Client's view that he was damaged led to abandoning his previous values and living recklessly (g).
- Client initially tried to change his values, but came to accept that he could not (g).
- The first level of spiritual concern for the client was her specific spiritual questions and struggles (i).
- Client's existential experience involved a great pursuit to find, in a sense, a "God" – a spiritual or existential foundation (i).
- Client's specific experience involved tremendous anger about her questions about the existence of God (i).
- Therapist explores areas of intensity with clients and often finds this leads to a deep sense of a spiritual void and/or hopelessness (i).
- Client had questions and conflict with her gender and her religion (j).
- Therapist saw client as struggling within the confines of a limited view of God and herself (j).
- Therapist used metaphor of cruise ship to describe client's current situation and faith (k).
- Client did not feel at home in her current faith, but was not prepared to find something completely new either (k).
- Client was loosely clinging to previous beliefs, yet not prepared to let them go (k).
- Client felt spiritually lost and confused (k).
- Client asked not to attend worship ceremonies by family advisor, but not asked to leave faith (l).

B) Underdeveloped spirituality or arrested development

- Therapist believed client had a well developed "doing" side but an underdeveloped "being" side (b).
- Client is underdeveloped spiritually, that is, not fully "awake" to transcendent and spiritual concerns (b).
- Therapist sensed that client did not recognize his religious faith as a place to become more spiritually connected with himself and world around him (b).

- Therapist assessed that client's main issue was developing the capacity to be mindful about himself and his life (b).
- Therapist views maladaptive religious beliefs as developmental arrests (b).
- Client questioned whether religious faith he had as a child would fit him as an adult (d).
- Client's spiritual beliefs developmentally lagged behind his adult beliefs about God and life (d).
- Client was attempting to recapture emotional connection and experience of God that he had in high school (e).
- Therapist conceptualized that client's spiritual problem as developmental—i.e., he was learning to adjust to changes in his spiritual experience (e).
- Therapist assessed that grief and spiritual development were the core aspects of his spiritual problem (e).
- Therapist conceptualizes most problems as developmental (e.g., spiritual, psychological, object-relations) problems (f).
- Therapist viewed the client's faith became more about prescribed ritual rather than relationship with God after his crisis (g).
- Therapist explores areas of intensity with clients and often finds this leads to a deep sense of a spiritual void and/or hopelessness (i).
- Therapist attributed misunderstanding of grace to client's youth and lack of stable identity (k).
- Therapist views client's spirituality as developmentally delayed (l).
- Therapist views client's spirituality in adolescent exploration and rebellion stage (l).

C) Unhealthy religious/spiritual beliefs

1) Problematic religious/spiritual beliefs

- Therapist sensed that client did not recognize his religious faith as a place to become more spiritually connected with himself and world around him (b).
- Therapist felt that client was intentionally resistant to secular psychological beliefs because of religious beliefs (b).
- Therapist told client that her religious beliefs are what have created her problem (c).
- Therapist believes that the client is using religious beliefs about righteousness and servitude as protection to continue to be a paragon and be a perfectionist (c).
- Therapist believes client uses religious beliefs about righteousness and servitude to provide justification for unhealthy choices and behavior (c).
- Client beginning to confront unhealthy patterns and beliefs (c).
- Therapist determined that fundamental religious beliefs about sexuality hindered her psychological development (f).
- Everything the client was taught about spirituality was oriented toward self-denial and submission to others (h).
- This subservient role was encouraged by the client's husband, whose father shared her "doormat theology." (h)
- Client's belief system affirmed belief that she was not only at fault for the failing marriage, but also that God was judging and punishing her (h).
- Therapist conceptualized spiritual problem as consisting of distress resulting from overemphasis on her role as servant in contrast to need to care for herself (h).
- Any concept client had of a God included seeing Him as distant and hurtful (i).
- Therapist viewed client's guilt as misunderstanding of God's grace and forgiveness (k).

- Therapist thought client did not comprehend God's grace which could allow her to experience forgiveness and righteousness (k).
- 2) Scrupulosity or rigid spiritual beliefs**
- Therapist did not feel client's resistance to treatment was the result of a purely psychological problem, but because of strict religious values/beliefs (b).
- Therapist believes client needs to integrate religious values (e.g., compassion, grace, forgiveness) other than righteousness or perfection to develop a healthier and more balanced view of herself (c).
- Therapist viewed primary spiritual problem as conflict between a rigid rules perspective of spirituality and a more open and accepting perspective (f).
- Client struggled to learn how to live in accordance with religious beliefs—he was not interested in changing them—and integrate forgiveness into his experience (g).
- Therapist conceptualized spiritual problem as consisting of distress resulting from overemphasis on her role as servant in contrast to need to care for herself (h).
- Therapist saw client as struggling within the confines of a limited view of God and herself (j).
- Client believed she had to behave in certain ways or God would punish her (k).

D) Angry at God or church

- Client is angry with God because she believes her situation is unfair (c).
- Therapist feels that the client needs to question and confront God in order to deal with her anger (c).
- Therapist views her as withdrawing from and rejecting God (c).
- Therapist views her as blaming God (c).
- Client felt abandoned by church and angry with them, which precipitated his fall into sin (g).
- Client's specific experience involved tremendous anger about her questions about the existence of God (i).
- Client tried to fill this spiritual void with a passion for school and the sciences, which she used to attack God (i).

E) Conflict in relationship with God

- Client has spiritual conflict because she wants to divorce but faith prohibits it (c).
- Therapist views her as withdrawing from and rejecting God (c).
- Client begins by taking a submissive stance with God; thus, closing off communication with God (c).
- Therapist viewed client as struggling with fear of failing as a son, a man, and a Christian (d).
- Client felt conflicted about the job he had and a career in music ministry that he thought he was called by God to do (e).
- Client questioned how his career choice affected his relationship with God (e).
- Client questioned his original calling and commitment to God (e).
- Client felt guilty and confused and as if he were disappointing and betraying God (e).
- Client felt she was betraying her religious faith (f).
- Therapist conceptualized that client experienced conflict about how her sexual orientation affected her relationship with God (f).
- But the central feature of his pain lay in his belief that he had lost not only his children and wife, but also his relationship with God (g).
- Therapist viewed the client's faith became more about prescribed ritual rather than relationship with God after his crisis (g).

- Therapist did not use formal assessment to determine presence of pathology, but determined through sessions that source of distress was connected with her relationships with God and men (h).
- Similarly, client craved a relationship with God but sabotaged it with aggressive doubt fueled by her interest in the sciences (i).
- Client felt she failed God (k).

F) Spiritual distress associated with sexuality

- Client's spiritual problem consisted of conflict between religious beliefs and sexual orientation (d).
- Client viewed being gay as wicked and sinful (d).
- Client prayed that God would help him change his sexual orientation (d).
- Client believed he had two choices: extinguish gay inclinations within him to stay in the auspices of his faith or reject his religious beliefs and become a stereotypical gay man (d).
- Therapist assessed that client was confused about her sexual orientation (f).
- Therapist conceptualized that client experienced conflict about how her sexual orientation affected her relationship with God (f).
- Therapist determined that fundamental religious beliefs about sexuality hindered her psychological development (f).
- Client fears parents will reject her if they discover her sexual orientation (f).
- Client had questions and conflict with her gender and her religion (j).
- Client felt conflicted about morality of her affair and sexuality (j).
- Client had always viewed herself as heterosexual and struggled to integrate her new experiences with sexuality (j).
- Client was confused about her affair and the fact that it was with a woman (person of the same sex) (j).
- Client experienced distress resulting from inferior sense of her womanhood (j).
- Major problem was sexual orientation issues (l).
- Client identified as bisexual and eventually lesbian (l).
- Being gay is discouraged in her religion (l).
- If client identifies as lesbian she may have to leave membership in her faith (l).
- Therapist thought client would give up idea that she is a lesbian b/c of strong ties to faith, but she has not (l).

G) Client feels guilty, sinful, or being punished by God

- Client viewed being gay as wicked and sinful (d).
- Client felt guilty and confused and as if he were disappointing and betraying God (e).
- Client viewed himself as damaged and unable to begin new romantic relationships because his divorce was not for religiously acceptable reasons (g).
- Client's view that he was damaged led to abandoning his previous values and living recklessly (g).
- Client's belief system affirmed belief that she was not only at fault for the failing marriage, but also that God was judging and punishing her (h).
- Client felt conflicted about morality of her affair and sexuality (j).
- Client experienced tremendous guilt—she felt she was not living up to God's rules (k).
- Client believed she had to behave in certain ways or God would punish her (k).
- Client could not move past confessing sins in her prayer life (k).

- Client thought what she was doing was bad and wrong (sinful) (l).

H) Grief/Loss

- Therapist assessed that client was experiencing tremendous grief over loss of dream of being a minister and loss of earlier emotional/spiritual experiences (e).
- Therapist assessed that grief and spiritual development were the core aspects of his spiritual problem (e).
- Therapist believed anger and resentment at spouse was a result of unprocessed grief over his loss of calling and spiritual experience (e).
- Therapist assessed that grief was a major issue (j).

I) Client fears rejection or isolation from God or community

- Client fears parents will reject her if they discover her sexual orientation (f).
- Therapist determined that fundamental religious beliefs about sexuality hindered her psychological development (f).
- Client had significant fear that he would be rejected by his church community (g).
- Client had significant fear that he might lose his salvation if he divorced (g).
- He questioned his very salvation, and as a result, was resisting divorce despite his marked unhappiness in the marriage (g).
- Client faces dilemma in returning to his previous religious community: he must cease living hypocritically (g).
- Client felt abandoned by church and angry with them, which precipitated his fall into sin (g).
- After examination of his behavior with the therapist, client discovered that he felt that church and colleagues did not care about him or how he performed (g).
- Subsequently, client's reputation (rather than her husband's) suffered greatly in their small community after affair was discovered (h).
- Concerned about being removed from faith b/c client wants her daughter educated in Baha'i (l).
- Client asked not to attend worship ceremonies by family advisor, but not asked to leave faith (l).
- Client believed she would be thrown out of church (l).
- Client was afraid of being excommunicated from faith (l).

J) Spiritual distress associated with career or calling

- The spiritual problem was connected to her vocation as a Christian minister (a).
- Her spiritual problem consisted of struggling with the demands and expectations of serving as a minister (a).
- Client struggled with public role as minister; for example, being constantly observed by parishioners as to her conduct (a).
- Client was unable to find job in music ministry (1e).
- Client felt conflicted about the job he had and a career in music ministry that he thought he was called to do (e).
- Client questioned how his career choice affected his relationship with God (e).
- Client questioned his original calling and commitment to God (e).
- Client attempted to find ministry jobs and encountered spiritual crises when they did not work out (e).

- Therapist believed anger and resentment at spouse was a result of unprocessed grief over his loss of calling and spiritual experience (e).
- At one point, client's coworkers were calling the therapist to say the client might be losing his job b/c of his behavior (g).
- The second level of spiritual concern for the client was her general existential hopelessness and lack of a clear sense of identity, purpose, and self-esteem (i).
- Client was confused about her calling to the ministry (j).
- Therapist viewed spiritual problem as problem of finding and following her passion (j).

Conceptualization of Spiritual Problem

A) Viewed as developmental issues

- Therapist views maladaptive religious beliefs as developmental arrests (b).
- Client's spiritual beliefs developmentally lagged behind his adult beliefs about God and life (d).
- Therapist conceptualized that client's spiritual problem as developmental—i.e., he was learning to adjust to changes in his spiritual experience (e).
- Therapist assessed that grief and spiritual development were the core aspects of his spiritual problem (e).
- Therapist conceptualizes most problems as developmental (e.g., spiritual, psychological, object-relations) problems (f).
- Therapist viewed client as very concrete and in need of boundaries and structure (g).
- Therapist believes that people are in a process of becoming and pain is an invitation to grow (j).
- Therapist attributed misunderstanding of grace to client's youth and lack of stable identity (k).
- Client individuating in spirituality parallels striving for living autonomously (l).
- Individuation complicated by fact she wants her daughter to have Baha'i education (l).
- Therapist views client's spirituality as developmentally delayed (l).
- Therapist views client's spirituality in adolescent exploration and rebellion stage (l).
- Therapist identifies developmental issue of individuation in spiritual problem (l).

B) Intertwined with psychological issues

1) Depression or anxiety

- Therapist looked for evidence of defensiveness and anxiety in client's spirituality (f).
- The client was experiencing depression and anxiety over the dissolution of his family (g).
- Therapist viewed client as having psychological issues (e.g., anxiety, depression) separate from his spiritual problems (e.g., loss of church and God) (g).
- Therapist determined client was extremely depressed (non-psychotic type) and looking for a father-figure (h).
- Therapist views depression as problem with a spiritual nature (j).
- Therapist referred client for further assessment for anxiety (k/email).
- Client displayed symptoms of generalized anxiety disorder (k).

2) Self-concept or loneliness issues

- Therapist observed that client had abandonment and loneliness issues as well (h).

- The second level of spiritual concern for the client was her general existential hopelessness and lack of a clear sense of identity, purpose, and self-esteem (i).
- Client had personal and identity issues as well as psychological and spiritual (j).
- Therapist views shame as a problem with a spiritual nature (j).
- Therapist attributed misunderstanding of grace to client's youth and lack of stable identity (k).

3) Miscellaneous

- Therapist believed client's concerns were a combination of psychological and spiritual issues, not just one or the other (b).
- Therapist distinguished client's fundamental religious beliefs from psychopathology (f).
- Therapist recognized that psychological and spiritual issues were closely intertwined for the client (g).
- Client's existential experience involved a great pursuit to find, in a sense, a "God" – a spiritual or existential foundation (i).
- Client excelled at many activities but felt like an imposter (i).
- Therapist intuited that there was a void or woundedness in the client that precluded her ability to make decisions and be confident in her decisions in life (i).
- Therapist approaches addictions as an issue of spirit as well as mind and body (j).
- Therapist views some problems as psychological, some as spiritual, and some as both (k).
- Therapist views forgiveness as a psychological and spiritual issue (k).
- Client had history of bad decision making (l).

C) Intertwined with relationship issues

1) Partner or spouse

- Therapist sensed that client wanted to develop more spiritually intimate relationships with himself and others (b).
- Client desired a drastic change in her husband and he, in fact, did change (c).
- Client is miserable because husband has changed but she no longer wants to be with him (c).
- She began to have an affair and developed a strong bond with a married man (c).
- Client faces dilemma of whether or not to admit affair to husband (c).
- Therapist tells client that having a secret affair complicates her ability to relate with her husband (c).
- Client in predicament about whether to reveal affair and risk hurting her husband (c).
- Therapist views marriage as compromised because of secret life client is living (c).
- Client wants to be a good wife and have a good marriage (c).
- He questioned his very salvation, and as a result, was resisting divorce despite his marked unhappiness in the marriage (g).
- Client viewed himself as damaged and unable to begin new romantic relationships because his divorce was not for religiously acceptable reasons (g).
- As though she were playing the part of "the bad one" to avoid the pain of seeing husband in that role, the woman became involved with another man in the church who took advantage of her (h).
- Client felt conflicted about morality of her affair and sexuality (j).
- Client was confused about her affair and the fact that it was with a woman (j).
- Another concern was conflict with her father (l).
- Father wanted client to remain at home under his care and supervision (l).
- Worried about upsetting father (l).

2) Other relationships

- Therapist viewed client as struggling with fear of failing as a son, a man, and a Christian (d).
- Therapist did not use formal assessment to determine presence of pathology, but determined through sessions that source of distress was connected with her relationships with God and men (h).
- Therapist determined client was extremely depressed (non-psychotic type) and looking for a father-figure (h).
- Therapist observed that client had abandonment and loneliness issues as well (h).
- The therapist saw client's pursuit of God as related to her experience of hurtful neglect from her own father growing up, leaving her without that relational foundation (i).
- Client tried to fill this feeling of void with other relationships, including friendships and a caretaking relationship with her father (i).
- Despite coveting intimate relationships, however, client also feared and sabotaged them (i).
- Client had difficulty relating to her children, although she had significant relationships with other family members (j).
- Client transferred expectations and pressure from parents to her concept of God (k).
- Client had bad experiences with male relationships in her past (l).
- Client has history of abuse from male relationships (l).
- Therapist thinks sexual orientation issue may be a flight from bad relationships with males (l).

D) Viewed as opportunity for growth or healing

- Therapist believed potential for spiritual understanding and awareness existed in client (b).
- Therapist believes situation is good for client because it has demolished her idealized view of herself and made her more human (c).
- Therapist believes she will be transformed through experience of confronting God (c).
- Therapist believes client's confrontation with unhealthy religious views of herself will lead to development of an authentic self and faith (c).
- Therapist conceptualized that client's experiences with AA and her academic environment helped move her away from a rigid religiosity to a more open spirituality (f).
- Therapist believes that people are in a process of becoming and pain is an invitation to grow (j).

Diagnosis

A) Psychological/developmental history

- Therapist assessed client's object relations of God to determine presence of pathology (f).
- Therapist conducted thorough sexual history with client (f).
- Therapist determined client was extremely depressed (non-psychotic type) and looking for a father-figure (h).
- The therapist saw client's pursuit of God as related to her experience of hurtful neglect from her own father growing up, leaving her without that relational foundation (i).
- Therapist believes all people's actions and experiences affect one's spiritual identity, thus he attempts a very comprehensive exploration of the client's lived experience or reality (i).
- Therapist examines issues of hope, trust, relationship, and sense of purpose or direction (i).
- Client's toughness and interpersonal hostility contributed to her surviving a difficult and unsafe childhood (i).

- Therapist conceptualized some of current problems and blessings as resulting from generational issues in her family (j).
- Therapists attempted to determine if client is serious about sexual orientation or only experimenting (l).
- Therapist begins therapy by taking a social history (l).
- Therapy begins therapy relationship by trying to fully understand client's life and problem (l).

B) Health of client's spirituality

- Therapist believes client uses religious beliefs and frameworks to provide justification for unhealthy choices and behavior (c).
- Therapist conceptualized that client's experiences with AA and her academic environment helped move her away from a rigid religiosity to a more open spirituality (f).
- Therapist viewed primary spiritual problem as conflict between a rigid rules perspective of spirituality and a more open and accepting perspective (f).
- Therapist assessed client's object relations of God to determine presence of pathology (f).
- Therapist begins assessment by examining where clients are in their moral and spiritual development (f).
- Client's belief system affirmed belief that she was not only at fault for the failing marriage, but also that God was judging and punishing her (h).
- Therapist examines issues of hope, trust, relationship, and sense of purpose or direction (i).
- Therapist explores areas of intensity with clients and often finds this leads to a deep sense of a spiritual void and/or hopelessness (i).
- Therapist saw client as struggling within the confines of a limited view of God and herself (j).
- Therapist viewed client's guilt as misunderstanding of God's grace and forgiveness (k).
- Client has behaved contrary to religion through premarital sex, drinking, drugs, etc. (l).
- Client received strong moral foundation from religious faith (l).
- Therapist views client as spiritual person with strong sense of values (l).

C) Characterological or personality traits

- Therapist intuitively and inwardly perceived that client was an empathic and compassionate person (b).
- Therapist determined that client was someone who was perceived as an "asshole" by others (b).
- Therapist viewed client as very concrete and in need of boundaries and structure (g).
- Therapist helped client recognize that there was something about him that needed structure and explicit boundaries (g).
- Client excelled at many activities but felt like an imposter (i).
- Therapist examines issues of hope, trust, relationships, and sense of purpose or direction (i).
- Client's toughness and interpersonal hostility contributed to her surviving a difficult and unsafe childhood (i).
- Client behaving in irresponsible and passive-aggressive ways b/c of pressure (k).
- Client viewed herself as wild and rebellious (l).
- Therapist helped her see that she was conforming rather than rebelling (l).

D) Religious background/history

- The spiritual problem was connected to her vocation as a Christian minister (a).
- Client's religious beliefs and practices were and continued to be very important for her (c).

- Therapist conceptualized that client's experiences with AA and her academic environment helped move her away from a rigid religiosity to a more open spirituality (f).
- Client is an active member in a conservative religious group (g).
- Client was raised in a conservatively religious church (h).
- She was raised Catholic (i).
- Client considered herself agnostic and had no relationship with a supreme being (i).
- Client had minimal involvement in church (i).
- Client had a strong sense of relationship with God (j).
- Client received strong moral foundation from religious faith (l).
- Therapist views client as spiritual person with strong sense of values (l).
- Therapist begins therapy by taking a social history (l).

E) Differentiated spiritual difficulties from secular/psychological problems

- Therapist differentiated deep spiritual conflict from his worldly difficulties like adjusting to professional stressors, efforts to reduce his drinking, and lingering anxiety and depression (d).
- Therapist assessed client's object relations of God to determine presence of pathology (f).
- Therapist looked for evidence of defensiveness and anxiety in client's spirituality (f).
- Therapist distinguished client's fundamental religious beliefs from psychopathology (f).
- Therapist conducted thorough sexual history with client (f).
- Therapist viewed client as having psychological issues (e.g., anxiety, depression) separate from his spiritual problems (e.g., loss of church and God) (g).
- Therapist determined client was extremely depressed (non-psychotic type) and looking for a father-figure (h).
- Therapist observed that client had abandonment and loneliness issues as well (h).
- Therapist views forgiveness as a psychological and spiritual issue (k).
- Client displayed symptoms of generalized anxiety disorder (k).
- Therapist views PTSD, abuse, and shame as frequently problems with strong psychological contributions (k).
- Therapist views shame as a psychological problem that can be resolved through spiritual understanding (k).

F) Therapist avoids pathologizing client or client issues

- Therapist does not pathologize spirituality/religion (b).
- Therapist communicates to clients that diagnostic labels are typically for insurance purposes—to appease a system that looks for sickness (j).

Client's desires, needs, or goals

A) Initial therapy goals not explicitly spiritual

- Spiritual issues not primary concern, but a major subplot (a).
- Client's initial goals for counseling were to improve marriage and work through ending affair (c).
- Therapist examines where pain is for clients and what brought them into therapy rather than beginning assessment with specific spiritual or religious questions (i).
- Therapist approaches problem by questioning goals of client, why the client has come at that time and what issues are they wanting to resolve (j).
- Client's initial goals were to move out of parent's home (l).

- Client's initial goal was to live on her own (l).

B) Client striving for authenticity or relatedness

- Therapist believes she needs to fully confront God with her experience (c).
- Client wanted to find self-acceptance, love, and community while being true to himself (d).
- Client struggled to learn how to live in accordance with religious beliefs—he was not interested in changing them—and integrate forgiveness into his experience (g).
- Client faces dilemma in returning to his previous religious community: he must cease living hypocritically (g).
- Therapist sensed that client wanted to develop more spiritually intimate relationships with himself and others (b).

Categories Therapy Process

Therapist Strategies

A) Promoted new experience of self

1) Self-acceptance

- Therapist helps clients develop “nonjudging muscle” to deal with shame and negative thoughts about oneself (a).
- Therapist encourages client to accept her flaws to facilitate growth (c).
- There was additional use of scripture and metaphor to support the notion that self-love is essential to loving others (h).
- The experience provided in not judging the client for her affair was apparently very healing as it began to reset old beliefs that aberrant sexuality was automatically her fault (9h).
- Therapist attempted to change client’s beliefs about her self (k).
- Therapist attempts to change faulty core beliefs and internalizations in clients (k).

2) Self-awareness

- Therapist emphasizes how client is creating problems for herself (c).
- The result was a value affirming process in which the therapist helped her client to explore his beliefs/values and to process the implications of violating them (g).
- Therapist and client discussed his self-destructive behavior and concluded that he needed the structure and boundaries provided by his religion (g).
- Therapist used a form of “depth mirroring” he found highly effective with this client as it allowed her to see how she interacts in the world and how she was angry with God and others (i).
- Therapist helped her to examine her sense of self (j).
- Therapist helped her to analyze her pastoral calling and her relationship to God (j).
- Had client question her friends about her identity to learn more about herself (k).
- Therapist uses metaphors to help clients understand internalization of faulty beliefs about themselves (k).
- Therapist attempts to change faulty core beliefs and internalizations in clients (k).

3) Authenticity

- Therapist helped client recognize benefits of being authentic (d).
- Therapist believed client needed to learn to manage her own anxiety around forming her own spiritual beliefs apart from what someone else believes (f).
- Therapist encourages client to examine relationship with woman and sexual orientation (l).
- Therapist encourages client to examine decision to identify as lesbian (l).

B) Promoted spiritual development or transformation

- Therapist helps clients develop “nonjudging muscle” to deal with shame and negative thoughts about oneself (a).
- Therapist attempts to entice client to further spiritual development through presenting thoughtful questions for exploration (b).
- Therapist helped client develop observing ego (b).
- Therapist believes client will be transformed through process of confronting God (c).
- Therapist believes client can still receive God’s love and relationship despite her affair (c).
- Therapist attempted to move client away from thinking dichotomously about his faith (d).

- Client's view of God expanded from recognizing how his fears contrasted with other religious beliefs such as God's love and compassion (d).
- Client saw changing circumstances and his responses to them as opportunities to prove his faith (e).
- Therapist believed client needed to learn to manage her own anxiety around forming her own spiritual beliefs apart from what someone else believes (f).
- Therapy grew to include a deeper look at the beliefs and messages he'd grown up with (g).
- Therapist worked to respect client's values and integrate values about redemption to help resolve his conflict (g).
- Therapist helped client move from "either/or" thinking to a more sophisticated and comprehensive perspective on herself, life, and spirituality (h).
- The experience provided in not judging the client for her affair was apparently very healing as it began to reset old beliefs that aberrant sexuality was automatically her fault (h).
- Therapist believes spiritual development affected by one's relationship with God, self, and others (i).
- Therapist believes that therapeutic relationship is central because we are meant to be in relationship with God and are therefore relational beings (i).
- Therapist recited poem to client that communicated idea of spiritual development in the midst of distress (j).
- Therapist helped her reexamine and broaden her concept of God (j).
- Therapist attempted to change client's beliefs about her guilt and sin (k).
- Therapist sees client developing more mature spiritual life (l).

C) Openness towards client's spirituality

- Therapist tried to be aware of client's beliefs (a).
- Therapist demonstrates curiosity and interest in clients' spiritual lives which encourages exploration of spiritual issues in therapy (d).
- Therapist lets clients know that he understands spirituality is important to them and that he is willing to discuss it in therapy (e).
- Therapist believed client probably trusted that therapist would be objective about spiritual issues (e).
- The therapist asks about spirituality on his intake form and considers it an important aspect of the client's background (h).
- The experience provided in not judging the client for her affair was apparently very healing as it began to reset old beliefs that aberrant sexuality was automatically her fault (h).
- Clients usually pick up on therapist's openness to spirituality by observing artwork, sayings and symbols within the therapist's office environment (j).
- Counselor advertises as biblically based counseling, thus most clients are aware of their openness to religion (k).
- Some clients come to the therapist because they perceive she has higher integrity than secular therapists (k).
- Some clients come to her b/c they prefer religious morality to secular humanist morality (k).
- Family brought religious literature for therapist to read (l).
- Therapist recognizes importance of Baha'i faith to client (l).
- Therapist learned about Baha'i faith from client (l).

D) Personal spiritual experiences facilitated understanding client and R/S problem

- Therapist used his own religious background and experiences to inform his understanding of the client's spiritual problem (a).
- Therapist believes having similar religious background contributes to establishing therapeutic alliance (c).
- Therapist's religious background facilitated understanding and communication of empathy to the client (d).
- Reflecting on his own experiences helped the therapist relate to the client's intense positive religious experiences (e).
- Therapist believed her religious beliefs both helped and hindered her work with the client (f-Background).
- Therapist believed having a similar religious background facilitated empathy, confidence, and patience with her client (f-Background).
- Therapist relies on her personal spiritual journey to facilitate understanding of her clients (k).

E) Addressed psychological issues to facilitate work with R/S problems

- Therapist views client as self-critical and in a lot of pain (c).
- Therapist first addressed depression, anxiety, and drinking behavior which helped client focus more clearly on spiritual problem (d).
- Client discovered that some of his conflictual feelings about being gay were more about early abusive sexual relationships (d).
- Client was reluctant to try medication, but eventually found it very helpful (d).
- Therapist believes that client felt more freedom to discuss spiritual concerns after he felt some resolution over initial presenting problem (e).
- Therapist attempted to focus primarily on client's affect to draw out the spiritual issue (e).
- Therapist helped client look at spiritual struggles from both a spiritual and psychological perspective (g).
- Part of working with the client's punitive spiritual perspective involved processing through her need to see herself as at fault for early abuse she suffered (h).
- So following as establishment of the therapeutic alliance, work began on recognizing what happened to her and that it was not her fault (h).
- Therapist pursued multiple avenues with clients: thoughts, feelings, experiences, relationships, previous traumas (i).
- Therapist found that she had little trust in others, especially men (i).
- Therapist moved between examining her daily struggles and how these related to questions of her identity and spiritual beliefs (j).
- Therapist referred client for further testing because anxiety prevented client from changing beliefs (k).
- Client viewed as striving for acceptance (l).
- Therapist and client examining decisions and what client is learning from them (l).
- Therapist helped client set boundaries with other people (l).

F) Recognized client obstacles to therapy, healing, or growth

- Therapist attributed slow process of therapy to client's many projections onto her (f).
- As a small-town, traditional male, the client reportedly had difficulty accepting the need for therapy or for allowing himself to form an attachment to the therapist (g).

- Part of working with the client's punitive spiritual perspective involved processing through her need to see herself as at fault for early abuse she suffered (h).
- So following as establishment of the therapeutic alliance, work began on recognizing what happened to her and that it was not her fault (h).
- She stated that she was unsure whether she could work with someone who doubted evolution and believed God created the universe (i).
- Therapist found that she had little trust in others, especially men (i).
- The client remained extremely distrustful and challenging (i).
- Client initially rejected concept of grace (k).
- Client's worldview did not allow for concept of grace (k).
- Therapist explores what clients obstacles are (l).

G) Monitored client's reactions to therapist interventions

- Therapist tried to monitor the client's reactions to things such as suggestions or statements that he made (a).
- Therapist intuitively and empathically feels whether particular interventions are appropriate for client (b).
- Therapist was cautious and thoughtful about how he communicated with the client (i).
- When stuck, the therapist collaborates with the client to find what is missing in therapy (k).
- Therapist expects clients to resist changing beliefs b/c they are deeply held (k).

Therapist Interventions

Spiritually themed interventions

A) Explicitly religious/spiritual interventions

1) Meditation/Mindfulness

- Therapist introduces meditation to clients dealing with shame (a).
- Therapist helps clients develop "nonjudging muscle" to deal with shame and negative thoughts about oneself (a).
- Therapist attempted to provide client with a different way to respond to wife (i.e., mindfully) (b).
- Therapist described new course of therapy as "mindfulness training" (b).
- Therapist occasionally used relaxation or meditation-type exercises with client (b).
- Therapist found client open to exploring other spiritual practices such as meditation and spiritual gardens (j).
- Therapist asks about meditation practice (l).

2) Use of scripture

- Therapist challenged some of client's scripture-based self-criticism by countering with passages that might be interpreted as less harshly (d).
- Use of religious language and texts facilitated connection with client and achievement of therapeutic goals (d).
- Therapist found use of scripture to be helpful and comforting to client (f).
- Therapist sometimes quoted scripture to client (f).
- There was additional use of scripture and metaphor to support the notion that self-love is essential to loving others (h).
- Had client create list of dos and don'ts and compared it with list from Bible (k).

- Therapist uses scripture with clients, usually verses about grace (k).
- Therapist uses scripture to reeducate clients about their own Bible or religion (k).
- Therapist uses spiritual sayings with clients (l).

3) Other

- Therapist helped client process what he wanted to communicate to God in prayer (e).
- Therapist lights candle during therapy to signify hope, possibility, and life (j).
- Therapist recited poem to client that communicated idea of spiritual development in the midst of distress (j).
- Therapist used knowledge of chakras, energy centers, moving and acting to access and explore her experience (j).
- Therapist found client open to exploring other spiritual practices such as meditation and spiritual gardens (j).
- Therapist asked client about her prayer life (k).
- Therapist asks clients to describe their spiritual journey at the outset of therapy (k).
- Therapist uses circle diagram to help clients distinguish between guilt and conviction (k).
- Therapist attempts to help clients understand grace and forgiveness (k).
- Therapist helps clients understand that genuine conviction is empowering, while guilt is defeating (k).
- Therapist utilizes spiritual aspects of 12 step program with some clients (11).
- Therapist prayed about how to handle client going off medication (l).

B) Used religious/spiritual language of client

- Therapist would use the language of her spiritual framework so as not to impinge his own beliefs (a).
- Therapist uses client's religious language to communicate concepts of grace and redemption (c).
- Use of religious language and texts facilitated connection with client and achievement of therapeutic goals (d).
- Therapist found using spiritual language with client helpful in building and maintaining alliance (f).
- With Christians, therapist uses more specifically religious terminology (i-from Approach).
- Therapist asks for clarification of what clients mean by religious language (j).
- With this client the therapist used spiritual and more traditionally psychotherapeutic labels to represent change for the client (j).
- Therapist uses spiritual sayings with clients (l).

C) Recommended religious/spiritual books or tapes

- Therapist mindfully recommended books to client about her spiritual problem (a).
- Therapist recommended Buddhist tapes on mindfulness to client (b).
- Therapist recommends book he has written to client (c).
- Therapist recommended books with theological perspectives on issues such as sexuality (f).

D) Reframing client problems with R/S perspective

- Therapist encourages client to end affair and bring it into view for everyone involved to break the power of holding a secret (c).
- Therapist challenges client stop trying to "play God" and acknowledge her mistakes and humanity, even if it is painful (c).

- Therapist encourages client to acknowledge truth of her affair to husband (c).
- Therapist attempted to move client away from thinking dichotomously about his faith (d).
- Therapist challenged dichotomous thinking about sexual orientation and faith by introducing client to gay affirming churches (d).
- Therapist challenged some of client's scripture-based self-criticism by countering with passages that might be interpreted as less harshly (d).
- Therapy grew to include a deeper look at the beliefs and messages he'd grown up with (g).
- Therapist used value affirming process in which the therapist helped her client to explore his beliefs/values and to process the implications of violating them (g).
- Therapist helped her examine oppression and gender oppression and its spiritual and emotional effects (j).

E) Therapist self-disclosure

1) About personal religious/spiritual beliefs

- Therapist believes some clients want to know their therapists' religious beliefs before disclosing to them (e).
- In general, therapist is willing to answer questions about his spirituality in a forthright manner (e).
- Therapist found self-disclosure about her interests and experience in theology helpful to building and maintaining alliance (f).
- Therapist believed not gratifying client's desire to know details of the therapist's spiritual beliefs/practice was helpful to therapy process (f).
- Therapist acknowledged their differences in spiritual views (g).
- Client tested the therapist with scientific topics and was aghast when the therapist revealed that he saw validity to an intelligent design theory (i).
- Therapist prefers to disclose his sexual orientation and broad spiritual beliefs to his clients (j).
- Therapist believes that ethically it is important to understand and be upfront about your values and where you stand spiritually in relationship to your client (j).
- Therapist fears client might view therapist's spiritual beliefs as "correct beliefs." (l).
- Therapist withholds her spiritual beliefs (l).
- Therapist might tell clients that spirituality is important to her personally (l).

2) About therapist's work with R/S issues

- Therapist lets clients know that he understands spirituality is important to them and that he is willing to discuss it in therapy (e).
- Therapist disclosed her experience with other people with similar religious views to facilitate building the therapeutic alliance (g).
- Therapist let client know she had familiarity with spiritual and theological issues (g).
- Therapist might tell clients that she understands importance of spirituality (l).

F) Guided by divine or spiritual force

- Therapist has awareness of some sort of spiritual force in his practice (h).
- Therapy feels that he is a channel for a loving force for his clients (h).
- Therapist views all therapeutic encounters are spiritual encounters (i).
- Therapist relies on spirituality to guide and direct her when making difficult decisions (l).

G) Respected client's religious/spiritual beliefs or values

- Therapist tried to be aware of client's beliefs (a).

- Therapist tried not to infringe his own beliefs and experiences upon the client (a).
- Therapist attempts to validate healthy aspects of client's current stage of spiritual development (b).
- Therapist respects client's goals and faith (c).
- Therapist informs client he views her religious faith as an asset (c).
- Therapist found it easy to establish rapport because client was insightful and could talk about his feelings (e).
- Therapist worked to respect client's values and integrate values about redemption to help resolve his conflict (g).
- Therapist used value-affirming process in which the therapist helped her client to explore his beliefs/values and to process the implications of violating them (g).
- The therapist asks about spirituality on his intake form and considers it an important aspect of the client's background (h).
- Therapist was cautious and thoughtful about how he communicated with the client (i).
- Therapist asks clients to describe their spiritual journey at the outset of therapy (k).
- Therapist makes effort not to judge where people are in their journey (k).
- Therapist emphasizes that she does not try to explicitly influence clients' spiritual direction (l).

H) Encouraged client to confront God or express anger toward God

- Therapist feels that the client needs to question and confront God in order to deal with her anger (c).
- Therapist believes client will be transformed through process of confronting God (c).
- Therapist helped client determine if he had damaged his relationship with God (e).
- Therapist helped client determine how to repair any perceived damage in his relationship with God (e).
- Therapist helped client process feelings of anger at God, himself, and situation (e).
- Therapist helped client focus on relationship with God, even while he was estranged from his religious community (g).
- Therapist used a form of "depth mirroring" he found highly effective with this client as it allowed her to see how she interacts in the world and how she was angry with God and others (i).
- Therapist helped her to analyze her pastoral calling and her relationship to God (j).

General therapist interventions

A) Exploration techniques

- Therapist reflected client's way of being (failing to "stop and smell the roses") to him in a way in which helped the client recognize the problem (b).
- Therapist attempts to entice client to further spiritual development through presenting thoughtful questions for exploration (b).
- Therapist reflected understanding of ambivalence client was experiencing (d).
- Therapist used a form of "depth mirroring" he found highly effective with this client as it allowed her to see how she interacts in the world and how she was angry with God and others (i).
- Through a mirroring approach, therapist believes client was able to be vulnerable and use therapy as support system (i).

- Therapist initially became a very reflective compassionate listener to help her know she was understood and establish hope (j).
- Therapist examined client's problem in depth (k).
- Therapist uses childhood pictures to help clients understand origins of shame and effects of abuse (k).
- Therapist encourages clients dealing with shame/abuse to be an advocate for that abused child within them (k).
- Therapist helps client explore meaning of spirituality and spiritual beliefs (k).
- Therapist uses metaphors to help clients understand internalization of faulty beliefs about themselves (k).
- Therapist and client consider other religions that may be more tolerant of sexual orientation issues (l).
- Therapist and client discuss implications of identifying as lesbian (l).
- Therapist primary technique is questioning/interviewing and exploring client's concern (l).

B) Empathy and understanding

- Therapist intuitively and empathically feels whether particular interventions are appropriate for client (b).
- Therapist reflected understanding of ambivalence client was experiencing (d).
- Therapist believed having a similar religious background facilitated empathy, confidence, and patience with her client (f-Background).
- Therapist invited client to help point out when the therapist might misunderstand his perspective (g).
- The therapist's confidence in his own statements and empathic approach allowed him to remain non-defensive and unintimidated, which helped him remain present and connected to the client even as the client vocalized anger (i).
- Through empathic responding and receptivity to client's anger, therapist created the opportunity for the client to experience her feelings in a safe and supportive environment (i).
- Therapist asks for clarification of what clients mean by religious language (j).
- Therapist initially became a very reflective compassionate listener to help her know she was understood and establish hope (j).
- Therapist uses personal spiritual and life experience to understand client's problem and empathize (k).
- Therapist used metaphor of cruise ship to describe client's current situation and faith (k).
- Therapist does not assume to know client's journey, but asks questions for clarification (k).
- Therapist believes understanding current situation and beliefs is central to moving forward and changing (k).

C) Managed client transference

1) Recognition

- As a small-town, traditional male, the client reportedly had difficulty accepting the need for therapy or for allowing himself to form an attachment to the therapist (g).
- Therapist grew to represent the church at times and used this displaced authority to allow client to explore more liberal behavior (i.e., dating) and to rein him in when that new behavior became self-destructive (g).
- Therapist found that client had little trust in others, especially men (i).

- Client stated that she was unsure whether she could work with someone who doubted evolution and believed God created the universe (i).
- **2) Used to facilitate therapy or client change**
- Therapist has not used client's transference for his personal gratification (c).
- Therapist helped client sort through meaning of her projections onto the therapist without revealing her actual thoughts/feelings (f).
- Therapist believed not gratifying client's desire to know details of her spiritual beliefs/practice was helpful to therapy process (f).
- Therapist viewed long term course of therapy as providing reparenting opportunity for client (h).
- Through empathic responding and receptivity to client's anger, therapist created the opportunity for the client to experience her feelings in a safe and supportive environment (i).
- Client was eventually able to trust therapist and be vulnerable with him (i).
- Through a mirroring approach, therapist believes client was able to be vulnerable and use therapy as support system (i).

D) Validated client's strengths

- Therapist viewed client's fairly healthy mental status as contributing to the client making rapid progress in therapy (b).
- Therapist believes mindfulness tapes are appropriate for those with hidden potential (like the client) for having a more spiritual approach to life (b).
- Therapist attempts to validate healthy aspects of client's current stage of spiritual development (b).
- Therapist perceived that the client was motivated and took responsibility for growth and healing (d).
- Therapist thought the client used therapy effectively (d).
- Client had strong ability to state what he needed and know whether he could obtain it (d).
- Client's ability to name what he feared facilitated rapid growth and change (d).
- Therapist found client bright and talented (f).
- Therapist used the client's natural propensity for art and creativity as a source of healing and growth (j).
- Therapist respects client's timing in her decision making and developmental process (l).

E) Formed therapeutic alliance

1) Established initial rapport

- Therapist finds client easy to connect with (c).
- Use of religious language and texts facilitated connection with client and achievement of therapeutic goals (d).
- Therapist found it easy to establish rapport because client was insightful and could talk about his feelings (e).
- Therapist facilitated rapport by allowing the client to discuss issues in his own time (e).
- Therapist invites clients to trust her (k).
- Therapist establishes relationship through understanding clients' feelings (l).

2) Built and maintained alliance

- Therapist does not believe there was anything in particular that made discussing spiritual issues easier for the client other than time and establishing the relationship (e).

- Therapist found using spiritual language with client helpful in building and maintaining alliance (f).
- Therapist found self-disclosure about her interests and experience in theology helpful to building and maintaining alliance (f).
- Therapist believed having a similar religious background facilitated empathy, confidence, and patience with her client (f-Background).
- Therapeutic alliance aided in that he was referred by his pastor (g).
- Therapeutic alliance helped because counseling took place away from home town (g).
- Therapeutic alliance facilitated because client identified with television character who attended therapy (g).
- Therapist disclosed her experience with other people with similar religious views to facilitate building the therapeutic alliance (g).
- Alliance facilitated by utilizing a behavioral and problem focused approach early on in counseling (g).
- So following as establishment of the therapeutic alliance, work began on recognizing what happened to her and that it was not her fault (h).
- Therapist found establishing a strong therapeutic alliance was of utmost importance for the client (i).
- Therapist views therapeutic alliance as central to change (k).
- Therapist cannot help client change without strong therapeutic alliance (k).
- Therapist bases therapy on relationship (l).
- Therapist usually able to establish strong relationship with clients (l).

F) Introduced client to external resources to promote healing and growth

- Therapist challenged dichotomous thinking about sexual orientation and faith by introducing client to gay affirming churches (d).
- Group therapy was later added to individual therapy (d).
- Acceptance from a group of heterosexual men appears to have been very healing (d).
- Client would consult with pastor for additional support and confirmation after discussing certain theological issues in therapy (g).
- Therapist helped her evaluate her involvement with and exploration of various religious organizations (j).
- Therapist referred client for further testing because anxiety prevented client from changing beliefs (k).
- If therapist does not intuit client's problem within 4-5 sessions she often refers out for diagnostic testing (k).
- Had client question her friends about her identity to learn more about herself (k).
- Therapist recommend client visit gay affirming churches that therapist is familiar with (l).
- Refers clients to support groups through churches (l).

G) Focused on and processed emotion

- Therapist attempted to focus primarily on client's affect to draw out the spiritual issue (e).
- Therapist helped client process feelings of anger at God, himself, and situation (e).
- Therapist believed client's anger stemmed from loss (e).
- Therapist helped client examine self-destructive behavior as it emerged and discovered anger at the church and church members (g).
- Therapist worked to identify areas of emotional intensity for the client (i).

- The therapist's confidence in his own statements and empathic approach allowed him to remain non-defensive and unintimidated, which helped her remain present and connected to the client even as the client vocalized anger (i).
- Through empathic responding and receptivity to client's anger, therapist created the opportunity for the client to experience her feelings in a safe and supportive environment (i).
- Therapist often used a focus on the body to identify sensations related to grief and anger (j).
- Therapist facilitates emotional catharsis to establish alliance and work with spiritual problems (k).

H) Intuition (transferred from Approach)

1) Guided by intuition or inner experience

- Therapist uses intuition to avoid gratifying his own needs at expense of client's well-being (a).
- Therapist uses self-awareness to avoid gratifying his own needs at expense of client's well-being (a).
- Therapist intuitively and empathically feels whether particular interventions are appropriate for client (b).
- Treatment approach emphasizes the therapist's personal, inner experience of the client and their interpersonal relationship rather than a theoretical framework (b).
- Therapist relies on faith in his inner experience and therapy process rather than forcing preconceived theories onto someone's experience (b).
- Therapist relies on internal cues to inform him when he forcing theory on client and not trusting the process (b).
- Therapist had an intuitive sense that the client was in a spiritual and existential crisis (i).
- Therapist intuited that there was a void or woundedness in the client that precluded her ability to make decisions and be confident in her decisions in life (i).
- Therapist counsels intuitively (k).
- Therapist has learned to understand body language and human nature through years of experience (k).
- Therapist believes knowledge gained from experience has become an integrated part of her work (k).
- Therapist able to listen to client's story and intuit what primary problem is (k).

2) Conceptual frameworks secondary to intuition

- Therapist believes conceptual frameworks are useful for gaining clarity on therapeutic process with client when things get complicated in the therapy process (b).
- Therapist views forcing conceptual frameworks onto client or situation as contrary to his personal values (b).
- Therapist relies on faith in his inner experience and therapy process rather than forcing preconceived theories onto someone's experience (b).
- Therapist views forcing conceptual frameworks onto client or situation as reflecting a need in the therapist to control outcomes (b).
- Therapist more effective when operating out of his own theoretical system of therapy, rather than someone else's prescribed approach (c).
- Therapist follows client process and does not rely on technique (l).

Course of Therapy

A) Context

- Therapist has been treating client for four years on a weekly basis (a).
- Therapist saw client in therapy for approximately 6 to 8 months (30-40 sessions) (b).
- Group therapy was later added to individual therapy (d).
- Therapist worked with client over a five-year period (e).
- Therapist found it helpful to meet with client 2 to 3 times a week because of intensity of her suffering (f).
- Therapy has taken place for about three years on a weekly basis (g).
- Treatment occurred over approx. four years (h).
- Worked with client for 2 years (l).

B) Therapeutic issues during course of therapy

- Due to the nature of the client's issues, the therapist did not want to rush therapy process (e).
- Therapist experienced client as oscillating between periods of resolution and conflict with his spiritual problem (e).
- Client would feel content when serving in the ministry, but circumstances would change and he would question his calling (e).
- Client would feel better for awhile but then find faith tested when another music ministry job opportunity would come (e).
- Client had previously rejected an intern therapist as her intellectual inferior; she wanted an intelligent, experienced counselor (i).
- After first round of therapy, client returned after new circumstances tested her ability to cope (i).
- Therapist attempted to work with client's parents (l).
- Parents saw that daughter needed therapist as advocate (l).
- Spiritual conflict for client and her family about seeing counselor (l).

C) Spiritual problem emerged over course of therapy

- Therapist did not conduct systematic assessment but found that the spiritual problem unfolded over time (a).
- Spiritual problem emerged after 10 sessions together (b).
- Recognition of spiritual problem (that is, lack of mindfulness) shifted primary focus away from marital concerns (b).
- Focus of therapy shifted from marriage to living more mindfully (b).
- Therapist first addressed depression, anxiety, and drinking behavior which helped client focus more clearly on spiritual problem (d).
- It took the client 4 months to introduce the spiritual issues (e).
- Therapist does not believe there was anything in particular that made discussing spiritual issues easier for the client other than time and establishing the relationship (e).
- Client was unclear about her goals when she first entered therapy (f).
- As therapy progressed, client discovered that she had questions about her faith (k).

Reactions in therapy

A) Therapist reactions to client or therapy

1) Positive reactions

- Therapist and client found work around mindfulness satisfying (b-Results).
- Therapist finds client likeable (c).
- Therapist finds client attractive (c).
- Therapist finds client easy to connect with (c).
- Therapists believes he would enjoy having sex with client, but did not gratify himself in this way (c).
- Therapist found work with client enjoyable and moving (d).
- Therapist experienced client as stimulating, insightful, and intelligent (e).
- Therapist found therapy rewarding and daunting (f).
- Therapist found client bright and talented (f).
- Therapist viewed client as strong, creative, and amazing person (h-CD).
- Therapist viewed client as a person with a sweet nature (1h-CD).
- Therapist was impressed with her ability to cope with her circumstances at that time (i).
- Therapist felt honored by receiving client's anger and hurt and felt sad for the client that her previous therapists did not view it that way (i).
- Therapist viewed client as sweet, caring, bright and fun (k).
- Therapist found work positively challenging (l).
- Therapist found client and her faith very interesting (l).

2) Negative reactions

- Therapist views client as self-critical and in a lot of pain (c).
- Therapist found therapy rewarding and daunting (f).
- Therapist initially felt internally intimidated, but showed poise externally (i).
- Therapist felt burden and sense that working with client would take a lot of energy (i).
- Therapist initially felt some discomfort surrounding the client, related to his own personal issues such as feeling inferior and inadequate and aging (j).

3) Difficulty witnessing client's suffering

- Therapist found it difficult to withhold her actual feelings and thoughts about client while the client was suffering (f).
- Therapist found it difficult to witness client suffer with conflict set up by religious beliefs and not directly intervene (g).
- Therapist found it hard to witness client's pain (g).
- Therapist found it difficult to watch client be paralyzed by strict rule bound religious beliefs and not intervene (g).
- Therapist experienced anger and sadness at harm client was experiencing through her narrow understanding of God (h).

4) Other reactions

- Therapist worries that client may terminate therapy prematurely (c).
- Therapist thought it was best that the client's marriage dissolved (g).
- Therapist found it easy at times to be more rule focused because client's behavior had the potential for being embarrassing to him and his family (g).

B) Client reactions in therapy

1) Positive reaction

- Therapist and client found work around mindfulness satisfying (b-Results).

- Client was enthusiastic about skill of mindfulness (b).
- Client was motivated and took responsibility for growth and healing (d).
- Therapist believed client probably trusted that therapist would be objective about spiritual issues (e).
- Client felt better after reframing situation as meaningful to himself and church (e).
- Client saw changing circumstances and his responses to them as opportunities to prove his faith (e).
- Client enjoyed discussion of spiritual issues and problems in therapy (g-Results).
- Client was eventually able to trust therapist and be vulnerable with him (i).
- Client seems to enjoy therapy relationship (l).

2) Negative reactions

- At one point in therapy, the client became consumed with feelings of contempt for his wife (b).
- Client often felt confused about what God wanted him to do (e).
- Client tested the therapist with scientific topics and was aghast when the therapist revealed that he saw validity to an intelligent design theory (i).
- The client remained extremely distrustful and challenging (i).
- The therapist's confidence in his own statements and empathic approach allowed him to remain non-defensive and unintimidated, which helped him remain present and connected to the client even as the client vocalized anger (i).

C) Countertransference or therapist bias

1) Manifestations

- Therapist believes he would enjoy having sex with client, but did not gratify himself in this way (c).
- Therapist found it difficult to withhold her actual feelings and thoughts about client while the client was suffering (f).
- The therapist acknowledged her own differences and guarded against their interference in therapy (g).
- Therapist made conscious decision to inhibit her desire to impose her own beliefs (g).
- Therapist initially felt some discomfort surrounding the client, related to his own personal issues such as feeling inferior and inadequate and aging (j).
- Therapist found it hard to withhold her spiritual beliefs from client (l).

2) Management strategies

a) Behavioral strategies

- Therapist uses self-discipline to avoid gratifying his own needs at expense of client's well-being (a).
- Therapist makes value/belief differences explicit for client (c).
- Therapist believes he would enjoy having sex with client, but did not gratify himself in this way (c).
- Therapist has not used client's transference for his personal gratification (c).
- Therapist helped client sort through meaning of client's projections onto her without revealing her actual thoughts/feelings (f).
- Therapist acknowledged their differences in spiritual views (g).

- Therapist invited client to help point out when the therapist might misunderstand his perspective (g).
- **b) Cognitive or internal strategies**
- Therapist uses intuition to avoid gratifying his own needs at expense of client's well-being (a).
- Therapist uses self-awareness to avoid gratifying his own needs at expense of client's well-being (a).
- Therapist values having faith in the client's process and inner experience without impinging his own beliefs on them. (b—from Process)
- The therapist acknowledged her differences from client's views and guarded against their interference in therapy (g).
- Therapist made conscious decision to inhibit her desire to impose her own beliefs (g).
- Therapist intentionally kept differing spiritual views to herself, even though that was contrary to a humanistic approach (g).
- Therapist made cognitive decision not to interfere or influence client's religious views (g).
- The therapist's confidence in his own statements and empathic approach allowed him to remain non-defensive and unintimidated, which helped her remain present and connected to the client even as the client vocalized anger (i).
- Therapist believes that ethically it is important to understand and be upfront about your values and where you stand spiritually in relationship to your client (j).
- Therapist listens to his bodily reactions and internal sensations of discomfort to inform him of countertransference reactions (j).
- Therapist makes effort not to judge where people are in their journey (k).
- Therapist careful about how she works with someone's spirituality (l).
- Therapist does not want to impinge her beliefs on clients (l).

Categories Therapy Results

A) Self-improvement

1) Increased sense of self-worth or self-esteem

- Client has learned that she is valuable (a)
- Client learned she is worthy of appreciation (a).
- Client learned she is worthy of validation. (a).
- Client evidenced growth and maturity when she returned for additional therapy (i).
- On an existential and spiritual level, she learned to allow herself to be human and accepted by God– to be simultaneously “abused” and of utmost value (i).
- Client recognized that her inherent value was not taken away because of how she was treated or some academic failure (i).
- Client developed compassion and acceptance for herself (i).
- Client began to form a more independent view of herself (k).
- Client becoming stronger (l).

2) Gained new understanding of self

- Client has learned that she is valuable (a).
- Client learned she is worthy of appreciation (a).
- Client learned she is worthy of validation. (a).
- Client discovered how early sexual relationships were abusive and contributed to his sexual confusion (d).
- Client developed compassion and acceptance for herself (i).
- Client ultimately saw that compassion for herself was possible because there is a transcendent, ultimate being (i).
- Client was able to label negative feelings and accept them as part of her without accepting what was done to her (i).
- On an existential and spiritual level, she learned to allow herself to be human and accepted by God– to be simultaneously “abused” and of utmost value (i).
- Client developed compassion and acceptance for herself (i).
- Client has connected more fully with her artistic and spiritual nature (j).
- Recognized and acknowledged pressure she was experiencing (k).
- Client has matured (l).
- Client becoming more autonomous (l).
- Client learning to make better decisions and learn from mistakes (l).
- Client becoming more aware of her values (l).

B) Improved relationships

1) Spouse or partner

- Client learned to relate more effectively (i.e., less contemptuously) with his wife (b).
- Client’s mindfulness skills contributed to improving and maintaining relationship with his wife (b).
- Client developed successful romantic relationship and introduced his partner to his family (d).
- Client maintained a cordial relationship with his ex-wife and children, even sharing a Christmas with her boyfriend and his lover (d).
- Client was able to consider remarrying someone and not fear loss of faith or salvation (g).
- Client’s conflicts with her divorce were resolved (j).

2) Family

- Client disclosed sexual orientation to his family and eventually developed closer relationships with them (d).
- Client developed successful romantic relationship and introduced his partner to his family (d).
- Client maintained a cordial relationship with his ex-wife and children, even sharing a Christmas with her boyfriend and his lover (d).
- Client found way to have meaningful relationship with children (d).
- Developing compassion for herself allowed her to feel what love her mother could give, what others could offer (i).
- Client reached a place where she could allow her parents to be flawed and human (i).
- Client is not conflicted about her relationship with her kids as much (j).
- Relationship with mother improved (k).

3) Other

- Client opened up to therapist (i).
- Client was vulnerable with therapist (i).
- Client was able to establish strong trust with therapist (i).
- Client became vulnerable enough to use therapy as source of healing and support (i).
- Client was able to decrease her need for therapeutic support (j).
- Client was able to find support for herself (j).

C) Religious/Spiritual Change

1) Changed spiritual community or environment

- Client found new church and religious community (d).
- Client changed from a rejecting to a supportive religious community (d).
- Client helped by attending gay affirming church (f).
- Client began taking courses in a liberal seminary (j).
- Client left previous denomination and found a new, more inclusive denomination that she enjoys (j).

2) Changed views of God or spirituality

- Client began to practice mindfulness on his own outside of therapy (b).
- Client broadened his thinking about his potential options for being gay and religious (d).
- Client expanded his view of God (d).
- Client incorporated ideas of forgiveness into his religious beliefs/values (g).
- Client was able to consider remarrying someone and not fear loss of faith or salvation (g).
- Of central importance, the client finally learned to focus on the loving aspect of God as well as the judging, that is, she developed a bigger, more comprehensive view of God (h).
- On an existential and spiritual level, she learned to allow herself to be human and accepted by God– to be simultaneously “abused” and of utmost value (i).
- Client ultimately saw that compassion for herself was possible because there is a transcendent, ultimate being (i).
- Client was able to begin seeing God outside of her limiting figurative box (j).
- Client was able to expand her spiritual views to include femininity (j).
- Client has connected more fully with her artistic and spiritual nature (j).
- Client gradually began to integrate concept of grace into her beliefs (k).
- Client was beginning to understand concept of grace (k).
- Client initially rejected concept of grace, but eventually became more open to it (k).
- Client began to understand and accept God’s grace and love (k).
- Client began to believe God had a plan for her life (k).

3) Resolved spiritual conflict

- Client experienced recurring periods of peace about issue followed by periods of conflict (e).
- Client feels solid and comfortable with current spirituality (f).
- Client experiences less struggles with sexual orientation issue (f).
- Client eliminated self-destructive behaviors and returned to adhering to previous religious beliefs and values (g).
- Client developed compassion and acceptance for herself (i).
- Client has connected more fully with her artistic and spiritual nature (j).
- Client growing spiritually (l).
- Client developing her own spiritual beliefs (l).

D) Made decision to start a new life

- Client left uncomfortable job situation and started his own successful medical practice (d).
- Important changes were seen for the client particularly as she physically began to choose a new life (house, clothes, hair) for herself (h).
- Client began to literally throw old things/memories out of her house and began a new life (h).
- Client began taking courses in a liberal seminary (j).

Categories: Therapy Impact on Therapist

A) Reexamined or reinforced previous beliefs/values

- The ongoing work on mindfulness reinforced the therapist's own mindfulness practice (b).
- Therapist believed work with client reinforced his belief in the benefits of mindfulness (b).
- The process of grappling with the client's relationship with God pushed the therapist to examine his own relationship and beliefs (h).
- Therapist re-learned his need for God and His strength in his work (i).
- Therapist was reminded of how a more comprehensive, systemic approach is helpful with clients (j).
- Therapist was reminded of the freedom and forgiveness that comes from God's grace (k).

B) Learned new approaches or gained knowledge

- Therapist learned to meet the client where she was developmentally. (a)
- Therapist learned importance of creating a space for clients to discover their own ways to grow and heal (d).
- Therapist learned that spiritual problem contributed to marital problems (e).
- Therapist learned developmental aspect of spiritual problem—how it can resurface from time to time (e).
- Therapist learned that working with spiritual issues is like working with other emotional issues (e).
- Therapist learned to minimize interpretations of client's religious beliefs (f).
- Therapist reminded to be cautious of acting out her negative reactions towards client's family in session (f).
- Therapist learned the tremendous value of allowing clients the freedom to experience where they are at emotionally and psychologically and express it with him (i).
- Therapist recognized complexity of human beings and their multiplicity (j).
- Therapist has been educated about Baha'i faith (l).
- Therapist learned about importance of mentors in spirituality and life (l).
- Therapist learned importance of small, supportive community groups (l).

C) Self-growth

- The ongoing work on mindfulness reinforced the therapist's own mindfulness practice (b).
- Therapist became more aware of his own lack of mindfulness and failure to be attuned to client's needs (b).
- Therapist grew in appreciation for what is possible in terms of human growth and healing (d).
- Therapist reminded to be cautious of acting out her negative reactions towards client's family in session (f).
- The therapist gained from this experience a sense that therapy truly does help people to make significant life changes (h).
- Therapist re-learned his need for God and His strength in his work (i).
- Therapist learned the value of his internal strength, his genuine patience with clients (i).
- Therapist felt she grew as a person from watching client grow (k).

VITAE

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Education

The Pennsylvania State University Ph.D.

University Park, PA Major: Counseling Psychology

Dissertation Title: Psychotherapy with Troubled Spirits: A Consensual Qualitative Investigation of Spiritual Problems in Psychotherapy. (Chair: Jeffrey A. Hayes, Ph.D.)

Trinity University M.A. (1998)

San Antonio, TX Major: School Psychology

Texas A&M University B.A. (1995)

College Station, TX Major: Psychology Double Minor: Philosophy and Classical Studies

Employment

2003-present, **Senior Staff Psychologist**, Student Counseling Service, Iowa State University, Ames, IA.

2002-2003, **Predoctoral Clinical Internship**, Vanderbilt University-Department of Veterans Affairs Internship in Professional Psychology (Consortium)

2000 (May-November), **Private Practice**, Blair Medical Associates, Hollidaysburg, PA.

1997 (June-Aug.), **Project Employee**, The Psychological Corporation, Psychological Measurement Group.

Publications

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

Johnson, C.V., Riester, A.E., Corbett, C., Buehler, A., Huffaker, L., Pena, E. & Levich, K. (1998). Group activities for children and adolescents: An activity group therapy approach. *Journal of Child and Adolescent Group Therapy, 8* (2), 71-88.

Honors and Awards

Nominee for the Council of Counseling Psychology's Training Programs Outstanding Graduate Student Award, 2003

Edwin L. Herr Scholarship for the Education of Counselors, Penn State University, 2002

Magna Cum Laude, Texas A&M University, 1995

Dean's List, Texas A&M University, 1994 and 1995

Mendon B. Krischer Memorial Award, 1993

Lechner Merit Award, 1992

Academic Incentive Award, 1992