

## SPIRITUAL COMPETENCIES AND PREMISES

Kristi, a mental health therapist in private practice, had just listened to a phone message from a potential client. (The term *therapist* will be used throughout the book to refer to various mental health clinicians, including psychologists, social workers, marriage and family therapists, and professional counselors.) On the voice mail, the client reported that she had the names of three therapists, and she was looking for the best fit. The client indicated that she wanted a therapist who could work with her nagging feelings of depression as well as her relationship issues. She described herself as “very spiritual” and needed her therapist to be a “good match” with her spiritual beliefs and practices. The client wanted to speak with Kristi, to ask questions about Kristi’s theoretical orientation as well as her spiritual beliefs in order to determine if they could work well together.

Although eager to build her practice and interested in talking with the client, Kristi experienced some apprehension about how to respond to the client’s desire to learn about *her* spiritual beliefs. Similar to many therapists, Kristi’s professional training had provided little guidance about how to respond to such requests, other than to not engage in excessive, personal self-disclosure. For the most part, she was diligent about keeping her personal values separate from her professional practice. In this case, she didn’t want to come across to the client as rigid, distant, and unapproachable. Yet, discussing her personal beliefs with the client felt invasive and complicated.

Kristi wasn’t entirely sure she knew what her own spiritual beliefs were. So, how could she discuss them in a therapeutic manner with the client? She had been raised in a family that did not

attend church. She saw religion and spirituality as foreign to her, preferring to live her life based on rationality rather than faith. In addition, it seemed that the client wanted to integrate spirituality into the therapy process; Kristi had very little idea about how to do that, or even what the client meant by spirituality. She had received no training on how psychological theories and techniques could interface with religion and spirituality. Specifically, she wondered if her psychodynamically oriented approach was compatible with the client's self-defined spirituality. Maybe the client needed a referral to a pastoral counselor instead of a therapist? The more she thought about it, the more unsettled she felt.

Carlos, a therapist working at a community mental health agency, had been seeing a 40-year-old client in weekly, outpatient therapy for five sessions. The therapy was focused on addressing generalized anxiety and panic attacks. Carlos had introduced various cognitive-behavioral techniques, including mindful breathing and thought stopping and thought replacement, which seemed to be helping reduce the client's anxiety. In the sixth session, the client articulated that she "is a strong Christian" and attends church services several times a week. The client asked Carlos if he felt comfortable with her talking about the Bible and her "personal relationship with Jesus." She indicated that she wanted to make sure that the therapy supported "God's plans" for her.

Carlos was hit instantly by a wave of emotions, most notably anxiety and irritation. Carlos suddenly felt less comfortable with and trusting of his client. Part of him wanted to challenge the client's beliefs while another part felt exhausted and unable to address her questions. The client's words had obviously activated strong reactions in Carlos, including memories of his childhood.

Carlos was raised in a Christian family, which at times he experienced as oppressive and judgmental. His parents often used very similar words to the ones his client was now using. In young adulthood, he had a series of painful encounters with his parents

whereby he vehemently disagreed with aspects of their beliefs and practices, which culminated in a several-year period of cutoff from his parents and extended family. He has since reinitiated limited contact with his family, and is raising his own kids without organized religion. Based on his strong emotional reactions, Carlos wondered if he could work effectively with the client; he considered referring her to another therapist.

Jana, a student in a clinical graduate degree program, was about to work with her first client at her practicum site. She had completed courses in theories and techniques, assessment, diagnosis and treatment planning, ethics, and basic counseling skills, and was excited to put her newly forming skills into action. She was anxious, however, about the interface between her personal beliefs about health and healing and traditional talk therapy.

Over the past few years she had been engaged in a variety of personal growth activities, including mindfulness practices, body-oriented therapy, yoga, and Buddhist meditation retreats. She had been in a great deal of talk therapy in the past, but nothing helped as much as the experiential approaches that she now utilized. She believed strongly that traditional therapy models were too restrictive and wouldn't produce the lasting change that "spiritually oriented" techniques would. She felt that it was her responsibility to provide the best care for her clients, which included an infusion of spiritual practices and beliefs, although she was conflicted about this because of clinical concerns and ethical cautions raised by her professors. The concerns and cautions focused on the need to not impose her beliefs and practices on her clients. She wondered if she could be true to her beliefs and still be accepted into the traditional therapy community. Specifically, how could she integrate the therapy approaches she had been learning in graduate school with her spiritual beliefs?

These are just three of the many possible examples of the interface between therapy and religion/spirituality. Scenarios like these

tend to generate a variety of reactions and questions for therapists, such as:

- ◆ What is spirituality, and how is it similar to and different from religion?
- ◆ Do clients have a right to know about therapists' spiritual and religious beliefs when choosing a practitioner, much like asking about their theoretical orientation or cultural background?
- ◆ Is it even appropriate to address spiritual and religious issues in therapy?
- ◆ If yes, how does this happen without imposing the therapists' beliefs and values onto the client?
- ◆ What should therapists do if they have strong beliefs about spirituality and religion, especially if they differ to a large degree from their clients' beliefs?
- ◆ How do therapists deal with clients who espouse spiritual and religious beliefs and practices that the therapist views as unhealthy?
- ◆ What should therapists do if they are unclear about their own spiritual and religious beliefs?
- ◆ How should therapists manage their emotional reactivity to spiritual and religious issues that are based on their own upbringing and life events?
- ◆ How can spiritual and religious beliefs and practices be integrated with traditional therapy approaches?
- ◆ Are there models in the therapy field that provide a framework for addressing and integrating spiritual and religious issues?
- ◆ How could addressing spiritual and religious issues in therapy be useful to the therapeutic change process?

To address questions such as these, the following are central premises of the approach described in this book.

*Central Premises*

**Premise 1:** Spiritual, religious, and philosophical reflections, beliefs, and practices are foundational to the human experience and, therefore, are an essential aspect to consider in effective therapy.

**Premise 2:** Spiritually and religiously informed therapy is a form of multicultural therapy.

**Premise 3:** Many therapists struggle with addressing spiritual and religious issues in therapy based on foundational theoretical paradigms in the mental health field.

**Premise 4:** The therapist's own level of *spiritual-differentiation* most often predicts his/her effectiveness with addressing spiritual and religious issues in therapy.

**Premise 5:** Utilizing a model that integrates psychological theories with a broad-based, thematic, and inclusive view of spirituality increases therapists' competency in assessing and addressing spiritual and religious issues with clients from a variety of faiths and spiritual and philosophical positions.

**Premise 6:** The concept of the *Real Self* provides a conceptual link between psychological theories and client-defined, spiritual, and religious beliefs and practices.

**Premise 7:** Utilizing a client-defined sense of spirituality and religion in therapy can be a significant avenue for connecting with clients and a great asset and ally in the therapeutic change process.

Each of these premises is now discussed in greater detail.

*Premise 1: Spiritual, Religious, and Philosophical Reflections and Practices Are Foundational*

Research has consistently shown that a high percentage of Americans believe in God, pray, are church members, and attend religious services (Harris Interactive, 2009; Kosmin & Keyser, 2009). Many other people engage in a variety of ways of understanding and practicing spirituality

outside of organized religion. Ninety-three percent of Americans consider themselves to be religious and/or spiritual (Gallup, 2007), with nearly 75% describing spirituality and/or religion as integral to their worldview, sense of self, and part of their daily lives (Hagedorn & Gutierrez, 2009). Virtually everyone has some philosophical beliefs about existence and meaning, which have significant implications for how they live life. People that define themselves as atheists or agnostics also have some philosophical notions about their lives.

Increasingly clients are seeking spiritual answers in therapy and view spiritual development as essential for dealing with concerns in their lives (Morrison, Clutter, Pritchett, & Demmitt, 2009; Sperry, 2003). A vast amount of research has shown that spirituality is positively related to health and inversely related to physical and mental disorders (Miller & Thoresen, 2003). Therefore, it behooves therapists to understand and address clients' spiritual beliefs and philosophical notions as well as the practical implications of these beliefs and reflections, especially as they relate to clients' thought processes and behavioral choices.

In response to client needs and research data, professional organizations and accreditation bodies (e.g., American Psychological Association, American Counseling Association, Council for Accreditation of Counseling & Related Educational Programs, National Association of Social Workers, Council on Social Work Education, American Association for Marriage and Family Therapy, Commission on Accreditation for Marriage and Family Therapy Education) have increasingly recognized spiritual and religious issues as foundational to the human experience, and as an important client variable to be assessed in therapy. Along with other cultural variables, having the clinical skills to address spiritual and religious issues is now viewed as an expectation for effective therapy and graduate-level clinical training. Specific competencies for addressing spiritual and religious issues in counseling have been created by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) and have been adopted by the American Counseling Association.

ASERVIC (2009) lists 14 competencies across six categories for addressing spiritual and religious issues in counseling. The six categories are: (1) culture and worldview, (2) counselor self-awareness, (3) human and spiritual development, (4) communication, (5) assessment, and (6) diagnosis and treatment. Although the language of the competencies is focused on professional counselors, the message is aimed at all clinical mental health professionals. The complete ASERVIC standards can be accessed at [www.aservic.org](http://www.aservic.org), and require that therapists are able to:

- ♦ Recognize the centrality of spirituality and religion in many clients' lives as well as have an understanding of various spiritual systems, major world religions, agnosticism, and atheism.
- ♦ Have a high level of self-awareness of their own spiritual attitudes, beliefs, and values and how their attitudes, beliefs, and values may impact the therapeutic process.
- ♦ Apply theoretical models of spiritual and religious development.
- ♦ Identify spiritual and religious themes and communicate with clients about spiritual and religious issues with acceptance and in ways that match clients' worldviews.
- ♦ Consider spiritual and religious issues when conducting client assessments.
- ♦ Consider and utilize clients' spiritual and religious views when diagnosing and treating clients' issues in ways that match clients' preferences.

The development and adoption of the ASERVIC competencies point to the foundational importance of spiritual and religious issues in the lives of many individuals and the associated need for therapists to have the skills to address these issues. Unfortunately, many therapists feel unprepared to integrate

these issues into the therapeutic process. In one survey, 73% of therapists reported that spiritual issues are important to address but did not believe that they possess the necessary competency to do so (Hickson, Housley, & Wages, 2011). Furthermore, although graduate faculty indicate that integration of spiritual and religious issues are important, many educators do not feel prepared to teach these topics to students (Kelly, 1995; Robertson, 2010; Young, Cashwell, Wiggins-Frame, & Belaire, 2002). Not adequately addressing spiritual and religious issues in therapy misses a central aspect of client functioning and fails to utilize a primary resource in clients' lives (Robertson, 2010; Robertson, Smith, Ray, & Jones, 2009).

*Premise 2: Spiritually Informed Therapy Is a Form of Multicultural Therapy*

A multicultural perspective reminds therapists to conceptualize client worldviews as containing a variety of factors that combine to create a lens through which they define and experience themselves and the world. Cultural factors may include ethnicity, race, age, sex, gender identity and expression, sexual orientation, disabling conditions, spirituality and religion, political ideology, immigration status, and socioeconomic status, to name a few. Both clients and therapists bring their cultural lens to the therapy room. To raise awareness of the impact of culture for both therapists and clients, a commonly accepted process in multicultural therapy includes three general steps (e.g., Vacc, DeVaney, & Wittmer, 1995). Therapists should:

1. Be open to learning about and knowing themselves culturally.
2. Be open to learning about and knowing their clients culturally.
3. Be open to discussing the interface between their own and their clients' cultural worldviews.

Although most therapists have embraced these steps as a minimum expectation for multicultural competency, many struggle with the execution of this process related to spirituality and religion, despite the generally accepted view that spirituality and religion are intertwined and interrelated with culture (Fukuyama, Siahpoush, & Sevig, 2005). For example, most therapists do not have difficulty addressing racial or sexual orientation differences between themselves and clients, but spiritual and religious issues seem to be a different story. This struggle is partly due to the personal and private nature of spiritual and religious values and experiences. In addition, spiritual and religious beliefs are often in flux and in process, which tend to make quick, sound-bite responses much more difficult for therapists.

Some therapists do not have a clear idea of their spiritual and religious beliefs, while others have very strong convictions. Either way, it can be quite intellectually and emotionally complicated to understand and then articulate one's beliefs to others, especially clients, who may be engaged in their own spiritual identity process and journey.

Although challenging for many therapists, it is increasingly likely that clients will ask therapists about spiritual and religious beliefs, just as they might ask about a therapist's theoretical orientation or other cultural variables. There is an increased expectation from clients that therapists will understand spiritual concerns and utilize holistic interventions (La Torre, 2002; Sperry, 2003).

One source of this increased expectation is the consumer/survivor movement within the mental health field, which attempts to improve mental health services, increase accessibility of services, and encourage educated and informed choices for consumers as well as transparency and collaboration from providers. From this perspective, consumers should be well informed about the services they are purchasing. If spiritual and religious issues are important to them, clients should inquire about how potential therapists would address

these issues in therapy, similar to asking a therapist about his/her theoretical orientation and, for example, experience with and beliefs about gay and lesbian issues, or any other cultural variable.

Thus, therapists need to understand their own spiritual and religious beliefs, be interested in learning about their clients' spiritual and religious worldviews, and be able to respond to client inquiries about the interface of spiritual and religious issues and the therapy they provide. In general, therapists need to have the skills to individualize treatment to match their clients' needs and preferences (Norcross & Wampold, 2011a; Swift, Callahan, & Vollmer, 2011). In particular, research suggests that for clients who specifically request that religious and spiritual issues be addressed in therapy, the match between the client's beliefs and the therapist's ability to accommodate treatment to address these issues significantly affects psychological and spiritual outcomes in therapy (Smith, Bartz, & Richards, 2007; Worthington, Hook, Davis, & McDaniel, 2011). Even when clients do not specifically request that therapy have a spiritual and religious focus, clients seem to benefit from treatment that incorporates their spiritual and religious framework (Norcross, 2002; Pargament & Saunders, 2007; Worthington & Atten, 2009).

*Premise 3: Therapists Often Struggle With Spiritual and Religious Issues in Therapy*

Kristi, Carlos, and Jana, the therapists in the scenarios at the start of this chapter, are not alone with their difficulties in addressing spiritual and religious issues in therapy. Along with the aforementioned challenges of executing a multicultural process with regard to spiritual and religious issues due to the private, personal, and ongoing nature of one's spiritual identity development process, there has been a deep-seated tension between the practice of therapy and spirituality and religion that has been a foundational aspect of modern psychology and clinical training, largely due to three pervasive

perspectives. The first is Freud's views on religion as well as his ideas about the therapist's role in the psychotherapeutic change process.

*Freud*

Although most practicing therapists do not adhere to a classical psychoanalytic perspective, almost all have been heavily influenced by psychoanalytic ideas related to maintaining the analytic framework. This includes the creation and maintenance of a holding environment for clients with firm boundaries between therapists and clients, consistent meeting times, and very little therapist self-disclosure, primarily as a way to facilitate client transference and projection processes. A key aspect of the change process occurs when clients reexperience past relational dynamics with the therapist. From this perspective, therapist self-disclosure can interfere with these dynamics, and is often seen as gratifying the therapist's needs at the expense of the therapeutic process.

The admonitions regarding therapist self-disclosure, in particular, can make addressing spiritual and religious issues in therapy quite challenging. Spiritual and religious issues are often very personal, for both clients and therapists. While most therapists feel comfortable discussing their theoretical orientations with clients, the personal nature of spiritual and religious issues leaves many therapists feeling unsure of the appropriate boundaries. They tend to either refuse to discuss the topic with clients or end up feeling as if they revealed too much.

Although therapeutic boundaries and a healthy holding environment are often crucial for therapeutic success, for some clients the ability to have discussions with their therapists regarding spiritual and religious ideas promotes the therapeutic alliance and contributes to the development of a holding environment. Many therapists need guidance on how to navigate therapeutic boundaries when clients are revealing their spiritual and religious beliefs and experiences and are asking therapists to reveal their own.

Another influential belief that Freud espoused was that religion served the neurotic purpose of gratifying an individual's infantile needs to be cared for by an omnipotent father figure. Once individuals emotionally and psychologically matured, it was argued, they would no longer need such childish security blankets. Freud also saw religion as providing overly simplistic explanations and prescriptions for the ills of people and society. He argued that therapy, in his case psychoanalysis, should remain morally neutral, focusing on the facilitation of deep psychological self-awareness as the key to softening neurotic suffering. The best humans can hope for is a reduction in the intensity of neuroses through increased awareness and understanding of internal dynamics, leading to a transformation of "neurotic misery into common unhappiness" (Breuer & Freud, 1895/1962, p. 304). Thus, we can live an informed and rational life, more aware of our patterned tendencies and without the false hopes of religious salvation.

Within this Freudian framework, there is virtually nothing said about joy, growth, abundance, or any understanding of positive health. As noted in Rubin (2003), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* "contains over four hundred entries for neurosis and pathology and not one for health" (p. 395). Although I wouldn't argue with Freud's point that suffering is an inevitable aspect of living, I do believe that humans are capable of far more than living an informed and rational life and that spirituality, rather than simply creating false and childish hopes, can assist many people in experiencing deeper meaning and holistic health in their lives. Therapists can utilize the integrated model presented in this book to understand how a client-defined sense of spirituality can be a vital aspect of the therapeutic process.

### *Scientific Rationalism*

Related to the Freudian view is modernist thinking, predominately expressed by scientific rationalism. From this view, religion is seen as

an attempt to explain the unknown. God simply fills the gap until more reasonable explanations can be found. The core of this belief system is that science, and specifically the scientific method, will eventually find the answers to all of life's mysteries, thereby rendering religion as archaic and unnecessary. Underlying this view is the idea that empirical knowing and intellectual thought are superior to affective and intuitive knowing. The bottom line is that, similar to Freud's view, rational people should let go of whatever can't be proven through the scientific method. This paradigm espouses an acceptance of and absolute faith in science and a dismissive and pathologizing view of spiritual and religious faith.

In addition to Freud, an example of this pathologizing view comes from Albert Ellis (1980), founder of rational-emotive behavior therapy, who indicated, "Religiosity is in many respects equivalent to irrational thinking and emotional disturbance" (p. 637). He contended that atheism is the only reasonable and rational choice for those interested in optimal human functioning.

Scientific rationalism continues to offer a great deal to the world, with few arguing that scientific, medical, and technological advances don't carry with them enormous potential for improving the quality of life. The problem is that excessive rationalism, or the belief that reason is superior to all other forms of knowing, is quite limiting and can be experienced as condescending by faith-oriented clients, especially clients who embrace fundamentalist views. Clients who have experienced profound spiritual experiences, for example, often feel misunderstood, minimized, and judged by therapists. Again, the model presented in this book can assist therapists to respectfully utilize a client-defined sense of spirituality as an aspect of the therapeutic process.

### *Value-Free Therapy*

A third voice in the field that has contributed to therapists having difficulty with addressing spiritual and religious issues in therapy

is the belief that therapy should be value-free. This view, which is perhaps most strongly represented by humanistic thought, is that all individuals are completely unique. Consequently, it is disrespectful and unhelpful for therapists to impose their own values or belief-systems onto clients. Individuals are capable of choosing their own beliefs and of finding their own way in the world. Attempts to integrate religion or spirituality into the therapy process are viewed with skepticism, particularly of the therapist's motives. The very personal nature of spiritual and religious beliefs and practices makes the process even more complicated for therapists and clients.

This view about managing one's own personal values is warranted and carries an important caution. As a general rule, therapists should be careful not to impose their values or beliefs onto clients. Therapists have a sacred responsibility to manage their power appropriately, especially when working with clients in pain or crisis who are eager to relieve their suffering and may be vulnerable to blindly adopting the values of others. In the broadest sense, extreme religious views and fanaticism have certainly caused great destruction and suffering in the world. When a person or group of individuals thinks that they have *the answer* and the right way to live life, there is great potential for intolerance and oppression. However, to throw the baby out with the bath water, while possibly the safest route, also seems extreme.

Furthermore, to assume that therapy can be value-free is simply erroneous. Every therapy theory and approach is value-laden, even humanism, which values not imposing values! Therapists need to recognize the values and beliefs about health and pathology that are embedded in their personal worldviews and their theoretical approaches to helping. Part of effective therapy is a dynamic process of developing shared and hopefully more functional realities with clients. As with any topic, a discussion of spirituality and religion needs to be handled with respect for different

worldviews, including cultural beliefs and unique phenomenological perspectives.

*Premise 4: Spiritual-Differentiation Predicts Effectiveness With Spiritual and Religious Issues*

Along with these foundational sources of difficulty, I have found that it is the therapists' own level of differentiation that is most predictive of their ability to address spiritual and religious issues as they emerge in therapy. *Differentiation of self* refers to an individual's ability to function in an autonomous and self-directed manner while staying in contact with significant others (Bowen, 1978; Kerr & Bowen, 1988). Differentiated individuals are able to separate themselves from unresolved emotional attachments in their families without emotionally cutting off from significant relationships. Undifferentiated individuals, on the other hand, tend to remain fused in relationships with parents and significant others and/or emotionally cut off from these relationships (Kerr & Bowen, 1988; Skowron, Holmes, & Sabatelli, 2003; Titelman, 1998a). Thus, fused relationships are characterized by enmeshment and emotional reactivity whereas emotional cutoffs are characterized by reactive disengagement (Johnson & Waldo, 1998).

A central barometer of differentiation is an individual's level of emotional reactivity, often seen in the ability to separate thoughts and feelings (Bowen, 1976, 1978; Johnson & Buboltz, 2000; Skowron & Dendy, 2004; Titelman, 1998b). Differentiated individuals are not overwhelmed by emotionality at the expense of their intellect whereas undifferentiated individuals tend to be ruled by their emotions. Differentiated individuals are "inner-directed" and readily take an "I position" rather than act reactively in response to external events and others' emotionality (Johnson, Buboltz, & Seemann, 2003; Kerr & Bowen, 1988). The key components of differentiation, then, include an individual's level of fusion

versus emotional cutoff, and *I position* versus emotional reactivity (Skowron & Friedlander, 1998).

The ability to differentiate is largely determined by how an individual's nuclear family manages anxiety related to balancing the issues of separateness and togetherness. Projection of anxiety onto children typically produces lower levels of differentiation (Bowen, 1978). When individuals are overwhelmed by emotionality and anxiety in their family, they are likely to remain fused or emotionally cut off.

Assessing the various dimensions of differentiation not only provides markers of psychological health and dysfunction for clients, but also for therapists. High levels of differentiation allow therapists to be near others' anxiety without owning it or becoming emotionally reactive (Chen & Rybak, 2004). This is vital when addressing spiritual and religious issues, which tend to have great potential for reactivity. Emotional reactivity by therapists makes the three steps of multicultural process very challenging.

*Spiritual-differentiation*, in particular, refers to one's level of resolution and ownership versus reactivity in regard to spiritual and religious issues. Everyone, including therapists, has had some experiences with religion and spirituality, which influence the development of beliefs, values, and practices. When past experiences with religion and spirituality are intrusive, the process of developing and choosing one's own beliefs and practices, without blindly adopting and/or reacting against those experiences, can be quite challenging (Johnson, Buboltz, et al., 2003). For therapists, like Carlos in the vignette, who have experienced *spiritual-violence*, also referred to as "religious wounding" (Fukuyama et al., 2005), which is judgment, abuse, oppression, and/or restriction of a person's authentic self in the context of religion or spirituality, it can be very difficult to work with spiritually and religiously oriented clients due to the therapist's own sensitivities and associated reactivity. Due to the importance of spiritual-differentiation for

therapist competency, the last chapter of the book will be devoted to this topic.

*Premise 5: An Integrated Model Increases Competency*

Many therapists are simply lacking a model for how to conceptualize and address spiritual and religious issues in therapy, largely due to the foundational tensions within the therapy field. Despite these impediments, there are several theorists who have attempted to bridge the gap between psychology and spirituality. Of great importance is the work of Carl Jung. Jung broke radically from Freudian thought by focusing on what could be termed *psychoanalytic mysticism*. He believed that religion held more healing and redemptive power than did psychological analysis alone. He argued that each person has potential access to a deep pool of collective knowledge (i.e., the collective unconscious) and that the kernels of knowing exist inside everyone, in the form of archetypes. He proposed the idea of the Self as an archetype that represents human striving for unity. The Self strives for wholeness, especially through the avenues associated with religion and spirituality, and is described as “the only accessible source of religious experience” (Jung, 1957, p. 101).

More recently, the integration of psychology and spirituality has been given fresh energy, as the definition of spirituality has been broadened and clarified as potentially distinct from organized religion. This broadening has engendered a more inclusive view of spirituality that is sparking interest in many who have felt unrepresented by and reactive to organized religion. Movements in the field of psychology, such as dialectical behavior therapy (e.g., Linehan, 1993a, 1993b), acceptance and commitment therapy (e.g., Hayes, Follette, & Linehan, 2004; Hayes & Smith, 2005; Hayes, Strosahl, & Wilson, 1999), transpersonal and integral psychology (e.g., Boorstein, 1996; Cortright, 1997; Forman, 2010; Vaughan, 2000; Walsh, 1999; Wilber, 1996, 2000, 2006), body-oriented therapies

(e.g., Eisman, 2001; Kurtz, 1987, 1990; Ogden, 1997; Roy, 2003), mind-body medicine (e.g., Benson & Proctor, 2010; Proctor & Benson, 2011), and Buddhist psychology (e.g., Brach, 2003; Epstein, 2007; Germer, Siegel, & Fulton, 2005; Magid, 2002; Prendergast, Fenner, & Krystal, 2003; Safran, 2003; Welwood, 2000) are connecting with people who are interested in learning about various forms of holistic, reflective practice.

A primary goal of this book is to provide readers with a model that integrates traditional and contemporary psychological theories with a broad-based, thematic, and inclusive view of spirituality. Using a model that integrates various psychological theories provides therapists from different theoretical orientations with increased competency in assessing and addressing spiritual and religious issues with clients from a variety of faiths and spiritual and philosophical positions, especially when such competency is combined with a high level of spiritual-differentiation.

*Premise 6: The Real Self Provides a Link Between Psychological Theories and Spirituality*

A number of theories from different schools of psychological thought converge around the idea that there is a core self, a higher self. There are different names for it (e.g., inner knowing, Self, ego, wise mind, natural self, authentic self, core self), but the idea seems to be the same. That is, there is a part of everyone that exists at the center of one's being, which holds great potential for growth, health, and creativity and possesses knowledge about what is life-affirming and life-enhancing. Borrowing from Karen Horney, a post-Freudian analyst, I call this the *Real Self*. The Real Self has access to the collective knowledge described by Jung and is each person's guide to healing, growth, abundance, and the potential for transcendence. Horney (1950) defines the Real Self "as that central inner force, common to all

human beings and yet unique in each, which is the deep source of growth” (p. 17).

Throughout this book, I propose that the Real Self provides a conceptual and practical link between psychological ways of understanding health and healing and a broad-based, thematic, and inclusive view of spirituality. Being out of touch with the Real Self has both psychological and spiritual consequences, which lead to the majority of difficulties that motivate clients to seek mental health treatment. Assisting clients with embracing their Real Self enables them to regain the most significant source of guiding wisdom in their lives.

*Premise 7: Client-Defined Spirituality Is an Asset in Therapy*

Understanding client-defined spiritual or religious beliefs and practices can be a significant avenue for connecting with clients and very useful for therapeutic change. When therapists are open to learning about their clients’ philosophical, spiritual, and religious views, they will come to understand their clients on a deeply personal level. For clients who have a preference for discussing these issues, matching clients’ preferences significantly improves therapy outcomes (Smith et al., 2007; Swift et al., 2011; Worthington et al., 2011).

Even for clients who do not specifically request that spiritual or religious issues be addressed in therapy, a broad-based and inclusive view of spirituality can inform and support therapeutic change. The therapist’s task is to listen for how clients talk about existential issues of meaning, values, mortality, and sense of self in the world. Philosophical notions of existence will often reflect spiritual beliefs and practices, broadly defined. The goal is to be open to how clients define, experience, and access whatever helps them stay connected to their core values and the inner wisdom of their Real Self. Some clients will experience and access spirituality through traditional methods such as prayer and meditation, while others may connect to personal clarity through a variety of nontraditional

ways. It shouldn't matter to therapists *how* their clients connect with spirituality. What matters most is whether the spiritual practices are life-affirming and support personal integrity.

Personal integrity provides an inner compass, based on core values. I often ask clients to consider how their lives and choices would be if they were based on the wisdom of their Real Self. When choices are made from the centered wisdom of the Real Self, clients lead a *value-driven life*. They tend to make choices that are congruent with their core values. Helping clients define, experience, and access their own life-affirming spiritual beliefs and practices (even if they don't refer to them as "spiritual") supports them in leading a discerning and intentional life and is a tremendous ally in the therapy process.

### *Spirituality and Religion*

There is no clear consensus on what is meant by the terms *religion* and *spirituality*, although there seem to be some common themes associated with the two concepts. For example, Hodges (2002, p. 112) provided the following list of similarities between religion and spirituality; both provide:

- ♦ Meaning in life
- ♦ Intrinsic values as the basis for one's behavior
- ♦ Transcendence
- ♦ A relationship with a Higher Power
- ♦ A belief in a creative and universal force
- ♦ A shift of "locus of centrality to humancentricity, of egocentricity to cosmiccentricity"
- ♦ Inclusion within a larger collective
- ♦ Guidance through a divine plan
- ♦ An experience, a sense of awe and wonder when contemplating the universe
- ♦ Shared values and support within a community

Others have articulated the differences between religion and spirituality. According to Hill et al. (2000), religion can be understood as adherence to a belief system and practices associated with a tradition in which there is agreement about what is believed and practiced while spirituality can be understood as a general feeling of closeness and connection to the sacred. The sacred can be a divine being or object, or a sense of ultimate reality or truth. Similarly, Koenig (2008) defines spirituality as a personal desire for connection with the Sacred, transcendent, or ultimate truth/reality, while religion:

- ♦ Is a system of beliefs and practices of those within a community with rituals designed to acknowledge, worship, communicate with, and come closer to the Sacred, Divine, or ultimate Truth or Reality.
- ♦ Usually has a set of scriptures or teachings that describe the meaning and purpose of the world, the individual's place in it, the responsibilities of individuals to one another, and the life after death.
- ♦ Usually has a moral code of conduct that is agreed upon by members of the community, who attempt to adhere to that code.

Many individuals experience spirituality through religion, while many others do not equate their spiritual beliefs and practices with religion (Worthington et al., 2011). Spirituality can be viewed as the umbrella concept, with religion being one of many avenues for connecting with the sacred and divine. Kelly (1995) described religion as “creedal, institutional, and ritual expressions of spirituality associated with world religions and denominations” (p. 5). As cited in Gold (2010), spirituality is “broad enough to accommodate the uniqueness of all individuals . . . and indeed the whole of humanity irrespective of beliefs, values, or religious orientation” (Hollins, 2005, p. 22).

For the remainder of the book, I will exclusively use the term spirituality as an overarching concept that refers to religion as well as broader spiritual and philosophical beliefs and practices. Borrowing from Hodges (2002), I conceptualize spirituality as any beliefs and practices that foster meaning, intrinsic value, and integrity as a basis for one's behavior, and a life-affirming conception of and connection with something larger than oneself. In short, spirituality helps individuals move from a narrow, egocentric position to a sense of connection with a greater whole and a divine force or purpose. This broad definition allows for an inclusive and client-defined view of spirituality. The focus for therapists is on being open to the unique ways that clients define, experience, and access life-affirming spiritual beliefs and practices.

In the next chapter, I provide a discussion of the many ways that clients may define, experience, and access spirituality. Having an understanding of how clients may speak about spirituality provides therapists with an avenue to nonjudgmentally invite a collaborative exploration of the role of spirituality in their clients' lives.