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Spirituality and Counselling: Are Counsellors Prepared to Integrate Religion and Spirituality into Therapeutic Work with Clients?
La spiritualité et le counseling : Les conseillers sont-ils préparés à intégrer religion et spiritualité dans le travail thérapeutique avec clients?

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ABSTRACT

An online survey of 341 Registered Clinical Counsellors in British Columbia was used to understand how therapists view and integrate spirituality and religion in their practice. Therapists were asked about their education and training in this realm, and about their perceived abilities, comfort, and competence when working with religious and/or spiritual content. Results suggest that spirituality, but not necessarily religion, is important in participants' lives and their work with clients, while fewer than half indicated that they were integrating spirituality into their practice. Discussion focuses on the need for practitioner comfort, confidence, and competence regarding spirituality in the therapeutic process.

RÉSUMÉ

Une enquête en ligne chez 341 conseillers cliniciens agrées en Colombie-Britannique a été utilisée pour comprendre comment les thérapeutes considèrent et intègrent la spiritualité et la religion dans leur pratique. Les thérapeutes ont été questionnés sur leur éducation et formation dans ce domaine, et leurs capacités perçus, confort, et compétence en travaillant avec un contenu spirituel et/ou religieux. Les résultats suggèrent que la spiritualité, mais pas nécessairement la religion, est importante dans la vie des participants et leur travail avec les clients; cependant, moins que la moitié ont indiqué qu'ils intégraient la spiritualité dans leur pratique. La discussion vise le besoin du praticien de confort, confiance, et compétence quant à la spiritualité dans le processus thérapeutique.

Because individuals with a religious and/or spiritual worldview typically find comfort in their religious or spiritual beliefs and practices during times of uncertainty or crisis, it is important that counsellors, when building a therapeutic alliance with clients, encourage spiritual expression:

> [F]or the majority of clients, religion and spirituality are important to them and … they would like to be able to talk about this area of their lives in therapy. Therapists should facilitate this by creating a setting of openness, trust, and respect for client spiritual expression. (Eck, 2002, p. 269)

Religion and spirituality contribute to increased rates of well-being and life satisfaction and decreased rates of "suicide, substance abuse, and antisocial behavior" (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002, p. 4). Reportedly, however, most mental health practitioners have not been adequately prepared in their clinical programs to work with religious/spiritual clientele (Brawer et al., 2002; Eck, 2002; Kahle, as cited in Griffith & Griffith, 2002).

The present study attempts to gain insight into how practicing therapists view the place and limits of religion and spirituality in therapeutic work. The following section reviews what the literature reports about religious/spiritual beliefs and practices regarding American and Canadian populations, mental and physical health, and clinician competency and clinical programs.

LITERATURE REVIEW

The research reviewed in this section has a predominantly Judeo-Christian bias (as does the author) as the bulk of the research on integrating religion and spirituality into counselling, in the field of counselling psychology and psychology in general, is from American academics and practitioners. The American Religious Identification Survey 2008 (ARIS; as cited in Wikipedia, 2010) reported that 76.0% of the adult Americans surveyed identified themselves as Christian. Given this statistic, it is arguably practical that American researchers would focus on integration from a Christian perspective.

In the United States, "94% of adult Americans are members of a church, synagogue, or place of worship, and 58% of the same population rate religion as being very important in their lives" (Gallup, as cited in Wolf & Stevens, 2001, p. 1). Of Americans surveyed by *Free Inquiry*, an agnostic-orientated publication, 90% "expressed belief in a personal God who can answer prayer" (Griffith & Griffith, 2002, p. 5).

Canadians are reportedly not as religious as Americans. Statistics Canada reports that "in 2004 over half of Canadians ages 15 to 29 and almost 60% of British Columbians either had no religious affiliation or did not attend any religious services" (Clark & Schellenberg, 2006, p. 2). However, many Canadians, while not participating regularly in formal religious services, do engage in personal religious practices privately (Clark & Schellenberg, 2006).

Mental and Physical Health and Religion/Spirituality

Religion and spirituality can either help or hinder the healing process. Research shows that religious and spiritual beliefs and practices are beneficial for improving and maintaining good mental and physical health (Larimore, Parker, & Crowther, 2002), and that they have benefits for people dealing with mental illness. Such benefits include (a) greater strength in coping and decision-making, (b) enhanced social support, and (c) personal coherence or wholeness (Fallot, 2001). In contrast, rigid religious beliefs based on sin and guilt may deepen mental illness such as depression, and delusions and hallucinations may be accentuated by religious content (Fallot, 2001).

Cotton, Grossoehme, and Tsevat (2007) reviewed the literature of the past two decades on the effects of religious and spiritual beliefs and practices on mental, emotional, and physical well-being in the lives of American youth from the ages of 12 to 20 years. The authors found that "in general, adolescents that have higher religiosity and/or spirituality fare better than their less religious or spiritual peers" (Cotton et al., p. 146). This included "lower rates of risky health behaviors and fewer mental health problems—even when taking into account other factors that may affect health outcomes such as age, sex, or family income" (Cotton et al., 2007, p. 146).

Cotton et al.'s (2007) hypotheses related to how spirituality may influence health in adolescents, in particular indirect effects such as social support and positive role models and direct effects from coping mechanisms such as prayer. Further, these researchers identified that religion and spirituality can play a negative role in the lives of teenagers (i.e., increased risk of sexually transmitted diseases and/or pregnancy due to a disbelief in contraception and feeling ostracized for their sexual orientation and/or premarital sexual activity in general).

Cotton et al. (2007) emphasize the need for a spiritual screening or spiritual assessment initiated by the helping professionals involved in the lives of youth for the purpose of developing "an appropriate plan of care." One such screening tool described by Cotton et al. (2007) is the FICA:

- **F** (faith): What is your faith tradition?
- **I** (important): How important is your faith to you?
- **C** (church): What is your church or community of faith?
- **A** (address): How would you like me to address these issues in your healthcare? (p. 149)

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

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

- History-taking validates religion as an important part of the patient's life and identifies a potential coping resource.
- It draws the person's attention to past circumstances when religion may have been used successfully to combat a stressor.
- Past negative experiences with religion may be uncovered and worked through so that the person may now be free to use religion as a resource if he or she chooses.
- It provides vital information that is necessary in designing any future interventions that may include the patient's religious faith. (p. 169)

Hermsen and ten Have (2004) recognize that, because of ever-increasing older populations, there is a growing need to provide care that will meet the spiritual and religious needs of geriatric patients in continuing and palliative care facilities. The authors reviewed the topic of pastoral care, spirituality, and religion by auditing 12 palliative care journals from 1984 to 2002. They found 80 articles that covered four central issues related to their topic:

- concepts of pastoral care, spirituality, religion, and patients' search for meaning;
- coping with terminal disease and the experience of hope;
- the nature of suffering;
- education and training. (Hermsen & ten Have, 2004)

While reviewing these articles, Hermsen and ten Have (2004) found that there was a lack of clarity regarding the central concepts, especially between religion and spirituality. The authors also found a disconnection between the essence of spirituality and religion, but not necessarily from the search for meaning—in particular, the meaning of life and death. When looking at hope and the nature of suffering, Hermsen and ten Have (2004) found that the articles explored hope as a dynamic experience regarding meaning-making in life and death, and with coping with chronic illness. Having a faith in God impacts chronically ill and dying patients both positively and negatively, including eliciting a spiritual crisis while patients try to understand or control suffering and the onset of death (Hermsen & ten Have, 2004).

Education and training are important aspects of providing ethically competent care to culturally and religiously diverse clientele. This includes training caregivers in nursing and residential homes on introspection or self-reflection about their beliefs and attitudes on life and death and how these might affect their work with patients (Hermsen & ten Have, 2004).

A thorough assessment is necessary in professional practice when considering using spiritual interventions with clients, as it helps the therapist to understand "the client's belief system, values, and religious practice" in order to "engage the client in a way that is ethno-religiously congruent and that does not potentially violate their religious tradition and practices" (Eck, 2002, p. 269).

Clinician Competency and Clinical Programs

Graduate programs in counselling are lacking when it comes to preparing students to invite clients to "share their spiritual or religious concerns, issues, and values in the same way they share any other area of their life" (Eck, 2002, p. 269). Eck asked:

> if clients prefer that therapists include their religious and spiritual values in treatment, why don't more clients bring them up in therapy[?] … given these client and cultural contexts, why hasn't spirituality and religion become better incorporated within our clinical models, training, practice, and protocols? (2002, p. 268)

The silence in this area may be due to an unspoken rule of "don't ask, don't tell," where both the therapist and the client find it uncomfortable to speak about religious and spiritual matters (Eck, 2002). Clients may hold back because they may prefer to keep the sacred from the secular or they may fear religious coercion by therapists discussing their own religious and spiritual beliefs (Eck, 2002).

A study involving student counsellors at the master's level revealed that most students experienced discomfort when discussing spiritual issues in counselling, mainly due to fears of offending or of being judged personally (Souza, 2002). Students' opinions vary as to whether they view spirituality as negative or positive, based on their own experiences, which could produce counter-transference issues. "For example, it is possible for a student's disillusionment with religion to interfere with her or his ability to counsel a religious client. On the other hand, a fervently religious student may be unable to relate to nonreligious clients" (Souza, 2002, p. 214).

Another area of concern for students was in defining spirituality. One student expressed his view in the following way:

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

Ankrah (2002) emphasizes the risks for clients wanting to explore spiritual experiences in counselling:

> [A] person coming into a counselling relationship who has experienced a spiritual emergency, or some other state of spiritual consciousness, runs the risk of having their spiritual experiences misinterpreted or not feeling there is space or permission to share that part of the self, and so feel silenced. (p. 58)

Ankrah's (2002) descriptive and heuristic research found that for 25% of the participants, their counselling experiences were negative in that their spiritual experiences were either pathologized and/or dismissed by their counsellors. The results also showed that the non-European participants experienced racism regarding their spiritual beliefs and experiences.

Koenig et al. (1996) stress that when religion is brought into the therapeutic relationship, transference and counter-transference reactions may be intensified. Therapists can deal with these reactions by first acquiring understanding and experience about the neurotic and non-pathological use of religion in clients' lives—this may include inferences of clients trying to "defray or cover an underlying conflict" and/or inferences that may indicate a "mature religious faith that is usually adaptive, supportive, and freeing" (Spero, as cited in Koenig et al., 1996, p. 180). In this respect, Spero (as cited in Koenig et al., 1996) adds that therapists need to compare and contrast their own religious beliefs to those of their clients.

Negative emotional responses, whether due to overconcern or overidentification, also need to be recognized and prevented from interfering with therapy so as to continue to appreciate and respect client needs (Spero, as cited in Koenig et al., 1996). Lastly, Spero (as cited in Koenig et al., 1996) emphasizes that it is

important for a religious therapist working with a religious client to remember that "he or she is a mental health professional with the goal of enhancing the patient's psychological stability and range of functioning, not a religious professional with the primary goal of enhancing spiritual development" (p. 181).

A study conducted by Kahle (as cited in Griffith & Griffith, 2002) reported that of the 151 therapists surveyed, 98% would discuss spirituality and God in the counselling process but only if initiated by the client. On the other hand, 60% of therapists were willing to initiate a discussion on spirituality, but only 42% were willing to initiate a discussion on the topic of God (Kahle, as cited in Griffith & Griffith, 2002). This study also revealed that most therapists had received discouraging messages about discussing God with their clients through their respective education and training programs, but were encouraged to discuss God by clients and patients (Kahle, as cited in Griffith & Griffith, 2002). Other barriers to inclusion were "concerns about imposing their belief systems on their clients, convictions that reliance on God was disempowering of people, and a fear that religious differences between client and therapist could put a barrier between them" (Kahle, as cited in Griffith & Griffith, 2002, p. 31).

Research indicates that many therapists are integrating religion and spirituality into counselling "through intrapersonal integration" (interventions based on one's own religious experience); this can be problematic in that it "creates a risk of therapists imposing their own values or applying religious or spiritual interventions inappropriately" (Walker, Gorsuch, & Tan, 2004, p. 77). A study by Frazier and Hansen (2009) supports Walker et al.'s (2004) findings in that the psychologists who identified as religious/spiritual were more likely to report that they were engaging in religious/spiritual psychotherapy behaviours, such as the use of prayer, scripture references, and religious metaphors.

Because clients report the need to be able to integrate the religious and spiritual dimensions of their lives into the counselling process, and due to the reported use of intrapersonal integration by therapists as a means to meet that need, a greater risk exists for causing harm to the client. Therefore, relevant and diverse professional training is needed in this area:

> In addition to an assessment of the client, the therapist must perform a self-assessment to determine if spiritual interventions are appropriate and compatible with their role and scope of practice … the therapist must be properly trained, supervised in its use, and able to practice the technique safely. The therapist should also be self-aware enough that their own personal values, beliefs, conflicts, and biases do not hinder their service to the client or impose practices that violate the client's own beliefs and values. (Eck, 2002, pp. 270–271)

METHOD

As described below, clinical counsellors from the British Columbia Association of Clinical Counsellors were surveyed regarding their personal religious/spiritual beliefs and practices, and about their views and practices regarding integrating religion and spirituality into counselling. Other areas that were explored included

counsellors education and training in this realm, and perceived comfort and competence when working with religious and/or spiritual content. They were also asked if they were interested in receiving continued education and training in this area.

The survey was developed by the researcher and posted on <SurveyMonkey.com>. The self-administered survey was distributed to participants with an introduction, instructions, and a highlighted link to the survey through electronic mail.

Participants

Members of the British Columbia Association of Clinical Counsellors (BCACC) were invited to participate in this study. In total, 341 counsellors participated in the survey, giving a response rate of 17.1%. Participation was voluntary and anonymous. Participants in the survey were not required to identify themselves. The protocol used by Survey Monkey does not track or record computer identifications as a further assurance of anonymity.

Risks

It is possible that some participants may experience distress over religious ideas and their reaction to them. However, since there was no direct demand to participate in or complete the survey, and since the survey was entirely anonymous, the risk of such distress was considered very small.

Instrument

The survey was adapted from an instrument developed by Prest, Russel, and D'Souza (1999) that was previously adapted from a survey by Sheridan, Bullis, Adcock, Berlin, and Miller (1992). It contained 35 closed-ended exploratory questions to which participants were to respond using a five-point Likert-scale (*strongly agree* to *strongly disagree*), two comment sections, and four open-ended questions. Respondents were presented with working definitions of "spirituality" and "religion" taken from Prest et al. (1999). Spirituality was defined as "the human experience of discovering meaning, purpose, and values, which may or may not include the concept of a God or transcendent being" (Prest et al., 1999, p. 64). Religion was defined as "the formal institutional contexts for spiritual beliefs and practices" (Prest et al., 1999, p. 64).

The survey included four sections: demographics; practitioner ideology; appropriateness of spiritual and religious interventions; and education, comfort, and competence.

Section 1 included questions on sex, age, and number of years practicing in the field. Section 2 examined respondents' ideological orientation towards spirituality and religion by first asking them to select an ideological position (see Table 1). Next, respondents were asked to rate themselves as spiritual and/or religious persons and to identify whether or not they regularly spend time getting in touch with their spirituality and/or religion; this included a space for comments. The last part of this section examined respondents' attitudes toward spirituality and wellness (see Table 2); this part also included space for comments.

Table 1
Epistemological Positions Regarding Spirituality and Religion

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

Table 2
The Importance of Spirituality for Wellness

Position	Description
One	There is a relationship between spiritual health and mental health.
Two	There is a relationship between spiritual health and physical health.
Three	There is a relationship between spiritual health and the health of the community.

Section 3 of the survey examined respondents' attitudes and practices regarding the appropriateness of integrating spirituality (see Table 3) and religion (see Table 4) into professional practice, including a comments area for both.

Table 3
The Integration of Spirituality and Professional Practice

Intervention	Description
One	Ask a client about his/her spirituality.
Two	Wait until the client brings up his/her spirituality.
Three	Help client to develop spiritually.
Four	Discuss client's spiritual experiences.
Five	Use spiritual language.
Six	Discuss client's spiritual symbols.
Seven	Recommend spiritual program.
Eight	Pray for client.
Nine	Pray with client.
Ten	Meditate with client.
Eleven	Recommend spiritual books.
Twelve	Discuss own spirituality.
Thirteen	Discuss meaning of life.
Fourteen	Refer to 12-step program.
Fifteen	Use spiritual issues to connect with community.

Table 4
The Integration of Religion and Professional Practice

Intervention	Description
One	Ask clients about their religion.
Two	Wait until the client brings up his/her religion first.
Three	Recommend client join a religion.
Four	Recommend client leave a religion.
Five	Recommend participation in a religious program.
Six	Discuss own religious beliefs.
Seven	Talk with client about God.
Eight	Recommend religious books.
Nine	Use religious language.

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

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

The items on comfort and competency included:

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

DATA ANALYSIS

Descriptive statistics were used to summarize the data that were collected and reported by <SurveyMonkey.com>. Descriptive statistics were chosen as a means to quantify the data without using probability formulas as typically used in inferential statistics.

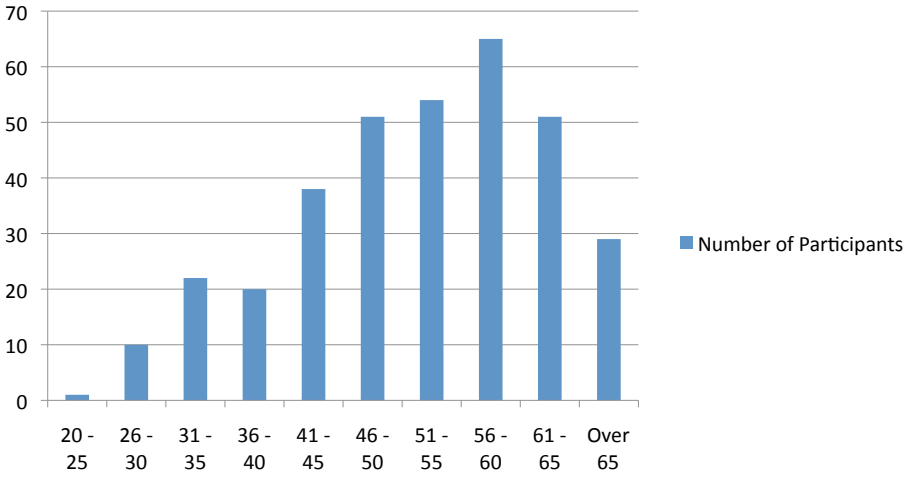
RESULTS

The main areas that this study explored were

- counsellor spiritual and religious identity and practice;
- counsellor beliefs about the importance of spirituality for mental, physical, and community health;
- counsellor beliefs and practices regarding the appropriateness of addressing spirituality and religion within the context of therapy.

Other areas that were explored were counsellors' education and training on these topics, and their perceived abilities regarding comfort and competence when working with religious and/or spiritual clientele. It is important to note that the majority of the participants were women (72%) and were between 41 and 65 years old (76%) (see Figure 1); 35% of respondents indicated that they had been practicing in the field over 20 years (versus 16% for each of the remaining four categories).

Figure 1
Age of Participants



The results of this study showed that clinical counsellors believe that spirituality—but not necessarily religion—is an important dimension in their lives and in their work with clients. The results also showed that although participants indicated that they support specific interventions, fewer than half indicated that they are using these interventions in their clinical practice.

Clinician Epistemology

The majority of the clinical counsellors in this study identified with two out of six epistemology positions; 38% of participants identified with position 4 (*there is a transcendent or divine dimension found in all manifestations of nature)*, and 34% of participants identified with position 1 (*there is a personal God of transcendent existence and power whose purpose will ultimately be worked out in history*). When it came to describing oneself as spiritual and/or religious, the majority of the participants identified as spiritual (94%) versus religious (24%). Of the 289 participants that identified as spiritual, 248 (86%) also reported that they *regularly get in touch with [their] spirituality*, while 60 (81%) of the 74 participants that identified themselves as religious reported that *participation in organized religion is the primary source of [their] spirituality*. Comments in this section of the survey aligned with the choices reported regarding the beliefs and practices of the participants: (a) *organized religion is unnecessary for practicing spirituality*, (b) *a spiritual path is not religion,* (c) *spirit is everywhere,* and (d) *relationship with God and Jesus is most important*.

It is clear that the clinical counsellors in this study support the concept of a positive relationship of spirituality to mental health (91%), to physical health (84%), and to community health (89%). Comments in this section typically referred to the interrelatedness of the three components—mental, physical, and community health: "As humans we are whole beings … mental, emotional, physical and spiritual. We are spiritual beings in a physical body. All parts of us must be nurtured for optimal health."

Spiritual Interventions

Surprisingly, of the 341 clinical counsellors of the BCACC that began this study, 81–84% responded to the Likert-scale questions on the appropriateness of the integration of spiritual interventions listed, but only 46% responded to the question *List the items that you are using in your work with clients*. Some of the comments referred to the dimension of spirituality as being the arena of spiritual leaders and mentioned the necessity to refer spiritually-minded clients, while others emphasized competence in this area as being associated with the necessity of training in pastoral counselling. Most of the spiritual interventions were either highly endorsed (see Figure 2) or rated as neutral (see Figure 3), with the exception of *recommend spiritual program*, *pray for client*, and *pray with client*.

Religious Interventions

In the section of the survey that inquired on the appropriateness of integrating religious interventions, 82–84% responded to the Likert-scale questions, while only 39% responded to the question *List the items that you are using in your work with clients*. As in the previous section, comments by participants recommended referring clients to religious leaders as well as including collaboration with clergy.

Figure 2
Items That Were Highly Endorsed as Appropriate Interventions

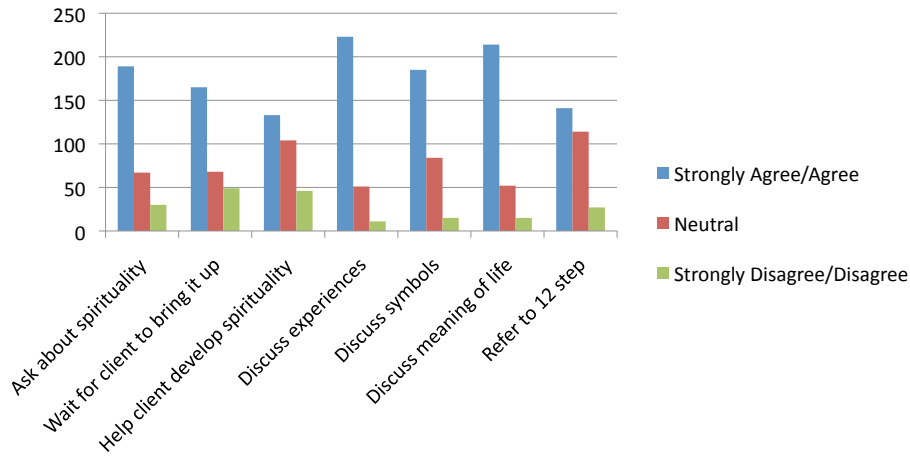
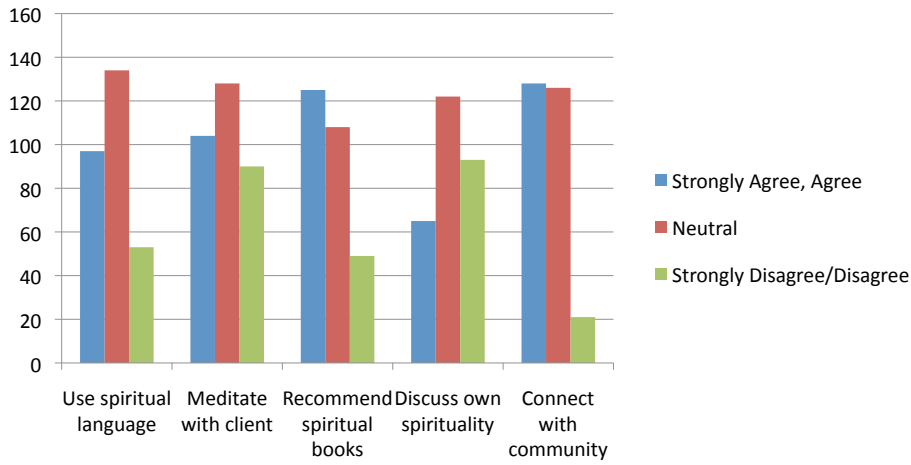


Figure 3
Items That Were Considered Neutral/Depends on Client



Only three religious interventions were somewhat endorsed: *Ask clients about their religion* (48%), *Wait until client brings up his/her religion first* (60%), and *Talk with client about God* (37% agreed, and 40% scored neutral or "depends on

client"). The remaining six items were not endorsed. Participants identified as being more willing to initiate a discussion on spirituality than one on religion: *Ask clients about their spirituality* (66%) and *Wait until client brings up his/her spirituality first* (59%).

Graduate Coursework

For the questions on previous program coursework regarding integrating religion and spirituality into counselling, one third of the counsellors that participated in this study expressed that they were satisfied with the content presented in their graduate programs, one third were neutral or uncertain on the subject, and one third were dissatisfied. When presented with the question on interest in continuing education on these themes, the participants appeared to be somewhat receptive; there were approximately 40% interested in further education, 40% were neutral or uncertain, and 20% were not interested.

Comfort and Competence

The majority of the clinical counsellors who participated in this study identified as being both comfortable and competent/prepared when working with spiritual and/or religious clients. Age was compared with comfort and competence/preparedness levels, and the results indicated that age was not a determining factor. For comfort level in the 20–40 year age group, 92.5% chose *strongly agree/agree*, while in the 41–60 year age group, 90.4% chose *strongly agree/agree*. With the oldest age group (over 60 years), the results were slightly lower as 85% *strongly agreed* or *agreed* that they were comfortable working with spiritual and/or religious clients. For competence/preparedness levels in the 20–40 year age group, 81.6% chose *strongly agree/agree*, while in the 41–60 year age group, 81.3% chose *strongly agree/agree*. With the oldest age group (over 60 years), 81.6% *strongly agreed* or *agreed* that they were competent/prepared to work with spiritual and/or religious clients. Overall, the results indicated that participants are feeling slightly more comfortable than competent when working with religious and/or spiritual clients. Of the 341 clinical counsellors that began this study, 81% responded to the Likert-scale questions for this section, and 48% qualified their answers in the comments section.

DISCUSSION

It appears that the majority of participants in the present study support a biopsychosocial-spiritual paradigm both personally and professionally. As reported in previous research, it seems that the counsellors in this study are biased when it comes to discussing religious versus spiritual content within the therapeutic process in their work with clients: more than two thirds of respondents are willing to initiate a discussion on spirituality, while fewer than half are willing to initiate a discussion on religion. This outcome is likely the result of the majority of the participants self-identifying as being spiritual versus religious: participant comments

often refer to the dimensions of religion and spirituality as being a dichotomy, and that religious discussion should be assigned or referred to religious leaders.

Wolf and Stevens (2001) also note that religion and spirituality have been referred to as a dichotomy. Yet they can also be understood as overlapping or interrelated phenomena with important psychological meaning—one can be spiritual and irreligious or religious and unspiritual, and one can be both religious and spiritual. As previously mentioned, Hermsen and ten Have (2004) found that there was a lack of clarity regarding the central concepts, especially between religion and spirituality. Therefore, when incorporating religion and spirituality into counselling, it may be helpful to get an understanding of what these terms mean to clients, and how they might define or describe religion and spirituality.

The literature reports that transference and counter-transference issues interfere with counsellor comfort and competence regarding initiating or allowing the dimensions of religion/spirituality into the therapeutic process with clients (Koenig et al., 1996; Souza, 2002). Participants' comments regarding comfort and competence revealed various degrees of aversion to the discussion of religious content within the therapeutic process, especially with clients presenting as fundamentalists. Some reported that they would be willing to work with clients that share similar religious/spiritual beliefs and values as their own; it appears that being able to identify with a client regarding spirituality and/or religion is a factor in counsellor comfort.

As previously noted, over-identification can be problematic in that religious/spiritual counsellors may assume that they share the same belief system as their clients and proceed without caution in this regard in the therapeutic process. For example, there are many denominations in the Christian religious community (e.g., Protestant, Anglican, Catholic), and although they may share similar theology and doctrine, individual religious leaders and organizations may offer diverse interpretations.

Does comfort equate to competence, or is it just one aspect of the formula? One participant responded, "'Competence' is the right question, not 'comfortable.'" It is important to highlight the difference between competency and applying intrapersonal religious/spiritual experiences in the therapeutic process with clients. As previously mentioned, research indicates that counsellors and psychologists are integrating religion and spirituality into counselling based on intrapersonal experiences (Frazier & Hansen, 2009; Walker et al., 2004), and this creates risks for clients through the intentional or unintentional imposition of values and through inappropriate interventions. This is where in-depth dialogues, including assessments, can be helpful to counsellors with respect to fully understanding a client's worldview, and how their beliefs might be helpful and/or harmful regarding the presenting issue introduced in the counselling process.

Spiritual screening and assessment tools, including recording clients' religious history, help therapists understand their clients' religious/spiritual beliefs, values, and practices. They can also be useful for introducing the dimensions of religion and spirituality into the counselling process (Cotton et al., 2007; Koenig et al.,

1996). If we as professional counsellors do not prepare ourselves personally and professionally to bring (or allow) the dimensions of religion and spirituality into the therapeutic process, our clients may believe it is not safe to do so, and we would therefore be doing them a disservice.

Limitations of the Study

Participants were limited to membership of the BCACC. To gain a broader Canadian perspective, it would have been efficacious to include the membership of the Canadian Counselling and Psychotherapy Association and the Canadian Counselling Association as well. A second limitation was a possible sampling bias of counsellors from mixed samples—those who received their education and training through faith-based graduate programs and internships and those who received them through secular programs. It would have been helpful to include a question regarding secular/non-secular training in the demographics section of the survey.

Another possible sampling bias is self-selection in that the participants were likely to have a prior interest in the subject matter being presented in the study. A fourth limitation was the ambiguity surrounding one of the questionnaire answer choices. The Likert-scale option *neutral*, for the questions regarding beliefs about appropriate spiritual and religious interventions, would have been better labelled as "depends on client" or "I might." It would also have been helpful to ask for a qualifier if a respondent answered *neutral* to a question.

Implications for Further Research

As previously stated, although there is support for integrating religion and spirituality into counselling, the results showed that fewer than half of the participants in this study reported doing so in their practice. What does this mean? Are the counsellors that indicated they support initiating discussions on religion and/or spirituality actually doing so, and if not, what may be the possible reasons? For the counsellors who responded that they are integrating these dimensions into counselling, have they received training in these areas or are they using intrapersonal experiences to guide their judgement, interventions, and practice?

What is needed is more research on this subject, specifically in the area of determining or understanding why counsellors are not feeling comfortable, confident, or competent regarding introducing or initiating the subject of religion and spirituality into the counselling process. There also needs to be more empirically-based research on the efficacy of existing and future multi-theoretical techniques and practices in the counselling field for integrating these dimensions.

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