
Integrating Spirituality into Counselling and Psychotherapy: Theoretical and Clinical Perspectives Intégration de la spiritualité dans les perspectives théoriques et cliniques du counseling et de la psychothérapie

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ABSTRACT

In recent decades, spirituality has become a prominent focus of psychological inquiry. As research begins to elucidate the role of spiritual beliefs and behaviours in mental health and the influences of spirituality in psychotherapy, developing therapist competency in this domain has increased in importance. This article will first situate spirituality as an interdependent facet of culture and then expand the tripartite model of multicultural competency—attitudes, knowledge, and skills—to consider the theoretical, empirical, and practical foundation that supports existing spiritual competencies and work with clients' spirituality. The applicability of spirituality within mainstream theories is reviewed and highlighted with a clinical case.

RÉSUMÉ

Au cours des récentes décennies, la spiritualité est devenue un important sujet d'étude en psychologie. Tandis que la recherche commence à élucider le rôle des croyances et comportements spirituels en santé mentale et les influences de la spiritualité en psychothérapie, on assiste à un accroissement du développement des compétences du thérapeute en ce domaine. Dans cet article, on situe d'abord la spiritualité comme étant une facette interdépendante de la culture, puis on étend le modèle tripartite de compétence multiculturelle—attitudes, connaissances, et habiletés—dans le but d'examiner le fondement théorique, empirique, et pratique qui soutient les compétences spirituelles existantes et pour permettre de travailler avec la spiritualité du client. On passe aussi en revue les possibilités d'application de la spiritualité aux grandes théories courantes, et l'on illustre le tout au moyen d'un cas clinique.

Exploring cultural diversity is both a resource and a challenge in clinical practice (Fukuyama & Sevig, 1999); while it has rich therapeutic potential, it requires focused personal and professional development by clinicians. Cultural diversity includes the individual's complete social identity comprising age, sexual orientation, disability, socioeconomic status, race/ethnicity, and religious and spiritual orientation (Loden, 1996). Although the cultural considerations for therapy have traditionally been discussed in terms of race, ethnicity, or gender (Fukuyama & Sevig, 1999), mental health professionals are increasingly being called to work holistically with all of the elements of a client's cultural identity (American Psy-

chological Association [APA], 2003). This movement has been underlined by the APA definition of evidence-based practice in psychology that includes culture (APA Presidential Task Force on Evidence-Based Practice [APAP], 2006) and the more recent CPA initiative to develop a similar definition (Canadian Psychological Association [CPA], 2012).

The spiritual competencies identified by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC), a division of the American Counseling Association (ACA; ASERVIC, n.d.), point us in the direction of competently integrating spirituality into counselling. However, much work remains to be done translating these competencies into a practical understanding of *how* to work with clients' spirituality in counselling sessions. This article will structure the issue of competency in working with clients' spirituality, culminating in a case vignette that illustrates principles that operate within various theories of practice.

One may not fully understand spirituality without first identifying the broader meaning of culture and developing awareness of the various influences to its unique (e.g., to time and geographic location) display. Culture is defined as "the embodiment of a worldview through learned and transmitted beliefs, values, and practices" (APA, 2003, p. 380). Like culture, spirituality is ever changing (Fukuyama & Sevig, 1999) and evolves with the values of society. The relationship between culture and spirituality is not unilateral; spirituality and culture are mutually informative. Cultural values such as moral and social responsibility support spirituality while materialism, individualism, and hedonism are antagonistic to it (Eckersley, 2007). Spiritual values or the absence thereof can also influence how we conceptualize and treat mental illness (APA, 2003); even the term "mental illness" denotes a certain kind of value system, one that seems to remove spiritual and contextual factors as a central source of inquiry.

In some cultures, spiritual beliefs permeate the therapeutic encounter. Therapist and client efforts are concentrated solely on spiritual issues, internal conflict is viewed as having a spiritual origin, treatment is focused on healing the soul, and traditional medicines are prescribed to restore harmony. For example, the Aboriginal community adopts a holistic view of healing that strives to achieve balance among the mental, emotional, physical, and spiritual dimensions of self. Healing is supported by ceremonial ritual, sacred teachings, song and dance, and the use of natural herbs, all of which are designed to foster inner balance and connection with the natural and spiritual world (Canadian Institute for Health Information, 2009). Traditional healers such as elders in Aboriginal communities, curanderos among Latin Americans, folk healers in Asian cultures, and shamans in Australia have all connected spirituality with the treatment of mental health issues (Fukuyama & Sevig, 1999; Winnipeg Regional Health Authority, 2009). Undeniably, cultural variables such as spiritual, racial, and ethnic diversity and their intersections impact the understanding and treatment of mental illness.

In North America, psychology and psychological practice are dominated by western models with western assumptions about mental illness (see Watters, 2010, for a discussion). Western ideas are partial to the medical model that privileges

the framing of problems with medical solutions and tends to overshadow more holistic assessment and treatment approaches. The rising multiculturalism of western countries means that clients are increasingly treated within a framework in which their important spiritual values are largely absent. When spirituality is peripheral or absent in our models, the discussion of the soul in treatment can be silenced; understanding the importance of individual and group beliefs in the expression and treatment of mental illness undermines this narrow view of human experience (see Arthur & Collins, 2005, for a discussion).

Research supporting the connection between spirituality and well-being (see Koenig & Larson, 2001, for a review), along with increased acknowledgement of the importance of spirituality for individuals across cultures (Fukyama & Sevig, 1999), highlights the need to broaden our theories to accommodate spirituality. In the last three decades, there has been a significant increase in the literature dedicated to understanding the psychology-spirituality intersection. These works provide some guidance in the supervision and training of counsellors (Aten & Hernandez, 2004; Bartoli, 2007; Bishop, Avila-Juarbe, & Thumme, 2003), spiritual-based intervention (Eck, 2002; Miller, 2003; Sperry, 2001), and the efficacy of spiritual-based intervention (see Harris, Thoresen, McCullough, & Larson, 1999; Hook et al., 2010, for reviews).

In addition to its inclusive definitions of evidence-based practice, our field considers the domain of client spirituality in its ethical codes and professional standards. The CPA (2000), the Canadian Counselling and Psychotherapy Association (CCPA; 2007, 2008), the APA (2010), and the American Counseling Association (ACA; 2005) support this integration by highlighting the need to respect culture (including religion and spirituality) and to engage in competent practice within the scope of received training and supervision.

A prominent source of support for integration comes from the multicultural counselling movement and its multicultural competencies as well as the spiritual competencies identified by ASERVIC. The multicultural theories have led to an increased appreciation of the role of diversity in counselling. Effective multicultural counselling includes specific awareness, knowledge, and skills related to cultural competence (Sue, Arredondo, & McDavis, 1992). While multicultural competencies have offered us a greater appreciation for the role of culture in counselling and categorization of these competencies into a manageable framework, existing competencies have focused almost exclusively on race and ethnicity.

The ASERVIC competencies have filled the gap in the neglected area of spirituality in the multicultural literature. These competencies developed alongside existing accreditation standards mandating that curricula include spiritual and religious diversity issues as a core requirement of counsellor education (Robertson, 2008). Despite increased attention in the literature to religious and spiritual issues in counselling, including competencies and accreditation criteria, few students actually receive proper training and supervision during their graduate programs (Aten & Hernandez, 2004; Bishop et al., 2003; see Hage, Hopson, Siegel, Payton, & DeFanti, 2006, for a review). The ASERVIC guidelines have been instrumental

in delineating what counsellors need to know to work with client spirituality—the *what*—but do not direct us to the strategies needed to achieve these competencies. In order for our profession to move forward in this domain and step outside the dominant and unilateral medical prescriptions for health, we must develop the strategies—the *how*—to achieve spiritual competency (Bolletino, 2001) in the ASERVIC domains. Spiritual competency is defined as “the ability to carry out a task that has been attained by gaining the knowledge, attitudes, and skills proposed by the ASERVIC Spiritual Competencies” (Robertson, 2008, p. 21).

This article will review current literature relating spirituality to counselling. Within the multicultural framework of attitudes, knowledge, and skills, we will offer strategies to support the ASERVIC competencies.

TERMINOLOGY: SPIRITUALITY AND RELIGIOSITY

There continues to be debate about exactly what the terms religiosity and spirituality mean. Numerous attempts to operationalize these constructs have been attempted. Some authors highlight the commonalities among religiosity and spirituality while others choose to focus on the distinctions. Until recently, religion was viewed as relating both to the individual and to the institution (Hill & Pargament, 2003). However, with the rise of secularization in the 20th century (Turner, Lukoff, Barnhouse, & Lu, 1995), in addition to socio-demographic changes, religious movements, and socio-cultural trends such as individualization (Pargament, 1999), religion has come to represent the extrinsic and public expression of belief, and spirituality the intrinsic and personal experiencing of the transcendent (Koenig, McCullough, & Larson, 2001).

Popular usage denotes spirituality as immaterial and relational and religion as material and institutional (Miller & Thoresen, 2003). Religion, unlike spirituality, is confined by the predetermined beliefs, values, and practices of a socially based institution whose focus extends beyond the transcendent to also include social, cultural, economic, and political endeavours. “Spirituality has to do with experience; religion has to do with the conceptualization of that experience. Spirituality focuses on what happens in the heart; religion tries to codify and capture that experience in a system” (Legere, 1984, p. 376). Spirituality generally refers to a broader dimension than religiosity (Miller & Thoresen, 2003). That said, individuals can be both religious and spiritual, be one or the other, or be neither. Some would also assert that spirituality does not necessarily have to do with belief in God but more with connection with nature and the relationship between animate and inanimate things around us. With religion being the system and spirituality being the goal, individuals more often identify with the title “spiritual” over “religious.”

Hill and Pargament (2003) encourage a pluralistic view as opposed to a polarized one. To frame our discussion, we have defined spirituality inclusively to denote both the personal and private as well as public and organized manifestations of a relationship to the transcendent. Spirituality has been commonly conceptualized as a manifestation of unifying interconnectedness, purpose and meaning in life, inner

resources, and transcendence (Howden, 1992). This conceptualization includes elements that are personal—going beyond formal ideologies and practices—and elements that can be expressed through institutional religion with its specific rituals and doctrines (Helminiak, 2001; Sermabeikian, 1994). We acknowledge that our definition may not fully correspond with some individual definitions but agree that progress within this realm is built upon broad acceptance of what the term attempts to capture (Zinnbauer & Pargament, 2005).

ELABORATING IDEAS FOR THE TRIPARTITE MODEL OF CLIENT SPIRITUALITY

In order to reference a large body of multicultural scholarship, we have used Sue et al.'s (1992) multicultural tripartite model of attitudes, knowledge, and skills to structure our discussion of how to achieve the ASERVIC spiritual competencies, a widely accepted standard among professionals and governing bodies (Robertson, 2008). The ASERVIC competencies include six categories: (a) Culture and Worldview, (b) Counselor Self-Awareness, (c) Human and Spiritual Development, (d) Communication, (e) Assessment, and (f) Diagnosis and Treatment. These categories are further divided into 14 competencies that directly address what knowledge bases are needed to competently integrate spirituality into counselling (ASERVIC, n.d.). We refer readers to Table 1 to demonstrate our mapping of the tripartite model with ASERVIC competencies and to highlight how the ASERVIC competencies can be achieved using theoretical and clinical perspectives.

Table 1
Mapping of Sue et al.'s (1992) Tripartite Model to 14 ASERVIC Spiritual Competencies and 6 ASERVIC Categories

<i>Tripartite Model</i>	<i>ASERVIC Competencies</i>	<i>ASERVIC Categories</i>
<i>Attitudes</i> Counsellor awareness of own assumptions, values, and biases	Competency 3 Counsellor actively explores his or her own attitudes, beliefs, and values about spirituality.	Counsellor Self-Awareness
	Competency 4 Counsellor continually evaluates the influence of personal spiritual beliefs and values on the client and the counselling process.	Counsellor Self-Awareness
<i>Knowledge</i> Understanding the worldview of the culturally different client	Competency 1 Counsellor understands the differences and similarities between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism.	Culture & Worldview
	Competency 2 Counsellor recognizes that the client's beliefs (or absence of beliefs) about spirituality are central to their worldview and can influence psychosocial functioning.	Culture & Worldview

Table 1 continued on next page

	Competency 5 Counsellor can identify the limits of their understanding of the client's spiritual perspective and has spiritual resources and leaders who can be avenues for consultation and referral.	Counsellor Self-Awareness
	Competency 6 Counsellor can describe and apply various models of spiritual development and understands their relationship to human development.	Human & Spiritual Development
	Competency 11 When making a diagnosis, the counsellor recognizes that the client's spiritual perspectives can (a) enhance well-being, (b) contribute to problems, and/or (c) exacerbate symptoms.	Diagnosis & Treatment
<i>Skills</i>	Competency 7 Counsellor responds to client communications about spirituality with acceptance and sensitivity.	Communication
Developing appropriate intervention strategies and techniques	Competency 8 Counsellor uses spiritual concepts that are acceptable to the client.	Communication
	Competency 9 Counsellor can recognize and is able to address spiritual themes in client communication when they are therapeutically relevant.	Communication
	Competency 10 During intake, the counsellor strives to understand a client's spiritual perspective by gathering information from the client and/or other sources.	Assessment
	Competency 12 Counsellor sets goals with the client that are consistent with their spiritual perspectives.	Diagnosis & Treatment
	Competency 13 Counsellor is able to (a) modify therapeutic techniques to include a client's spiritual perspectives, and (b) utilize spiritual practices as techniques when appropriate.	Diagnosis & Treatment
	Competency 14 Counselor can therapeutically apply theory and current research supporting the inclusion of a client's spiritual perspectives and practices.	Diagnosis & Treatment

To be competent to deal with client spirituality, clinicians need to be aware of personal values, assumptions, and biases about spirituality and how those beliefs impact their work with others (attitudes). Mental health professionals also need to understand the spiritual worldviews of individuals and groups, how those be-

liefs influence psychological health, and what to do when what we know is not enough (knowledge). Self-awareness and knowledge coalesce to support counselors in their use of culturally appropriate and ethical interventions in working with client spirituality (skills). Although the three facets are interwoven, we will elaborate each separately to structure the discussion. For the domain of attitudes, we offer rationales supported by relevant research and theory (the *what*), as well as strategies for clinicians in developing self-awareness that supports their work with client spirituality (the *how*). The knowledge section deals primarily with areas of spirituality that clinicians should know (the *what*) and where the authoritative sources of this information can be obtained (the *how*), and the skills section deals with ways to work with client spirituality in training or practice (the *how*).

Attitudes

Theory and research. To foster the APA best-practices approach (APAP, 2006), which includes integration of spiritual variables in therapy and is consistent with the APA *Guidelines on Multicultural, Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003), the first competency in the tripartite model (Sue et al., 1992) is attitudes. As it extends to discussions of spirituality, this involves developing sensitivity to our spiritual values and biases and deepening our understanding of the influence of these worldviews in our work with clients (see Table 1).

Therapy is inherently a value-laden endeavour. Through training, a therapist's beliefs can be translated into personal theories of change and professional conduct. At the pinnacle of professional maturation, these beliefs are cohesively integrated into a theoretical stance and methods (Skovholt & Ronnestad, 1992). However, values can contain spiritual biases that stem from personal and professional experiences with spirituality. Personal spirituality biases have been shown to influence the course of therapy. Positive experiences with spirituality support therapist integration of spiritual techniques into counselling while negative spiritual experiences undermine their use (Frazier & Hansen, 2009; Walker, Gorsuch, & Tan, 2004). All human relationships exist within a multicultural context (APA, 2003); the therapeutic relationship is not exempt from multicultural exchanges, with interaction outcomes conspiring toward varying degrees of similarity and difference between client and therapist.

Unexamined personal values can dramatically alter the course of therapy. Reluctance by therapists to raise spiritual issues in therapy (Helmeke & Bischof, 2002) may lead to a "therapist-client collusion" in which therapists do not ask and clients do not tell about spirituality (Eck, 2002, p. 268). As a result, a key aspect of the client's experience may be silenced. While non-spiritual therapists may not attend to spiritual concerns due to their own bias against spirituality, the unreflective spiritual therapist may too readily pinpoint spiritual themes at the expense of other salient issues presented in therapy (Miller, 2003) or unintentionally undermine a client's unique worldview or behaviours that the therapist considers to be immoral.

Therapist biases may also stem from professional experiences. Spirituality is not yet well integrated into the education, training, and supervision of mental health professionals (Aten & Hernandez, 2004; Bishop et al., 2003; Hage et al., 2006). While standards mandate education and training in multicultural issues, 87% of program directors in accredited counselling psychology programs reported that faculty did not introduce spirituality in teaching, except as it related to spiritual expressions of psychological disorders (Schulte, Skinner, & Claiborn, 2002). Accredited psychology predoctoral internship sites also lag in the degree to which they incorporate formal training in matters of spirituality for their interns (Russell & Yarhouse, 2006). These rates are surprising given that 72% of clinical and counselling psychologists acknowledge that their personal spiritual beliefs influence their work with clients (Bilgrave & Deluty, 1998). These are systemic barriers that impede the development of clinicians who are prepared to integrate spirituality into psychotherapy.

Therapist biases can also be embedded within a theoretical orientation (Miller, 2003) and within the models of human behaviour that undergird psychological theories (Tjeltveit, 1989). Some theories contain biases that pathologize client spirituality. Unexamined professional biases have the potential to reduce client spirituality to destructive conceptualizations that do more harm than good. For example, therapists may understand belief in a god as an unconscious wish for an omnipotent father figure (psychodynamic), spiritual beliefs as irrational thought distortions (cognitive), spiritual rituals as reinforced behaviours (behavioural), and spirituality in its entirety as a defense against anxiety surrounding death and a way of avoiding personal responsibility and freedom (existential; Frame, 2003; Miller, 2003). Next to completely neglecting spirituality in psychotherapy, leading experts in the field warn against the pitfalls of spiritual reductionism (Pargament, Murray-Swank, & Tarakeshwar, 2005).

The lack of discussion regarding spirituality during therapist training and supervision impedes important and much needed self-reflection in this domain. In addition, the limited exploration of biases embedded in psychotherapy's theoretical and professional models is a subtle message that spirituality is universally irrelevant or psychologically harmful to clients. When therapists are not privy to the personal and epistemic values that inform their work, those values may play out in ways that are counterproductive (Northcut, 2000; Tjeltveit, 1989); the degree to which we can understand our clients is influenced largely by how well we know ourselves. Because all therapists bring personal worldviews and values into the therapy session (Arthur & Collins, 2005), respect for clients can be enhanced by engaging in a process of reflection aimed at enhancing self-awareness (Bartoli, 2007).

Methods of working with attitudes. Non-defensive examination of personal beliefs about spirituality can occur in academic settings such as counsellor group supervision. Initially, supervisors need to reflect on what is needed to foster a safe space where spiritual views, stereotypes, and their impact on the process of therapy can be discussed (Miller, 2003). Creating guidelines for sensitive dialogue regarding personal spirituality in supervision is also essential. Miller (2003) recommends

implementing “ground rules” and guiding terminology to focus these types of discussions (p. 143). Polanski (2003) suggests that supervisors structure discussions using supervisee definitions of spirituality and spiritual development models to dispel anxiety of exploring such a personal topic. In this context, trainees and supervisors can talk about the nature of spirituality and its relevance to therapy (Bishop et al., 2003).

Bartoli (2007) elaborates three exercises that can be incorporated into training: an exploration of the therapist’s religious and spiritual histories; their conceptual inheritance of spirituality (ASERVIC #3); and the intersections of religion, spirituality, and mental health. She recommends that trainees discuss their spiritual histories with particular reference to the impact of familial influences and familial spiritual traditions on their own spiritual development. Questions to consider include:

1. What role did spirituality play in your life as a child, teenager, and young adult?
2. What spiritual beliefs and rituals are most important to you now? Which have you let go?
3. How do these beliefs influence your relationships with family members?

The spiritual genogram, a graphical exercise depicting familial and generational influences of spirituality, can facilitate trainee self-awareness (see Frame, 2001, for instructions). The genogram can inform trainee understanding of the historical and domestic trends in their own spiritual development. Pairing trainees to complete this task could provide more in-depth reflection and an opportunity to practice assessment skills.

An exercise to extend the discussion beyond familial influences is the spiritual lifemap, a personalized pictorial image of an individual’s spiritual journey including chronological depictions of important spiritual events in art form (see Hodge, 2005, for instructions). Significant memories of spirituality and the images associated with them (Fukuyama & Sevig, 1999) can initiate this task. In reviewing one’s lifemap, trainees can assess how their spiritual development as depicted through expressive symbols extends beyond relational influences to include events, abstract ideas and feelings, and assigned meanings. Spiritual strengths can be gleaned from how trainees overcame obstacles in their past. For the more verbally oriented trainees, a spiritual autobiography can also tell the story of how events and experiences have led to their current spirituality and can inform spiritual self-knowledge (Wiggins, 2008).

Beyond examination of spiritual beliefs rooted in family environment and personal life, supervisors need to facilitate reflection on spirituality within professional systems. Trainees can consider the degree to which spirituality has been discussed in their program or clinical placements; the context, tone, and content of the discussions; and the inferences about spirituality inherent in their chosen theoretical orientations (Bartoli, 2007). Aten and Hernandez (2004) recommend that supervisors and supervisees explore the historical tension between spirituality and psychological approaches. This exploration could be informed by relevant

literature (e.g., Vande Kemp, 1996), followed by discussions of how these factors have influenced their emerging professional identity and subsequent work with clients.

Therapists also need to examine their personal models of psychological and spiritual health and pathology (Zinnbauer & Pargament, 2005) and explore how their spiritual beliefs connect with their role in therapy (Frame, 2001; ASERVIC #4). Useful discussions can consider the attributes of a spiritual or religious person and foster a dialogue about how these attributes correspond to or conflict with conceptualizations of mental health (Bartoli, 2007). For example, a religious person may be seen as illogical by a therapist who views rationality as a hallmark of mental health. Fukuyama and Sevig (1999) provide additional questions designed to facilitate the exploration of mental health and its intersection with spirituality (see Table 2).

Table 2

Reflection Questions to Enhance Therapist Self-Awareness in the Domain of Spirituality

To what degree do you view spirituality as a part of health and illness?

How, if at all, is spirituality related to the healing process?

What biases or stereotypes do you have regarding other cultural religious or spiritual beliefs?

How comfortable are you in exploring personal spiritual issues as they relate to your role as a counsellor?

Can you articulate any concerns, resistances, or questions about integrating spirituality into counselling?

In what ways have you been trained to understand the interface between mind, body, and spirit? How do you plan to extend this training to find a balance between these three dimensions? In what ways does your training intersect multiculturalism and spirituality?

SOURCE: Adapted from Fukuyama and Sevig (1999).

Professional development extends beyond training to the ongoing development of a life philosophy (Karasu, 1999). Experienced clinicians need to continually engage in thoughtful reflection of the impact of their personal and spiritual worldviews on their work (Crossley & Salter, 2005). Those whose training did not include these kinds of experiences can still explore how their family and educational backgrounds and their personal conceptualizations of spirituality inform their work. Even among therapists with well-developed knowledge and skills in this realm, the process of self-reflection is life-long, leading to our continuous personal and professional evolution.

Knowledge

Theory and research. The second competency of the tripartite model is therapist knowledge and understanding of clients from diverse backgrounds (Sue et al., 1992; see Table 1). In elaborating this facet of culturally competent practice within the domain of client spirituality, we need to understand the centrality of spiritual worldviews for individuals and groups and the impact of these views on the process

of therapy. We cannot know everything there is to know about spiritual traditions different from our own; some form of multicultural and spiritual ignorance will always be present (Constantine & Ladany, 2001). By acknowledging this reality and aspiring to a deeper understanding of what is foreign to us, we broaden the scope and understanding of others' struggles and experiences. The prevalence of spirituality among the general population supports the need for this expanded framework.

Many individuals turn to spirituality when faced with life difficulties (Pargament, 1997). Spirituality can reframe the understanding of a difficulty into an opportunity for change and growth. The 2001 national census indicated that 83% of Canadians identify with spiritual groups; Christians comprise 77% of Canada's religious population, and spiritual minorities include roughly 580,000 Muslims, 330,000 Jewish, 300,000 Buddhists, and 297,000 Hindus (Statistics Canada, 2003). Among Canadians, 60% can be characterized as moderately to highly spiritual as determined by attending spiritual services, engaging in spiritual practices, and viewing spirituality as important (Clark & Schellenberg, 2006). We need to assume that many clients who come for a "secular" treatment will have spiritual beliefs. Research indicates that more than half of clients want to discuss these beliefs in their sessions (Rose, Westefeld, & Ansley, 2001). The view that spirituality is essential for healing and growth, personally important, and central to human personality and worldview were cited as the main reasons by clients for wanting to talk about spirituality in their sessions.

Research supports the spirituality-mental health connection (ASERVIC #2). Higher levels of spirituality have been linked to greater well-being and life satisfaction, fewer depressive and anxious symptoms, and lower rates of suicide and substance abuse (see Koenig & Larson, 2001, for a review). Spiritual individuals have been shown to experience better mental health across gender, racial/ethnic groups, spiritual traditions, age, and socioeconomic class (see Ellison & Levin, 1998, for a review). Therefore, the appeal to integrating spirituality in counselling not only entails a desired focus by clients, but one that has demonstrated intersections with other cultural identities and global and specific indices of improved health.

While spirituality is more commonly linked with salutary effects, negative associations have also been found. Research has linked certain forms of spiritual-based struggles to higher levels of psychological distress including poorer adjustment, depression (Belavich & Pargament, 1995), confusion about values (Johnson & Hayes, 2003), anxiety, panic disorder, poorer quality of life, and suicidal ideation (see Hill & Pargament, 2003, for a discussion). Because spirituality has the capacity to influence individuals in myriad ways, a central tenet to understanding spirituality is in acknowledging its vast complexities. For counsellors and therapists, it is important to identify how spirituality can be helpful and how it can be harmful in dealing with life issues.

Explanations for the pathway from spirituality to mental health or distress have been proposed. Healthy lifestyle prescriptions, the greater availability of social support, psychological factors such as faith and optimism, superempirical

influences such as the supernatural power of intercessory prayer, and physiological mechanisms have been theorized as positive, partial, mediating variables in the spirituality-health connection and have been supported by relevant research (see Ellison & Levin, 1998; George, Larson, Koenig, & McCullough, 2000; Levin, 2010; Oman & Thoresen, 2002; Seybold & Hill, 2001, for reviews). Spirituality can provide opportunities for positive relations with others, personal growth, autonomy, self-acceptance, environmental mastery, and a sense of life purpose (Daniels, DiTommaso, & Freeze, 2007).

On the negative side, investigations have revealed that spirituality may foster feelings of guilt, shame, incompetence, and hopelessness (Sorenson, Grindstaff, & Turner, 1995). Miller and Thoresen (2003) point to the anecdotal evidence that suggests the potential for negative effects of spirituality on mental health, such as cognitive inflexibility and intolerance. Ellison and Levin (1998) mention other potentially harmful aspects of spirituality: passive surrender to God when it impedes personal responsibility and productive problem solving, the concept of "original sin" that encompasses a sense of being characterologically flawed, and institutional expectation or conflict.

Religious coping studies have demystified some of the divergent spirituality-health connection findings (Pargament, Koenig, Tarakeshwar, & Hahn, 2004; Pargament, Smith, Koenig, & Perez, 1998), identifying distinct pathways to health through assessing an individual's coping response to a stressor. Both harmful and helpful spiritual patterns have been identified. Negative patterns consist of spiritual discontent, punishing God reappraisals, demonic reappraisal, and interpersonal religious discontent. Positive patterns include religious forgiveness, seeking spiritual support, and benevolent religious reappraisal (see Pargament et al., 2004, for a detailed list of positive and negative religious coping methods). Positive religious coping has been linked with greater psychological and spiritual growth in the face of stressors, whereas negative religious coping was linked with more depression, emotional distress, and harshness when stress was encountered. There were a few exceptions to these findings; spiritual outcomes may not always coincide with better mental health outcomes.

It is clear that there are a number of spiritual configurations that impact thoughts, feelings, and behaviours, and outcomes range from helpful to inconsequential to occasionally harmful to mental health (Pargament et al., 1998). These findings are significant to therapists whose primary task is to deal with this domain.

Clients' needs are best met when therapists possess knowledge of diverse spiritual worldviews and understand the practical implications of clients' spiritual beliefs and practices in therapy (Hage et al., 2006). However, mental health professionals are liable to rate spiritual beliefs that stray from mainstream traditions as more pathological (O'Connor & Vandenberg, 2005). The tendency to view spirituality as pathology is of particular concern given that clients who are members of spiritual communities are already hesitant to seek out secular services, fearing that professionals will misunderstand or mislabel their struggles (Mitchell & Baker, 2000). To allay these fears and competently engage clients for whom spirituality is

a central force, therapists can become knowledgeable of spiritual worldviews—the range of spiritual beliefs, the process of spiritual development, specific faith systems, cultural interchanges, networking supports, treatment options, and avenues for continuing education and literature searches. As knowledge expands, so will openness to integrating spirituality into the resolution of client concerns.

Methods of increasing spiritual knowledge. To elaborate therapists' knowledge base, the process might begin with sensitivity to the range of possible differences, moving beyond generalizations in spiritual worldviews. Spirituality is often a deeply subjective phenomenon; it can embody a very personalized process of selecting beliefs and practices within the dominant narrative of a faith and beyond it (Pargament et al., 2005). Thus, naming a spiritual affiliation does not always tell the therapist about a client's unique faith. Therapists need to adopt a stance of wonder when striving to understand a given client's spirituality so that their own assumptions do not cloud the therapeutic process (Griffith as cited in Helmeke & Bischof, 2002).

Knowledge of the phases of spiritual development is another way to understand client spirituality (ASERVIC #6). Most spiritual development models include an initial stage involving a lack of awareness of the importance of spirituality, an intermediate stage of over-identification with beliefs and/or discomfort leading to self-examination, and a final stage of self-acceptance and integration of spirituality (Fukuyama & Sevig, 1999). Knowledge of spiritual development (e.g., Allport, 1950; Fowler, 1981) can help therapists to normalize clients' experiences of grappling with deep existential questions. These models also provide a general pattern for growth; embedded in each stage are inferred suggestions on how to overcome spiritual-based struggles and proceed to healthy spiritual development.

Strategies to increase knowledge in the domain of client spirituality (ASERVIC #5) include (a) building connections with local religious and spiritual communities; (b) building relationships with local religious leaders and spiritual healers, including those who incorporate alternative healing practices (e.g., acupuncture, massage, reiki, tai-chi); (c) seeking literature resources on established spiritual-based treatments (e.g., spiritually integrated therapies, 12-step programs, prayer, meditation, mindfulness); (d) increasing familiarity with diagnostic culture-bound syndromes and religious or spiritual V-codes in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000); (e) seeking out conferences and workshops on spirituality in psychotherapy; (f) training and continued education (e.g., east-west psychology, shamanic studies, religious studies); (g) consulting with professionals who have expertise in the area of spirituality in counselling and psychotherapy; and (h) reading widely in the professional and popular literature on spirituality.

There are several excellent literature resources that explore dominant and non-dominant spiritual worldviews (e.g., Ellwood & McGraw, 2009; Josephson & Peteet, 2004; Matthews, 2010; ASERVIC #1) and ones that explore the relationship between spirituality and other cultural dimensions such as racial and ethnic background, gender, age, sexual orientation, and disability in therapy

(Frame, 2003; Fukuyama & Sevig, 1999; Kelly, 1995; Miller, 2003). Similarly, there are a number of literature resources to guide mental health professionals in understanding healthy (Griffith & Griffith, 2002) and unhealthy spiritual beliefs (Griffith, 2010; ASERVIC #11). These resources point therapists to an expanded appreciation of clients' spiritual worldviews including insights into the dynamic intersections among spirituality and other cultural identities and spirituality and psychological health.

Acquiring a strong knowledge base addresses problems associated with cultural misunderstanding and miscommunication in therapy (APA, 2003). The fact that "the spiritual dimension of life is fully interwoven with other life domains" (Pargament et al., 2005, p. 160) is a compelling reason for mental health professionals to understand and tap into the power of spirituality in a therapeutic context. To do this, clinicians must not only become more knowledgeable about diverse spiritual worldviews, but they must also have the skills to use that knowledge in a culturally sensitive and therapeutic way.

Skills

The third competency in Sue et al.'s (1992) model of multicultural competence is skills (see Table 1). In psychotherapy, this means the therapeutic interventions and strategies that allow therapists to modify traditional approaches to be more consistent with the cultural values of each client. Therapists must actively develop strategies that are sensitive to client spirituality, be flexible in their mode of intervention, and work in collaboration with the values of clients presenting from a diverse range of backgrounds.

Assessment strategies. Integrating spirituality into therapy begins with proper assessment. The first contact sets the tone for treatment (Faiver, Ingersoll, O'Brien, & McNally, 2001). Assessment of the client's spirituality and unique worldview has many purposes: (a) to enhance therapist empathy and reduce bias, (b) to facilitate the client's process of self-exploration and growth, (c) to assist in diagnosis, (d) to provide information about the client's spiritual resources that can facilitate effective treatment, (e) to ascertain healthy and unhealthy spiritual beliefs and their impact on the client's presenting problems, (f) to identify spiritual issues that are core areas of clinical concern, and (g) to assist in treatment planning and in the selection of appropriate interventions (Frame, 2003). Assessment does not always need to follow a fixed approach; not all constructs are readily observable or easily quantifiable.

Although there are many methods of spiritual assessment, not all methods are culturally sensitive (Chatters, Taylor, & Lincoln, 2002). Because many paper-pencil measures were standardized with only White, middle-class Protestant participants, results to assess client spirituality using these tools may produce faulty information and/or be offensive to test-takers (Hill, 2005). Overreliance on Christian philosophy, use of belief in God as the focus of measurement, and the lack of normative information on these measures render them problematic for accurate assessment of clients with diverse beliefs (e.g., Eastern or non-religious

based views; Stanard, Sandhu, & Painter, 2000). In the realm of spiritual assessment, quantitative measures presuppose the ability to define a construct that is by its very nature a subjective and personalized reality (Hodge, 2001). For this reason, we propose assessment interviews as a more accurate way for the therapist to understand the client's spiritual attitudes and functioning and to respect the client's subjective spirituality. In practice, the first step is to assess whether a client would benefit from addressing spiritual issues (ASERVIC #10). The following questions (Matthews, 1998) can initiate this assessment: (a) Is spirituality important to you? (b) Do your spiritual beliefs change the way you think about your problems and the way you think about your health? (c) Would you like to talk about your spiritual beliefs and practices in therapy? Affirmative responses to these questions indicate the need for a more complete spiritual assessment (Sperry, 2001) that can determine the influence of spiritual beliefs on functioning and presenting concerns, and can open up the discussion of how to integrate spirituality into the therapeutic process.

Therapists will assess their client's spirituality in much the same way they do their own spiritual values as reviewed earlier in this article. In a comprehensive assessment, clinicians should elicit data about their client's spiritual development from early childhood to the present. Rooting spiritual values in a chronological context attunes the client to the process of change that occurs throughout their life as experiences and perceptions collide to form present beliefs. Together, the therapist and client can explore the client's current spiritual values including but not limited to denominational affiliation; examine the purposes of spirituality (e.g., coping, comfort, meaning-making, morals, social networking); review spiritual disciplines and practices; and assess internalized image(s) of God and familial influences (Koenig & Larson, 2001; Sperry, 2001). The multiple areas important to understanding a client's spiritual development may also include socio-political, cultural heritage, interpersonal, and personality influences. Often influenced by the therapist's chosen theoretical orientation, assessment can follow many courses. The case vignette in the following pages depicts integrative orientation-specific assessment approaches. By incorporating spirituality in the assessment, we alert clients to the value and relevance of these parts of their life experience in therapy.

Interventions. We do not need to develop new systems in order to incorporate spirituality into practice; traditional theoretical interventions can be adapted to meet the needs of diverse clients (McKittrick & Jenkins, 2000; ASERVIC #13). Strategies within psychoanalytic, cognitive-behavioural, and humanistic therapies have been developed to incorporate spiritual dimensions (Kelly, 1995; Miller, 2003; Sperry, 2001). Propst (1980) used a variation of cognitive restructuring from cognitive therapy that involved the application of religious imagery to replace depressive images (e.g., "I can visualize Christ going with me into that difficult situation in the future as I try to cope") for mildly depressed religious individuals. Later, Propst, Ostrom, Watkins, Dean, and Mashburn (1992) used an explicitly religious version of cognitive-behavioural therapy (CBT) for clinically depressed

clients. In addition to using religious imagery procedures, they provided clients with religious rationales for their methods and used religious arguments to counter irrational thoughts.

Other CBT methods include teaching clients to replace negative thoughts with positive religious statements such as “God loves, accepts, and values us just as we are” (Pecheur & Edwards, 1984, p. 49). Incorporating a brief prayer at the end of each session and encouraging clients to make use of religious prayer, thought, and imagery in their homework (Johnson & Ridley, 1992) are modifications that have been applied to traditional rational-emotive therapy. Most spiritually integrated therapies have used Christian principles or more generalist spiritual approaches. However, Muslim modifications consisting of reading verses from the Koran, using the Prophet as a model to support lifestyle changes, and praying are supported by preliminary research (see Hook et al., 2010, for a review).

While cognitive-behavioural therapy is the most common theoretical backdrop for integrating spiritual techniques in counselling, including third-wave approaches such as Acceptance and Commitment Therapy, Dialectical Behavior Therapy, and Mindfulness-Based Cognitive Therapy that broach religious philosophy, interested professionals have returned to existing theoretical principles to excavate additional sources for modification. Eliason, Hanley, and Leventis (2001) consider how psychoanalytic theory can be modified to take spirituality into account in therapy: exploring unconscious spiritual expressions vis-à-vis free association, slips, resistance, and transference. They also point to Jung’s original concepts of myth, metaphor, archetype, and ritual that Jung felt led to spiritual growth and healing when applied in therapy. Existentialist approaches, while not overt in their modifications, use presence and spiritual language pertaining to the process in therapy and in life, meaning-making, and connection to honour clients’ unique worldviews and foster the therapeutic alliance.

There is an emerging research impetus for the formation of empirically supported modifications to traditional interventions. Research indicates that modifying traditional interventions brings benefits such as (a) a more thorough understanding of the client’s psychological conflict, (b) culturally sensitive interventions (that facilitate compliance), (c) a broader network of helpful resources, (d) strengthening of the therapeutic relationship (Koenig & Pritchett, 1998), and (e) for treatment gains, a reduction in unwanted symptoms and improvements in health and daily functioning (Harris et al., 1999; Hook et al., 2010). The benefits of adapting our more conventional approaches are paramount. Guiding ethical standards espoused with evidence of these aforementioned benefits remind us that we must work in ways that support the best interests of our clients.

There are some important caveats to consider when determining the appropriateness of intervening on a spiritual level in therapy. Eck (2002) points to the importance of fit between treatment for the client and their degree of spiritual maturity. Spiritual interventions for clients who are actively psychotic or delusional are not recommended. Also, spiritual interventions that are not relevant to the client’s presenting issue, are not supported by the therapist’s work setting,

or are not implemented within the context of a strong therapeutic relationship (Richards & Bergin, 1997) should be avoided. We also need to be sensitive to the extensiveness of our training with the amount of focus needed on spiritual issues in counselling with a given client so as to not usurp the role of religious authorities, pastoral counsellors, or spiritual directors (Plante, 2007). Our professional ethics mandate that we respect diversity in counselling, but of equal importance is working within the bounds of our training. We therefore need to determine the specific spiritual and religious interventions in which competence has been achieved (Miller, 2003) and work within the frame of our abilities.

CASE VIGNETTE

In order to smooth the transition from theory to practice (ASERVIC #14), the following section outlines how clinicians using the primary theoretical orientations in psychology, including psychodynamic, cognitive-behavioural, and humanistic, might assess client spirituality and include orientation-consistent spiritual interventions (ASERVIC #s 7, 8, 9, and 12).

To illustrate each modality, we present the same case of Susan across three approaches to session work. Susan is a 38-year-old woman, employed as an accountant who identifies as a lesbian and as a Christian. She came to therapy because the anxiety that is normally manageable in her life has become intolerable and she is having panic attacks. Her anxiety is focused on her parents' impending separation. Susan was raised in a Christian home and attended church regularly, although she has reduced her involvement with her church in the last 2 years. She has self-identified as a lesbian since she left home and went to university and is currently active in a large metropolitan lesbian community. Five years ago, she came out to her family and in her church community. Many of her community of friends have supported her through her coming-out process. People in the church seem relatively unaffected by her revelation and seldom acknowledge it; occasionally a comment is made about God loving everyone. She continues to be one of a very small group of self-identified lesbians in her church.

While Susan experiences her mother as vaguely supportive of her sexual identification, she portrays her father as angry, hostile, and rejecting. Her parents have fought bitterly about the religious implications of her sexuality and lately their long-rocky marriage has floundered. Two years ago, Susan applied for a volunteer position as a church youth worker for an adolescent girls' group. She had hoped to offer young Christian girls some of the support she felt she found only later in her own life. The minister chose someone else for the position. She is certain this is because she defines as a lesbian and was considered inappropriate to work with young girls, although the minister did not give a rationale for his choice. She subsequently took a volunteer position with a community group working with runaway girls. She experiences the minister's choice as a rejection and has reduced her attendance at services and in the church community. In her first session, she responds to her therapists' questions about spirituality by indicating that it is

important to her, that her beliefs come up when she thinks about her problems, and that she would be open to addressing spirituality in the sessions.

Psychodynamic assessment. A psychodynamic therapist might attempt to assess Susan's internalized images. Parental images would help to develop a picture of her representations of God, and her capacity to create a God based on her own needs (Rizzuto, 1979). Throughout the assessment the therapist could investigate the congruence between Susan's conscious and unconscious manifestations of God, paying attention to details such as a belief that God is forgiving and a belief that God is angry because her sexuality is a sin that has created a rift between her parents. The therapist could explore Susan's ego functioning, including her judgement and defenses (Northcut, 2000). Does the split between a loving mother and an angry father, between a church that accepts and a church that rejects her, and between a forgiving God and a punishing God represent a defensive style? Information about her parents' and her own spiritual practices such as prayer, involvement in her church, and beliefs such as the significance of divorce might also be elaborated. The meaning of significant experiences such as the spiritual meaning of her decision to volunteer in the church would be important (Sperry, 2001).

Psychodynamic interventions. Unconscious representations are inaccessible without psychic exploration (Sperry, 2001). Exploration is compatible with a faith-based approach: both aim for deeper inner exploration. Susan's view of God as both a supporter and a judge are useful for exploring conflictual relationships including her relationship with her parents, her church community, and other significant people in her life. Susan's dynamic therapist might confront the split between good and bad in her parents and in her view of God and how that split plays out in her active involvement in her lesbian community together with her internalized homophobia. Using dynamic strategies such as guided imagery and dream analysis (Sperry, 2001), her therapist might attempt to develop a deeper understanding of how the unconscious layers of her particular spiritual meanings are present in her daily relationships (Hall, Brokaw, Edwards, & Pike, 1998).

The therapist could pay close attention to Susan's transference reactions inferred in her free associations and share accompanying interpretations with Susan. Is the therapist forgiving when she listens carefully to Susan's story or judgemental when she tries to understand the connections between what happens at home and in the church and with God? As Susan begins to examine her relationship with the therapist, with her parents, and with God, she may be able to transform unhealthy internalized God and self-representations (Rizzuto, 1989).

Cognitive-behavioural assessment. A CBT therapist who wanted to bring spirituality into the session would enlarge the assessment to include the relationships among Susan's thoughts, feelings, and behaviours related to spiritual themes. What aspects of Susan's spiritual life have given her pleasure or distress? Does she fear or love God? Does she believe that God accepts or condemns her? Feelings of alienation from God may be a source of anxiety. Her current religious beliefs about sexuality and divorce, her thoughts about how people are kind and cruel to one another, and about why people have helped her and gotten in her way may provide

insights into how her faith intersects with her life's difficulties. Susan's religious practices, for example, her use of prayer, study, or fasting as ways of resolving or facing difficulties in her life and her connection to both her church and her lesbian communities might offer insights into the practices that could be used to change problematic thoughts and soothe difficult feelings. Initially the therapist might assess the effects of Susan's spiritual beliefs and practices on thoughts and behaviour with a view to helping her to monitor these aspects (D'Souza & Rodrigo, 2004).

Cognitive-behavioural interventions. For Susan, the therapeutic processes of cognitive restructuring and the development of adaptive behaviours would include the modification of problematic spiritual beliefs that influence her well-being (Propst, 1988, 1996). Susan's therapist might attempt to help Susan begin to assert spiritual images of lesbians as individuals with moral and spiritual integrity, drawing on positive God images, accessed through prayer, as a strategy to align positive spiritual beliefs with a more accepting sense of self. The therapist might explore and ultimately challenge her sense of responsibility for the disintegration of her parents' difficult marriage or her belief that her rejection by the minister represents God's rejection. If Susan found evidence that these beliefs were unfounded, she might be encouraged to develop a more assertive voice in her home and her spiritual life. Scriptural passages such as the one below might be used to challenge any negative automatic thoughts and facilitate coping:

Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus. (4 Phil. 6–7, New International Version)

A visualization of Christ accompanying her in conversations with her father or her congregation could help Susan to cope with anxiety (Propst, 1980). Susan might also be helped to challenge harmful scripture-based beliefs such as 1 Cor. 6:9 (New American Standard Bible) "Or do you not know that the unrighteous shall not inherit the kingdom of God? Do not be deceived; neither fornicators, nor idolaters, nor adulterers, nor effeminate, nor homosexuals" or other passages such as Romans 1:26–27 (New American Standard Bible). By helping her to reconsider other perspectives on Biblical prescriptions for life (Prest & Keller, 1993), Susan might generate healthier beliefs that create less anxiety. If Susan were open to it, meditation—a practice associated with Hinduism and Buddhism (Harris et al., 1999)—might be used to train her in attentive relaxation (Kelly, 1995). Using meditation and acceptance-based approaches, the losses represented by the divorce and the minister's decision can become opportunities for the transcendence of personal pain and spiritual growth, for understanding how her commitment to helping others has grown from her own pain, and seeing the work of the Holy Spirit guiding her life.

Humanistic assessment. Susan's humanistic therapist would likely see assessment as integrated within the ongoing therapeutic process. In a moment-by-moment encounter, the therapist and Susan would explore her as a whole human being,

conscious and unconscious, past, present, and future (Schneider, 2003). Although assessment would be holistic and evolving, the therapist could use tools such as the spiritual lifemap (Hodge, 2005)—a pictorial image constructed by the client that illustrates spiritually significant life events—to integrate assessment with exploration and intervention. Susan might be asked to diagram her relationship with God as it has evolved over time to indicate the age at which her own sexuality emerged and the impact of that on her relationship with God. Her therapist could encourage her to find and map the emergence and development of spiritual resources such as her friendships and her community, her practice of prayer, and her ongoing relationship with God. Together they would elaborate the spiritual milestones in her development, such as her coming out.

Susan could also trace her spiritual struggles from early childhood to come to terms with the conflict in her home, through the development of her sexual identity, and up to her current difficulties with her parents' divorce and her minister. The therapist's interest and curiosity, and ability to empathically relate to Susan's life history, would begin to engage her in the exploration of her spiritual reality. In the process, it is possible that Susan might recognize a spiritual crisis as she struggles to reconcile her desire to be free to create her life and her fear of the loss of God's love.

Humanistic interventions. Spirituality is a significant element of human development that can expand human potential and self-actualization (Kelly, 1995). Existential issues—death, freedom, isolation, and meaninglessness—are also the heart of spiritual crises (Schneider, 2003). Buber's "I-thou relationship"—the meaningful and present moment encounter between client and therapist—is a kind of spiritual practice (Morgan, 2007). In that genuine encounter, the therapist might speak about her own spiritual journey in a way that would allow Susan to know that she was also a traveller on a spiritual journey. Whether or not she chose to share her path, her clearly evident acceptance of Susan's version of her struggle and empathy for how that has influenced her life could help to open a dialogue about the struggles in Susan's relationship with God and in the world. Ideas about how humans strive to self-actualize are the core of many spiritual traditions. As her therapist remained alert to the meanings in her story, Susan would likely find elements of her movement to self-actualization and her movement toward God. Episodes of patience or acceptance in her volunteer work or moments of forgiveness and trust with her father might be the signposts that would guide them to understanding her life path. The therapist would need to indicate with her presence her belief in Susan's ability to create a personally meaningful life (Bolletino, 2001). By allowing her to express her unique spirituality, her responsibility for creating her life and her capacity to decide what is meaningful would develop.

As Susan works in therapy she will be confronting the "givens" of her existence (Yalom, 1980): her powerlessness to make peace between her parents, her need to hold onto a meaningful God in the face of scripture that seems to reject her, and her striving for connection in a church that seems indifferent to her sexual identity. Process-oriented visualizations of walking with Christ or enactments of a

dialogue between Susan and God can bring spirituality into session while keeping Susan attuned with her inner-self (Schneider, 2003). As she discovers the meanings of her spiritual beliefs, she can move toward greater authenticity and away from her anxiety.

FUTURE DIRECTIONS

It is clear that spirituality is best understood as a complex and multifaceted concept. Psychological theories can be modified to include the spiritual dimension. However, spiritually integrated psychotherapy must be informed by science; questions about how to address spirituality and how to tailor helpful and avoid unhelpful interventions remain. Studies are generally supportive of spiritually integrated therapies (Grossman, Niemann, Schmidt, & Walach, 2004; see Harris et al., 1999; Hook et al., 2010, for reviews). More work is needed to develop integrated theoretical models (Eck, 2002), to identify causal mechanisms, moderators, and mediators in the spiritual-health connection, and to support the efficacy of spiritual-based treatments (Harris et al., 1999, Hook et al., 2010).

Moreover, spiritual-based practice begins with proper training and education. Curricula need to be developed to include a more complete focus on spirituality. Research to test how training leads to increased competence and willingness to engage client spirituality needs to be conducted. Much of the research to date on incorporating competencies into training and curriculum has had to do with the conceptualization of terms and the current state of counsellor education programs (Cates, 2009).

However, Robertson (2008) points to current drawbacks to integrating spirituality into counselling. She explains that we have no empirically supported standards for curriculum development in teaching spiritual competencies. To date, opinion-based inclusion of spiritual-based material in counsellor education has been done on the basis of educator preferences. Thus, integration is dependent solely on the basis of interested faculty. Yet, supervisors themselves may not be adequately trained, nor has there been research to suggest the best method for integration, be it in a single-course format or as a dimension of other courses taught. In addition, while the ASERVIC competencies are the best existing standards for integrating spirituality in counselling, they too have not been empirically supported. Spiritual-based course material needs to be explicated in terms of these competencies in order to understand the actual quality of the existing competencies, training methods, and training outcomes. A focus on spirituality in education with direct reference to ASERVIC competencies along with measurement tools to assess the quality and outcome of training is therefore an integral component to the next steps in integrating spirituality into counselling.

Existing resources designed to assess counsellors' multicultural counselling competence focus almost exclusively on race and ethnicity (Constantine & Ladany, 2000). For this reason, the Spiritual Competency Scale built upon ASERVIC competencies (Robertson, 2008) could facilitate the development process and

assess training outcomes. Such research could provide a necessary feedback loop throughout the process of curriculum development. Additional methods to compare attainment of spiritual competencies with the actual application of these competencies in counselling and subsequent client satisfaction with therapy can further substantiate ASERVIC competencies, teaching methods, and counselling approaches. While we have outlined some relevant methods from which one may integrate spirituality into counselling and psychotherapy training and practice, we hope that others continue to bridge the gap between ASERVIC competencies and training methods used in order to provide an empirically driven understanding of what we need to know and how we may come to know it so that practicing mental health professionals can more confidently and deeply address client spirituality.

CONCLUSION

The field of psychotherapy research and practice is increasingly interested in spirituality. This article has reviewed an empirical, theoretical, and practical basis for integrating spirituality in counselling and psychotherapy. Competent work with client spirituality centres on attitudes, knowledge, and skills that facilitate work in this arena. Competence is not a final destination to be reached but an ongoing process. By providing theoretical and research-based perspectives, we hope that therapists will begin to implement spirituality into their practice and continue to make adjustments to their integration as theoretical and empirical investigations lead to an enhanced understanding of human complexity.

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