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Introduction

Bringing Spiritually Integrated Psychotherapies Into the Health Care Mainstream

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Polls and demographic statistics show that there is enormous religious and spiritual diversity in the United States and throughout the world. This diversity is rapidly increasing and spreading due in part to global communication, travel, and immigration (Pew Research Center, 2015).

Significant numbers of adherents to the five major Western, theistic religions (i.e., Christianity, Islam, Judaism, Sikhism, Zoroastrianism) and six major Eastern world religions (i.e., Buddhism, Confucianism, Hinduism, Jainism, Shintoism, Taoism) now live in the United States and Canada (Pew Research Center, 2015). Growing numbers of people, however, are not affiliated with one of the major world religions (Pew Research Center, 2015) but embrace spirituality from within some other spiritual and philosophical perspective, such as transpersonal, humanistic, existential, and Indigenous traditions (e.g., Pew Research Center, 2015; Richards & Bergin, 2014). Others are unaffiliated with a religious tradition but nevertheless consider themselves spiritual (Pew Research Center, 2015). In addition, many people are atheistic or nonreligious. They also face universal human questions about the purpose of life, morality, love, suffering, anxiety, evil, and death (Pew Research Center, 2015; Sedlar et al., 2018).

The breathtaking variety in religious and spiritual beliefs in the world makes it challenging for psychotherapists to effectively address spiritual issues during treatment (American Psychological Association [APA], 2017;

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Richards & Bergin, 2014). Most practitioners receive little or no training in spiritual aspects of diversity and treatment (Pargament et al., 2013). This lack of training can create problems for psychotherapists and their patients. Consider the following case vignette written by a psychotherapy patient whom we'll call "Katherine";[1] she has granted us permission to include the story in this chapter:

> When I was 33 years old, and after 14 years of marriage, I was forced into a terrible, painful divorce when my husband committed adultery and left me and my four small children for another woman. My husband and I divorced quickly, and within a month, he had remarried. Then he and his new wife started attending my church. Due to circumstances beyond my control, I was unable to attend a different church, so I continued to attend the same church despite how painful it was to see my former husband and his new wife in the pews. The people in our Christian church community were torn between conflicting loyalties. Most of them chose to stay neutral rather than siding with one or the other of us, thus leaving me feeling very alone and unsupported. I felt like I lost most of my friends and the social support system I had previously enjoyed in my religious community.
>
> The stress I lived under during this time took a tremendous toll on my emotional health. I realized that I needed professional help as I was suffering from anxiety and what later turned out to be trauma-related issues. One day I looked up "psychologists" on the internet and randomly picked one.
>
> The psychologist I chose turned out to be a nice man and seemed very knowledgeable and good at what he did. He had been raised in the Christian tradition but had left it as an adult and no longer believed in God. He was a strong supporter of cognitive therapy, and we worked on that for a while, but we soon ran into difficulties. He saw organized religion as restrictive and suffocating and encouraged me to question my beliefs. I saw my religion as my lifeline to God, who, in my mind, was a real person with whom I had an intimate relationship, even though, at the moment, I was struggling. I still loved God but felt like He had let me down, and I wanted to work through these feelings. However, my psychologist couldn't suspend his disbelief even though this would have benefited me greatly. He was convinced that religion damaged people.
>
> The last time I saw him, I told my psychologist that I had recently gone out on several dates with a divorced man who wanted to have a sexual relationship with me, which I had refused to do. My psychologist asked me why I was unwilling to have a sexual relationship with the man. I told him that I believed sexual relations should be reserved for marriage. My psychologist shook his head and said, "Katherine, I think you'd be happier if you would let yourself enjoy a new sexual relationship." I told him it would violate my religious beliefs. He said, "Maybe you should consider leaving your church." That was the end of therapy for me. I felt like my psychologist should have been more understanding and respectful of my faith and spiritual values and that he shouldn't have tried to push his own beliefs on me.

[1]Details of case examples and patient names presented in this chapter have been altered to protect patient confidentiality.

A few weeks after that experience, I started with a new psychologist to whom my pastor had referred me. This psychologist had his own private practice, and his informed consent document said that he had received specialized training in religion and spirituality. He said he was willing to include discussions about faith and spirituality during treatment if that was my desire. He also had 20 years of counseling experience behind him.

It didn't take me long to discover that, when it came to religion, we were completely in sync. My new psychologist believed in God and wasn't ashamed of sharing that with me when I asked him about it. He understood why I felt God had betrayed me and why I wanted so badly to work out my relationship with God. He also understood why I was so devoted and committed to the teachings of my church. We spent hours digging deeply into spiritual issues that my other psychologist had ignored or shown little interest in. My new psychologist never preached or caused me to feel like I was unrighteous or lacking in faith because of the struggles I was going through. I could tell him when I received answers to my prayers, and he believed those answers—he didn't subtly question my sanity. He was competent as a psychologist about my emotional struggles and sensitive and insightful about my religious and spiritual questions and struggles. He was exactly what I needed.

I have simplified my story for the sake of brevity, for there were other, more complicated psychological issues going on, which my psychologist also helped me work through. I know that my religious belief system and spirituality played an important, even vital, role in the process of my recovery. In my view, to ignore the spiritual part of a person is to ignore something essential that ultimately can help make him or her healthy and whole.

As can be seen in this case example, Katherine had religious and spiritual issues that were intertwined with her presenting problems, but her first psychologist struggled to effectively address them, perhaps because of lack of training and perhaps because he may not have worked through his own biases and negative feelings about religion. Fortunately, Katherine persisted in her efforts to get professional help and was able to find a psychologist who was competent in religious and spiritual aspects of diversity and treatment. Katherine's treatment was much more successful when her new psychologist addressed her spiritual beliefs and issues in a more sensitive and competent manner.

The purpose of this *Handbook of Spiritually Integrated Psychotherapies* is to help mental health professionals more fully understand how they can integrate spiritual perspectives and interventions into their practices in an ethical and competent manner so that they can work effectively with patients from a diversity of religious, spiritual, and racial and cultural backgrounds. The book provides helpful clinical insights into an impressive variety of empirically supported, spiritually integrated treatment approaches that have been used with many psychological issues and in many different treatment settings. We anticipate that this book will be helpful for licensed mental health practitioners, graduate students, educators, and researchers in clinical and counseling psychology, psychiatry, clinical social work, marriage and family therapy, and pastoral counseling.

DEFINING SPIRITUALLY INTEGRATED PSYCHOTHERAPIES

Many spiritually sensitive mental health treatment approaches have been developed during the past 40 years (Richards & Bergin, 2005, 2014; Sperry & Shafranske, 2005). Buddhist, Hindu, Christian, Jewish, Muslim, African, African American, Native American, and Pacific Islander psychotherapy approaches have been described (Epstein, 1995; McMinn, 1996; W. R. Miller & Delaney, 2005; Miovic, 2004; Rabinowitz, 1999; Richards & Bergin, 2014). Spiritual approaches have been integrated with many mainstream psychotherapy traditions, and they have been applied in practice with a wide variety of clinical issues and populations (Fukuyama & Sevig, 1999; L. Miller, 2011; W. R. Miller, 1999; Pargament et al., 2013; Smith & Richards, 2005; Sperry, 2001).

In the *APA Handbook of Psychology, Religion, and Spirituality*, Sperry (2013) provided a helpful definition of *spiritually integrated* mental health treatment:

> Spiritually integrated psychotherapy is a term that broadly characterizes a variety of psychotherapeutic approaches that are sensitive to the spiritual dimension. These approaches range from non-Christian approaches and transpersonal psychotherapies . . . to theistic . . . and various Christian approaches . . . and evidence-based religious accommodative forms of psychotherapy. . . . Individuals seeking explicitly spiritually integrated psychotherapy range from relatively healthy spiritual seekers to disordered clients presenting with symptomatic distress or impairment in one or more areas of life functioning . . . spiritually integrated psychotherapy is distinct from pastoral counseling and spiritual direction in its emphasis and treatment focus. It draws on spiritual resources in addressing spiritual issues and struggles to resolve psychological and relational problems. Although it can also foster spiritual change and growth, spiritually integrated psychotherapy accomplishes this as a by-product that accompanies psychological change. (p. 227)

We like *spiritually integrated psychotherapy* as a catchall term that refers to approaches delivered by mental health professionals that draw on spiritual resources to address psychological and relational problems and that are distinct from pastoral counseling and spiritual direction. Consistent with Sperry (2013) and other leaders in the field (e.g., Pargament, 2007), we use the term *spiritually integrated psychotherapy* in this manner in this book.

It may also be helpful to briefly discuss what the integration of spirituality into psychotherapy does *not* mean. For one, it does not mean proselytizing patients toward or away from any particular set of religious or spiritual beliefs, practices, or affiliations. Simply put, this would be unethical. Spiritual integrated psychotherapy rests instead on a respect for the patient's orientation to spirituality, whatever that orientation may be, and values the patient's right to make informed decisions about spiritual issues as in all dimensions of human functioning. This is not to say that the therapist will not have their own orientation to spirituality but, rather, that the therapist guards against overt or covert efforts to impose a particular spiritual worldview on the patient.

In addition, spiritually integrated psychotherapy does not mean a new alternative to other therapeutic orientations. Instead, it could be relevant to any therapeutic approach, including cognitive behavior therapy, dialectical

behavior therapy, rational emotive behavior therapy, acceptance and commitment therapy, emotion-focused therapy, existential therapy, or psychodynamic therapy.

Spiritually integrated therapy rests on the assumption that we are spiritual as well as psychological, social, and physical beings. *Spirituality*—the relationship we take to whatever we hold sacred—is a part of our beliefs, practices, emotions, values, and relationships (Pargament et al., 2013). It is intertwined with the problems we experience and the solutions to those problems. Psychotherapy that neglects this dimension is then incomplete. Spiritually integrated therapy simply means the bringing of attention, sensitivity, and evidence-based knowledge about the spiritual dimension into the process of psychotherapy—specifically, the way the patient is understood and the way the patient's problems are addressed in treatment.

WHY DOES SPIRITUALLY INTEGRATED PSYCHOTHERAPY MAKE GOOD SENSE?

With the increasing demands on mental health providers, it is not unreasonable to ask why additional time and energy should be spent on the spiritual dimension of patients' lives. There are some very good empirically based reasons, highlighted briefly here:

- *Religion and spirituality are significant parts of the lives of a majority of people in the United States.* Consider a few indications. According to the 2014 Pew Research Center religious landscape study of a national sample of Americans, 63% reported that they are "absolutely certain" of God's existence, with only 9% indicating that they do not believe in God (Pew Research Center, n.d.). Furthermore, 53% felt that religion is very important to them; only 11% said it is not at all important. In addition, 55% reported that they pray once or more a day, whereas only 23% indicated that they never pray.

- *Spirituality is a resource for many people.* In times of adversity, religion and spirituality are among the first places many individuals look to for support, meaning, comfort, and guidance (Pargament, 2011). For example, following the September 11, 2001, terrorist attacks, 90% of Americans reported that they turned to God for solace and support (Schuster et al., 2001). Spirituality offers a distinctive set of coping resources (e.g., spiritual support, confession and forgiveness, transcendent experience, benevolent reframing of pain and suffering) that are particularly well designed to help people come to terms with human frailty and finitude. Moreover, spirituality is especially concerned about cultivating a life of wholeness (Pargament et al., 2016). Greater use of religious and spiritual resources has been linked to mental health benefits, including recovery among people dealing with psychological problems (Koenig et al., 2012).

- *Spirituality can also contribute to psychological problems.* There is a darker, seamy side (see Pruyser, 1977) to religion and spirituality. Religion and spirituality

can be sources of denial, prejudice, avoidance, rigidity, and extremism. The growing research literature on spiritual struggles provides an apt illustration. *Spiritual struggles* are defined as tensions, strains, and conflicts about sacred matters within oneself, with others, and/or with God (Exline, 2013). Spiritual struggles are not uncommon, and they have been robustly associated with psychological distress and problems (Pargament & Exline, 2022).

- *Many people want spiritually integrated help.* Surveys indicate that most patients view religion and spirituality as relevant to their mental health and would welcome the chance to discuss religious and spiritual issues in therapy, including their spiritual struggles (Exline et al., 2000; Harris et al., 2016; Rose et al., 2001). For example, in one survey of patients from six mental health centers, 55% said they would like to be able to talk about religious or spiritual concerns in their therapy (Rose et al., 2001).
- *Integrating spirituality into psychotherapy may enhance the effectiveness of treatment.* According to a recent meta-analysis, spiritually integrated forms of treatment were more effective than nonreligious/spiritually integrated treatments in fostering improved psychological and spiritual functioning (Captari et al., 2018). In analyses that focused on the most rigorous evaluations, spiritually integrated therapies were as effective as nonreligious/spiritual treatments in reducing psychological distress and more effective in facilitating greater spiritual well-being. We say more about the treatment outcome research in this domain later in this chapter and in other chapters throughout the book.

HOW DO WE INTEGRATE SPIRITUALITY INTO PSYCHOTHERAPY?

Integrating spirituality into psychotherapy begins with a recognition that doing so is in the best interests of many of our patients. Having a desire to respond in sensitive and competent ways to our patients' religious and spiritual beliefs is another foundational motivation. With such recognition and motivation, psychotherapists can prepare themselves to be competent in this domain of psychotherapy by gaining competency, staying true to their beliefs, helping patients access spiritual resources, and helping patients address spiritual problems. We say more about each in the following sections.

Gaining Competency

For psychotherapists to work effectively and ethically with spiritual patients and issues, it is essential for them to develop competency in religious and spiritual aspects of diversity. The foundational skills of spiritually sensitive psychotherapists are similar to those required of effective multicultural counselors (Sue & Sue, 1990). Spiritually sensitive psychotherapists also acquire specialized knowledge and training about religious and spiritual aspects of diversity and about religious and spiritual treatment competencies (Richards & Bergin, 2005,

2014). In many diverse groups in the United States, spirituality is deeply entrenched in the framework of their cultures. The unification of culture and spirituality is not only prominent but also inherently permeated in their way of being (Allen et al., 2017).

Psychotherapists can increase their competency to work with patients from diverse religious, spiritual, and cultural backgrounds by seeking (a) general knowledge about the world religions; (b) specific expertise about religious and cultural traditions they frequently encounter in psychotherapy; and (c) knowledge about theories and research in the multicultural, psychology of religion, and sociology of religion fields. They can also read books or take workshops, classes, and online webinars about clinical competencies required for working effectively with cultural, religious, and spiritual issues in psychotherapy (e.g., Pearce et al., 2019). We also recommend that they seek to stay current with scholarly literature about religion and spirituality in mental health and psychotherapy, seek supervision or consultation from colleagues who have expertise in religious and spiritual aspects of diversity and treatment, and engage in personal spiritual exploration and growth practices (L. Miller, 2011; Richards & Bergin, 2005, 2014; Shafranske & Malony, 1996).

Staying True to One's Own Beliefs

It is also important for psychotherapists to select a spiritually integrative treatment approach that is consistent with their personal and professional beliefs. Fear and Woolfe (1999) suggested that "therapists need to operate within a theoretical orientation which encompasses the same underlying metatheoretical assumptions as their personal philosophy" (p. 253). They suggested that congruence between a practitioner's personal values and theoretical orientation is necessary for treatment effectiveness and to prevent burnout.

Because the mainstream mental health professions are dominated by the naturalist-atheistic worldview that assumes that spiritual realities do not exist (Bergin, 1980; Richards & Bergin, 2005), psychotherapists may feel pressured to abandon or ignore their spiritual beliefs in their work. This seems counterproductive given that most people are religious and believe in spiritual realities (Bergin, 1980).

We recommend that psychotherapists learn about various spiritually integrative psychotherapy approaches and integrate one that is most consistent with their own spiritual beliefs into their work. This *Handbook* provides many spiritually integrative treatment options that psychotherapists can consider as they seek to develop competency in spirituality and psychotherapy.

Helping Patients Access Spiritual Resources in Treatment

When people experience psychological problems, they can lose touch with the resources that, up to that point, helped orient and stabilize their lives. Under emotional stress, many patients "lose their rhythm," eating and sleeping irregularly, losing touch with friends, missing work, and giving up on exercise.

The same point can apply to religious and spiritual resources. In difficult times, patients may become disengaged from the religious activities, spiritual practices, and sources of ultimate purpose that had given meaning to their lives. Encouraging patients to reengage in their religious and spiritual practices can be one part of the larger therapeutic goal of helping patients get back into the normal rhythm of their lives. We see this in the following example, which is a more detailed description of a case initially presented in Pargament (1997, p. 380).

Bob, a 60-year-old truck driver, came to therapy with symptoms of posttraumatic stress disorder. Several months ago, he had pulled over on the side of the road to assist someone whose car was stuck in the middle of the highway. While helping the motorist, another car came around a curve in the road and hit the disabled car head on, instantly killing the young driver. Bob witnessed the horrible accident and over the next weeks experienced nightmares, panic attacks, and flashbacks.

Before the accident, Bob had been content with his life; he had a good job, a solid marriage of 35 years, and children who were prospering. Since the accident, however, Bob had become moody, irritable, and increasingly isolated, symptoms that were not alleviated by medication.

As the therapist got to know Bob, he learned that Bob had been an active member of his church and was good friends with the pastor. All of that had come to an end though with the tragic accident. When asked why he had disconnected from his church, Bob said, "Well, I don't want to burden other people with what I'm going through. It's pretty awful stuff." The therapist pointed out that Bob had been there for others in his church when they were going through hard times. Perhaps he could give them a chance to help him out in return. As a homework assignment, the therapist asked Bob to share something of his experience with one member of his church. Bob agreed, but reluctantly.

Asked how the week had gone in the next session, Bob shook his head ruefully and said,

> I've been love-bombed. I told the minister about what I've been going through and the next thing I know, everyone from the church is calling, stopping over, and bringing me cakes and pies. I swear I've already gained 10 pounds.

Bob's complaints were only half-hearted. He was clearly buoyed by the support from his church, and he began to reinvolve himself in its activities. The solace and comfort he received from members and the clergy played an important role in his recovery.

In some cases, patients may be unaware of resources from within their own religious traditions that could be of help to them. For example, individuals struggling with unrelenting guilt could explore rituals of confession and forgiveness within their faith tradition. Patients unable to give voice to their grief and suffering could look to prayers of lamentation and solace for the words they cannot find themselves. Religious literature could also provide patients with stories of inspirational models of figures who faced and came to terms with the full range of problems in living.

Therapists can also help patients explore, identify, and access untapped spiritual resources within themselves. Consider the following clinical example of "Barbara," a composite character representing bits and pieces of numerous patients from our practice.

Barbara, a 52-year-old single woman, came to therapy complaining of long-standing depression. She felt like she was just going through the motions in her life: wake up, go to work as an accountant, come home, check in on her mother in assisted living, and go to bed by 8 p.m. Barbara had a few friends from work but no hobbies or other outside interests. She had tried antidepressant medication with little effect and had sought out psychotherapy a few times in the past but hadn't found it helpful.

In therapy, Barbara presented as listless and dysphoric, speaking in a dull monotone and showing little affect. Although she denied suicidal thoughts or prior attempts, she was unable to describe anything she looked forward to in her life. She felt as if she were walking in a vast empty desert toward a distant, featureless horizon.

Barbara's depression did not appear to be rooted in childhood abuse or in trauma. She had grown up as the only child of a conservative farming couple who had had Barbara late in life, and Barbara spent a lot of time doing chores by herself on the farm. Although she had no great love for accounting, she went into the field to provide herself with a secure job and income.

Barbara's therapist had a difficult time trying to motivate and energize her patient. Initially, Barbara would follow her therapist's suggestions, such as starting to exercise, getting more regular sleep, and spending more time with friends. However, she would soon lose interest. Frustrated with the lack of progress in treatment, the therapist decided to take a more spiritually integrated approach.

The therapist asked Barbara to think about a time in her life when she felt more energy and enthusiasm, when she felt just plain glad to be alive:

BARBARA: [*Takes a long pause*] Sometimes I would get that feeling on the farm when I was growing up.

THERAPIST: What was that feeling like for you?

BARBARA: I remember one time I was walking in the woods. I was only 10 or 11, but I came across a deer. I stopped, and the deer stopped. I was surprised the deer didn't run away, but it didn't. It just stood there looking right at me. I felt like it was really seeing me, or seeing into me. And I looked back, right into the deer. I felt like we truly saw each other. I know this must sound crazy.

THERAPIST: No, not at all. It sounds like it was a very special moment.

BARBARA: Yes, it was. [*Takes a long pause*] You know, I've never had God speak to me the way other people in church have talked about. But that deer spoke to me, and when it did, it felt like time stood still. It was like we saw into each other's souls. And that's

when I knew there was a God. No other way to explain it. I can still see that deer now.

THERAPIST: Have you had any similar experiences since that one?

BARBARA: That's the one that's stayed the most with me. But after that, I started to carry my little camera with me when I took walks on the farm. And sometimes I'd see something that touched me deep inside, and I'd take a picture [*eyes become moist, voice becomes shaky*].

THERAPIST: By your voice and your expression, I can tell that those moments were very important to you and continue to speak to you. Do you still have any of those pictures you took as a child?

BARBARA: [*Nods*] I've kept them in the back of my closet, though it's been years since I've looked at them.

THERAPIST: Could you bring some in for our next session? [*Barbara agrees*.]

The next session was spent looking at the pictures Barbara had taken as a child on her farm. As she described the photos of animals, trees, creeks, and weather, Barbara became more animated than she had ever been in therapy, laughing at some pictures, catching her breath at others, and staring in rapt attention at still others.

THERAPIST: These are lovely pictures. I'm struck how they continue to move you, even 40 years later. They do seem to touch something deep inside you, maybe something sacred.

BARBARA: They are sacred to me, though I had never thought about them that way.

THERAPIST: I'd like you to try something for me, if you're willing. I'd like you to take a walk outdoors sometime this week, take some pictures, and bring them to our next session. Okay? [*With a somewhat puzzled look, Barbara agrees*.]

In the next session, Barbara shared a series of close-up shots of leaves from different trees: oaks, maples, poplars, birches, and sycamores. She spoke in a hushed, reverent voice about the leaves: "Each leaf has its own personality. Each one tells a story. Each one has something to say if you just listen."

Over the next few months, Barbara continued to pursue her nature photography and, as she did, much of the depression that had come to define her life lifted. Even after therapy ended, Barbara continued to send her therapist copies of her photographs. She even began to enter her pictures into art festivals and had received some prizes.

As Barbara's case illustrates, therapists can help patients access internal spiritual resources as well as external religious assets. Barbara's therapist recognized that Barbara had experienced a sacred moment as a child when she encountered the deer in the woods. For Barbara, the moment was transcendent.

It was timeless. It revealed a divine force in the universe. And it elicited awe, wonder, and a deep sense of connectedness. The sacred moment pointed to a "sacred spark" within Barbara. The therapist was able to help her identify that spark and fan it into a small flame that added energy, warmth, and purpose to her life. The significant change in Barbara's mood was consistent with empirical literature showing that people who experience sacred moments more regularly report more positive outcomes in psychotherapy (Pargament et al., 2014) and better mental health more generally (Magyar-Russell et al., 2020).

Helping Patients Address Spiritual Problems in Treatment

Although spirituality can be a potent resource for many people who are experiencing psychological problems, it can also be a source of distress and problems in and of itself. As noted earlier, it is not uncommon for people to experience tensions, strains, and conflicts around spiritual matters focused on oneself, other people, or the supernatural domain (Exline, 2013; Pargament & Exline, 2022). Empirical studies have focused on six specific types of spiritual struggles: (a) divine, (b) demonic, (c) moral, (d) ultimate meaning, (e) doubt-related, and (f) ultimate meaning struggles (Exline et al., 2014). As reviewed in detail elsewhere (see Pargament & Exline, 2022; see also Chapter 6 in this book), these spiritual struggles, individually and as a group, have been associated with distress and decline among people facing a full range of psychological problems and stressors as well as among people from diverse religious orientations (including atheists) and demographic groups. However, some studies also suggest that spiritual struggles may be a source of growth and transformation (e.g., Gall et al., 2011; Hart et al., 2020; for a review, see Pargament & Exline, 2022).

Pargament and Exline (2022) presented the illustration of the case of "Joe," a 62-year-old Jewish man suffering from depression. He had recently lost his job as a vice president in an airplane parts manufacturing company and had become irritable, moody, and isolated from his family. The roots of his depression, however, went further back in time. As a child, he had been a musical prodigy on the piano and had been told by his grandfather that "God has given him a gift." As an adolescent, though, Joe developed a benign tumor on his hand that required surgery, and as a result, his hand suffered irreparable damage. His dreams of a career as a concert pianist were shattered, and he blamed God for his misfortune. "God had turned his back on me," he said, "and I was on my own" (p. 196). Joe was unable to find another source of higher meaning in his life and worked in a job that simply "put food on the table" (p. 196). Losing his position in later life brought back his struggles with God and ultimate meaning. Joe's progress in treatment rested on his therapist's willingness to address his spiritual struggles and discover a new source of meaning later in life: teaching piano to his musically gifted young grandson. "Maybe my real purpose now is to make sure that God's gift of music gets passed on to someone else," he concluded (p. 211). More is shared about working with patients' spiritual problems in psychotherapy later in this *Handbook* (e.g., Chapter 6).

CHALLENGES TO THE MAINSTREAM IMPLEMENTATION OF SPIRITUAL APPROACHES

Meta-analytic and narrative reviews of the outcome research to date have shown that spiritually integrated approaches are most often as effective as secular ones—and sometimes more effective, especially with religiously devout patients (Captari et al., 2018; Hook et al., 2010; Smith et al., 2007; Worthington et al., 2011). The reviews have consistently shown that spiritually integrated psychotherapies are effective. There is also evidence that spiritually integrated psychotherapies result in greater spiritual improvement than do standard secular treatments (Captari et al., 2018).

Although the outcome research to date is encouraging, we think at least three major challenges need to be addressed before spiritually integrated psychotherapies will be more fully implemented in mainstream mental health care. The first challenge is that despite the growth in the evidence base, it is still the case that most spiritually integrative treatment approaches have not been empirically evaluated. Given the growing importance of evidence-based practice (APA, Presidential Task Force on Evidence-Based Practice, 2006), we think it is essential for those who develop spiritually integrated approaches to conduct and publish treatment outcome and process studies (Richards et al., 2015).

A second major challenge for the field of spiritually integrated psychotherapies is that more information is needed about how practitioners incorporate spirituality into their clinical practices. What spiritual interventions do psychotherapists use during treatment, and how often do they use them? What spiritual interventions and approaches are most effective for different types of patients, clinical issues, and treatment settings? We need more clinical descriptions from practitioners about how they integrate spiritual perspectives and interventions into treatment, and we need more practice-based evidence research that links treatment outcomes and processes (Richards et al., 2015). We need more insight into what the best practices are for the integration of spirituality into psychotherapy.

The third challenge that must be overcome is that more training opportunities in religious and spiritual treatment competencies are needed (Richards & Bergin, 2014). Relatively few graduate mental health programs provide training in religious and spiritual aspects of diversity and treatment competence (Oxhandler et al., 2015; Schafer et al., 2011; Vogel et al., 2013). Continuing education offerings for licensed practitioners are also scarce (Pearce et al., 2019). Graduate students and mental health practitioners need more opportunities for education, supervision, and consultation to develop their religious and spiritual treatment competencies.

PLAN FOR THE *HANDBOOK*

This *Handbook* seeks to respond to these three challenges by providing theoretical, clinical, and empirical information about a wide variety of contemporary spiritually integrative treatment approaches. In 2016, the John Templeton

Foundation awarded Professor P. Scott Richards a $3.57 million grant to conduct a large research project about the processes and outcomes of spiritually integrated psychotherapy with 19 different collaborating research teams in North America, Israel, and several additional countries (see https://bridgescapstoneconference.wordpress.com/bridges-capstone-conference-proceedings/). Many of the authors of the chapters in this book were participants in this large research grant project, and the treatment approaches they describe in their chapters were empirically evaluated as part of the grant project. Several additional scholars and practitioners who have developed and conducted research about spiritually integrated psychotherapy approaches have also contributed chapters to the book.

The chapters in this *Handbook* describe a wide variety of spiritually integrated mental health treatment approaches. Table 1.1 summarizes some important characteristics of the spiritually integrated treatment approach described in each chapter, including what spiritual tradition(s) the approach is grounded in and intended for, what clinical issues or types of patients the approach has been and can be used with, what treatment settings and modalities it has been used in, what types of spiritual interventions are used with the approach, what mainstream theoretical approaches has it been integrated with, and what research evidence has been conducted to date on the approach. Table 1.1 reveals the great variety of spiritually integrated treatment approaches that have been developed and included in this *Handbook*. The approaches included here are appropriate for patients from diverse religious and spiritual traditions, including Christianity, Islam, Judaism, and many other traditions. Nearly all of the approaches are used in an ecumenical and spiritually inclusive manner that is reflective of the need for sensitivity and competence in the great cultural, racial-ethnic, sexual orientation and identity, and religious and spiritual diversity that psychotherapists encounter in our modern world.

The approaches included in the *Handbook* have been used in clinical practice with a wide variety of psychological, relationship, and spiritual issues and problems. They have been used in multiple treatment settings, including outpatient, inpatient, hospitals, community mental health clinics, university counseling centers, private practices, and churches. The approaches have been used in several treatment modalities, including individual, couples, family, and group therapy. Many different types of spiritual practices and interventions have been integrated into these approaches, such as prayer, collaboration with clergy, teaching and modeling spiritual principles and virtues, forgiveness, guided meditation, discussion of sacred texts and religious parables, spiritual assessments, correction of unhealthy images of God, encouragement of reconciliation, and contemplation of grace. These spiritual approaches have been integrated with many traditional mainstream psychotherapy traditions and theories, including psychodynamic, cognitive behavior, emotion-focused, gestalt, relational development theory, family systems, and object relations and attachment theory. Unfortunately, we were unable to include chapters on all spiritually integrated psychotherapy approaches that have been developed. Noticeably absent is a chapter devoted to meditative and mindfulness approaches

TABLE 1.1. Characteristics of Spiritually Integrated Psychotherapy Approaches in This *Handbook*

Chapter no.	Chapter author(s)	Spiritual tradition(s)	Clinical issues	Settings and modalities	Spiritual interventions	Theoretical integration	Research[a]
2	Weisman de Mamani et al.	• Christian • Ecumenical • Spiritually inclusive	Serious mental illness (e.g., schizophrenia)	• Religious institutions • Family therapy	• Prayer • Collaboration with clergy • Spiritual assessment • Discussions of religious teachings (e.g., forgiveness, gratitude, view of God, empathy) • Guided meditation • Volunteering and service • Spiritual methods of coping • Sharing of religious parables and writings	• Cognitive behavior • Psychoeducation	• Brown & Weisman de Mamani (2018) • Maura & Weisman de Mamani (2018) • Weisman de Mamani et al. (2014) • Weisman de Mamani & Suro (2016)
3	Hollman and Marmarosh	• Theistic • Spiritually inclusive	Religious and psychological attachment struggles	• Outpatient • Individual therapy	Exploration of God image and attachment style issues (e.g., correspondence pathway and compensation pathway)	Attachment theory	• Mohammadi et al. (2017) • Thomas et al. (2011) • Tisdale et al. (1997)

4	Sandage and Stavros	• Ecumenical • Spiritually inclusive	• Variety of psychological issues • Spiritual, religious, and existential concerns	• Outpatient • Individual, couples, group, and family therapy	• Spiritual assessment • Rupture and repair alliance work • Facilitation of emotion regulation practices • Detriangling • Exploration of spiritual and existential meaning • Processing of grief and loss	• Relational development theory • Relational spirituality • Attachment theory • Family systems • Relational psychoanalytic • Cognitive behavior	• Jankowski et al. (2019, 2021) • Paine et al. (2018) • Sandage, Jankowski, et al. (2020)
5	Brownell and Doric	• Christian • Ecumenical	• Variety of relationship issues • Spiritual struggles • Psychological disorders	• Outpatient • Individual, group therapy • Integrated health care centers, couples and families, religious organizations, retreat centers	• Religious and spiritual discussions • Prayer • Field perspective • Spontaneity • Presence (both divine and personal) • Awareness • Contact • Dialogue	• Postsecular • Gestalt therapy • Contemporary gestalt therapy	• Currier et al. (2018) • Duggal & Sriram (2021) • Rothman & Coyle (2020) • Shafranske & Cummings (2013)

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TABLE 1.1. Characteristics of Spiritually Integrated Psychotherapy Approaches in This *Handbook* (*Continued*)

Chapter no.	Chapter author(s)	Spiritual tradition(s)	Clinical issues	Settings and modalities	Spiritual interventions	Theoretical integration	Research[a]
6	Pargament and Exline	• Ecumenical • Spiritually inclusive	• Spiritual struggles • Depression • Anxiety • Stress • Sexual abuse • Veterans • HIV/AIDS patients	• Outpatient • Individual, couples, group, and family therapy	• Assessment for spiritual struggles • Naming and normalizing of spiritual struggles • Facilitation of acceptance and reflection	• Integration with variety of therapy traditions	• Dworsky et al. (2013) • Murray-Swank & Pargament (2005) • Pargament & Exline (2022) • Reist Gibbel et al. (2019) • Starnino et al. (2019) • Tarakeshwar et al. (2005)
7	Berrett, Hardman, and Richards	• Theistic • Spiritually inclusive	• Eating disorders • Marital conflict • Mood disorders • Sexual abuse	• Inpatient • Residential • Outpatient • College counseling centers • Individual, couples, and group therapy	• Prayer • Reading sacred writings • Teaching spiritual principles • Spiritual pathways • Contemplation and meditation • Listening to the heart	• Person-centered • Cognitive behavior • Psychodynamic • Family systems • Emotionally focused	• Lea et al. (2015) • Richards et al. (2017)[b] • Sanders et al. (2015, 2019) • Simon et al. (2013)

8	Salcone and Rosmarin	Spiritually inclusive	Variety of psychiatric disorders (e.g., mood/anxiety disorders, psychotic disorders, substance use disorders, PTSD and dissociative disorders, eating and feeding disorders)	• Inpatient and residential medical settings • Group psychotherapy	• S/R beliefs and reframes • S/R coping in treatment • S/R struggles • Meditation on the Psalms, sacred verses, the power of prayer, forgiveness	• Cognitive behavioral • Psychospiritual education	Rosmarin et al. (2011, 2019, 2021)
9	Nielsen et al.	• Theistic • Spiritually inclusive	Variety of psychological and relationship issues (e.g., depression, anxiety, spiritual struggles, academic difficulties, relationship conflicts)	• Outpatient • Individual and group therapy • College counseling centers	• Discussion of scriptures • Scriptural rationales and disputations of irrational beliefs	REBT	Nielsen et al. (2019)[b]

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TABLE 1.1. Characteristics of Spiritually Integrated Psychotherapy Approaches in This *Handbook* (*Continued*)

Chapter no.	Chapter author(s)	Spiritual tradition(s)	Clinical issues	Settings and modalities	Spiritual interventions	Theoretical integration	Research[a]
10	Khan and Keshavarzi	Islamic (Sunni)	• Depression, anxiety, trauma- and stressor-related disorders • Spiritual and interpersonal-related issues • Acculturation • Religious struggles • Family and marital conflict	• Outpatient • Individual, couples, and family therapy	• Psychospiritual education and relationship • Virtue development (e.g., humility, hope, patience, mercy) • Prayer	• Emotionally focused • Behavioral • Psychodynamic • Humanistic • Cognitive behavior • Other approaches	• Awaad et al. (2020) • Keshavarzi et al. (2020) • Keshavarzi et al. (2020)
11	Kim, Cha, and Keller	Protestant Christian	• Anxiety, depression, eating disorders, mild personality disorders, spiritual struggles • Individuals with limited affective abilities (e.g., schizoid personality disorder, catatonic conditions, dysthymia) may not be suitable	• Outpatient • Individual therapy	• R/S assessment • Imaginative reenactments • Meditations over biblical scripture • Prayer • Involvement in spiritual communities • God image exploration • Repentance • Rejoicing • Reflection about Christ	• Object relations theory • Attachment theory • Emotionally focused	• Kim et al. (2019) • Kim & Chen (2021)

12	Norberg et al.	Christian, ecumenical, spiritually inclusive	Wide variety of clinical issues (e.g., depression, anxiety, suicidality, spiritual crisis, facing death, grief/mourning, trauma, sexual trauma, PTSD, addictions, relational conflict, marital issues)	• Outpatient • Individual counseling • Small group retreats	• Spiritual companioning • Spiritual discernment • Healing prayer • Gestalt experiments • Faith imagination • Personalized healing liturgies • Collaboration with clergy	• Gestalt theory • Pastoral care	Thomas et al., 2022
13	Hwang and Sim	Catholic Christian	• Struggles in relationships with authority figures and members of religious communities • Psychosexual and affective development • Self-esteem and identity, personality disorders • PTSD • Childhood trauma • Spiritual discernment and growth	Individual therapy with patients in Asia, Africa, Latin America, and Europe	• Prayer • Encouragement of participation in the sacraments of Eucharist (i.e., Mass) and Penance (i.e., Sacrament of Reconciliation or Confession) • Exploration and discernment images of God • Confirmation of divine self-worth	• Psychoanalysis • Cognitive behavior therapy • Interpersonal psychotherapy	Sim et al. (2021)

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TABLE 1.1. Characteristics of Spiritually Integrated Psychotherapy Approaches in This *Handbook* (*Continued*)

Chapter no.	Chapter author(s)	Spiritual tradition(s)	Clinical issues	Settings and modalities	Spiritual interventions	Theoretical integration	Research[a]
14	Mayseless et al.	• Judaism • Spiritually inclusive	• Variety of psychological and relationship issues • Spiritual struggles	• Outpatient • Individual and couples therapy	• Attending to the heart • Exploration of patients' spiritual soul • Discussion of choice from spiritual perspective • Hope • Listening to spiritual issues • Recognition of inner spiritual goodness • Prayer • Use of Jewish texts • Gratitude to God	Integrate with a variety of traditional therapy approaches (e.g., psychodynamic, cognitive behavior)	Mayseless et al. (2021; unpublished study)[b]
15	Saloumeh DeGood	Islamic (Sufi)	• Variety of psychological and relationship issues (e.g., depression, anxiety) • Spiritual struggles	• Outpatient • Individual therapy	Wide variety of spiritual interventions (e.g., Sufi spiritual practices, deep breathing, heart concentration, meditation, visualization, spiritual artwork, exploration of heart values, prayer)	• Cognitive behavior • Motivational interviewing • Other traditional approaches	• Bahadorani et al. (2021) • Bozorgzadeh & Grasser (2021) • Crumpler (2002)

16	Fung et al.	• Christian • Ecumenical • Spiritually inclusive	Variety of psychological and relationship issues with East Asian Canadians (e.g., abuse and trauma, academic challenges, grief and loss with immigration, parenting, sexuality, marriage and family issues, spiritual issues, work stress)	• Outpatient • Individual, couples, and family therapy • Group therapy	Wide variety of spiritual interventions (e.g., prayer, meditation, scripture, finding meaning and purpose, attendance at worship services, practicing of spiritual disciplines, gratitude, kindness, seeking of social justice)	Variety of traditional therapy approaches (e.g., psychodynamic, family systems, cognitive behavior, narrative therapies)	• Fung et al. (2021; unpublished JTF study) • Wong et al. (2018)
17	Mikahere-Hall, Conklin, and Allen	Pacific Islanders Indigenous spirituality	Variety of psychological and relationship issues (e.g., family and relationship conflicts, abuse, spiritual struggles, acculturation conflicts, depression, suicide)	• Outpatient • Individual, couples, and family therapy	Culturally accepted spiritual practices (e.g., prayer, discussion of spiritual experiences, discussions of family and deceased ancestors)	• Multicultural • Trauma therapy • Indigenous strengths-based approaches	None cited

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TABLE 1.1. Characteristics of Spiritually Integrated Psychotherapy Approaches in This *Handbook* (*Continued*)

Chapter no.	Chapter author(s)	Spiritual tradition(s)	Clinical issues	Settings and modalities	Spiritual interventions	Theoretical integration	Research[a]
18	Worthington et al.	Christian	• Marital conflict, communication skills • Intimacy • Marital enrichment, depression, anxiety	• Outpatient • Couples counseling	• Religious assessment • Religious perspectives about relationship problems • Promotion of hope and faith • Forgiveness • Prayer • Contemplation of grace • Reconciliation	Christian-oriented, hope-focused couple approach; emotionally focused couple therapy; others	• Hook et al. (2014) • Ripley, Solfelt, et al. (2021) • Ripley, Worthington, et al. (2021)
19	Everett L. Worthington, Jr.	• Christian • Theistic • Spiritually inclusive	• Marital conflict • Offenses, hurt, transgressions • Injustice • Difficulties in forgiving • Self-forgiveness	• Outpatient • Individual, couples, group, and family therapy • Hospitals • Criminal justice • Christian churches	Learn and apply the forgiveness model to promote emotional and decisional forgiveness	Eclectic (emphasizing emotional and motivational change); stress and coping theory; psychoeducational	• Toussaint et al. (2020) • Wade et al., (2014, 2018)

20	Angel, Sullivan, and Starnino	Spiritually inclusive	• Military veterans • PTSD • Spiritual wounding	• Outpatient • Inpatient (VA hospitals) • Group therapy • Psycho-education	• Spiritual exploration and formation • Working through anger, moral injury, guilt, shame • Forgiveness • Trust and connectedness	• Trauma theory • Exposure therapy • Cognitive processing therapy	Starnino et al. (2019a, 2019b, 2020)
21	Gafford et al.	Spiritually inclusive	Wide variety of psychological and relationship issues (e.g., depression, anxiety, anger, trauma, PTSD, abuse, addictions)	Inpatient; correctional facilities (e.g., jails)	• Attending to cultural humility, cultural opportunities, and cultural comfort • R/S assessment, discussions about religious and spiritual issues, collaboration with clergy • Devotional journaling and readings	Multicultural counseling	Coleman et al. (2022)

Note. S/R = spiritual/religious; REBT = rational emotive behavior therapy; JTF = John Templeton Foundation; R/S = religion/spirituality; PTSD = posttraumatic stress disorder; VA = Veterans Administration.

[a]For the references corresponding to the research citations listed in this column, please refer to the specific chapter in this *Handbook*, unless otherwise noted. [b]See the corresponding reference in the References list for this chapter (i.e., Chapter 1).

to psychotherapy, but fortunately there are many other excellent clinical and theoretical sources about these approaches (e.g., Hendlin, 2016).

Practitioners and researchers who have developed these spiritually integrated psychotherapies have also begun empirically evaluating the effectiveness of their approaches and have reported relevant studies in their chapters. Much work remains to be done in this regard to help spiritually integrated treatment approaches gain greater acceptance in the mainstream mental health and medical professions (Richards et al., 2015; Richards & Worthington, 2010), but the approaches described in the *Handbook* show how much progress has been made in this regard.

In the concluding chapter, we describe training and research opportunities and resources in the field of spiritually integrated psychotherapy that are available for graduate students, mental health practitioners, and researchers. We also offer recommendations for hastening the inclusion of spiritually integrated treatment approaches into the mainstream mental health and medical professions.

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