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INTRODUCTION

Spiritual Diversity in Psychotherapy

STEVEN J. SANDAGE AND BRAD D. STRAWN

Ethical mandates within all the professional mental health fields now call for clinician awareness, sensitivity, and skill related to spiritual and religious dynamics in clinical practice. This marks a tremendous shift in recent decades away from the residual antipathy toward religion by such historical figures in psychotherapy as Sigmund Freud and Albert Ellis. Yet these mandates also represent calls for active engagement by clinicians that move beyond the relative neglect of religion and spirituality in many approaches to psychotherapy during the 20th century, when the mental health field was trying to establish itself as an objective science of human behavior. I (S.J.S.) remember being taught in a graduate school psychology class in the 1990s that psychotherapy was “behavioral engineering” (curiously, by a faculty member who was not in clinical practice). The 1990s was a decade in which the multicultural movements in various mental health fields sparked significant changes in training curricula and intensified research on diversity dynamics in treatment. The 1980s to 1990s was also a period of growing empirical research in the areas of (a) spirituality, religion, and mental health; and (b) positive psychology of human strengths, virtues, and flourishing.

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Spiritual Diversity in Psychotherapy: Engaging the Sacred in Clinical Practice,

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For clinicians interested in the roles of spirituality, religion, and related dynamics (e.g., mindfulness) in counseling and psychotherapy, the scientific knowledge base has been rapidly accumulating for at least 30 years into what is now arguably a mainstream set of topics in mental health.

At present, we now have a vast international body of research showing spiritual and religious factors are often positively associated with mental health and well-being (Koenig, 2018). For the majority of people around the world, spirituality or religion, or both, shape meaning systems and practices related to suffering and healing in ways that will impact their views of what counts as effective “health care.” However, spirituality and religion are complex phenomena that can emerge from and become embedded in human experiences of trauma and suffering. There is a growing literature on spiritual and religious struggles that shows various forms of struggles with the sacred can be associated with mental and physical health problems (Pargament & Exline, *in press*). In addition, some initial evidence suggests both spiritual well-being and spiritual and religious struggles can predict the psychosocial functioning of psychotherapy clients over and above the effects of mental health symptoms (Sandage, Jankowski, et al., 2020).

Because spirituality and religion can impact mental health in both positive and negative ways depending on the dynamics and contexts involved, it is encouraging to now see many different treatment approaches that integrate spirituality and religion combined with a growing body of clinical research. A meta-analysis of 97 outcome studies ($N = 7,181$) of spiritually and religiously adapted therapies found these treatment approaches were typically effective for psychological and spiritual outcomes, showing equivalent effectiveness to secular therapies for psychological outcomes and higher effectiveness for spiritual outcomes (Captari et al., 2018). This latter point speaks to the interesting diversity questions related to what gets defined as clinical outcomes and the reality that some clients hold values about spiritual or religious growth that go beyond the simple focus on the alleviation of mental health symptoms that remains dominant in most of Western health care. This means it is increasingly important for clinicians to attend to clients’ perspectives on well-being in addition to their reports about symptoms (Jankowski et al., 2020).

Mental health practitioners are expected to respect and respond to client preferences regarding treatment goals and processes, and a considerable body of research over the past 50 years has also investigated individuals’ preferences related to spirituality and religion in counseling and psychotherapy (for reviews, see Harris et al., 2016, and Oxhandler et al., 2018). Overall, this research has shown a majority of individuals (a) consider spirituality and

religion to be relevant topics in therapy and (b) would prefer to be able to discuss spiritual or religious issues in their own therapy (at least hypothetically). These trends are particularly strong for individuals who score high in spiritual or religious commitment; however this is not exclusively the case. Some clients want to process negative or ambivalent experiences with spirituality or religion, whereas other clients are in a process of spiritual or religious questing (Sandage, Jankowski, et al., 2020).

Some research also shows that individuals can be concerned about disclosing their spiritual or religious beliefs with therapists, and the safety to disclose may depend on their perceived spiritual or religious similarity to their therapists or the openness and acceptance communicated by their therapists (Cragun & Friedlander, 2012; Oxhandler et al., 2018). For example, one of our colleagues reported that a client from a Christian Pentecostal tradition “confessed” to him in the second year of treatment that, during prayer, she sometimes tried to hear God’s voice of direction for her life. Her adult son, a family practice doctor, had warned her against ever admitting this to a mental health professional because she would likely be put on antipsychotic medication. This therapist had effectively cultivated the client’s trust to share her spiritual practice over approximately 18 months of treatment, but we can wonder about cases in which clients’ core values and goals remain hidden because of these kinds of fears and reductionistic biases within the power structures of some health care settings.

SPIRITUAL AND RELIGIOUS COMPETENCE

Many of the aforementioned clinical considerations involving spirituality and religion can be related to the development of cultural competence (or multicultural, intercultural, or diversity competence), which involves the skillful and effective application of awareness and sensitivity to cultural diversity. Some have voiced concerns about the term “competence” in terms of clinically navigating diversity considerations for various reasons. We affirm the wisdom of the many excellent scholars and practitioners forming the robust literature on cultural humility (Davis et al., 2018; Hook et al., 2017; Owen et al., 2016), and we see great benefit in holding the themes of cultural competence and cultural humility in a productive dialectical tension. In our view, *cultural competence* suggests a crucial goal of developing capacities to relate effectively across cultural differences and skillful abilities to adapt clinical strategies to the diverse worldviews, values, and practices of clients. *Cultural humility* speaks to the need for a lifelong journey of ongoing learning, critical self-reflection,

and accountability to progress in the transformation of power structures toward greater diversity, equity, and inclusion (Tervalon & Murray-García, 1998).

Similar to cultural competence, the emerging literature on spiritual and religious competence in mental health practice emphasizes (a) developing constructive awareness and attitudes about the relevance of spiritual and religious issues in treatment, (b) acquiring relevant knowledge, and (c) cultivating skills to work with clients' spiritual and religious perspectives in treatment (Vieten & Scammell, 2015; Vieten et al., 2016). There is also some empirical evidence that spiritual and religious competence among clinicians is associated with humility and relational maturity (Crabtree et al., 2020). Despite the relevance of spirituality and religion to clinical practice, research findings also suggest this is an area of diversity that is often neglected or absent in clinical training with clinicians frequently reporting the need for more training in this area (Crabtree et al., 2020; Pargament, 2011; Vogel et al., 2013). There are numerous clinical training programs in the United States located in the contexts of religiously affiliated schools, and some of those programs are intentional about seeking to integrate spirituality and religion into training. However, it remains unclear whether clinical trainees from religiously affiliated programs actually fare better, worse, or similar to trainees from secular programs when it comes to effectively engaging spiritual and religious diversity in practice.

The average clinician likely works with clients representing a variety of spiritual and religious traditions and perspectives (including little or no interest in spirituality or religion), and familiarity with a particular tradition or two might not translate into openness and skill in working within a diverse range of client perspectives and traditions. We are also familiar with spiritually or religiously committed clinicians who attended secular training programs in which faculty communicated in various ways that spirituality and religion were unacceptable topics for professional or scholarly discussion. However, trying to compartmentalize those aspects of human experience is not an effective pathway toward spiritual and religious competence (or any form of diversity competence; Sorenson & Hales, 2002).

The development of spiritual and religious competence can also be complicated by the ways the clinical literature on spirituality and religion sometimes uses general definitions of these constructs in an effort at inclusion or eticlike universality. For example, some authors define "spirituality" in positive terms as beliefs or practices that provide a sense of transcendence or meaning. This strategy can seem to offer the efficiency of a generic definition of spirituality that could apply to most people. It has even been suggested

that everyone is “spiritual” based on this type of definition, which is actually problematic from a diversity perspective in that some clients do not define themselves as spiritual or religious. These generic definitions of spirituality or religion, typically cast in relatively positive terms, might seem to counter some of the negative views of these constructs in mental health fields. However, overreliance on these kinds of generalizations can be a form of spiritual and religious minimization by focusing on sameness in ways that obscures attention to the vast and meaningful differences in client understandings of spirituality and religion, including positive, negative, and mixed experiences with the sacred (Sandage, Rupert, et al., 2020). Spiritual and religious dynamics can also intersect with other aspects of identity in complex and even painful ways, so we have also emphasized intersectional perspectives in this present volume.

SPIRITUAL, EXISTENTIAL, RELIGIOUS, AND THEOLOGICAL FRAMEWORK

At The Albert & Jessie Danielsen Institute at Boston University, where this project originated, my (S.J.S.) colleagues and I use a spiritual, existential, religious, and theological (SERT) framework in our training program, research, and clinical practice (Rupert et al., 2019; SERT training videos are also available for free viewing; see The Albert & Jessie Danielsen Institute, n.d.). The SERT acronym can remind us of the multiple dimensions involved in the diverse ways individuals orient themselves to sacred and ultimate meaning as well as highlight differing sources of ancient and contemporary wisdom about suffering and healing. Clients and clinicians locate themselves in a variety of ways relative to these SERT dimensions. For example, a client might self-identify as Buddhist and atheist and be matched with a therapist who is Orthodox Jewish, which could involve interesting dynamics as they navigate potential similarities and differences in beliefs, values, and practices. Or, a Sufi Muslim therapist might be working with a couple in which both partners are Evangelical Christian but are conflicted over differing theological beliefs about the legitimacy of getting divorced. This couples therapist might believe it is outside their role to try to arbitrate the couples’ theological differences but might consider it relevant to have (a) skills for understanding the relevance of those particular theological issues in the couple relationship and (b) self-awareness of how their own SERT orientation and countertransference reactions might influence their approach to the differences in this case.

Yet another clinical situation can arise with clients who self-define as neither “spiritual” nor “religious” and without obvious commitments to theological traditions but present with concerns about various existential themes, such as loss, death, guilt, despair, or difficult choices in the face of ambiguous outcomes. The existential dimension of SERT might be the most inclusive in referencing human dilemmas of finitude and struggles with meaning that can be found both inside and beyond spiritual, religious, and theological contexts (Sandage, Rupert, et al., 2020; Yalom, 1980). While it is possible for clinicians to interpret existential dimensions of human life quite broadly, it is also important to recognize some clients may hold a pragmatic focus about treatment and a lack of personal interest in any of the SERT dimensions as they understand them (Sandage, Jankowski, et al., 2020).

It is also important to note that SERT dynamics can be complicated to negotiate in therapy even when therapists and clients both identify with the same general SERT tradition or orientation (e.g., atheist, Buddhist, Christian). There is diversity within every SERT tradition and orientation. Moreover, it is possible for clinicians to sometimes experience stronger counter-transference in working with some clients who hold SERT values closer to their own. This could result from complicated personal feelings and opinions about issues that emerge and greater self-consciousness about trying to manage those responses. But it is worth remembering that a general therapist–client “match” on SERT identifications, like other areas of diversity, will still require therapist self-awareness and diversity competence in navigating SERT issues.

In this edited volume, we did not give the chapter authors specific definitions of SERT dimensions; rather, we asked authors to locate themselves and share the ways particular SERT traditions and values inform their practice of psychotherapy. We sought out a diverse group of clinician-scholars who are intentional about integrating SERT dynamics into psychotherapy to offer insights into the differing forms this can take and illuminate the healing influence of various traditions. In this way, the present volume is intended to complement other resources, such as the *Handbook of Psychotherapy and Religious Diversity* (Richards & Bergin, 2014), by showing some of the differing ways clinicians seek to integrate their particular SERT traditions and values with their preferred theories of psychotherapy into spiritually integrative approaches. We also selected authors who have differing therapy orientations but hold a shared emphasis on interpersonal process and the therapeutic alliance as key sources of gain in psychotherapy, which is a needed area for development in the literature on spiritually integrated psychotherapy.

SPIRITUALLY INTEGRATED PSYCHOTHERAPY

This brings us to the topic of spiritually integrated psychotherapy. To date, the growing literature on spirituality and religion in psychotherapy has tended to focus sizable attention on the use of specific spiritual or religious practices (e.g., mindfulness, other forms of meditation, prayer, forgiveness, yoga, gratitude; see Aten et al., 2011). The consideration of specific practices and clinical techniques or interventions has been a useful pathway toward the integration of spirituality and religion into relatively established treatment approaches. There are also other excellent volumes on related clinical topic areas, such as spirituality and the treatment of trauma (Park et al., 2017; Walker et al., 2015) or spirituality and family therapy (Walsh, 2009, 2019). Pargament (2011) has also been a leader in this field by offering a research-informed model of spiritually integrated psychotherapy that views spiritual and psychological dynamics as mutually interactive for many clients, and he also outlined a coherent theory of therapeutic change that engages both spiritual and psychological dynamics. Pargament's approach to *spiritually integrated psychotherapy* moves beyond specific techniques, modalities, or problem areas toward the integration of (a) psychotherapy theory, (b) in-depth awareness of SERT traditions and values, and (c) specific clinical strategies for intentionally engaging clients' spiritual and religious dynamics in ways that are intended to be theoretically and clinically coherent. Based on this multidimensional definition of spiritually integrated psychotherapy, we note that numerous different models and approaches have been published (e.g., Al-Karam, 2018; Bland & Strawn, 2014; Cashwell & Young, 2014; Frankel, 2003; Jennings, 2010; Johnson, 2013; Jones, 2019; Knabb, 2016; Linehan, 2015; McMinn & Campbell, 2007; Richards & Bergin, 2005; Rosmarin, 2018; Sandage, Rupert, et al., 2020; Sorenson, 2004; Sperry, 2011; Starr, 2008; Worthington & Sandage, 2016). These approaches differ in numerous ways, including (a) varied combinations of theoretical orientations and SERT influences and (b) applications to clients from particular spiritual and religious traditions versus applications to more general client populations.

This consideration of spiritually integrated psychotherapy models and applications invites reflection on the question of whether any approaches to psychotherapy are actually spiritually and religiously neutral. Browning and Cooper (2004) offered rich and insightful interdisciplinary insights into the ways theories in psychology and psychotherapy are built not only on the descriptive sciences of human behavior but also on what they called "metaphors of ultimacy" (p. 15), or ideals of functioning that are actually

more ethical and religious than purely scientific. These ideals are sometimes cloaked in scientific language that might seem more palatable to modern sensibilities, but they argued that models of therapy will inevitably rest on certain values and assumptions about human nature that are philosophical or even theological. We share their hermeneutical or late modern view that this is not an inherent problem and that it is more problematic when we who are professional therapists deny or remain unaware of the influence of specific values and ideals on our approaches to our clinical practice. If I am aware of and can articulate my ideals and values, I am in a better position to work at negotiating across differences with clients and colleagues who hold other ideals and values. However, if I pretend that my clinical approach is purely objective and devoid of any connections to particular SERT traditions, principles, or values, I might run the risk of imposing my values and perspectives without awareness of the ways they do not fit for others.

But beyond this problem of bias or SERT microaggression, we want to affirm the benefits of maintaining respectful connections to the deep wisdom on healing and growth to be found in the diverse array of sociocultural and SERT traditions that have been part of efforts at the therapeutic throughout human evolution. The authors of this volume describe a diversity of approaches to spiritually integrative psychotherapy that draw on both ancient and contemporary wisdom, and we think there is great advantage in this kind of reflection and transparency related to SERT dynamics.

PERSON OF THE THERAPIST

Many psychotherapy approaches have emphasized the personal qualities or self of the therapist as central to therapeutic effectiveness. Therapist effects are emerging in psychotherapy research as a significant source of variance predicting outcomes (Constantino et al., 2017). Moreover, there is evidence that therapists do not tend to improve in effectiveness over time combined with concerning findings about risks for burnout (Goldberg et al., 2016). This raises important questions about therapist strengths, virtues, and personal values that might contribute to both effectiveness and resilient capacities to continue to find clinical work meaningful despite chronic exposure to suffering (Jankowski et al., 2020). Psychotherapy is a difficult vocation, and we think it is crucial to understand some of the formative processes and life-giving values that can sustain hopeful practice among different clinicians.

In this book, we invited authors to share some of their personal SERT journeys as they have impacted their clinical approaches. A previous project

that tasked master clinicians to reveal connections among their own lives, their SERT values and perspectives, and their clinical work proved to be immensely rewarding through an Albert & Jessie Danielsen Institute conference and a prior edited volume (Stavros & Sandage, 2014). Clinical scholars in this earlier project, including some authors in this present book, have noted it was refreshing to be transparent about the influence of their core values. At this time of extreme polarization and conflict in the United States and many parts of the world, we are encouraged share the work of clinicians who value diversity as a sacred value and are eager to learn from colleagues from diverse SERT traditions.

The meta-analytic review of research on the spiritually and religiously adapted therapies cited earlier (Captari et al., 2018) noted the need for further attention to such therapies (a) with complex “real world” diversity dynamics and “adaptations to other major world religions and spiritual traditions beyond Christianity” (Captari et al., 2018, p. 1948), (b) that are integrated with a variety of theoretical orientations beyond the cognitive behavior models that dominate this research literature, and (c) that illuminate interpersonal process factors that interact with spiritual and religious dynamics. Rather than report original empirical studies, the present volume has a primarily clinical focus. However, as we unpack in the concluding chapter, we hope this project offers clinical models and applications that can serve to advance both research and practice in spiritually integrated psychotherapy in ways that address some of the prior gaps.

OVERVIEW OF THIS BOOK

This book is organized into two main sections. In Part I, eight clinician-scholars articulate the ways their unique approaches to spiritually integrated psychotherapy are shaped by their SERT traditions, values, and experiences as illustrated in clinical case descriptions. Each author shares information on their own SERT background and narrative as it has influenced their clinical approach for engaging the sacred in psychotherapy in the context of human diversity.

In Chapter 1, Pratyusha Tummala-Narra provides an overview of diversity within Hindu spirituality and describes the influences of her Hindu background on her clinical work as illustrated in a case study with a young Indian American man struggling with anxiety. In Chapter 2, Ken Pargament reflects on the influence of both his Jewish background and other SERT traditions on the development of his model of spiritually integrative psychotherapy

in the field of psychology, which he applies to case vignettes of individual and couples therapy. In Chapter 3, Pilar Jennings relays her personal journey toward Tibetan Buddhism and her integration of Buddhist traditions into her approach to psychotherapy, including an in-depth case description with a Roman Catholic client. In Chapter 4, Phillis Sheppard describes ways her personal SERT background and move toward womanist traditions have shaped her approach to spiritually integrative psychotherapy, and she offers two contrasting case examples to reveal both clinical struggles and effectiveness. In Chapter 5, Shamaila Khan shares intersections between her multinational background and her Sufi Islam tradition as they influence her approaches to both psychotherapy and international disaster relief work in diverse religious contexts. In Chapter 6, Brad Strawn integrates his evangelical Christian Wesleyan theological tradition with a relational approach to psychotherapy applied to a case with an Eastern Orthodox and Armenian client. In Chapter 7, Karen Starr connects the Jewish mystical tradition of Kabbalah to her clinical approach and view of transformation as illustrated in a case of depressed atheist client. In Chapter 8, Theresa Clement Tisdale offers an integration of Roman Catholic spirituality and theology with psychotherapy applied to a case study of a client struggling with anxiety and interpersonal issues.

Part II focuses on spiritually integrated psychotherapy with specific diversity dynamics. As in Part I, six clinician-scholars share how their SERT traditions and values inform their psychotherapeutic approaches with specific diversity issues. Again, the goal is not for authors to try to describe a generic approach that would fit all clinicians. Rather, the authors seek to convey some of their own unique integration of SERT dynamics, psychotherapy theory and intervention strategy, and case illustrations related to a particular set of intersectional diversity dynamics.

In Chapter 9, Ruben Hopwood considers ways religion and spirituality intersect with nontraditional gender identities in psychotherapy and offers several case applications of his spiritually integrated gender-affirming approach. In Chapter 10, Sarah Moon thematizes authenticity, desire, and power in spiritually integrated psychotherapy with lesbian, gay, bisexual, and queer clients. In Chapter 11, I (S.J.S.) consider religious differences in couples therapy and apply a relational spirituality model to couples cases involving struggles with attachment, differentiation, and intersubjectivity. In Chapter 12, Katy Barrs and Carrie Doebling take an intercultural and process theology approach to spiritually integrated trauma treatment for military moral injury with an in-depth case description of a biracial older adult client. In Chapter 13, Neil Altman reflects on the intersections among spirituality, social class, and diverse understandings of healing as they have impacted his own clinical

work in various contexts and in mental health fields, more generally. Our concluding chapter puts forward a set of key themes and clinical dilemmas related to spiritually integrated psychotherapy and diversity that have emerged in this book and highlight future research directions. We also outline a set of considerations and reflection questions for readers who want to pursue growth in spiritual and religious competence and humility.

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