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Accepted version. *Psychotherapy Research*, Vol. 15, No. 3 (July 2005): 287-303. DOI. © Taylor & Francis 2005. Used with permission.

Addressing religion and spirituality in psychotherapy: clients' perspectives

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Abstract: *Twelve adult clients described the role of religion and spirituality in their lives and in therapy as a whole, as well as their specific experiences of discussing religious-spiritual topics in individual outpatient psychotherapy with nonreligiously affiliated therapists. Data were analyzed using Consensual Qualitative Research (CQR; Hill, Thompson, & Williams, 1997). Results indicated that clients were regularly involved in religious-spiritual activities, usually did not know the religious-spiritual orientation of their therapists, but often found them open to such discussions. Specific helpful discussions of religion-spirituality were often begun by clients in the 1st year of therapy, were related to clients' presenting concerns, were facilitated by therapists' openness, and yielded positive effects. Specific unhelpful discussions were raised equally by clients and therapists early in therapy, made clients feel judged, and evoked negative effects. Implications for practice and research are addressed.*

Outpatient psychotherapy clients report a desire to discuss religious or spiritual topics in their therapy, and many also indicate that religion and spirituality are of central importance to their healing and growth (Rose, Westefeld, & Ansley, 2001). Given the profession's historical ambivalence toward matters of religion and spirituality, however, much remains to be learned regarding how these conversations may be rendered beneficial to clients. Such is the focus of the current study.

We begin with some definitions, about which we acknowledge that full agreement has not been reached (Pargament, 1999). Religion, from the Latin *religare*, meaning "to bind together or to express concern" (Fukuyama & Sevig, 1999), has been defined as an organizing system of faith, worship, rituals, and tradition (Worthington, 1988, as cited in Fukuyama & Sevig, 1999). Religion may thus offer structure and community to one's personal sense of spiritual connection. In contrast, spirituality, from the Latin *spiritus*, meaning "breath, courage, vigor, or life" (Ingersoll, 1994), is a phenomenon unique to the individual and has been defined as the "breath" that animates life or a sense of connection to oneself, others, and that which is beyond self and others (e.g., the transcendent, God,[1] universal energy, love). Although spirituality is an individual construct, denoting a personal relationship with the transcendent, religion is a social

construct bespeaking of organizations, communities, or structures (Dyson, Cobb, & Forman, 1997). The two are neither mutually exclusive nor wholly overlapping, because religion may act as a platform for expressing spirituality but may also act as an inhibition for the expression of one's individual spirituality (Burkhardt, 1989). Throughout this article, we have chosen not to distinguish between these two constructs, given that our purpose was to explore the role that either religion or spirituality, or both, may have had in clients' psychotherapy. Likewise, this merging is consistent with how the participants actually responded to the interview questions. (The only exception to this merging occurs in those results that reflect our participants' definitions of these two constructs; see later discussion.)

Historically, differing theoretical orientations in psychology have espoused dramatically diverging views regarding the meaning and importance of clients' religiosity and spirituality, views that may well have contributed to the field's current uncertainty about how to address such topics in therapy. On one side of the spectrum, theorists and practitioners (e.g., Freud, Watson, Ellis) believed that religious expression and experience should be regarded as pathological, a sign of neurosis (Elkins, 1999; Kelly, 1995; Richards & Bergin, 1997; Strohl, 1998; West, 1998). Others, such as Jung, Frankl, and Rogers, believed that spiritual connection was a necessary component for inner healing (Benjamin & Looby, 1998; Frankl, 1984; Mack, 1994).

In addition to the potential challenge of placing themselves somewhere on this theoretical continuum, clinicians may also be ambivalent about bringing religion and spirituality into the counseling setting because of fears of imposing their own values, the belief that clients' religiousness or spirituality is too personal to discuss, or the clinicians' own struggles regarding their personal spirituality (Mack, 1994). Clinicians' uncertainty may be related as well to the minimal coursework, supervision, and training regarding the place of religion-spirituality in therapy that is currently available to therapists, leaving them little direction and guidance in this area (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Richards & Bergin, 2000; Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990). Furthermore, they may also feel that working with religious or spiritual issues in therapy is outside their area of expertise and may thus refer clients presenting with such concerns to other professionals (e.g., clergy).

This lack of training in religion and spirituality in psychotherapy may also serve as an impediment to the development of culturally competent counselors. Psychology has recognized the importance of multicultural awareness (e.g., Fukuyama & Sevig, 1999; Richards & Bergin, 2000). Furthermore, it has been suggested that religious affiliation and spiritual beliefs may be

‘‘a far more potent social glue than the color of one’s skin, cultural heritage, or gender’’ (Shafranske & Malony, 1996, p. 546). One’s religious-spiritual community, then, may merit attention as a component of multiculturalism and diversity (Yarhouse & Fisher, 2002).

Mental health and spirituality: empirical literature

The empirical literature has sometimes mirrored the aforementioned competing theoretical positions, wherein religiosity and spirituality have been equated with both neurosis and psychological healing (Al-Issa, 2000; Benjamin & Looby, 1998; Frankl, 1984; Mack, 1994). Studies in the 1950s, for example, suggested that individuals who identified as religious were more likely to be emotionally distressed, conforming, rigid, prejudiced, unintelligent, and defensive (Martin & Nichols, 1962, as cited in Kelly, 1995) as well as tense, anxious, and symptomatic (Rokeach, 1960, as cited in Kelly, 1995).

In later meta-analyses and reviews of the literature, however, the relationship between religion-spirituality and mental health has been found to be more positive than negative (Bergin, 1983; George, Larson, Koenig, & McCullough, 2000; McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000). More specifically, religiosity has been positively associated with measures of personal adjustment, control of compulsive behaviors, and absence of psychological symptoms (Kelly, 1995), lower mortality (George et al., 2000; McCullough et al., 2000), mental well-being (Plante & Sharma, 2001), and reduced onset and greater likelihood of recovery from or adjustment to physical and mental illness (George et al., 2000) and negatively associated with depression, anxiety, and substance abuse (Plante & Sharma, 2001). Relatedly, nonreligious therapists may differ from their clients with respect to the value they place on religion, a difference that may affect clinical judgment and behavior (Worthington, Kurusu, McCullough, & Sandage, 1996). Some studies have suggested that counseling effectiveness with religiously oriented clients may be increased if the client’s beliefs are not only respected but also incorporated into treatment (Miller, 1999; Plante & Sharma, 2001). The findings regarding the relationship between religion-spirituality and mental health are not unequivocal, as Bergin (1983) and Paloutzian (1996) acknowledge. Nevertheless, religiosity and spirituality have been empirically associated with more positive than negative psychological functioning (Plante & Sharma, 2001), and therapy effectiveness may be enhanced by the counselor’s respectful incorporation of the client’s religious or spiritual beliefs into treatment.

The question remains, however, as to how religion-spirituality may be used appropriately and effectively in the practice of psychotherapy. As noted earlier, religious and spiritual beliefs

and practices may be integral components of the individual's personal and cultural worldview (Shafranske & Malony, 1996; Worthington, 1988) and as such should be considered appropriate and potentially important topics for discussion in therapy. It would be valuable, therefore, to examine clients' perspectives regarding discussions of religion and spirituality in therapy.

Few empirical studies, however, have examined clients' views about addressing religious and spiritual matters in counseling. Of these few, one study completed in the Netherlands by Pieper and van Uden (1996) asked 425 former therapy clients a series of questions addressing religion and spirituality in counseling. This research indicated that the majority of clients who identified a religious or spiritual component to their presenting concerns expected to and did address (at least somewhat) such concerns with their secular counselors. A majority of respondents did not think it important that the counselor share their religious beliefs, preferred a secular rather than religiously oriented counselor, and felt that the counselor should be trained to address spiritual and religious matters in counseling.

In a second study, Goedde (2001) interviewed six clients of diverse religious-spiritual backgrounds in therapy with a secular, licensed psychologist about their perspectives on discussing religious and spiritual issues in therapy. Results suggested that religion or spirituality entered therapy through the clients' psychological issues or through the healing aspects of the therapeutic relationship and were perceived by clients as a healing force in therapy. Clients also felt that spirituality was important to discuss in therapy and felt validated and acknowledged by therapists' explicit and implicit religious or spiritual interventions. Further, clients perceived such religious and spiritual interventions as meaningful, supportive, and effective. Clients also expressed various concerns regarding the discussion of religion and spirituality in therapy, including a fear of being judged, having their religiosity or spirituality regarded as pathological, not speaking the same religious or spiritual language as the therapist and then having to instruct the therapist, having the therapist impose her or his values on the client, and having a therapist who was not sensitive enough to know when and how much to address religion or spirituality in therapy (Goedde, 2001).

Finally, Rose et al. (2001) examined clients' beliefs and preferences in examining spiritual issues in counseling. Results of this research suggested that the majority of these general outpatient psychotherapy clients wanted to discuss religious or spiritual issues in counseling. Additionally, more than one quarter stated that religion and spirituality were important to them and essential for healing and growth (Rose et al., 2001).

From these studies, then, we know that clients often wish to address religious-spiritual

topics in therapy and that they find such discussions important to their healing process. We do not yet know, however, how such discussions actually take place (e.g., when in therapy they tend to occur, who initiates them, how they proceed), what contributes to their reportedly positive effects, nor what clients' thoughts and feelings are about these conversations.

Purpose of current study

Clearly, we are only beginning to understand clients' needs and preferences in addressing religion and spirituality in counseling. Although the extant literature suggests that clients want to discuss such topics, and that such discussions often have salutary effects, it also suggests that clients may feel uncomfortable bringing their religious and spiritual issues into counseling (Goedde, 2001; Pieper & van Uden, 1996; Rose et al., 2001) and that therapists may be ambivalent about and un- or undertrained in addressing these issues with their clients (Richards & Bergin, 2000; Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990). Thus, we do not know how these topics might be addressed in counseling in a way that optimizes client comfort and allows for exploration of religious and spiritual topics in a therapeutically beneficial way. We felt, then, that it would be helpful to ask actual clients about their experiences of having raised religious or spiritual issues in therapy as well as their insights into what made such experiences either helpful or harmful to the treatment. As context for this central focus of the study, we also gathered background information regarding religion and spirituality in clients' lives and therapies as a whole. Thus, we sought to understand both the general context within which discussions of religion-spirituality occurred in therapy as well as distinct instances of such discussions.

We deliberately solicited clients in nonreligious therapy (i.e., their primary reason for seeking therapy was not of a religious-spiritual nature, and they saw a therapist who did not identify as a religiously oriented counselor) because our desire was to learn how religious-spiritual material was discussed in such general, "secular" therapy. When clients or therapists intentionally seek or provide religiously or spiritually oriented therapy, both parties presumably expect that discussions of religion-spirituality will occur, and both also may well have entered such therapy with the intention or hope of having such discussions. Clients and therapists in secular therapy, in contrast, may not enter the therapy process with such expectations, and thus we wished to understand better what happens when such discussions occur in these more general or secular contexts.

Finally, heeding the words of Ponterotto (2002), who acknowledged the increasing momentum for qualitative research in applied psychology, we chose a qualitative methodology

because doing so allowed us to explore our participants' experiences without restricting their responses. We believed that, given the state of existing research in this area, a qualitative design would foster a rich description of this phenomenon through its use of words rather than numbers as data. Hence, we used the consensual qualitative research (CQR) methodology developed by Hill, Thompson, and Williams (1997). In CQR, researchers intensively examine a relatively small number of cases to acquire a deep understanding of the phenomenon, data analysis relies on a consensual group process, and conclusions are derived from the data inductively. In addition, an auditor reviews the consensus judgments yielded by the analysis to ensure that the conclusions are as unbiased as possible and are indeed based on the data. We selected CQR over other qualitative approaches because this methodology demonstrates several marked strengths. First, CQR relies on several judges, as well as an auditor, thereby reducing the likelihood that any one researcher's perspective will inappropriately influence the data analysis. Furthermore, CQR allows a simultaneously consistent and flexible approach to the data-gathering process. The interview is semistructured, which fosters consistency across cases, yet it is also flexible, such that interviewers may deviate from the protocol as needed based on a participant's responses. Thus, CQR was an ideal methodology for this study: it allowed us to explore deeply an as yet relatively untapped area regarding clients' experiences in therapy, enabled us to ask the same basic questions of all participants, and allowed us to pursue paths opened up by participants' responses to these questions.

Method

Participants

Clients. Potential clients were recruited by posting flyers in two midwestern as well as two mid-Atlantic cities. These flyers were placed in a range of locations (e.g., community mental health centers, hospitals, reception areas of therapy practices, bookstores, counseling centers) and provided basic information about the study (i.e., a research team at a private midwestern university was seeking adult volunteers to participate in a study examining how religious-spiritual themes or topics are addressed in psychotherapy-counseling; participation will involve completing two audiotaped telephone interviews; participants must have been engaged, either currently or in the past, in outpatient individual therapy-counseling at a therapist's office and have discussed or wished to discuss religious-spiritual topics with their therapist-counselor). A tear-off strip at the bottom of the flyers enabled interested individuals to contact the primary researcher, who then confirmed that such persons were appropriate for participation (i.e., adults

who were able to maintain a coherent and lucid conversation with researchers over the telephone, who had been in individual outpatient psychotherapy at a therapist's office, and who had considered raising or had raised religion-spirituality in their psychotherapy). Those who met these conditions were invited to participate and were sent a packet of information about the study, including a cover letter fully describing the study, consent and demographic forms, the interview protocol, and a postcard they could return separately to request a copy of the study's results. The protocol for the first interview was included in this packet in the hope that it would help potential participants decide whether they desired to participate and stimulate the thoughts of those who did choose to take part in the study.

On return of completed consent and demographic forms, one of the researchers contacted the participant to schedule the first interview. Similar procedures were followed when recruiting clients on an Internet bulletin board (i.e., the topic of psychology on the bulletin board "Dejanews"). All potential participants who contacted the primary researcher were considered appropriate and invited to participate in the study. Because we do not know how many people read or received our postings, we have no way of calculating a return rate. Of the 12 study participants, 11 were recruited by means of flyers posted in the geographical areas indicated previously; one was recruited from the Internet.

A sample of 12 clients (one man and 11 women; all White) participated in this study by completing an initial and a follow-up telephone interview. Clients ranged in age from 21 to 56 years (M = 43.42 years, SD= 9.47), had seen a median of 6.5 therapists (mode= 3 therapists), and spent a median of two years in each therapy (mode= 2 years). They sought to address concerns (nonmutually exclusive) such as depression-anxiety (n= 8), family-of-origin issues (n= 5), trauma (n= 4), and loss (n= 4). As a group, they identified no one predominant religious or spiritual affiliation (e.g., six were religiously or spiritually active but identified with no particular religious or spiritual group, three were Roman Catholic, and three had had experiences with a number of different such groups, such as Buddhism, Hinduism, Judaism, paganism, and Unitarian Universalism). They reported discussing religious or spiritual topics in therapy frequently (e.g., from once a month to every session), and most stated that religion or spirituality, or both, was important to resolving the concerns that brought them to therapy. Eleven participants reported seeing psychologists, nine reported seeing psychiatrists, seven saw social workers, five saw marriage and family therapists, and five saw master's-level counselors over the course of their lives. One reported seeing a psychiatric nurse. The majority (i.e., 83%) of the therapists these clients reported seeing were female.

Interviewers and judges. Three researchers—a 41year-old White woman with a psychodynamic-humanistic orientation, a 49-year-old White woman with a Jungian orientation, and a 28-year-old White woman with a client-centered/solution-focused orientation—conducted the audiotaped interviews and served as judges on the primary research team. One was an assistant professor and two were graduate students at the time of the study. A 30year-old White male graduate student with an interpersonal orientation served as the auditor. All were authors of the study.

Before conducting the interviews, all four authors examined their expectations by responding to the interview questions as they anticipated participants might respond. The authors also recorded any biases they felt regarding the place of religion or spirituality in psychotherapy. As part of preparing for the interview process, the four research team members discussed various personal experiences and biases regarding religion and spirituality. In this discussion, all team members defined spirituality as being a more individual experience and religion as more of a structure or organization that provided a place for worship. One team member commented on the differences between personal views, as a non-Christian, and the views held by the rest of the team. Specifically, this member identified both religious and secular components to religion, which was attributed to this person being of a minority faith that also provided a cultural component. All team members described an evolution of their religious beliefs and spiritual practices, and all described a period of falling away from the religion of their family of origin. Two members eventually returned to a traditional religion (i.e., Jewish, Protestant), where they currently practice, and all stated that their sense of spirituality was continually developing. Likewise, all team members reported personal experiences discussing religion or spirituality in their own therapy. In all cases the experience was reported as largely positive, although two members stated that the conversation remained superficial and that they felt a reluctance to go deeper into the discussion because of fear of offending the therapist or a sense that the therapist was not open to religious or spiritual discussion. All team members reported being open to discussing religion and spirituality with their clients, felt it was appropriate and helpful to do so, and had done so with clients. Additionally, two team members expressed a potential difficulty in working with clients whose religious beliefs were strict and limiting and promoted hatred-negative attitudes toward others. Team members expressed cautious attitudes in assessing when and how much to discuss religion and spirituality with clients, and all agreed that staying with the client's needs was more important than their personal beliefs and ambivalence toward such discussions. All felt it crucial to be aware of their

own beliefs, attitudes, and biases regarding the importance of religious and spiritual discussions in therapy.

Measures

Demographic form. The demographic form asked for some basic information about participants: age, sex, race, number of times in therapy, number of therapists seen, time spent in each therapy, and training background (i.e., degree) of therapists seen. The form also asked participants to indicate their name, telephone number, and e-mail address to enable further contact as well as convenient times to call to arrange for the first interview.

Interview protocol. The semistructured interview protocol (i.e., all participants are asked a standard set of questions, but interviewers freely pursue new or additional areas that arise from participants' responses) opened with a series of broad and contextual questions, beginning with a question regarding participants' identification with religious or spiritual groups, the role of religion-spirituality in their current life as well as its evolution over the course of their life, and their definitions of religion and spirituality. Participants were then asked the main issues they had addressed in therapy and why they chose to address these issues with a psychotherapist instead of or in addition to a religiously or spiritually oriented counselor. Participants were also asked to describe the religious-spiritual themes they had addressed in therapy and to discuss whether they had identified a religious-spiritual component to their therapeutic issues before or during the therapy process. We then asked them to describe how open they perceived their therapists to be to religious-spiritual topics, how often such topics had been addressed in therapy, and their perception of the similarities between their own and their therapists' religious-spiritual beliefs.

The interview then moved out of these broader contextual queries and to the main focus of the study—the specific event section—in which participants were asked to describe three distinct incidents (a time in which religious-spiritual topics were addressed in therapy that participants perceived to have been helpful, a time in which religious-spiritual topics were addressed in therapy that participants perceived to have been unhelpful, and finally a time in which participants considered but then did not raise religious-spiritual topics in therapy). For each such incident, participants were asked to respond to specific probes (e.g., what were the religious-spiritual topics; who raised them; how, when, and why they were raised; facilitating conditions for raising these topics; the outcome of the conversation involving theses topics; and participants' satisfaction with the therapy). In the incidents involving an unhelpful discussion of religion-spirituality, participants were also asked to comment on what might have made the

incident less unhelpful. Likewise, when participants discussed an incident of considering, but then not raising, a religious-spiritual topic, we also asked why they chose not to raise the topic, what might have enabled them to raise the topic, and the effect on the therapy of not raising the topic. In closing the interview, we asked participants how important religion-spirituality was to resolving the concerns that brought them to therapy, their thoughts about who should raise such topics (i.e., client or therapist), and their experience of the interview.

The follow-up interview, conducted approximately two weeks after the initial interview but before data analysis had begun, was unstructured (i.e., contained no set questions) and provided an opportunity for the researcher to ask questions that may have arisen after the first interview and for the participant to clarify or amend previous responses. It also enabled both researcher and participant to explore what, if any, other thoughts had been stimulated by the first interview.

Procedures for collecting data

Interviewing. Each member of the primary team piloted the protocol with at least one nonparticipant volunteer. We used feedback from the pilots to revise the protocol (i.e., we clarified, combined, added, or deleted questions) and to familiarize ourselves with the questions. The pilot interviews also allowed the researchers to address any concerns regarding the mechanics or content of the interview process. Furthermore, piloting the protocol reinforced to each interviewer not only the need to standardize the interview process (i.e., all participants must be asked all questions) but also the inherent flexibility of the interview process (i.e., additional questions may be asked to allow clarification or elaboration of participants' responses). Each of the primary team members then completed both the initial and follow-up interviews with three to five participants. At the end of each interview, the researcher made notes on the interview, noting the length of the interview and the level of rapport built with the participant. At the end of the first interview (40-60 min), a follow-up interview was scheduled with each participant for two weeks later. At the end of the follow-up interview (5-20 min), the interviewer asked participants if they were willing to receive and comment on a draft of the final results. The second interview concluded with a short debriefing paragraph.

Transcripts. The interviews were transcribed verbatim (except for minimal encouragers, silences, and stutters) for all participants. All identifying information was deleted from the transcripts, and each participant was assigned a code number to maintain confidentiality.

Draft of final results. Those participants who so requested (N=12) were sent a draft of the final results of the study for their comments. They were asked to examine the degree to

which their individual experiences were reflected in the group results presented in the draft. In addition, they were asked to verify that their confidentiality had been maintained in any examples described in the Results section. Two participants provided brief responses and suggested minor changes, which were made.

Procedures for analyzing data

The data were analyzed using CQR methods (Hill et al., 1997). Central to this qualitative approach is arriving at consensus about the classification and meaning of data. Consensus is achieved through team members discussing their individual understandings and then agreeing on a final interpretation that all find satisfactory. At least some initial disagreement is anticipated and is later followed by agreement (i.e., consensus) on the meaning of the data.

Coding of domains. A "start list" (Miles & Huberman, 1994) of domains (i.e., topic areas) was first developed by the primary team through grouping the interview protocol questions. The domains were altered by reviewing the transcripts, and further changes (e.g., adding or collapsing domains) were made throughout the process to reflect the emerging data. The final domains appear in Tables I and II. Using the interview transcripts, the three judges independently assigned each meaning unit (i.e., a complete thought, varying from a short phrase to several sentences) from each transcript into one or more domains. Then, the judges discussed the assignment of meaning units into domains until they reached consensus.

Coding of core ideas. Each judge independently read all of the data within each domain for a particular case and then wrote what she considered to be the core ideas that represented the content of the data concisely. Judges next discussed each core idea until they arrived at consensus about both wording and content. The auditor then examined the resulting consensus version of each case and evaluated the accuracy of both the domain coding and the wording of the core ideas. The judges discussed the auditor's remarks and again reached consensus regarding the domain coding and wording of the core ideas.

Cross-analysis. The initial cross-analysis was based on ten of the 12 cases; two cases were held out as a stability check (see later). Using the core ideas from all cases for each specific domain, each member of the primary team independently and inductively developed categories that best represented these core ideas. The team then reached consensus regarding the conceptual labels (titles) of the categories and the core ideas to be placed in each category. The judges next reexamined the consensus versions of all cases to assess whether the cases contained evidence not yet coded for any of the categories. Categories and domains were thus continually revised until the judges agreed that the data were well represented. The auditor then

reviewed the cross-analysis. Suggestions made by the auditor were discussed by the primary team and incorporated if agreed on by consensus judgment, resulting in a revised cross-analysis. The auditor also checked this revised cross-analysis.

Stability check. After the initial cross-analysis had been completed, the remaining two cases were added to assess whether the designations of general, typical, and variant (see later) changed and also to explore whether the team felt that new categories should be added to accommodate the cases. The remaining cases did not change the results meaningfully (i.e., no new categories were added), and thus the findings were deemed stable.

Results

We first present findings that arose when clients talked broadly about their definitions and experiences of religion and spirituality in their lives and also in their therapy (see Table I). These findings create the necessary context within which readers may understand the subsequent, more central, results. However, because these broad findings were not the primary focus of the current study, we present them here in summary form and direct readers to Table I for the more detailed results.

Then we present fully the results that emerged from the study's central focus: clients' reports of specific instances of discussing religion-spirituality with a particular therapist (see Table II). Finally, we present illustrative examples to portray representative experiences of clients discussing religion-spirituality in therapy. Although we asked participants to define religion and spirituality early in the interview, other than in the definitional section, the results do not differentiate between these two constructs. We sought, therefore, to understand how clients defined these terms but then wanted them to respond to the questions in the way that was most relevant for them (i.e., whether in terms of religion or spirituality, or both); thus, we use the combined notation ''religion-spirituality'' for these results. Note that in order to protect the confidentiality of the one male participant, all client examples are referred to in feminine terms (i.e., she/her).

Background information about religion and spirituality in clients' lives and therapies

These participants defined religion as an institution or organization with rules, traditions, and leaders; they defined spirituality as a personal connection with a force beyond the self, with God/divine, creativity, or good in the world. All performed religious or spiritual activities, and most found that religion-spirituality was an important part of their lives, one that contributed to their understanding of the world and of others. When religious or spiritual discussions emerged

out of the therapy process (i.e., participants seldom identified such issues as the reason for seeking therapy), they focused on existential questions or anger at God. Although the participants tended not to know their therapists' religious-spiritual beliefs, they found their therapists open to such discussions.

Specific discussion of religion-spirituality in therapy

In contrast to the previous results depicting clients' broad and contextual discussion of their experiences of religion and spirituality in their lives and in their therapy as a whole, the following results describe specific instances of clients actually discussing religious-spiritual topics with a particular therapist. As noted previously, the interviewers asked participants to describe three distinct therapy incidents: (a) a time when religious-spiritual topics were addressed in therapy that participants perceived to have been helpful, (b) a time when religious-spiritual topics were addressed in therapy that participants perceived to have been unhelpful, and (c) a time when participants considered but did not raise religious-spiritual topics in therapy. All participants responded to the first such event (i.e., helpful specific event; results are presented later). Six participants reported examples of the second type of event (i.e., unhelpful specific event). Only three participants, however, reported experiences of the last type of event (i.e., considered but did not raise religious-spiritual topics in therapy). As such, participants' descriptions of these events are summarized only. For the helpful events, categories are general if they apply to all cases, typical if they apply to at least half but not all cases, and variant if they apply to at least two but fewer than half of the cases. In the unhelpful events, general categories again apply to all cases, typical categories apply to at least half but not all cases, and variant categories apply to two cases. In both types of events, core ideas that fit for only one case were placed into the "other" category for that domain (and are not presented here).

Helpful specific event (*N*= 12)

Religious-spiritual topic addressed. Three variant categories emerged. First, clients reported that the religious-spiritual topic addressed in therapy focused on their existential struggles. For instance, one client stated that, after the death of her husband, she felt that she was "walking around in love with a dead person" and wondered how she could still maintain a connection with her deceased husband and learn to love someone new. Another client struggled with how to live her life more authentically in accordance with her Jewish faith. Clients also variantly discussed the support they experienced from their religious-spiritual community. When one client lost her home and broke her arm, her spiritual community helped her, evoking

a greater sense of family than did her own biological family. Finally, clients variantly discussed their use of religious-spiritual beliefs or practices as part of their therapy. Here, for instance, one client described her practice of meditation in her therapist's office.

Who raised topic. When these topics were addressed, typically it was clients who raised them. Variantly, however, clients reported that the topics were mutually raised by clients and therapists together, such as when a conversation about spirituality evolved out of a client and therapist's discussion of the movie *Shine*.

How and why topic was addressed. According to the participants, these discussions typically arose because they were related to clients' presenting concerns. As one example, a client raised religious-spiritual topics when describing her difficult family situation and also when attempting to work through the pending loss of her elderly mother. Similarly, another client expressed to her therapist how difficult it was to pray because of the client's anger at God for making the client so ill. The therapist ''picked up on [the client's anger] right away'' and the client hoped the therapist could help her get back on a ''spiritual path.'' Such discussions variantly arose out of conversations focused on clients' religious-spiritual community or practices, such as when a client told her therapist about the feelings the client experienced during Mass.

When topic was addressed. Clients reported that all such discussions occurred less than one year into therapy, whether as part of an initial history taking, ''fairly early on,'' or after only a few months of therapy.

Facilitating conditions for addressing topic. Typically, these discussions were facilitated by clients' perception of therapists as open, accepting, and safe. Here, for instance, one client stated that she raised spiritual issues because she felt ''perfectly comfortable'' doing so and felt that her therapist was respectful of religious-spiritual things. Another client indicated that her therapist seemed open and kind and, therefore, a safe person with whom to discuss such topics. Variantly, these discussions were facilitated by clients' perceptions that they shared similar religious-spiritual beliefs or experiences with their therapists. One client, for instance, stated that she felt her therapist understood her sense of ''being outside,'' because both followed different non-Christian religions. Finally, clients reported that their therapists' sex (i.e., female) fostered such discussions, as noted by the client who stated that her therapist was a woman and seemed kind and thus eased such conversations.

Outcome of discussion. The outcome of these discussions was typically positive. (A single participant categorized the incident overall as helpful but reported that the specific ''conversation went well, to a point.'') One client, for example, stated that her therapist did not

condemn the client for having hateful feelings toward the client's mother but instead indicated that she (the therapist) understood those feelings, a validation that allowed the client to feel safe to discuss other concerns as well. Similarly, another client reported that these discussions greatly affected the progress of her therapy, which she described as ''the best [she] has ever done in therapy and in life.''

Satisfaction with therapy. Expectedly, these clients were typically satisfied with the therapy as a whole, as epitomized by the client who stated that she was ''extremely satisfied.''

Unhelpful specific event (*N*=6)

Who raised topic. The participants reported that half of the time, religious-spiritual topics were raised by themselves, and half of the time by their therapists.

How discussion became unhelpful. These discussions typically became unhelpful when clients felt that their therapists were passing judgment or imposing their own beliefs on them. As an example, one client reported that her therapist told the client that she was ''too Catholic,'' which made the client feel bad. Another client stated that, instead of addressing the client's presenting concerns (i.e., trauma inflicted by a previous therapist), her therapist made the client lie down on the floor so the therapist could read the client's ''aura'' and then told the client that she had ''holes in her aura.'' A third client was told that because she had not embraced the religion of her birth, she could not expect spiritual help.

How to make discussion less negative. When asked how the event could have been less negative, the clients variantly indicated that if the therapists had not imposed their own values, the effect would have been less hurtful. One client, as an example, felt that her therapist should have been more accepting of the client's feeling that ''the Jewish community of faith'' was not the answer for her. Clients also variantly stated that had therapists attempted to reduce the hierarchy in the therapy relationship and been more open with clients, such events would have been less negative. Here, for example, a client stated that had her therapist asked the client how therapy was proceeding, the client may have felt that her therapist indeed wanted to understand the client's religious-spiritual perspective. A second client indicated that had her therapist answered the client's question about whether the therapist believed in God, their discussion would have felt less negative.

When topic was addressed. These discussions typically occurred early in therapy, such as in the first session or ''very early'' in the therapy work.

Facilitating conditions. No facilitating conditions emerged in the unhelpful specific events.

Outcome of discussion. Not surprisingly, the outcome of all of these conversations was negative, wherein clients felt traumatized, confused, frustrated, stuck, angry, or judged. For example, one client indicated that after being told to lie down on the floor so her aura could be read, the client felt ‘‘used and completely disregarded’’; this client made no more appointments with this therapist, did not see another therapist for a long time, and continued to feel hurt and furious about the event. A second client reported that she was made to feel that something was wrong with her because, as part of her spiritual activities, she wanted to help others instead of being more career focused. A third client ‘‘got real mad inside and left therapy’’ because she did not know what the therapist meant by the comment that the client was ‘‘too Catholic.’’

Satisfaction with therapy. These clients were typically not satisfied with their therapy. One client, for instance, felt that her therapist had been negligent with her in making her do something she was not comfortable doing.

Considered raising, but decided not to raise, religion-spirituality in psychotherapy (*N*=3)

These participants reported that they thought about raising religion-spirituality in their therapy because religion-spirituality was an important part of their lives but chose not to raise the topic because they felt uncomfortable doing so (i.e., one indicated that she felt discomfort because of ‘‘differences’’ between herself and her therapist, and another felt that her therapist would judge her religious-spiritual beliefs and find them ‘‘kooky’’). The specific topics they considered raising involved a personal connection with God experienced during Mass and the numerous questions experienced when trying to understand religious-spiritual concepts. The effects of not discussing the religious-spiritual topics were negative (i.e., one participant indicated that she felt a barrier with her therapist that she had to ‘‘go around’’ and that by the time therapy ended, she was unable to discuss with her therapist any of the things that truly mattered to her). Only one participant offered any ideas as to how such a conversation might have been facilitated: had her therapist had a more open demeanor and been willing to listen and wonder with the client, she may have felt more comfortable broaching this topic. Finally, only one of the three participants who thought about but did not raise religion-spirituality in therapy reported being satisfied with her therapy and therapist.

Illustrative examples

We include here two examples, each from a different participant: an illustration of a discussion of religion-spirituality in therapy that the client considered to have been helpful and a discussion of religion-spirituality in therapy that the client considered to have been unhelpful.

These examples were chosen because they were representative of the experiences clients described of helpful and unhelpful discussions of religion-spirituality. Each illustration has been slightly altered to maintain confidentiality.

In the first example involves ‘‘Gayle’’, a 42-year-old White woman who had been seeing her White female non-Christian therapist ‘‘on and off’’ for several years. Currently, Gayle was struggling with existential concerns that focused on her anger at God. As she told her therapist, she was having difficulty praying, or even thinking about God, because she was so ill (i.e., Gayle reported having a debilitating chronic disease). Additionally, she was angry at God but felt such emotions to be sacrilegious (i.e., ‘‘I can’t be angry at God’’). Gayle indicated that she revealed these feelings to her therapist in the hope that her therapist could help her ‘‘get back on the spiritual path.’’ Gayle reported that she felt comfortable raising such concerns because she perceived a similarity between her own and her therapist’s beliefs that made it easier for her to open up to her therapist. She also stated that, because her therapist was female, this made Gayle feel that she would understand women’s issues, and this also facilitated the conversation. Gayle stated that the conversation went well and helped her realize that her anger was ‘‘okay ...it was okay to be angry at a time when [I] didn’t think [I] could go on anymore.’’ Gayle stated that she ‘‘loves’’ her therapist and felt lucky to have her as a therapist.

In contrast, Barbara, a 35-year-old White woman, saw her White female non-Christian therapist for approximately 1 year after the death of her husband. Barbara reported that, after the death, she felt hopeless and broken and feared that she would never be able to love again. Early in her individual therapy, Barbara discussed the dynamics of the widow’s support group she also attended, explaining that she felt out of place because she was much younger than the other women in the group. Additionally, she felt ‘‘condescension’’ because the other women would tell her that she was so young and pretty and would find someone else. As a result, she felt that her concerns were minimized, which ‘‘pissed her off.’’ Barbara reported that her therapist intimated that Barbara’s anger was inappropriate. Furthermore, Barbara’s therapist said that because Barbara did not want to embrace her religion of birth as a way to work through her grief, she could not expect spiritual help with her loss and was, in effect, turning her back on this religion. Being told that she was ‘‘doing the grief wrong’’ was difficult for Barbara, who then started to avoid discussing spiritual topics at all in her therapy and instead talked about more trivial topics (e.g., ‘‘eating green vegetables’’). The result of this discussion was that Barbara did not feel helped and instead felt stuck and ‘‘put some [other] stuff to the side that was important’’ to her. She added that the incident made the therapy relationship less rich and

full and also limited her perception of her therapist's ability to help her. In terms of satisfaction with therapy, Barbara acknowledged that she and her therapist "were not the best match." Barbara felt that the incident could have been less negative had her therapist accepted that Barbara's religion of birth was not the answer for her and then pursued what might be suitable answers for Barbara's concerns.

Discussion

Background information about religion and spirituality in clients' lives and therapies

When defining religion, most of these White, largely female participants in secular therapy focused on institutional and organizational features, including rules, traditions, and leaders. Such a conceptualization is consistent with definitions proposed in the literature (e.g., Worthington, 1988). In their definition of spirituality, however, the respondents focused on a personal (i.e., noninstitutional) connection between self and forces beyond self (e.g., God, divine, creativity), again echoing other theorists' understandings of this construct (e.g., Dyson et al., 1997; Ingersoll, 1994). For these participants, then, religion was indeed construed as a perhaps more distant social construct, one that may provide a structure for spirituality, but one that seemed to lack the intimacy depicted in their definition of spirituality.

Whatever their definitions, all of these participants took part in religious-spiritual activities, and most acknowledged that such activities were an important part of their lives and facilitated their understanding of their world. Thus, it appears that, for this client sample, religion-spirituality played a central role in their existence, in some cases preventing them from "ending things," thereby supporting the assertion that religiosity may be more helpful than harmful in maintaining psychological well-being (Bergin, 1983; George et al., 2000; Kelly, 1995; McCullough et al., 2000; Rose et al., 2001).

When they discussed religion-spirituality in therapy, these respondents tended to focus on existential concerns (e.g., questions of meaning and purpose; anger at God) and less on any inherent connection between their religious-spiritual life and their presenting concerns. The religious-spiritual topics that arose usually emerged naturally out of the therapy process and were rarely identified by the participants as reasons unto themselves for seeking therapy, paralleling the finding of Goedde (2001). Once religious-spiritual topics entered the therapy room, most of these participants described their therapists, whose religious-spiritual beliefs were largely unknown to clients, as open to such conversations. Thus, these respondents' religious-spiritual discussions arose in the context of content commonly addressed in therapy (e.g.,

experience of loss or existential concerns), were not explicitly announced as a reason for therapy, and were received openly by most of their therapists. However, some participants reported that their therapists were either not open to or unappreciative of the place of religion-spirituality in their clients' lives and therapy. Such findings suggest that, even amidst what seems to be a secular therapeutic conversation, religious-spiritual content may emerge for discussion. The emergence of such content in therapy, coupled with the profession's commitment to multicultural competency (American Psychological Association, 2003), emphasizes again the importance of counselor training to identify and address such content appropriately (Brawer et al., 2002; Richards & Bergin, 2000; Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990).

Specific discussion of religion-spirituality in therapy

When these participants in secular therapy focused on a specific helpful discussion of religion-spirituality in therapy, they reported covering a range of topics (e.g., existential struggles, support gained from their religious-spiritual community, use of religious-spiritual beliefs or practices as part of therapy). Most of these discussions were raised by clients themselves because they felt them relevant to their presenting concerns, suggesting that they did not necessarily draw a distinct demarcation between their psychological and religious-spiritual concerns. They addressed both, and appeared to view them as connected, in the secular therapies they described here.

Consistent with earlier empirical work (e.g., Goedde, 2001), these participants' discussions of religion-spirituality were related to their psychological issues and were perceived as helpful. Perhaps an important contributor to such discussions' helpfulness was the fact that clients (and not therapists) raised these topics. As indicated, issues of religion or spirituality when raised by therapists were associated only with the unhelpful events. It may be, then, that these clients were most comfortable with, and thus perceived as most helpful, discussions of religion-spirituality that they raised alone or that they and their therapists raised mutually.

In addition, the participants' sense of their therapists as open, accepting, and safe seemed to facilitate such discussions, more so than any perceived similarity in religious-spiritual beliefs between client and therapist, a finding again parallel with earlier research (e.g., Pieper & van Uden, 1996). When they need not fear that their beliefs would be judged or pathologized (Goedde, 2001), these participants were able to engage in conversations integrating their psychological and religious-spiritual concerns, conversations that may have contributed to their satisfaction with therapy.

Participants' discussion of specific unhelpful therapy conversations involving religion-spirituality yielded expectedly different findings. First, clients reported that such discussions were initiated equally by themselves and by their therapists. Given the research indicating that clients may fear that their religious-spiritual beliefs will be judged by their therapist (Goedde, 2001), as well the historically negative views some theorists have espoused regarding religion-spirituality, it may be that therapists' initiation of such discussions made clients feel uncomfortable, invaded, or imposed on. In fact, these participants' experiences reflected this very possibility: According to the clients, such conversations became unhelpful primarily because clients felt that their therapists were passing judgment or imposing their own beliefs. Relatedly, when asked how the event could have been made less negative, a few clients suggested that had the therapists not imposed their own values, the conversation would have been experienced differently. All felt that these conversations led to negative outcomes, likely contributing to most participants' dissatisfaction with therapy.

Important differences between these two types of experiences, then, appear to reside in who raises the topic, and the degree to which clients perceive their therapists as accepting and safe. The findings based on these participants in secular therapy indicate that greater benefit may accrue from discussions of religion-spirituality in therapy if they are client initiated and if clients sense their therapists as nonjudgmental. Therapists, then, should heed such results: As would be expected, openness and acceptance toward discussions of religion-spirituality seem to bear greater fruit, and clients may prefer to raise such issues themselves. Given the mental health profession's historical ambivalence toward matters of religion and spirituality, the current lack of training available regarding how to address such topics in therapy, and the small body of empirical literature that has examined clients' views about addressing religion-spirituality in therapy, these findings begin to shed some light on how such discussions may occur in therapy so that clients indeed benefit.

Regarding those circumstances in which three participants considered raising religious-spiritual topics in therapy but ultimately did not, we offer only tentative thoughts and note that these experiences seem more similar to the unhelpful than the helpful therapy conversations described previously. Participants contemplated raising such topics because they were important parts of their lives but may have been inhibited from doing so because of a sense of discomfort (e.g., arising from therapist-client differences or a fear of being judged). The outcome of not being able to address these topics was negative, and seldom was any suggestion made as to how such conversations might have been facilitated.

Limitations. These results are limited to the 12 White, predominantly female participants in this study who had been in comparatively long-term secular therapy and had seen a relatively large number of therapists. We did not intend to include only White clients in this research; nevertheless, only White individuals responded to our solicitations for participation. Similarly, our hope was also to have a gender-balanced sample, but only one man responded to our research solicitations. The researchers did, however, examine the findings to determine whether the male participant's results were consistently different from those of the female participants; no such differences were found. Given these sample characteristics, we do not know the extent to which the current findings may reflect the experiences of non-White or other male clients. These participants acknowledged, as well, having seen a number of therapists and having been in therapy for relatively long periods of time. Without a comparison sample, we do not know what, if any, effect their comparatively greater experience in therapy may have had on these findings. It is possible that those in therapy with fewer therapists, or for shorter periods of time, may report different experiences regarding discussion of religion-spirituality in therapy. Such a possibility is worthy of further research. The results also represent only the experiences of those who volunteered to participate after seeing recruitment material for the study and thus may have self-selected because of an interest in the topic or an acceptance of discussing religious-spiritual issues in therapy. It is possible that those who saw the materials and then chose not to participate are different from these participants. The size of the final sample, however, is consistent with the guidelines of CQR (Hill et al., 1997). Additionally, although we asked participants to describe three distinct types of events related to discussion of religious-spiritual topics in therapy (i.e., helpful, unhelpful, considered but did not raise), only half of the sample reported unhelpful experiences, and only a fourth of the participants reported having considered but then not raising these topics. Furthermore, these results rest on what participants spontaneously reported when responding to the interview protocol, responses that may reflect different levels of accuracy of recall. We also included the interview protocol in the mailed packet so that potential participants could provide fully informed consent as well as think about appropriate experiences if they chose to participate in the study. We recognize that awareness of the interview questions, although possibly fostering richer responses, may also have enabled participants to change their remarks to appear socially desirable (Hill et al., 1997). Relatedly, our data were gathered via telephone interviews. Although some have asserted that this approach creates distance between researchers and participants and makes it difficult to assess participants' nonverbal responses, such was not our experience in this study. All participants

were quite open and disclosing, and interviewers were sensitively attuned to participants' nonverbal (although obviously also nonvisual) communications (e.g., when one participant became distressed recalling a difficult experience, the interviewer paused and checked in with the participant, asking her if she needed to take a break). Phone interviews may, in fact, allow the participant more privacy and confidentiality than face-to-face interviews would. Likewise, research has shown that participants were more likely to give socially desirable responses in face-to-face interviews than in telephone interviews or questionnaires (Wiseman, 1972). In addition, our pursuit of a national sample rendered phone interviews much more practical than face-to-face interviews. Finally, we have only the clients' report of these experiences and thus do not have access to therapists' perspectives. Client perspectives may be influenced, positively or negatively, by such factors as their therapy relationship or diagnosis.

Implications. This and previous research have found that clients indeed wish to discuss religious-spiritual topics in therapy, that such discussions are often integrated into clients' addressing their psychological concerns, and that therapy effectiveness may be enhanced by therapists' respectful incorporation of clients' religious-spiritual beliefs into treatment. The issue then becomes what therapists can do to facilitate such discussions and render them helpful. First, not only do therapists need to be perceived as receptive to such discussions, but they need also to foster an environment in which clients sense that such discussions are safe. As part of their routine intake procedures, for example, therapists may wish to consider including questions regarding the place, if any, of religion-spirituality in clients' lives (Chirban, 2001; see later). Such queries may communicate to clients that therapists are open to discussions of religious-spiritual content in therapy and may lessen the likelihood that clients will feel that their therapist does not appreciate the place of religion-spirituality in clients' lives, as was reported by some participants in the current study. It is also important that, should a discussion of religion-spirituality ensue, clients trust that therapists are neither judging nor imposing their own beliefs and values on them. Furthermore, therapists might also consider whether disclosure of their own religious-spiritual beliefs may be helpful for some clients. Recall that in the unhelpful specific event clients expressed a desire that their therapists be open with them and reduce the perceived hierarchy. Perhaps therapist self-disclosure could facilitate such effects. Therapists must consider carefully how clients' knowing, or not knowing, such information might affect the therapy. It may also be prudent for therapists to recognize that discussions of religion-spirituality do not necessarily announce themselves distinctly and explicitly but may instead be incorporated into clients' addressing of other therapy concerns. Thus, therapists may need to

have eyes and ears for more subtle client intimations that issues of religion-spirituality are part of what clients may wish to discuss (see later).

Griffith and Griffith (2002) also offered suggestions as to how clinicians might appropriately open the door to discussion of religion-spirituality in therapy. First, they recommend that clinicians strive to become aware of their own cynicisms and certainties regarding religion-spirituality in order to develop an attitude of wonder about the client. Next, they state that listening for the sacred is important. They suggest, for instance, that clinicians listen carefully and ask questions when clients use specific words or phrases (e.g., ‘‘I felt so at peace,’’ ‘‘I deserve this punishment,’’ or ‘‘It’s in God’s hands now’’) and then gently and respectfully query further regarding what clients may mean by such statements. Kelly (1995) adds that well-trained clinicians bring the foundational knowledge and technical training to address religious-spiritual topics appropriately, even when the clients’ beliefs are substantially different.

It is a delicate balance, however, between fostering an atmosphere of openness toward and acceptance of discussions of religion-spirituality in therapy and being careful not to scare or even repel clients who may have had aversive experiences with religion or spirituality. Might questions on an intake form, for example, be experienced by some as benignly irrelevant to therapy but by others as threateningly private and imposing? In the current study, we note that solely therapist-initiated discussions of religion-spirituality appeared only as unhelpful incidents. Thus, Chirban’s recommendation (2001) that therapists consider including, as part of an intake, questions regarding the place of religion-spirituality in clients’ lives needs to be considered quite cautiously. We suggest that, if therapists include such questions, they follow them up by asking clients about their responses to these very questions. From these responses therapists may learn not only what place, if any, religion-spirituality has in clients’ lives but also perhaps the nature of clients’ past experiences with religion-spirituality. Using such information, therapists may then be better able to meet clients’ needs regarding discussion, or lack of discussion, of religion-spirituality in therapy. Clearly, much more remains to be learned.

In addition, given that religious-spiritual components of clients’ presenting concerns may not be identified at the start of therapy but may instead gradually emerge, how are both client and therapist to approach a topic that neither of them may have anticipated and around which both may have discomfort? If therapists are struggling with their own spirituality, for example, their ability to help clients with such struggles may be impaired. As with any potentially unresolved therapist issue, therapists need to seek appropriate supervision, consultation,

training, or personal therapy to ensure that they are capable of serving clients effectively.

Furthermore, how do we train therapists to address religious-spiritual content, to know when and how much to address religion-spirituality in therapy (Goedde, 2001)? Although our field attends to multiculturalism, such attention has not always fully included religion-spirituality (Schlosser, 2003). As we train students to incorporate other multicultural factors in therapy effectively (e.g., race, age, socioeconomic status, sexual orientation), we need also to educate them to explore the impact of clients' and therapists' religious-spiritual orientation on therapy content and process.

Finally, the current study also poses several questions for further research. As mentioned, how might including questions, during intake, regarding the role of religion-spirituality in clients' lives affect the therapy relationship and process? Would clients experience such questions as an invitation to address this content if they wished, or would they perceive them as at best irrelevant, at worst invasive and frightening? How might therapists' disclosure of their own religious-spiritual beliefs likewise affect therapy? If therapists were to receive training regarding how to address religious-spiritual content in therapy, what effect, if any, might such training have, whether on therapists' comfort with or clients' experience of such discussions? Furthermore, given that our sample consisted predominantly of White women who had been in relatively long-term therapy, how do discussions of religion-spirituality proceed in therapy with those who are non-White or male or who may have been in therapy for shorter periods of time? It may also be fruitful to complement the current research based on clients' experiences with research that examines therapists' experiences of such discussions. Through such exploration, we may learn to acknowledge, and more powerfully honor, pivotal elements of our clients' lives.

Notes

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- We gratefully thank our participants in this study. We also thank Peggy Barott, Julie Bentzler, Angela Bryant, Paula Filtz, Shannon Gill, Dione Gisch, Nicole Hamilton, Tyson Kuch, Sara Murray, and Nicole Wheatley for their assistance with transcription. Finally, we thank Timothy Davis, Clara Hill, and Stacey Holmes for their comments on an earlier draft of this article.

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Endnote

1. We recognize that use of "God" as a written word is not a universal custom. For purposes of clarity and consistency with our participants' responses, however, we have chosen this usage. Received 10 February 2004; revised 02 January 2004; accepted 03 March 2005)

References

Al-Issa, I. (2000). Religion and psychopathology. In I. Al-Issa (Ed.), *Al-Junun: Mental illness in the Islamic world* (pp. 3-42). Madison CT: International Universities Press.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377-402.

Benjamin, P., & Looby, J. (1998). Defining the nature of spirituality in the context of Maslow's and Rogers's theories. *Counseling & Values, 42*, 92-101.

Bergin, A. E. (1983). Religiosity and mental health: A critical reevaluation and meta-analysis. *Professional Psychology: Research and Practice, 14*, 170-184.

Brawer, P. A., Handal, P. J., Fabricatore, R. R., & Wajda-Johnston, V. A. (2002). Training and education in religion-spirituality within APA-accredited clinical psychology programs. *Professional Psychology: Research and Practice, 33*, 203-206.

Burkhardt, M. (1989). Spirituality: An analysis of the concept. *Holistic Nursing Practice, 3*, 69-77.

Chirban, J. T. (2001). Assessing religious and spiritual concerns in psychotherapy. In T. G. Plante & A. C. Sherman (Eds), *Faith and health: Psychological perspectives* (pp. 265-290). New York: Guilford Press.

Dyson, J., Cobb, M., & Forman, D. (1997). The meaning of spirituality: A literature review. *Journal of Advanced Nursing, 26*, 1183-1188.

Elkins, D. (1999). Spirituality. *Psychology Today, 32*, 45-48.

Frankl, V. E. (1984). *Man's search for meaning* (3rd ed). New York: Touchstone.

Fukuyama, M. A., & Sevig, T. D. (1999). *Integrating spirituality into multicultural*

counseling . Thousand Oaks, CA: Sage.

George, L. K., Larson, D. B., Koenig, H. G., & McCullough, M. E. (2000). Spirituality and health: What we know, what we need to know. *Journal of Social and Clinical Psychology, 19*, 102-116.

Goedde, C. (2001). A qualitative study of the client's perspectives of discussing spiritual and religious issues in therapy. *Dissertation Abstracts International, 61*(9), 4983B. (UMI No. 9985193)

Griffith, J. L., & Griffith, M. E. (2002). *Encountering the sacred in psychotherapy: How to talk with people about their spiritual lives.* New York: Guilford Press.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25*, 517-572.

Ingersoll, E. (1994). Spirituality, religion, and counseling: Dimensions and relationships. *Counseling & Values, 38*, 98-111.

Kelly, E. W. (1995). *Spirituality and religion in counseling and psychotherapy.* Alexandria, VA: American Counseling Association.

Mack, M. (1994). Understanding spirituality in counseling psychology: Considerations for research, training, and practice. *Counseling & Values, 39*, 15-32.

McCullough, M. E., Hoyt, W. T., Larson, D. B., Koenig, H. G., & Thoresen, C. (2000). Religious involvement and mortality: A meta-analytic review. *Health Psychology, 19*, 211-222.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed). Thousand Oaks, CA: Sage.

Miller, W. R. (1999). *Integrating spirituality into treatment: Resources for practitioners*. Washington, DC: American Psychological Association.

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd edn). Boston: Allyn & Bacon.

Pargament, K. I. (1999). The psychology of religion and spirituality? Response to Stifoss-Hanssen, Emmons, *and* Crumpler. *The International Journal for the Psychology of Religion, 9*, 35-43.

Pieper, J., & van Uden, R. (1996). Religion in mental health care: Patients' views. In P. J. Verhagen & G. Glas (Eds), *Psyche and faith: Beyond professionalism* (pp. 69-83). Uitgeverij Boekencentrum: Zoetermeer.

Plante, T. G., & Sharma, N. K. (2001). Religious faith and mental health outcomes. In T. G. Plante & A. C. Sherman (Eds), *Faith and health: Psychological perspectives* (pp. 240-

261). New York: Guilford Press.

Ponterotto, J. G. (2002). Qualitative research methods: The fifth force in psychology. *The Counseling Psychologist, 30*, 394-406.

Richards, P. S., & Bergin, A. E. (1997). *A spiritual strategy for counseling and psychotherapy*. Washington, DC: American Psychological Association.

Richards, P. S., & Bergin, A. E. (2000). *Handbook of psychotherapy and religious diversity*. Washington DC: American Psychological Association.

Rose, E. M., Westefeld, J. S., & Ansley, T. N. (2001). Spiritual issues in counseling: Clients' beliefs and preferences. *Journal of Counseling Psychology, 48*, 61-69.

Schlosser, L. Z. (2003). Christian privilege: Breaking a sacred taboo. *Journal of Multicultural Counseling and Development, 31*, 44-51.

Shafranske, E. P., & Gorsuch, R. L. (1984). Factors associated with the perception of spirituality in psychotherapy. *The Journal of Transpersonal Psychology, 16*, 231-241.

Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy, 27*, 72-78.

Shafranske, E. P., & Malony, H. N. (1996). Religion and the clinical practice of psychology: A case for inclusion. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 561-586). Washington, DC: American Psychological Association.

Strohl, J. (1998). Transpersonalism: Ego meets soul. *Journal of Counseling and Development, 76*, 397-403.

West, W. (1998). Therapy as a spiritual process. In C. Feltham (Ed.), *Witness and vision of the therapists* (pp. 158-179). London: Sage.

Wiseman, F. (1972). Methodological bias in public opinion surveys. *Public Opinion Quarterly, 36*, 105-108.

Worthington, E. L. (1988). Understanding the values of religious clients: A model and its application to counseling. *Journal of Counseling Psychology, 35*, 166-174.

Worthington, E. L., Kurusu, T. A., McCullough, M. E., & Sandage, S. J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin, 119*, 448-487.

Yarhouse, M. A., & Fisher, W. (2002). Levels of training to address religion in clinical practice. *Psychotherapy: Theory, Research, Practice, Training , 39*, 171-176.

Appendix
Table 1
Background information about religion and spirituality in clients' lives and therapies

Domain/Category	Freq./No. Cases	Illustrative Core Idea
Definition of religion		
Institution/org. w/rules, traditions leaders	Typical/11	An institution grounded in tradition, with leaders
Provides structure for spirituality	Variant/3	A human organization dedicated to the promotion of a particular type of spirituality
Carried negative connotations	Variant/5	Caused guilt and worry
Definition of spirituality		
Personal connection with force beyond self, God/divine, creativity, good in world	Typical/10	Seeking a personal relationship with a higher power
Way person lives out beliefs	Variant/5	One's relationship with the divine and how that's lived out in someone's life
Current role of rel-spir		
Performs rel-spir-oriented activities	General/12	Attend services, pray, meditate
Contributes to understanding of world/others	Typical/7	The eyes through which I see the world
Important part of life	Typical/8	I would not be alive if I didn't have a spiritual base to keep me from "ending things"
Rel-spir topics in therapy[a]		
What topics		
Existential questioning, anger at God	Typical/6	Asked questions about God and faith
Link between rel-spir life & presenting concerns	Variant/3	A lot of psychological things are also spiritual
When/how identified		
As part of therapy process	Typical/7	Realized that the questions I was seeking to answer were "fundamentally spiritual"
Before therapy, as reason for seeking therapy	Variant/5	Aware of religious concerns before therapy
T openness and similarity of belief[a]		
T openness to rel-spir topics		
Open	Typical/11	T open and willing to talk about spirituality
C felt T did not fully appreciate rel-spir emphasis	Variant/2	T attended to psychological but not spiritual aspects of what I said
Psychiatrists not open	Variant/3	Psychiatrist "pulled me" into "scientific Freudian" terms that I found trivializing
Degree of similarity between C and T beliefs		

C did not know T beliefs	Typical/6	Did not know, and had never asked, about T's faith background
Beliefs similar	Variant/5	T and I had similar perspectives on the difference between religion and spirituality

Note: T = therapist; C = client; rel-spir = religious-spirtual.
[a]In the results reflected in these domains, participants may be referring to their experiences with more than one therapist.

Table 2
Specific discussion of religion-spirituality in therapy

Domain	Category	Freq./No. Cases
Helpful Specific Event [*N* = 12]		
Rel-spir topic raised	Struggles with existential concerns	Variant/5
	Support client gains from rel-spir community	Variant/2
	C's use rel-spir belief or practice as part of therapy	Variant/2
Who raised topic	C	Typical/7
	C and T mutually	Variant/5
How and why raised	Relevant to C's presenting concerns	Typical/8
	Via discussion of C's rel-spir community/activities	Variant/3
When raised	Less than 1 year into therapy	General/12
Facilitating conditions	T perceived as open, accepting, safe	Typical/7
	Perceived similarity in beliefs/experiences	Variant/3
	Sex of T (i.e., female)	Variant/2
Outcome of discussion	Positive	Typical/11
Satisfaction with therapy	Satisfied	Typical/10
Unhelpful Specific Event [N =6]		
Who raised topic	C	Typical/3
	T	Typical/3
How disc. became unhelpful	T passed judgment/imposed beliefs on C	Typical/5
How to make event less negative	T not impose own values	Variant/2
	T reduce hierarchy and be open with C	Variant/2
When raised	Early (e.g., first session)	Typical/4
Facilitating conditions	-	-
Outcome of discussion	Negative	General/6
Satisfaction with therapy	Not satisfied	Typical/3

Note: Rel-spir = religious-spiritual; C = client; T = therapist.