spirituality in clinical practice

theory and practice of spiritually oriented psychotherapy

second edition

LEN SPERRY
spirituality in clinical practice

theory and practice of spiritually oriented psychotherapy

second edition

LEN SPERRY
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Foreword</td>
<td>ix</td>
</tr>
<tr>
<td></td>
<td>Preface</td>
<td>xiii</td>
</tr>
<tr>
<td>SECTION I</td>
<td>Spirituality in Clinical Practice: Theory</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>The Spiritual Dimension in Clinical Practice</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Dimensional Perspectives on Spiritual Development</td>
<td>31</td>
</tr>
<tr>
<td>3</td>
<td>Developmental Models of the Spiritual Dimension</td>
<td>63</td>
</tr>
<tr>
<td>4</td>
<td>Spiritual Dynamics, Crises, and Emergencies in Psychotherapy</td>
<td>95</td>
</tr>
<tr>
<td>SECTION II</td>
<td>Spirituality in Clinical Practice: Practice</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The Practice of Spiritually Oriented Psychotherapy</td>
<td>123</td>
</tr>
<tr>
<td>6</td>
<td>Therapeutic Relationship</td>
<td>137</td>
</tr>
<tr>
<td>7</td>
<td>Assessment and Case Conceptualization</td>
<td>153</td>
</tr>
</tbody>
</table>

CONTENTS

8 Interventions 183

9 Termination and Evaluation 233

10 Cultural and Ethical Considerations 249

Bibliography 265

Index 269
Several changes and developments have occurred in the theory and practice of psychotherapy recently. Similar changes have occurred, and will continue to occur, in spiritually oriented psychotherapy. A review of these developments in conventional psychotherapy is useful in appreciating changes and the current status of spiritually oriented psychotherapy. This chapter begins with a description of developments in the practice of psychotherapy, and then describes similar developments occurring in the practice of spiritually oriented psychotherapy. This discussion serves as an introduction and overview of Chapters 6 through 10.

**RECENT DEVELOPMENTS IN PSYCHOTHERAPY**

The past decade has witnessed a remarkable evolution in the theory, research, and practice of psychotherapy. Many, but not all, of these changes and developments are due to the accountability movement in health care. Increasingly, psychotherapy has become more focused, effective, and accountable. In 2005, the American Psychological Association formally embraced “evidence-based practice” in psychology. Evidence-based practice can be defined as “the integration of best research evidence with clinical expertise and patient values” (Institute of Medicine, 2001, p. 147). It is broader than the concept of empirically supported treatment (described below) in that it explicitly considers
client values and clinical expertise, that is, utilizing clinical skills and past experience to rapidly identify the client’s health status, diagnosis, risks and benefits, and personal values and expectations. Presumably then, competent and well-informed clinicians would develop and maintain enhanced therapeutic alliances; utilize best practices information; implement treatment tailored to match client diagnoses, need, and preferences; and monitor clinical outcomes (DeLeon, 2003). Parenthetically, it can be noted that an alternative model and statistical methodology to evidence-based practice has emerged. Called “practice-based evidence,” this rather sophisticated model has already improved clinical practice in health care (Horn & Gassaway, 2007), although it is has yet to be extended to the practice of psychotherapy.

This section overviews five elements that reflect current theory, research, and practice, and their evolution. They are clinical outcomes, empirically supported treatment, the therapeutic alliance, client factors, and therapist factors. Figure 5.1 visually depicts the evolving role of these elements in the delivery of effective psychotherapy. Closely related to these elements are competencies and their role in training as well as in psychotherapy practice.

Clinical Outcomes

Outcomes have become the coin of the realm in psychotherapy today. Although processes are still considered important, the culture of accountability and the empirically based treatment movement have made clinical outcomes the central consideration in psychotherapy practice. Outcomes refer to the effects or end points of specific interventions or therapeutic processes. Two types of outcomes can be distinguished: immediate or formative outcomes and final or summative outcomes. Outcomes can be assessed in a pre-/posttreatment fashion or in an ongoing fashion, that is, by monitoring outcomes at each session. Research points to better outcomes when clinicians engage in ongoing monitoring than with pre-/postassessment or no formal assessment of outcomes (Lambert, Whipple, Hawkins, Vermeersch, Nielsen, et al., 2003).

Empirically Supported Treatment

In the 1990s the call for accountability in health care translated to demands for empirically supported treatment. Empirically supported treatments are interventions for which empirical research has provided evidence of
Phase 1: Two Factor Model: Interventions Emphasis

Phase 2: Two Factor Model: Therapeutic Alliance Emphasis

Phase 3: Three Factor Model: Combining Interventions and Therapeutic Alliance

Phase 4: Four Factor Model: Integrating Client, Alliance, and Intervention Factors

Phase 5: Five Factor Model: Integrating Therapist, Client, Alliance, and Intervention Factors

Figure 5.1 Factors and processes of effective psychotherapy: Evolution of models.

their effectiveness. As health care costs were spiraling upward, clinician practice patterns were portrayed as the basic cause of waste, inefficiency, and escalating costs. As a result, health care systems and managed care plans moved to standardize care and specify rules for the provision of that care. The expectation was that clinicians—including psychotherapists—would only provide encounter-based, as opposed to relationship-based, services, and be able to demonstrate that these services were evidence-based and cost effective. This was the beginning of what has been called the empirically supported treatment (EST) movement in psychotherapy (Reed, McLaughlin, & Newman, 2002).
Psychology had already embraced evidence-based assessments and treatments as part of its long-held commitment to research on assessment and psychotherapy. In 1995 an APA task force was formed to address ESTs in psychotherapy. This EST task force identified both “well-established treatments” and “probably efficacious treatments.” Not surprisingly, most were short-term behavioral and cognitive-behavioral approaches, and longer term, more complex approaches, such as psychodynamic interventions, were not well represented (APA Division of Clinical Psychology, 1995).

The EST movement has significantly impacted psychotherapy practice. It provided managed care and insurance companies considerable leverage in controlling costs by restricting the practice of psychological health care. It also prompted local, state, and federal funding agencies to require the use of ESTs. The result is that ESTs are becoming established as the standard of care in psychotherapy. This conclusion is problematic as it is based on a questionable assumption. The assumption is that providing an EST is the necessary and sufficient condition for a positive therapeutic outcome. Phase 1 of Figure 5.1 visually depicts the relationship between the factors of ESTs and therapeutic outcomes.

Therapeutic Alliance

The APA Task Force on Empirically Supported Therapy Relationships (ESRs) was formed in 1999 in reaction to the earlier task force on ESTs. ESRs emphasized the person of the therapist, the therapy relationship, and the nondiagnostic characteristics of the patient (Norcross, 2002). The therapeutic relationship has consistently been the single most important variable in the now extensive literature on psychotherapy outcome research. An earlier meta-analysis by Lambert (1992) had found that that specific techniques—those that were the focus of the studies underlying the EST task force report—accounted for no more than 15% of the variance in therapy outcomes. On the other hand, the therapy relationship and factors common to different therapies accounted for 30% of the variance in therapy outcomes. Therapeutic alliance is a type of therapeutic relationship that encompasses three factors: the therapeutic bond between client and therapist, the agreed-upon goals of treatment, and an agreement about methods for achieving that goal or goals. The therapeutic alliance is described in more detail in Chapter 6. Phase 2 of Figure 5.1 visually depicts the relationship between the factors of therapeutic alliance and therapeutic outcomes.
Following the ESR task force report, it became increasingly clear that an either–or stance (i.e., ESTs or ESRs) was untenable. Instead, there was increasing acceptance that both ESTs and ESRs were operative in treatment outcomes. Phase 3 of Figure 5.1 visually depicts the relationship among the factors of evidence-based interventions, therapeutic alliance, and therapeutic outcomes.

Client

But that “both–and” understanding would soon be found to be shortsighted. A subsequent meta-analysis of the elements accounting for psychotherapy change (Lambert & Barley, 2001) found that the largest element accounting for change (40%) was due to extratherapeutic factors, also referred to as “client resources” or “client.” This finding was essentially the same as previously reported (Lambert, 1992). The client element includes several factors such as motivation and readiness for change, capacity for establishing and maintaining relationships, access to treatment, social support system, and other nondiagnostic factors. Phase 4 of Figure 5.1 visually depicts the relationship among the factors of evidence-based interventions, therapeutic alliance, client, and therapeutic outcomes.

Therapist

As useful as the Lambert research (1992, 2001) has been in understanding the elements contributing to psychotherapy outcomes, there was no apparent role for the therapist. It has long been observed that some therapists are much more effective than others. For years, terms like master therapist and supershrink have been used to describe the expertise of such therapists. Recently, there has been a surge of research on therapist factors that positively impact the client, the therapeutic alliance, and the implementation of therapeutic interventions, resulting in improved clinical outcomes (Sperry, 2010b). Phase 5 of Figure 5.1 visually depicts the relationship among the factors of evidence-based interventions, therapeutic alliance, client, therapist, and therapeutic outcomes.

Psychotherapy Competencies

In addition to the focus on these five elements is the role of competencies. Competency is the current zeitgeist in psychotherapy practice.
and training. Competency represents a paradigm shift in psychotherapy training and practice and, not surprisingly, has effected and will continue to effect change. Requirement standards are beginning to be replaced with competency standards, core competencies are replacing core curriculums, and competency-based licensure is on the horizon. The shift to psychotherapy competency is also an accreditation standard in psychiatry training programs now that requires that trainees demonstrate competency in three psychotherapy approaches. Training programs in clinical psychology programs have solidly embraced competencies, and marital and family therapy and professional counseling programs are poised to follow suit. Because competencies involve knowledge, skill, and attitudinal components, competency-based education is very different in how psychotherapy is taught, learned, and evaluated.

Six core psychotherapy competencies have been described. They are (1) articulate an conceptual framework for psychotherapy practice, (2) develop and maintain an effective therapeutic alliance, (3) develop an integrative case conceptualization and treatment plan based on an integrative assessment, (4) implement interventions, (5) monitor treatment progress and outcomes and plan for termination process, and (6) practice in a culturally sensitive and ethically sensitive manner (Sperry, 2009, 2010b).

DEVELOPMENTS IN THE PRACTICE OF SPIRITUALLY ORIENTED PSYCHOTHERAPY

Much of the professional literature on spiritually integrated psychotherapy is rather recent, and there are aspects of it that mirror developments in psychotherapy. Initially, this literature advocated for clinician sensitivity to spiritual/religious concerns. Then, it focused on incorporating spiritual/religious concerns in conventional psychotherapy approaches. That is not to say that there are no unique spiritually oriented approaches, because there are some, most notably transpersonal psychotherapy. However, most approaches are adaptations. Sperry and Shafranske (2005) have chronicled these approaches, of which two are traditional (psychoanalytic and Jungian) and ten are contemporary (cognitive behavioral, humanistic, interpersonal, etc.).
Currently, the literature on spiritually oriented psychotherapy is mirroring developments in psychotherapy with a focus on the elements of psychotherapy and the phases of therapy. The recent book by Aten and Leach (2009), *Spirituality and the Therapeutic Process*, has chapters on the therapist, the therapeutic alliance, assessment, case conceptualization, treatment planning, treatment implementation, and termination. The editors also acknowledge the importance of evidence-based practice in spiritually oriented psychotherapy. Next, this section addresses the relationship of spirituality to psychology, and the matter of competencies in spiritually oriented psychotherapy.

In professional psychology there is currently no consensus on either competencies or ethical guidelines for practice in which religious or spiritual perspectives and resources are explicitly integrated. Nevertheless, Richards (2009) has offered some preliminary considerations for psychologists who endeavor to practice spiritually integrated psychotherapy. Others have also articulated competencies and ethical guidelines for the practice of spiritually integrated psychotherapy to be considered (Gonsiorek, Richards, Pargament, & McMinn, 2009). However, this lack of consensus on competencies and codes leaves a void for psychologists practicing in this area. The development of clear guidelines poses a significant challenge and simultaneously offers an opportunity for this specialty field to develop and mature. Central to consideration of professional ethics is the area of professional competence.

ASERVIC has specified and articulated a set of such competencies (Miller, 1999) and then offered a revision: “Competencies for Addressing Spiritual and Religious Issues in Counseling” (Cashwell & Watts, 2010). This document includes 14 competencies of which the first six are cognitive competencies (e.g., “can describe the similarities and differences between spirituality and religion”), and the last five are clinical competencies. These involve assessment, diagnosis, goal setting, and the utilization of spiritually sensitive treatment interventions. Table 5.1 compares the original and revised competencies.

Further development is required to articulate competencies and to establish clear standards for practice in each of the approaches presented in this chapter. Table 5.2 provides a tentative list of competencies for each approach. The tentative competencies were derived from Aten and Leach (2009) and Sperry (2010a).
Table 5.1  Evolution of Competencies for Addressing Spiritual and Religious Issues in Counseling (ASERVIC)

<table>
<thead>
<tr>
<th>Original Competencies*</th>
<th>Revised Competencies**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explains the difference between religion and spirituality (R/S)</td>
<td>Describes R/S, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism</td>
</tr>
<tr>
<td>Describes R/S beliefs and practices in a cultural context</td>
<td>Recognizes that client’s R/S beliefs (or absence of beliefs) about are central and can influence psychosocial functioning</td>
</tr>
<tr>
<td>Engages in self-exploration of R/S beliefs</td>
<td>Explores his or her own attitudes, beliefs, and values about R/S</td>
</tr>
<tr>
<td>Describes his or her R/S belief system and explains models of R/S development</td>
<td>Evaluates the influence of his or her R/S beliefs and values on the client and the counseling process</td>
</tr>
<tr>
<td>Demonstrates sensitivity and acceptance of a variety of R/S expressions in client communication</td>
<td>Identifies the limits of his or her understanding of the client’s R/S perspective and is acquainted with R/S resources</td>
</tr>
<tr>
<td>Identifies limits of understanding of a client’s R/S expression, and referral skills and sources</td>
<td>Responds to client communications about R/S with acceptance and sensitivity</td>
</tr>
<tr>
<td>Assesses the relevance of the R/S domains in the client’s therapeutic issues</td>
<td>Uses R/S concepts consistent with client’s R/S perspectives acceptable to the client</td>
</tr>
<tr>
<td>Is sensitive to, and receptive of, R/S themes in the counseling process</td>
<td>Recognizes R/S themes in client communication and addresses these when relevant</td>
</tr>
<tr>
<td>Uses client’s R/S beliefs in the pursuit of the client’s therapeutic goals and preference</td>
<td>Assesses client’s R/S perspective by gathering information from the client and/or other sources</td>
</tr>
<tr>
<td></td>
<td>Makes a diagnosis and recognizes client’s R/S perspectives can (a) enhance well-being, (b) contribute to client problems, and/or (c) exacerbate symptoms</td>
</tr>
<tr>
<td></td>
<td>Sets goals with the client that are consistent with the client’s R/S perspectives</td>
</tr>
<tr>
<td></td>
<td>Is able to (a) modify therapeutic techniques to include client’s R/S perspectives, and (b) utilize R/S practices when appropriate and acceptable to client</td>
</tr>
<tr>
<td></td>
<td>Can therapeutically apply theory and current research supporting the inclusion of a client’s R/S perspectives and practices</td>
</tr>
</tbody>
</table>

*Derived and summarized from *Miller (1999) and **Cashwell & Watts (2010).
Table 5.2  Spiritually Integrated Psychotherapy

1. Develop a therapeutic alliance that is sensitive to the spiritual dimension.
2. Maintain the therapeutic alliance and deal with spiritual transference, countertransference, alliance ruptures, ambivalence, and resistance.
3. Assess and diagnose, including the spiritual dimension.
4. Incorporate the spiritual dimension in the case conceptualization.
5. Incorporate the spiritual dimension in treatment planning and mutual goal setting.
6. Implement spiritual and psychological interventions.
7. Refer to, or consult with, religious/spiritual resources, if indicated.
8. Monitor and evaluate overall treatment progress and outcomes on all dimensions, including the spiritual dimension.
9. Incorporate spiritual dimension in the termination process.

TERMS AND DESIGNATIONS

As a field or specialty develops, a consensus slowly develops regarding terminology and the definitions of key constructs. In the interim, confusion about terms and designations is common. This is currently the situation in spirituality and psychotherapy. As noted in Chapter 1, there is no consensus yet on the definition of general terms such as spirituality or on the relationship of the spiritual dimension to the psychological dimension. More specifically, there is no consensus on the meaning of the designation psychospiritual problem and interventions and little consensus on the designations of the practice of psychotherapy that is sensitive to the spiritual dimension. This section addresses both of these considerations.

Psychospiritual Problem and Interventions

The terms psychological, spiritual, and psychospiritual seem like useful designations for describing the kind of problems and interventions employed in the practice of spiritually oriented psychotherapy. At first glance it would seem relatively easy to classify interventions as either psychological, spiritual, or psychospiritual. For example, there would be no question that cognitive restructuring should be classified as a psychological intervention or that prayer is a spiritual intervention or practice. But what constitutes a psychospiritual intervention? Whereas some would insist that mindfulness is a psychospiritual intervention (Mijares & Khalsa,
2005), others consider it a psychological intervention (Segal, Teasdale, & Williams, 2002), and still others classify it as a spiritual intervention (Aten, McMinn, & Worthington, 2011). The point is that there is no consensus among professionals about the meaning of the term psychospiritual.

A review of the professional literature over the past 30 years indicates that the term psychospiritual was used more often in the 1980s and early 1990s than in the present. Take, for example, the initial proposal for adding a new diagnostic category to DSM-IV that addressed religious and spiritual concerns. The proposed name for the category was “Psychoreligious and Psychospiritual Problems” (Lukoff, Lu, & Turner, 1992). DSM leadership voted against this terminology and instead chose the more conventional designation “Religion or Spiritual Problems.” Some 17 years later, the proposal for the DSM-V diagnostic category continued to use the conventional designation “Religion or Spiritual Problems” (Lukoff, Lu, & Yang, 2010). It is probably no coincidence that recent textbooks and professional books, book chapters, and articles on spirituality and spiritually oriented psychotherapy do not use the term psychospiritual, and if it is mentioned in passing, it is not formally defined. In short, because there is no consensus on the meaning of the designation psychospiritual, its usage is of questionable value, at least at this time.

Psychotherapy Sensitive to the Spiritual Dimension

Currently, the terms spiritually oriented psychotherapy, spirituality accommodative psychotherapy, and spirituality integrated psychotherapy are often used synonymously. Whereas there is some overlap among them, there are also differences. Typically, spirituality accommodative approaches combine a manualized treatment with practices and beliefs from a specific religious tradition. In contrast, spirituality oriented approaches are less standardized and more inclusive, which increases their applicability to a fuller range of spiritual beliefs and religious traditions (Schlosser & Safran, 2009). An example of spirituality accommodative psychotherapy is Christian-accommodative cognitive-behavioral therapy. In this widely used and researched approach, Christian images, prayer, biblical examples, and religiously focused cognitive disputation may be utilized with Christian clients (Johnson & Ridely, 1992; Propst, Ostrom, Ridley, Dean, & Mashburn, 1992). Examples of spirituality integrated psychotherapy include theistic integrative psychotherapy, which addresses spiritual issues from a theistic perspective (Richards, 2005), and integrative
SPIRITUALITY INTEGRATED PSYCHOThERAPY

Spiritually oriented psychotherapy, which is grounded in a biopsychosocialspiritual model, spiritual, direction, attachment theory, and God image research (Sperry, 2005).

Spirituality integrated psychotherapy has been described by Pargament (2007) as an “approach to treatment that acknowledges and addresses the spirituality of the client, the spirituality of the therapist, and the process of change” (p. 176). It is multimodal as it can draw on a wide range of approaches and interventions. It can be provided to clients from diverse spiritual or nonreligious backgrounds by therapists from diverse spiritual or nonreligious backgrounds. Spirituality integrated psychotherapy, from Pargament’s perspective, differs from spiritually accommodative and spiritually oriented approaches that are not theory and research based. It “will not gain widespread use and acceptance until it has proved to be effective” (p. 320).

As a result, Pargament (2007) contends that spirituality integrated psychotherapies will transform the nature of psychotherapy. Rather than being a new form of treatment, he envisions it as one that integrates or weaves greater sensitivity and explicit attention to the spiritual dimension into the therapeutic process. Accordingly, spirituality can be interwoven into virtually any psychotherapeutic system, whether it is dynamic, cognitive-behavioral, existential-humanistic, or family systems. Rather, through this process of integration, the “character of each of these forms of psychotherapy will be deepened and enriched, and psychotherapy as a whole will be transformed” (Pargament, Murray-Swank, & Tarakeshwar, 2005, p. 161).

CONCLUDING NOTE

Psychotherapy is a rapidly changing field. The culture of accountability, the evidence-based treatment movement, and the competency movement will continue to require that psychotherapy practice be accountable, effective, and competent. Spiritually integrated psychotherapy is also evolving. It is no longer sufficient for clinicians to demonstrate some sensitivity to a client’s religious/spiritual issues while adapting a conventional psychotherapeutic approach. Increasingly, clinicians working with clients with spiritual/religious issues will be expected to attend to all five elements: clinical outcomes, evidence supported treatments, the therapeutic alliance, client factors, and therapist factors throughout all phases of the
therapeutic process from assessment and establishing a therapeutic alliance to termination.

This first chapter in Section II of this book serves as an introduction to Chapters 6 through 10. Each of these subsequent chapters will further elaborate the therapeutic processes and elements that have been introduced and briefly discussed here.

REFERENCES


SPIRITUALITY IN CLINICAL PRACTICE