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UNDERSTANDING THE NEEDS AND EXPERIENCES OF SPIRITUAL AND RELIGIOUS CLIENTS SEEKING MENTAL HEALTH COUNSELING

By Alexander Christiano

Currently, mental health clinicians lack training in spiritual and religious competence, while counseling psychology research does not give adequate attention to the spiritual and religious concerns of clients seeking mental health counseling. In order to improve the quality of mental healthcare, I argue for more research and training to better understand clients' spiritual and religious needs. I review existing approaches to mental healthcare that integrate spirituality and religion, then outline my own survey- and interview-based research. My study assesses clients' levels of religiosity and spirituality, discovers the role of spirituality and religion in their mental health, and finds out their experiences working with mental health clinicians. My data indicates that spiritual and religious interest often intersects with defining life events, such as traumatic experiences and existential crises, and that mental health clinicians should be better prepared to understand the role of spirituality and religion to support clients' psychological and spiritual health.

I. Introduction and research aims

My research aims to understand the distinct needs and experiences of spiritual and religious people seeking mental health counseling (commonly referred to as "therapy"). Furthermore, I seek to understand the concerns unique to spiritual and religious people as well as the way in which such concerns were addressed by mental health clinicians.[1] Spirituality and religion often serve as instrumental sources of well-being and resilience, but what remains unclear is where they fit into the domain of psychological counseling. Are they acceptable within the boundaries of the field, or better addressed in more spiritual and religious settings like churches and retreat centers? Although my study also builds off of trends in research and practice within mental healthcare to consider the integration of spirituality into counseling, more research like this is needed to contribute to the conversation by providing detail and insight into the role of spirituality in mental health and counseling. Following these questions and considerations, I derived the following research questions:

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1 By mental health clinicians I refer to Licensed Marriage and Family Therapists (MFTs), Clinical Social Workers (LCSWs), Professional Counselors (LPCs), and Psychologists (PhD or PsyD). I did not include psychiatrists, who are medical doctors and prescribe psychotropic medication, in the scope of my study.

1. What needs and concerns were unique to spiritual and religious people when seeking mental health counseling?
2. What were the experiences of clients who voiced spiritual and religious concerns and questions in mental health counseling?
3. How do spirituality and religion benefit clients' mental health and subjective sense of well-being?

II. Background information

Before introducing debates within the field of mental health counseling, I would like to provide a definition of spirituality from the most comprehensive book I found on the intersection between health and religion. Koenig, King, and Carson define spirituality as follows:

> Spirituality is distinguished from all other things—humanism, values, morals, and mental health—by its connection to that which is sacred, the transcendent. The transcendent is that which is outside of the self, and yet also within the self—and in Western traditions is called God, Allah, HaShem, or a Higher Power, and in Eastern traditions may be called Brahman, manifestations of Brahman, Buddha, Dao, or ultimate truth/reality. Spirituality is intimately connected to the supernatural, the mystical, and to organized religion, although also extends beyond organized religion (and begins before it). Spirituality includes both a search for the transcendent and the discovery of the transcendent and so involves traveling along the path that leads from non-consideration to questioning to either staunch nonbelief or belief, and if belief, then ultimately to devotion and finally, surrender.[2]

Under such a definition, spirituality's characteristic focus lies in its transcendent and immanent qualities–being that which paradoxically goes beyond the boundaries of the individual self yet dwells intimately within us. Although known by many names and understood in a variety of outward forms of expression, spirituality extends before and beyond the doctrinal focus of institutionalized religion, albeit with substantial room for spiritual and religious overlap. Finally, this definition emphasizes the human experience of feeling alienated or ignorant of the truth, leading to the spiritual search and the eventual discovery of the transcendent. Given the individually expressed and dynamic nature of spiritual life, Dudley argues that within mental health counseling, "a consensus on a specific definition of spirituality may be less important to provide to others than encouragement for them [clients] to define spirituality for themselves."[3] Thus, even considering a broader framework of spirituality as the transcendent and immanent, the emphasis for clinicians lies in understanding the worldview and particularities of each client.

Although this previous definition characterizes spirituality as beyond and above religion, this does not discredit or devalue religion as a form of shared culture and community related to the transcendent. The same source also defines religion as a "multidimensional construct that includes beliefs, behaviors, rituals, and ceremonies that may be held or practiced in private or public settings, but are in some way derived from established traditions that developed over time within a community."[4] As I will touch on later in my theoretical framework, clinicians may consider spirituality and religion under the framework of multiculturally competent mental health counseling. In the same way that Dudley encourages clinicians to understand their client's individual spiritual characteristics, culturally competent clinicians use a more macro lens to "tailor healthcare that is equitable and ethical after becoming aware of oneself and others in a diverse cultural encounter. Cultural competence occurs when one is sensitive and embraces openness, has a desire to want to know other cultures, and actively seeks

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2 Harold G. Koenig, "Religion, Spirituality, and Health: The Research and Clinical Implications," *International Scholarly Research Notices* 2012, no. 278730 (2012): 46, https://doi.org/10.5402/2012/278730.

3 James R. Dudley, *Spirituality Matters in Social Work: Connecting Spirituality, Religion, and Practice* (Routledge, 2016), 8.

4 Koenig, "Religion, Spirituality, and Health," 45.

cultural knowledge,"[5] which applies to religion—group beliefs and behaviors related to the transcendent. With an understanding of spirituality and religion as two intertwined ways of viewing the transcendent, I will frame the debate over spiritually and religiously integrated care within the field of mental health counseling.

Despite increasing acceptance of spiritual and religious concerns in counseling, there remains a need to more comprehensively integrate spiritual and religious concerns into practice. Historical attitudes towards religion and spirituality from foundational figures in psychology argue an explicitly anti-spiritual/religious viewpoint. In *Civilization and Its Discontents*, Freud fits the "oceanic feeling" of eternity described by his friend Romain Rollan into his supposedly scientific framework and language, failing to fully understand Rollan's genuinely transcendent subjective experience. To Freud, the oceanic feeling of spiritual union results from a child's feelings of helplessness following separation from its mother, with the "religious attitude" following directly from an "early stage in ego-feeling."[6] Although I would characterize Freud's understanding of religion through the framework of the psychoanalytic ego as outdated, this foundational tension between religion and psychology retains influence in contemporary times.

A 2012 survey of American Psychological Association (APA)–affiliated psychologists found a trend towards including spiritual and religious attitudes in graduate training, but some dissenters voiced their opinion as follows:

> There needs to be a very clear line drawn between religion/spirituality as a component of multicultural sensitivity and religion/spirituality as a conceptual foundation for clinical practice. Clinical/counseling psychology is not pastoral counseling or "Christian counseling." It is a scientific practice, separate from religious/spiritual values and doctrine.[7]

The impact of this attitude, even if it represents a minority opinion today, can lead trainee counselors to feel unsupported in nurturing their interest in spirituality and religion, which might impair their ability to work with clients with similar interests. Anthony Nicotera, a Jesuit social worker, found professors in his MSW training program dismissed his interest in spirituality as outside the domain of therapy, not based on evidence, and proselytizing. He considers the failure of mental health counseling to integrate spirituality "not only a pedagogical and professional failure but also an ethical failure. Our ethical obligation requires that we meet people as they are, where they are, as people with religious and spiritual lives and beliefs that affect their well-being."[8] Following this perspective, the practice of counseling must include spirituality and religion as foundational concepts to address those who view spiritual life and religious beliefs as integral to themselves and their humanity.

Proponents of spirituality and religion as foundational concepts in mental health practice argue that a complete picture of mental health requires the inclusion of such categories. The authors of *The Psychospiritual Clinician's Handbook*, which I will touch on later in my theoretical framework, note that the discipline of psychology historically focused on the treatment of mental illness, but has "largely forgotten how to help people fulfill themselves; lead happy productive lives; develop their innate areas of genius; and awaken the conversation with their consciousness and soul in a uniquely human way."[9] Without dismissing the advances made in the classification and prevention of mental illness, the presented spiritual perspectives highlight a debate over the boundaries of the field of mental health counseling. Should mental healthcare operate under a model of mental illness prevention and treatment, or expand itself to positive domains such as spiritual flourishing, contentment, and resilience? Even though rates of religious belief and practice are dropping in the United States, the Pew Research Center still estimates that 89% of Americans believe in God and 77% identify with a religion, while

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5 Saras Henderson et al., "Cultural Competence in Healthcare in the Community: A Concept Analysis," *Health & Social Care in the Community* 26, no. 4 (2018): 599, https://doi.org/10.1111/hsc.12556.

6 Sigmund Freud. *Civilization and Its Discontents*, trans. Joan Riviere (Dover Publications, 1930), 20–21.

7 Rachel E. Crook-Lyon et al., "Addressing Religious and Spiritual Diversity in Graduate Training and Multicultural Education for Professional Psychologists," *Psychology of Religion and Spirituality* 4, no. 3 (2012): 177, https://doi.org/10.1037/a0026403.

8 Anthony Nicotera, "A History of Spirituality, Religion, and Social Work," in *Spirituality In Mental Health Practice: A Narrative Casebook*, ed. Miriam Jaffe et al. (Taylor and Francis, 2020).

9 Sharon G. Mijares and Gurucharan Singh Khalsa, *The Psychospiritual Clinician's Handbook: Alternative Methods for Understanding and Treating Mental Disorders* (Haworth Reference Press, 2005), 2.

about 50% of Americans cite religion as very important, pray daily, and attend monthly religious service. The same report also found that 59% of the population say that they feel a deep sense of spiritual peace and well-being at least once a week.[10] Given the widespread presence of religious belief and the reported sense of subjective well-being attributed to spirituality, I would argue for a paradigm shift to address and work with the spiritual and religious concerns of clients under the umbrella of positive psychology in mental health counseling.

This academic conversation occurs in the background of growing awareness about mental health and psychological well-being as a hot topic in the past years. Recent initiatives attempt to address disparities in access to mental health treatment, ranging from state-level efforts to fund nearly $500 million in grants for youth mental healthcare in California[11] to global calls from the World Health Organization to include mental healthcare under the umbrella of universal health coverage initiatives. Currently, the WHO estimates that 80% of people in need of mental health treatment lack adequate access to affordable and quality care,[12] while Mental Health America reports 21% of the US population experiences a form of mental illness and 55% of adults with a mental illness lack proper treatment.[13] Despite advances in reducing stigma, increased research, and more governmental attention to funding care, the data indicates an urgent need to enhance the quality of mental healthcare that addresses all aspects of a client's experience. To achieve further progress in mental healthcare it is essential to tap into all aspects of well-being and health—especially spirituality and religious well-being.

III. Literature review

Before describing my study design and results, I will review existing research that has examined the relationship between mental health, religious involvement, and spirituality. Findings demonstrate that active involvement in religion provided better mental health outcomes than a more passive style of engagement in religion. Additionally, spirituality and religion were associated with overarching positive mental health outcomes with various explanatory mechanisms, such as lifestyle, coping strategies, and social support as possible explanations. Research into counseling training programs and clinical internship sites demonstrates a worrisome gap between clinician attitudes toward the integration of spirituality and religion into mental health practice and the actual implementation of such training.

A. Religion

Literature reviews and empirical studies demonstrate the ways in which religious involvement connects to psychological well-being and positive mental health outcomes. In one of the largest reviews of literature related to religiosity and mental health covering 850 studies, Moreria-Almedia, Neto, and Koenig concluded that higher levels of religious participation are associated with life satisfaction, happiness, and higher morale and less depression, suicidal ideation, and substance abuse. They found this impact most prominent for those facing life challenges, such as the disabled, elderly, and ill. This team of researchers identified seven mechanisms that might help explain these associations, citing healthy lifestyle behaviors, social support, a belief system to cope with life, spiritual practices (such as meditation or prayer), and cathartic rituals.[14]

On the other hand, some researchers' findings contradict these benefits and present a more neutral view of the benefits of religion. A review of 147 studies covering 98,975 participants found an insignificant association

10 Pew Research Center, "U.S. Public Becoming Less Religious," November 13, 2015, https://www.pewresearch.org/religion/2015/11/03/u-s-public-becoming-less-religious/.

11 Governor of California, "Governor Newsom Announces an Unprecedented $480.5 Million in Grants for Youth Mental Health," December 7, 2022, https://www.gov.ca.gov/2022/12/07/governor-newsom-announces-an-unprecedented-480-5-million-in-grants-for-youth-mental-health/.

12 World Health Organization, *The WHO Special Initiative for Mental Health (2019–2023): Universal Health Coverage for Mental Health*, 2019, https://iris.who.int/bitstream/handle/10665/310981/WHO-MSD-19.1-eng.pdf?sequence=1&isAllowed=y.

13 Mental Health America, *The State of Mental Health in America 2023*, 2022, https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf.

14 Alexander Moreira-Almeida et al., "Religiousness and Mental Health: A Review," *Brazilian Journal of Psychiatry* 28, no. 3 (2006), https://doi.org/10.1590/S1516-44462006005000006.

between greater religiousness and fewer depression symptoms.[15] In another study using longitudinal data based on health and mortality outcomes in Alameda County, researchers found only a slight relationship between organized religiosity and fewer depression symptoms.[16] These results both demonstrate that religious populations do not necessarily enjoy significantly greater mental health outcomes by the sole trait of being religious.

More recent evidence has clarified these mixed results and explained the potential of religion to provide greater mental health outcomes. Sternthal and others looked into varieties of religious practices and mental health outcomes across ethnicities and found that religious service participation for Hispanic Americans is associated with slightly worse mental health outcomes. The authors of this study attribute this finding to semi-involuntary religious participation in certain communities, meaning that failing to participate in religious norms may come with social sanctions and a loss of social reputation. The authors of this study point to Pargament's argument that intrinsic motivation for religiosity correlates with positive mental health outcomes, whereas semi-involuntary behavior to preserve social acceptance had the opposite effect.[17,18] Consequently, the requirement of active participation might explain the mixed data on the mental health benefits of religion, as a portion of people could identify and participate in religion without feeling a strong intrinsic interest in religion. This leads me directly into the next section of spirituality, which, owing to its more individually expressed and dynamic characteristic, offers more clear and tangible benefits than religious involvement alone.

B. Spirituality

Koenig, a leading researcher on health and spirituality from Duke University who contributed to the definition of spirituality I cited, combed through an estimated 75% of studies published up until 2010 on religion, spirituality, and health, finding that approximately 80% of those studies focused more specifically on mental health. He found overwhelming support for religion and spirituality as a helpful tool for coping with stressful events. To his point, 79% of reviewed studies found significant positive associations between religion and spirituality and well-being/happiness. Furthermore, of the studies on religion and spirituality and depression with the highest methodological rigor, 67% of them reported a significant relationship between spirituality and religion and fewer depression symptoms. To explain these findings Koenig turns towards three key mechanisms: a belief system and worldview to cope with difficult events and provide a sense of purpose; rules and doctrines promoting positive choices for health (such as discouraging crime, risky sexual behavior, or substance use); and promotion of compassion towards others, altruism, and communal support. Koenig also acknowledges religion's potential for hatred, prejudice, and rigid thinking, so it is important to take the results of these studies on balance and to consider the potential for religion to foster opposite outcomes described in the review.[19]

More specific studies also describe in finer detail the links between spirituality and mental health, which helps add more mechanisms for understanding the consensus that Koenig describes in his review. Bożek and collaborators focused on the role of spirituality as a connection an individual has with a higher power and purpose and studied the role of spirituality by administering a program of study related to the human mind and spirit, concluding that the spirituality course correlated with higher subjective reports of well-being.[20] In addition, spiritual practices link to measurable changes in positive emotion and brain activity, leading to more prosociality and altruism as well as subjective feelings of peace and well-being. Researchers have found that loving-kindness meditation, a practice associated with Buddhism, found a gradual increase in positive emotion, improvements in

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15 Timothy B. Smith et al., "Religiousness and Depression: Evidence for a Main Effect and the Moderating Influence of Stressful Life Events," *Psychological Bulletin* 129, no. 4 (2003), https://doi.org/10.1037/0033-2909.129.4.614.

16 William J. Strawbridge et al., "Religiosity Buffers Effects of Some Stressors on Depression but Exacerbates Others," *The Journals of Gerontology: Series B* 53B, no. 3 (1998), https://doi.org/10.1093/geronb/53B.3.S118.

17 Michelle J. Sternthal et al., "Religious Practices, Beliefs, and Mental Health: Variations Across Ethnicity," *Ethnicity & Health* 17, no. 1–2 (2012), https://doi.org/10.1080/13557858.2012.655264.

18 Kenneth I. Pargament, *The Psychology of Religion and Coping: Theory, Research, Practice* (Guilford Press, 1997).

19 Koenig, "Religion, Spirituality, and Health," 45.

20 Agnieszka Bożek et al., "The Relationship Between Spirituality, Health-Related Behavior, and Psychological Well-Being," *Frontiers in Psychology* 11 (2020), https://doi.org/10.3389/fpsyg.2020.01997.

life satisfaction, and reduced depression symptoms.[21] Individuals instructed in loving-kindness, concentration, and choiceless awareness meditation styles experienced a reduction in mind wandering and thinking while at rest beyond the same type of reduction associated with active tasking. A reduction in this mental activity can lead to extended periods of mental settledness, less self-centered mental patterns, and stress reduction.[22] Although these studies show how contemplative practice produces measurable and replicable results, it is important to understand the limits of their benefits. Koenig argues in another review that in times of mental health crisis and distress of certain severity, clinicians must be able to ascertain the limits of spiritual practice and turn towards other modalities designed for handling more severe symptoms, such as medication or crisis counseling.[23]

C. Religion, spirituality, and mental health practice

In line with the movement to establish culturally competent and sensitive mental health counseling, trends in research into the attitudes of mental health counselors find a consensus that most support the adoption of more religious competence and spiritual sensitivity training.[24] Whether among APA-affiliated psychologists, Marriage and Family Therapists (MFTs), or Licensed Professional Counselors (LPCs), a clear majority of respondents favored the integration and inclusion of spiritual and religious concerns into training programs and clinical practice. Surveyed psychologists viewed spirituality as essential to clients' worldviews and their relationships with others, a majority of MFTs believed in a link between spirituality and mental health, and counselors with a stronger interest in spirituality themselves were more likely to note an interest in spiritually integrated counseling.[25,26,27] Despite these attitudes, only about 50 of 1,914 articles and studies over a 13-year period of research in three major counseling psychology journals covered spiritual and religious issues in counseling psychology.[28] In training programs for LPCs, a review of 14 syllabi found substantial variation in "spiritual competence" training and suggested the implementation of a more standardized set of competencies.[29] Furthermore, a survey of 138 internship sites for psychologists found that approximately two-thirds of sites lack training in spirituality and religion, and never foresee such training being integrated into their programs.[30]

In order to remedy the gap between attitudes and reality, researchers often proposed religious competence and spiritual sensitivity training in graduate programs and at professional sites. LPCs from Young, Wiggins-Frame, and Cashwell's survey who felt unprepared for integrating issues of spirituality and religion requested additional training such as workshops and seminars to further understand spiritual and religious perspectives, increase self-awareness in counseling, and learn from case studies. In the following section I will provide a more in-depth section on the benefits of such training, but for now I will turn to Russel and Yardhouse's concern that a lack of such training forces trainees to address spiritual and religious concerns only in supervision—sessions

21 Barbara L. Fredrickson et al., "Open Hearts Build Lives: Positive Emotions, Induced Through Loving-Kindness Meditation, Build Consequential Personal Resources," *Journal of Personality and Social Psychology* 95, no. 5 (2008), https://doi.org/10.1037/a0013262.

22 Kathleen A. Garrison et al., "Meditation Leads to Reduced Default Mode Network Activity Beyond an Active Task," *Cognitive, Affective, & Behavioral Neuroscience* 15 (2015), https://doi.org/10.3758/s13415-015-0358-3.

23 Harold G. Koenig, "Spirituality and Mental Health." *International Journal of Applied Psychoanalytic Studies* 7 (2010), https://doi.org/10.1002/aps.239.

24 Henderson et al., "Cultural Competence."

25 Crook-Lyon et al., "Religious and Spiritual Diversity."

26 Thomas D. Carlson et al., "Religion, Spirituality, and Marriage and Family Therapy: A Study of Family Therapists' Beliefs About the Appropriateness of Addressing Religious and Spiritual Issues in Therapy," *The American Journal of Family Therapy* 30, no. 2 (2002), https://doi.org/10.1080/019261802753573867.

27 J. Scott Young et al., "Spirituality and Counselor Competence: A National Survey of American Counseling Association Members," *Journal of Counseling and Development* 85 (2007), https://doi.org/10.1002/j.1556-6678.2007.tb00443.x.

28 Lewis Z. Schlosser et al., "Why Does Counseling Psychology Exclude Religion? A Content Analysis and Methodological Critique," in *Handbook of Multicultural Counseling*, 3rd ed., ed. Joseph G. Ponterotto et al. (Sage Publishing, 2010).

29 Craig S. Cashwell and J. Scott Young, "Spirituality in Counselor Training: A Content Analysis of Syllabi From Introductory Spirituality Courses," *Counseling and Values* 48, no. 2 (2004), https://doi.org/10.1002/j.2161-007X.2004.tb00237.x.

30 Stephen R. Russell and Mark A. Yarhouse, "Training in Religion/Spirituality Within APA-Accredited Psychology Predoctoral Internships," *Professional Psychology: Research and Practice* 37, no. 4 (2006), https://doi.org/10.1037/0735-7028.37.4.430.

where trainees present cases, concerns, and questions to their supervising mental health clinician.[31] The adoption of a more formal method of training to take various spiritual and religious perspectives into account could enhance the ability of trainees to address spiritual and religious clients without over-relying on supervision, which would provide them with more experience and confidence prior to entering clinical practice. Even for clinicians who believe that psychology and spirituality are separate and incompatible disciplines in practice, I would argue that a baseline level of competency on spiritual sensitivity and religious backgrounds would be of benefit for all clinicians to be prepared to handle a wider range of clients without invalidating or misunderstanding the role of spirituality or religion.

IV. Theoretical framework

My theoretical framework relies on three existing theories of spirituality and religion in health, starting at the most macroscopic level and narrowing into a more specialized application through mental health counseling modalities. I start by explaining the inclusion of spirituality as a domain of health within healthcare practice in the clinician-client relationship. I then discuss existing theories in counseling of spirituality and religion under the umbrella of cultural competency and the concept of spiritual sensitivity, which builds off of cultural competence but offers a more individual way of understanding clients' spiritual lives. Lastly, I focus on psycho-spiritual modalities of counseling designed to go beyond a baseline level of competence, directly integrating spirituality with therapeutic modalities in mental health counseling.

A. Biopsychosocial-spiritual model

An expanded conception of health and clinical treatment was popularized by Engel (1977) when he argued against the biomedical model, an approach that explains disease as a purely biological issue or disorder without considering social or psychological elements of illness. Engel criticizes the use of this model as an exclusive paradigm for understanding disease by characterizing it as reductionist and lacking explanatory power as a theory of illness. In response, he proposed the biopsychosocial model as a more comprehensive way of understanding disease in the context of healthcare. For example, Engel points to the universal experience of grief, which occurs in response to a significant personal or social loss without any necessary neurobiological cause.[32] Anyone who has passed through the gates of grief will report upon some, if not all, of the range of intense physical and psychological symptoms, such as reduced concentration, emotional numbness, disrupted sleep, altered eating patterns, and low moods.[33] If a healthcare practitioner does not understand a patient's social and psychological determinants of health outside of biology, a client runs the risk of being misdiagnosed for sleep or diet-related illnesses.

Engel's argument that the biological sources of disease and treatment must be understood alongside the patient's unique psychological makeup and their broader social context and community went on to influence the biopsychosocially oriented clinical practice model, which emphasizes the empathic and open listening on behalf of the clinician as well as the emotional exchange that occurs in client interactions.[34] A review by Alvarez, Pagani, and Meucci of 32 full-length articles on the biopsychosocial model summarized it as "a new way to look at the clinician-patient relationship as well as to take into account the biologic, psychologic, and social dimensions within the individual,"[35] allowing health professionals to practice empathy and compassionate care by understanding multiple subjective elements of a client's experience.

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31 Russell and Yarhouse, "Training in Religion."

32 George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196, no. 4286 (1977), https://doi.org/10.1126/science.847460.

33 John W. James and Russell Friedman, *The Grief Recovery Handbook, 20th Anniversary Expanded Edition: The Action Program for Moving Beyond Death, Divorce, and Other Losses* (Harper Perennial, 2009), 13–14.

34 Francesc Borrell-Carrió et al., "The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry," *Annals of Family Medicine* 2, no. 6 (2004), https://doi.org/10.1370/afm.245.

35 Ana Sabela Álvarez et al., "The Clinical Application of the Biopsychosocial Model in Mental Health: a Research Critique," *American Journal of Physical Medicine & Rehabilitation* 91, no. 13 (2012): 177, https://doi.org/10.1097/phm.0b013e31823d54be.

However, there remains an underlying issue in the approach started by Engel and expanded by later researchers and clinicians. What about the *spiritual* dimension of a client's experience? The WHO's framework of health as laid out in their 1948 constitution defines health as physical, social, mental, *and* spiritual well-being, not as the absence of pathological conditions. Unfortunately, the spiritual domain receives dramatically less attention in research, leading researchers to argue for the biopsychosocial model's expansion to include spiritual concerns of clients.[36,37] The biopsychosocial-spiritual model establishes the human element of spirituality as a legitimate concern of healthcare and expands the boundary of health beyond biological, social, and psychological concerns. I find this especially pertinent to mental health counseling because of the link between active interest in spirituality and positive mental health outcomes. A biopsychosocial-spiritual view of health includes spiritual flourishing as a serious domain of human health, alongside biological illness, social determinants of health, and psychological disorders.

B. Spiritual sensitivity and religious competence

If the biopsychosocial-spiritual view of health establishes spirituality as a domain of health, healthcare clinicians must be willing and able to address spiritual and religious concerns in practice through training in spiritual sensitivity and religious competence. Already an important topic in healthcare, culturally competent care has the potential to produce higher client satisfaction and improved health outcomes.[38] Analogous to the developments of culturally competent care, I would propose that spiritually and religiously competent care deserves attention for all healthcare clinicians. Furthermore, mental and behavioral health clinicians deserve special attention to spiritual and religious concerns because of the association between mental health, spirituality, and religion.

Hage's review of research into spiritual and religious issues in counseling, therapy, and psychology programs argues that counselors with spiritual and religious incompetence risk stereotyping clients' belief systems. This can lead to an inability of a counselor to assess and understand the importance of spirituality and religion to their clients and implement psycho-spiritual intervention (prayer, meditation, etc.).[39] Such incompetence may lead to a clinician alienating spiritual and religious issues from their mental health practice and interventions, despite a client's true concerns. Religious competency and spiritual sensitivity come with the added benefit of multicultural awareness of a variety of spiritual and religious perspectives, which enables a clinician to assess their client's spiritual and religious needs without imposing a belief system or invalidating the critical role that spirituality and religion may play in a client's life. In comparison to religious leaders, clinicians must operate with self-awareness about their own ability to work with spiritual and religious concerns without imposing their own worldview onto a client when it differs from their own.

Hage suggests considering spiritual or religious concerns under the umbrella of multicultural education training, as spirituality and religion form a large part of individual and collective identity through belief systems, shared practices and rituals, and values. Such training could serve as a complement to the existing practice of supervision, where students can examine their potentially biased or prejudiced attitudes toward spirituality and religion. Hage also points to the potential development of spiritual-religious assessments to track a client's spiritual functioning throughout their time in mental health counseling, with domains of consideration such as, but not limited to, worldview, religious affiliation, orthodoxy, lifestyle, and spiritual identity. As I already mentioned in the literature review, there is not yet a universally adopted training curriculum among counseling programs. However, I will touch upon a more recent method in social work theory and practice that enables counselors to critically reflect on their own beliefs and competently engage with the religious and spiritual views of others.

Nicotera found graduate programs in social work, as well as historical attitudes of professionalism in

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36 Marcelo Saad et al., "Are We Ready for a True Biopsychosocial–Spiritual Model? The Many Meanings of 'Spiritual,'" *Medicines* 4, no. 4 (2017): 79, https://doi.org/10.3390/medicines4040079.

37 Daniel P. Sulmasy, "A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life," *The Gerontologist* 42, no. suppl_3 (2002), https://doi.org/10.1093/geront/42.suppl_3.24.

38 Henderson et al., "Cultural Competence."

39 S. M. Hage, "A Closer Look at the Role of Spirituality in Psychology Training Programs," *Professional Psychology: Research and Practice* 37, no. 3 (2006), https://doi.org/10.1037/0735-7028.37.3.303.

counseling, unsupportive to his interest in the spiritual concerns of clients. As a result, he proposed a theoretical framework called The Circle of Insight,[40] designed to allow clinicians to investigate and understand the beliefs of their clients as well as their own views and biases best clarified by the following quote:

> The Circle of Insight and spiritually sensitive social work practice require that practitioners: 1) ask the questions that hold open the possibility of surfacing spiritual conversations and sharing. Do not shy away from including spirituality in the initial assessment and as an ongoing discussion in treatment; 2) respect the client's spiritual place and autonomy. Use their language, their worldview, and their religious and cultural understanding of spirituality to guide and inform the discussion; and 3) engage in spiritual critical self reflection as a social worker, counselor, and human being. Be keenly aware of who you are as a spiritual person: what role spirituality plays in your life; how and when it informs your work; and how it differs from your client's spiritual beliefs and perspective.[41]

Nicotera's call for more spiritually engaged counseling invites clinicians to see their clients' worldview and spirituality in their entirety, reflect on their own perspectives and views (especially insofar as it differs from the client's), and act in practice by working directly with their clients' language and worldview. Unlike religious leaders or spiritual teachers, who might explicitly present their own views and beliefs for others to learn from, spiritually sensitive counseling respects the client's religious background and spiritual autonomy. Furthermore, a practicing counselor must be able to engage with beliefs that do not match up with their own, even when working with someone with more religiously conservative views or spiritually unique perspectives. Alluding ahead a bit, as an interviewer I was constantly confronted with worldviews and perspectives outside of my own, so I had to apply the Circle of Insight to my own research project.

C. Psychospiritual therapy and transpersonal psychology

The impact of subjective accounts of spiritual experience has long been of interest to influential figures early in psychology,[42] while contemporary spiritual teachers' writings continue to explore the capacity for spirituality to bring the human subject closer to the deepest possible contentment.[43,44,45] Psychospiritual modalities go beyond a baseline level of spiritual competence by combining the supportive space of counseling with spiritual modalities of healing. Various applications are demonstrated in *The Psychospiritual Clinician's Handbook*,[46] including the Sufi approach of understanding depression as a spiritual call for union with God or the practice of mindfulness and breath awareness for coping with OCD and anxiety disorder. In the popular Buddhist Psychology book *Thoughts Without a Thinker* (1995), Mark Epstein uses his experience as a long-term Buddhist meditator and a psychiatrist to build an argument for the complementary combination of meditation practice alongside psychotherapeutic counseling.[47] From this Buddhist-influenced perspective, meditative cultivation allows the practitioner to gradually peel back the layers of the chattering mind and fleeting emotional states to uncover deeper parts of the self to then address in counseling with a therapist.

Internal Family Systems Therapy (IFS) presents another psychospiritual modality of therapy that aims to integrate our human self's divided parts with the spiritual Self, the source of healthy leadership, self-integration, and wholeness. Richard C. Schwartz, the founder of IFS, describes the spiritual or transpersonal Self as the part of us that "encompasses curiosity, compassion, calm, confidence, courage, clarity, creativity, connectedness, and

40 Anthony Nicotera, "Teaching Note—Circle of Insight: A Paradigm and Pedagogy for Liberation Social Justice Social Work Education," *Journal of Social Work Education* 54, no. 2 (2018), https://doi.org/10.1080/10437797.2017.1350232.
41 Nicotera, "History of Spirituality."
42 William James, *The Varieties of Religious Experience* (Harvard University Press, 1985).
43 Rupert Spira, *You Are the Happiness You Seek: Uncovering the Awareness of Being* (New Harbinger Publications, 2022).
44 Monique M. Verrier, "A Psychospiritual Exploration of the Transpersonal Self as the Ground of Healing," *Religions* 12, no. 9 (2021): 725, https://doi.org/10.3390/rel12090725.
45 Eckhart Tolle, A New Earth: Awakening to Your Life's Purpose (Dutton, 2005).
46 Mijares and Khalsa, *The Psychospiritual Clinician's Handbook*.
47 Epstein, Mark. *Thoughts Without a Thinker: Psychotherapy from a Buddhist Perspective.* New York, NY: Basic Books, 1995.

kindness."[48] By nurturing a relationship with the spiritual Self and its inherently beneficial qualities, IFS therapists aim to uncover and heal our wounded human parts. Under the IFS framework, we exile parts of ourselves when we undergo psychological injury or trauma that is too painful to fully integrate or understand in the moment that it happens. These painful parts feel exploited, abandoned, damaged, and traumatized, which can impair the ability to feel and experience the qualities mentioned as a part of the spiritual Self. IFS also proposes two other parts that act in relation to our exiles. Manager parts try their best to protect the exile's wound from being exposed and through various strategies of locking up our exile from conscious attention. However, when the pain of an exiled part inevitably makes itself felt, firefighter parts engage in self-destructive behaviors of addiction and avoidance to cope with the aggravated exile's emotional firestorm.[49] In order to understand and work with these parts of the psyche, Schwartz pulls on the previously mentioned concept of the spiritual Self as the source of self-integration. Most importantly, the spiritual Self is essentially whole because it is not a fractured or wounded part.

In a similar vein of thought, practicing Bay Area therapist Monique Verrier builds off of the concept of the spiritual/transpersonal Self and expands upon its innate qualities of wholeness and potential for healing. She envisions a kind of psychospiritual therapy that "supports clients' recognition of the transpersonal, essential Self right now, and deepens that knowledge of Self into firm inner grounding, supporting what might otherwise be a challenging healing process by promoting innate safety and relaxing psychological ego defenses."[50] The implication here is that a connection with the transpersonal Self can diminish the psychological defenses propped up by manager and firefighter parts to foster a safe and inherently supportive ground from which our exiled parts may heal. Verrier insists that everyone has access to the transpersonal Self although it may be "veiled by the addition of psychological constructs and beliefs that seem to obscure this truth."[51] Unlike other visible or tangible parts of our personal self outlined by IFS, the transpersonal Self does not itself need healing or support—it is the supportive ground from which psychological healing occurs. Whether expressed as union with God, a meditative space, or a connection to the transpersonal Self, psychospiritual therapy aims to instill the client with a sense of wholeness behind their human wounds and psychological parts. It is from this spiritual foundation that, according to psychospiritual therapists, deep and transformative healing can take place.

V. Research methods

To further understand spiritual and religious client experiences seeking mental healthcare, I assess people's levels of religiosity, spirituality, and satisfaction with mental health counseling through 182 survey respondents and 14 interviews. My data helps me compare the experiences of highly religious or spiritual individuals with those who did not indicate strong interest in such domains, while also finding out how many people felt that their needs in seeking appropriately fitting and religiously or spiritually competent counseling were met. I also aim to shed light on the positive outcomes in counseling, such as stand-out counselors who validated clients with different backgrounds than their own, and also examine instances of incompetence as an example of what clients dislike in counseling. Survey data dovetails with interview data to reveal stunningly rich portraits and lived experiences of how religion and/or spirituality can play a deeply impactful role in navigating crisis, fostering well-being, and providing a sense of shared community, which may intersect with concerns that clients voice in mental health counseling.

A. Survey data

My survey, entitled *An Assessment on the Integration of Spirituality into Psychological Counseling,* assessed three domains: religiosity, spirituality, and satisfaction with mental health counseling. The goal of my survey was to find out how people's spiritual and religious backgrounds impacted outcomes in therapy, such as religious

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48 Schwartz, Richard C, and Martha Sweezy. *Internal Family Systems Therapy, Second Edition*. New York: Guilford Publications, 2019, 45.

49 Schwartz and Sweezy, *Internal Family Systems Therapy, Second Edition*, 31–35.

50 Verrier, "A Psychospiritual Exploration of the Transpersonal Self as the Ground of Healing," 1.

51 Verrier, "A Psychospiritual Exploration of the Transpersonal Self as the Ground of Healing," 1.

people's views on the religious competence of their clinicians or spiritual people's satisfaction with their clinician's spiritual sensitivity. Following this sectioned setup, I was able to compare differences, trends, and themes of the needs and outcomes of religious, spiritual but not religious, and nonreligious/agnostic individuals in mental health counseling. Questions were phrased with pre-set responses using Likert scales, which provided me with quantitative data to create pivot tables to compare religiosity or spirituality with outcomes and experiences in counseling.

I designed the religious section off of existing measures of religiosity in sociological and psychological models of assessment,[52] which narrowed me to religious dimensions of doctrinal adherence, religious exclusivity, external practice or community involvement, and personal identity with religion. The section on spirituality assessed spiritual identity, spiritual practice or prayer life, coping with stress and crisis, mystical experiences, transcendence and awe, connection to a higher power, peace, meaning, empathy, and respect for other religious beliefs. I came to these categories through the Spiritual Well-Being Questionnaire (SWBQ),[53] which de Jager Meezenbroek and others (2012) describe as the most promising spiritual assessment in the existing literature. If respondents had worked with a licensed mental health counselor they answered questions on overall satisfaction with their experience, with the additional categories of prevalence of religious belief in counseling, counselor spiritual sensitivity, and desire to discuss spirituality more often with a counselor. I also collected information on age, gender, ethnicity and race, and education level.

I recruited participants through my personal community, my social media profiles and blog, newsletters through the UC Berkeley Social Welfare Department and the Integrated Behavioral Health team at La Clinica de la Raza in Oakland, CA, the Greater Good Science Center Facebook page, and various classes and student organizations at UC Berkeley. I also asked people to snowball the survey to anyone they believed would be interested. I distributed the survey from November 2022 to March 2023, using a QR code and shareable link as well as creating a short blurb for email outreach. This led to a sample of 182 individuals, with 156 reporting experience with a licensed mental health clinician. The sample demographic for my survey mostly consists of highly educated individuals from the politically and socially liberal Bay Area. A vast majority (72%) of respondents had received an undergraduate degree or higher, with the remaining 28% having graduated high school. Additionally, 52% of my respondents were 18–24 years old, which likely results from my personal community and university network skewing heavily towards this age range. Lastly, 76% of my respondents identified as women, which follows recent data indicating that women are more likely than men to receive mental health treatment.[54]

B. Interview data

Open-ended interviews with guiding questions supplemented my survey with varied textures, lived experiences, and personal stories about the impact of spirituality and religion alongside anecdotes from experiences working with mental health clinicians. Through contact information provided in my survey, I interviewed 14 respondents, consisting of three men and 11 women, with representation of four spiritual but not religious, six Christians, and one Buddhist, Jew, Muslim, and Hindu. Eight of my 14 interviewees knew me from either a professional environment, my upbringing in a Christian church, or my personal community, but I believe that my proximity to these individuals provided a more comfortable environment for them to share their stories. Additionally, I found that younger individuals were more likely to respond to my email request to interview which meant half of my interviewees were 18–24 years old. I conducted interviews through Google Meet and used the built-in transcription feature, which I later edited for clarity and readability by removing speech tics and filler words.

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52 Pearce, Lisa D., George M. Hayward, and Jessica A. Pearlman. "Measuring Five Dimensions of Religiosity Across Adolescence." *Review of Religious Research* 59, no. 3 (2017): 367–393.

53 Gomez, Rapson, and John W Fisher. "Domains of Spiritual Well-Being and Development and Validation of the Spiritual Well-Being Questionnaire." *Personality and Individual Differences* 35, no. 8 (2003): 1975–1991.

54 Terlizzi, Emily P. and Benjamin Zablotsky. "Mental Health Treatment Among Adults: United States, 2019." *NCHS Data Brief*, no. 380 (2020): 1–8.

VI. Data analysis and findings

A. Overview of findings

In understanding the needs of spiritual and/or religious individuals seeking mental health counseling, I found it easiest to organize my results on a spectrum of interest in integrating spirituality and religion into mental health counseling. The spectrum is broken into three data points: (1) *Highly Interested*; where I focus on those who insisted on addressing spiritual and religious concerns with a counselor able to understand and validate the integral role of spirituality and religion, especially insofar as it pertains to their mental health and overall state of wellbeing (2) *Moderately Interested;* where I aim to understand those who describe an interest in spirituality or religion and were open to occasional discussion but did not find essential to their experience in counseling (3) *Less Interested;* where I demonstrate that for some clients spirituality and religion occupies a less significant role in life and therefore did not receive much attention in counseling. Figure 1 demonstrates this spectrum through the desire to further discuss spirituality in mental health counseling, while figure 2 demonstrates how not all respondents along this spectrum received satisfactory spiritual sensitivity in practice.

Starting with figure 1, only 28% of respondents indicated "strongly agree" or "agree" to discussing spirituality more in counseling, while "undecided" stood out as the most common response at 34%. Even when only analyzing spiritual but not religious respondents, "undecided" and "disagree" made up 68% of responses, indicating that most people did not have a pressing need to discuss spirituality further. Therefore, pressing spiritual concerns only pertain to a minority of respondents, which I will focus more on in the following section. Although different clients normally present a variety of concerns to their mental health clinician, with some less interested in spirituality, figure 2 demonstrates a worrying trend. For all respondents, "seldom" stands out as the highest category (36%) of how well respondents felt their clinician related to their spiritual well-being. For spiritual but not religious respondents, no single category stood out at higher than 35% ("seldom" again the highest), reinforcing the spectrum of mixed experiences across all respondents. These statistics indicate that some respondents interested in spirituality did not receive adequate spiritual sensitivity in mental health counseling, which means they might hesitate to discuss the role of spirituality in their lives. The following sections elucidate these initial findings by providing a more nuanced analysis of the experiences of respondents seeking spiritually sensitive and religiously competent mental health counseling.

B. Highly interested

In line with the benefits of spirituality summarized by Koenig,[55] a portion of my respondents viewed spirituality and religion as incredibly important sources of resilience and well-being, primarily through the mechanisms of an existential framework for making meaning, coping in response to traumatic events, and spiritual practices. On subjective measures of peace ("My spirituality provides me with inner peace and harmony in everyday life") and transcendence ("I feel an immense sense of transcendence and awe when contemplating spiritually"), 33% of my respondents indicated "a great deal" and "often," respectively. This indicates that about a third of my respondents were highly connected to spirituality for their subjective state of well-being, while some interviewees expressed a desire to nurture and cultivate such qualities by growing their spiritual life to tap into their spiritual potential. Accordingly, for a portion of people seeking mental health counseling, spiritual and religious concerns were of paramount concern in clients' search for a mental health clinician that would best meet their needs. Often, discussion of the most stressful and traumatic events in clients' lives overlapped with their initial interest in spirituality and religion, with the benefits instrumental to their long-term psychological recovery, healing, and thriving. However, not all clients felt that they were spiritually understood in counseling—my interview data supplements my survey data by revealing the range of experiences of clients, ranging from spiritual incompetence to standout examples of excellent spiritually sensitive counseling practice.

55 Koenig, "Religion, Spirituality, and Health," 45.

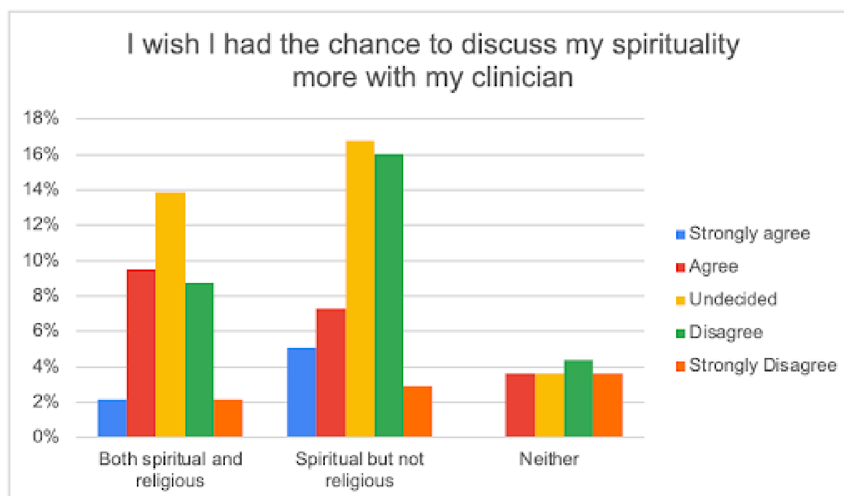

Figure 1. Percentage of survey respondents who did or did not want to further discuss spirituality in mental health counseling. Only respondents who answered the question in the title were included, resulting in 137 respondents.

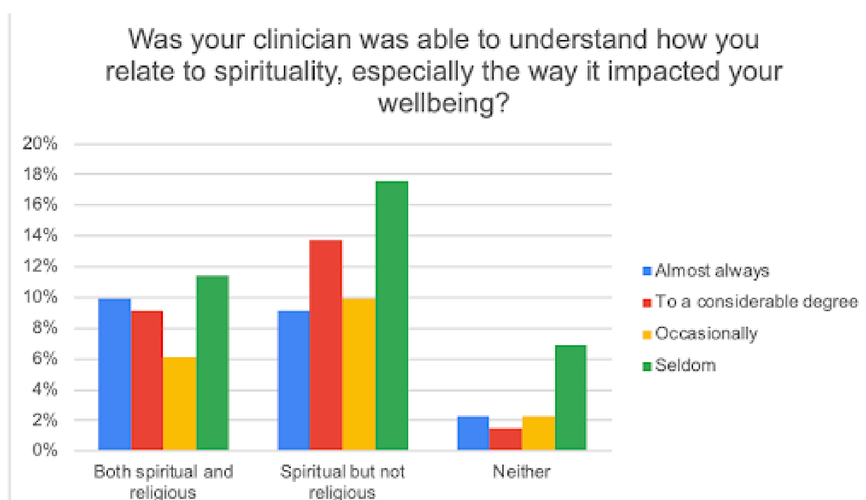

Figure 2. Percentage of survey respondents who felt or did not feel that they were spiritually understood in mental health counseling.

Figure 3 provides a more specific look into spiritual sensitivity in counseling practice by building off of figure 2, but includes a measure of spiritual practice as a way to understand client outcomes in the context of their own interest in spirituality.

From this finding, spiritual sensitivity ratings varied even among people with a strong interest in spiritual practice. For respondents who reported "a great deal" of strength and resilience in spiritual practice, 63% were spiritually understood "almost always" or "to a considerable degree." At the same time, 44% of respondents reporting "much" strength and resilience from spiritual practices were most likely to indicate that they "seldom" felt spiritually understood. Therefore, the range of satisfaction with spiritual sensitivity in figure 2 cannot be attributed to a lack of interest in spirituality on behalf of respondents, as those with a high interest in spiritual practice still varied in their satisfaction with spiritual sensitivity. To further understand these findings, I asked interviewees to tell me about the role of spirituality and religion in their lives and the experiences they had when trying to communicate their worldview, belief systems, and practices to their clinicians. My conversations confirmed my survey's exact findings, as respondents with a high interest in discussing spirituality and religion were occasionally met with prescriptiveness and misunderstanding, although I also found standout examples of excellent spiritually sensitive counseling.

One interviewee, who identified as Catholic and grew up in a religious community, described to me how she began a more serious interest in Catholicism in her 30s following a period of traumatic events that included a debilitating car crash, domestic violence from her former partner, and her son experiencing depression. She described the resiliency and support she found in her spiritual practice and relationship with God during the

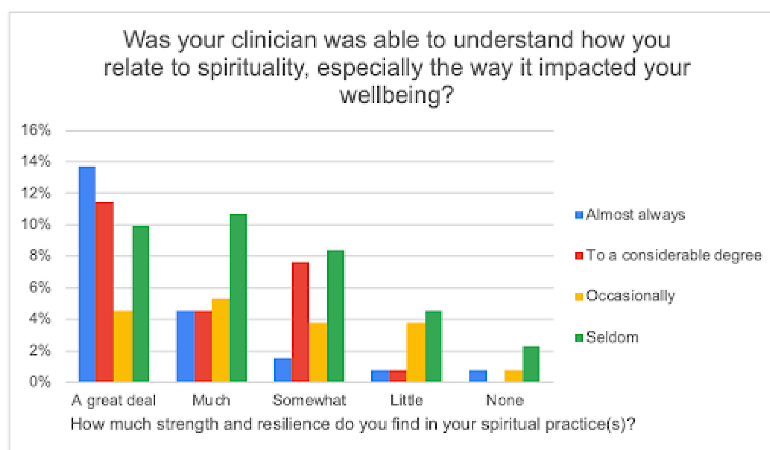

Figure 3. Percentage of survey respondents who felt or did not feel that they were spiritually understood in mental health counseling, based on the impact of spiritual practice. Only respondents who answered the question in the title were included, resulting in 131 respondents.

aftermath of those events as follows: "The only way I was able to be okay was when I had my rosary in my hands. I wasn't able to sleep, only with my rosary at nighttime. He [God] was the only one who was there for me." Following these events, this interviewee began working with a clinician who came across as "New Age" and slightly unsupportive of her practice of praying to God as a form of coping. Following repeated suggestions to consider yoga as a part of the healing process, my interviewee stated, "I don't think I need anything else because that's the way you do it but for yourself and you say it is good for you but it doesn't work for me." This comment mirrors the concerns of Nicotera, who calls for practicing mental health clinicians to respect their clients "spiritual autonomy" when engaging with their spiritual beliefs and practices.[56] Clearly, this interviewee felt that her clinician overstepped her role by making too strong of a suggestion. Closing out our conversation, this interviewee told me that she now works with a clinician who she finds much more supportive of her Christian spirituality and understands the role of her rosary practice and prayer life, which demonstrates the importance of working with a clinician who can work with a client's spiritual and religious worldview without coming across as prescriptive by revealing too many of their own opinions.

Another woman I interviewed, who identified as a Pentecostal Christian, developed an interest in Christian spirituality as a way to recover from substance abuse, a challenge that she partially attributed to growing up in a low-income area where many peers lacking social support struggled with similar issues. Although this interviewee did not have religious exposure in her upbringing, she described the impact of spirituality in her life with great praise:

> This spiritual chapter in my life is what has allowed for me to be set free in the sense of being able to break away from addiction. . . . In my spiritual practice what I believe is just nothing should have you bound like that, make you feel like you're trapped, like you can't get out.

With the introduction to a Pentecostal community, the development of a relationship of obedience to God, and prayer life as the turning points in her battle with addiction, this interviewee began to seek mental health counseling at the same time as exploring her newfound spiritual interest. However, in trying to share her view of freedom from addiction as a form of obedience to God, she found her clinician not fully supportive of this perspective because her clinician characterized her view of addiction as a form of self-condemnation. As a result, this interviewee resisted discussing Christianity in counseling and expressed her feelings:

> [There is] a little disconnect because I'm not feeling like I'm comfortably able to share really all the things that I could. They really just mix, all of me in one, but it is more like I have to pick and choose what area of me to work on [in therapy]. And then I found out that there is a Christian-based therapy. I was like, "What! How come no one ever told me this?"

56 Nicotera, "A History of Spirituality, Religion, and Social Work," 17–36.

In a similar point voiced by Hage, failing to fully understand the role of spirituality and religion risks alienating a client's true concerns and causing them to compartmentalize parts of themselves.[57] In this case where spiritual and religious interest overlaps with recovery from addiction, a highly sensitive and important topic in counseling, Hage's point stands out as even more relevant.

Unfortunately, I find these previous two examples unsurprising when put in context with the data from figure 3 and previously referenced evidence on the lack of training given to clinicians relating to spiritual sensitivity and religious competence. However, figure 3 also indicates that some respondents interested in spirituality did experience spiritually sensitive counseling. Rather than finding spiritual concerns met with prescriptiveness and misunderstanding, two of my interviewees developed a safe and understanding spiritual connection with their clinicians, who excellently exemplified spiritually integrated counseling. These cases modeled the framework provided by Nicotera's Circle of Insight and even included a psychospiritual element, where clinicians combined psychological counseling with an existential and spiritual perspective.[58] Although some of our conversations focused on shared spiritual and religious background, these two interviewees also emphasized the flexible and nonjudgemental quality of connection between the client and clinician as the most helpful aspect of their relationship.

The interviewee who identified as a Catholic—a woman now in the 45–54 age bracket—found herself struggling to navigate her relationship to religion and spirituality amidst an existential crisis upon leaving a more tight-knit and more conservatively religious hometown and entering college in her early twenties. Worried about her relationship to faith, she began working with a clinician with a Catholic background and active Jesuit practice who offered a supportive space to air out concerns and questions about faith without having to deal with any religious prescriptions or dogmatism:

> He definitely communicated that no matter what you won't lose yourself entirely. There's a way that you can really question and keep questioning and explore, and that doesn't mean that you are gonna lose yourself or your foundation, right? That was very much his very accepting space: go, just explore everything you need and this can be a safe container to do so. So there was no, "no we're not gonna talk about that." . . . I mean I really almost would just lose sight of the fact that he had that background and he was a practicing Jesuit.

Following her time in college and in mental health counseling, this interviewee found herself reinvigorated in faith and influenced by more progressive branches of the church that focused on social service, which she described as a "new template where I could still hold on to the pieces of my faith." This led to a career as a social worker and therapist, influenced by the spiritual values of seeing the fundamental good in others and the practice of social service. The accepting space to question and explore faith during a period of existential reckoning served as an essential stepping stone on her journey in the invigoration of Jesuit-influenced spirituality. From the Circle of Insight, a skilled clinician must understand and inquire into a client's spiritual concerns, but simultaneously understand the appropriate time to actively engage with and address such issues. Thankfully, the clinician she worked with offered the space to address existential questions while also offering a non-prescriptive reminder of the durability and foundational quality of faith.

Although the previous interviewee focused less on shared background, a Buddhist man in the 18–24 age range emphasized the importance of spiritual background, particularly in shared spiritual practice. This interviewee disclosed to me his motive for an interest in spirituality as follows: "Eventually I started to get kind of depressed because I felt like there was this dissonance between what I that longing for spirituality, knowing myself, and the culture I was in, which was very driven, very college prep kind of intense academics cerebral culture." Following a sort of spiritual longing, which mirrors the concept of a distinctly spiritual depression as described in *The Psychospiritual Clinician's Handbook*,[59] he experienced a profound shift in serenity and well-being as a result of

57 Hage, "A Closer Look at the Role of Spirituality in Psychology Training Programs," 303–310.
58 Nicotera, "Teaching Note—Circle of Insight," 384–391.
59 Mijares and Khalsa, *The Psychospiritual Clinician's Handbook*.

sustained involvement in meditation practice and silent retreat. Also, after developing an interest in Theravada Buddhism he also began working with a clinician with a very similar background:

> He [my therapist] is a very advanced [meditation] practitioner and that is huge for me because it's hard for me to imagine what therapy would be like with a therapist who does not have that [Buddhist] orientation because I just see it as so fundamental. It's such a fundamental level of the way I experience my mind and the way I relate to what's happening. . . . It's really nice to have the blend of the Dharma mindfulness angle with the really important relational stuff that comes up in therapy.

In comparison to the previous interviewee, this individual expressed an explicit interest in continuing to practice within a spiritual tradition, which might explain his focus on working with someone who directly shared his background. In this case, Theravada Buddhism and meditation function as a form of shared spiritual orientation by informing the way one views themselves and the world around them, but also operate as a mode of spiritual practice that gradually replaces a spiritual depression with a sense of spiritual wellbeing. The clinician in this quotation clearly has the ability to relate to the Buddhist background of this interview, and also often and successfully works with relational issues outside of the domain of Buddhism, reminding me of meditation combined therapy as described by Epstein (1995).[60]

Although the previous interviewees described a strong interest in exploring the beneficial aspects of their faith and spiritual life, I also must include that some individuals described a much more difficult and traumatic relationship to religion—especially in its more conservative forms. In particular, one woman in the 18–24 age range described her gradual disillusionment with her Evangelical church as members of her community exhibited abusive and unacceptable behavior in private despite the message preached. When I asked if she had considered addressing spiritual or religious concerns in counseling, she said:

> Now that I'm talking about it with you, I am realizing now that there's probably a lot more religious trauma that has impacted my healing process. . . . Religion is just not a big part of my life at all anymore, but I think it's kind of impossible to say that there isn't some form of religious trauma that's affected my healing when I've literally grown up with that [and] that's all I've ever known.

She also shared her desire to develop a spiritual life on her own terms alongside recovering from the adverse effects of a traumatic religious experience. For this type of client, it might be essential to not only find a clinician who understands the cultural context of the conservative versions of the client's religious background, but one who can also provide a form of psychospiritual therapy that integrates existential and spiritual concerns.

The examples of the two women who had poor outcomes because of their inability to feel spiritually understood serve as reminders of the impact of prescriptiveness and misunderstanding or stereotyping clients' views, while the latter two cases serve as models for working with clients experiencing existential or spiritual dissatisfaction as well as their ongoing commitment to a spiritual tradition. Finally, the last case demonstrates the dynamic and ongoing nature of spiritual and religious life, as well as the difficulties of working with spirituality following a turn away from religion. Moreover, all these interviewees' spiritual views and practices intersected with highly sensitive topics, such as traumatic events, addiction, or existential crises. In most of these cases, spirituality and religion intersected with these events and served as essential sources of recovery and resilience, which is why clinicians must take special care to treat these concerns with sensitivity and understanding when they are of such significance. Although I do believe that shared spiritual and religious background deserves attention as an important concern on behalf of the clients, the shared background must be supported and enhanced by the qualities of counseling with exploration, respect, and engagement. The same principles apply in cases where clients feel like they still would like to grow and develop their spiritual life.

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60 Epstein, *Thoughts Without a Thinker*.

Figure 4. Percentage of survey respondents who felt or did not feel the need to discuss spirituality more than they did with their clinician compared with the degree to which spirituality helps them find meaning in life. Both questions were answered by 137.

C. Moderately interested

For another subset of my respondents, spirituality and religion played a similarly important role by offering a framework for coping with stressful events as well as supportive practices but received less attention and focus in counseling than the previous group. However, interviews indicated that clients still appreciated the option and invitation to discuss spirituality and religion, when appropriate, while some focused more on developing an unspoken spiritual or religious connection with their clinician. As visible in figure 4, I asked respondents whether or not they wished to discuss spirituality more with their clinician, to which 21% answered "agree," 34% answered "undecided, and 29% of people answered "disagree." Unsurprisingly, 40% of respondents who found spirituality "not at all" helpful strongly disagreed on this question, whereas for the 42 respondents who would struggle to find meaning "to a great extent" without spirituality 26% agreed, 38% were "undecided," and 19% disagreed.

Interview data helped reveal a characteristic response of those undecided or neutral towards integrating spiritual concerns into counseling, which made up the largest category of survey responses. A typical response of the moderately interested client, replicated in a variety of interviews, indicated a preference to open up about such concerns if ever necessary, with the expectation that the clinician would offer a supportive and sensitive space to do so. As an 18–24 year old woman influenced by both Christianity and Buddhism explained:

> We would kind of like loosely discuss spiritiuality in my therapy sessions. My therapist would never be like "you need to rely on God to fix this or anything like that." . . . She knew that I'm not an atheist. . . . She was pretty understanding of that. . . . I don't know if it [spirituality] played a huge role in my therapy.

Despite this interviewee assigning limited importance of the discussion of her spirituality in counseling, she still made a point to comment the following: "My therapist was really welcoming and I trust her enough to know that if I ever wanted to dig more deeply into that [spirituality], she would be completely open to it." Her clinician provided an atmosphere of trust and openness, which enables her to address such concerns if they arise over time. As I already mentioned, some interviewees expressed a desire to nurture and grow their spiritual life after reflecting on the idea of spiritually integrated counseling.

This invites a conversation about the role of clinicians in exploring spirituality in their clients even if it isn't presented as an explicit or immediate concern in the earlier stages of a client and clinician's relationship. As one MFT voiced, "I am concerned about the effect of what we don't say as therapists. If we don't at least let clients know that we are willing to talk about their spiritual lives if they feel it would be helpful to therapy, then what we don't say is in effect telling them that it is not ok to talk about these things."[61] If a clinician can effectively explore a client's spiritual life while also explicitly mentioning their interest in ability in discussing such topics, I believe that clients will have a better sense of what they can share with their clinicians. Many interviewees told me that

61 Carlson, Kirkpatrick, Hecker, and Killmer, "Religion, Spirituality, and Marriage and Family Therapy," 168.

their clinicians modeled the previous MFT's point by actively asking questions about their spiritual practices, most frequently mindfulness and meditation, prayer, and dance. One interviewee, a Christian and Jewish woman in the 25–34 age range, described how her clinician asked about the role of spiritual practice:

> I just made this big kind of life decision. I was telling her [my clinician] that I've been praying about it for the last couple of months and she asked me. She's like, "You know, what does that look like for you? What is your prayer and meditation?" So she brings in curiosity about my process, and it's really nice to have somebody ask.

In this particular case, the clinician demonstrated their interest in the client's spiritual life and set the foundation for further discussion by providing a conversational invitation. This interviewee also told me that their conversations did not discuss spirituality much beyond the scope of the quotation I provided. By no means does this indicate that the interviewee lacked an interest in spirituality, as she attributed spirituality as an essential element of her journey to sobriety and well-being and attends Alcoholics Anonymous and church as outlets to explore spirituality. However, some spiritual and religious people do not have as pressing of a need to discuss spirituality or religion as frequently in counseling but still benefit from an atmosphere of support and understanding throughout their relationship with their clinician.

Some interviewees also expressed an interest in spirituality and religion in counseling, but more as a form of connection they felt with their clinician as a supportive force behind their conversations. In a perspective that confirms the benefits of culturally competent therapy as described by Henderson and collaborators,[62] an 18–24 year old woman with a Muslim background described her connection with a psychologist who shared her background:

> My therapist was raised in revolutionary Iran and we did have . . . conversations about her as well . . . She did know Islam. . . . Her cultural practices were somewhat similar to the ones I was raised with. I feel like since we had that baseline of understanding of like this is what I was raised with and this is what you were raised with. . . . I didn't have to explain that to her so I feel like that made therapy very much smooth [*sic*].

Although not identical to the way religion functions as a form of shared cultural practice, one interviewee, a spiritual but not religious woman in the 55–64 age range recovering from the loss of her adult son expressed a similar sentiment in more nondenominational spiritual terms:

> Our grief therapist . . . is just so spiritual in a non-denominational way and so compassionate. She is on a completely different level and she specializes in grief therapy because she's lost a lot of people in her life too. . . . I talked about kindness and vulnerability—that's what she was even though we were also that.

Someone else, a Christian woman in the 55–64 age range, reported the opposite experience, a meeting that lacked a shared spiritual connection:

> I wanted to do some EMDR[63] work . . . and there was something about the work—it could have been the Zoom factor, I don't know, it could have been me—but I just did not feel the connection. I did not feel the richness in terms of the encounter.

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62 Henderson, Horne, Hills, and Kendall. "Cultural Competence in Healthcare in the Community," 590–603.

63 Eye Movement Desensitization and Reprocessing (EMDR) is "a structured therapy that encourages the patient to briefly focus on the trauma memory while simultaneously experiencing bilateral stimulation (typically eye movements), which is associated with a reduction in the vividness and emotion associated with the trauma memories" (American Psychological Association 2017).

In these cases, the emphasis lies in the connection of values between the client and clinician, rather than the types of conversations or specific modalities taking place between them. Although religious competency fits under the existing framework of cultural competency between client and clinician, I would argue for the creation of a new category of spiritual compatibility as a factor to integrate into the client/clinician relationship. This connection may or may not extend into psychospiritual forms of therapy that directly address spiritual concerns and include spiritual practices, but in many cases operates underneath other concerns that a client may address, such as attachment issues, recovering from trauma, or cognitive behavioral therapy.

Another attitude demonstrates that for some a spiritual or religious connection to their clinician helped them feel bonded and comfortable on an individual spiritual or cultural religious level, even if spiritual or religious concerns were never voiced explicitly.

D. Less interested

For the last subset of respondents, spiritual and religious concerns played little to no concern in mental health or counseling. Interestingly, some people with quite active interests in spirituality voiced a preference for the separation of spirituality and psychology, as they viewed the space of psychological counseling as somewhat distinct from concerns they might address with a spiritual teacher or guide. A man in the 18–24 age range with a strong interest in contemplative traditions, specifically Advaita Vedānta[64], explained his view as follows:

> Contemplative beliefs [are] so far beyond your psychology, politics, or even religion. You shouldn't put them together because they're just different things. I think if you really want to dive into your psyche and get it figured out you're gonna have to take the chance of leaving your beliefs behind.

This view starkly contrasts with earlier interviewees who voiced discomfort with the compartmentalization of their spiritual and psychological sides in counseling. However, this quotation demonstrates that some spiritual clients might not feel the need to address or consider their spiritual life in counseling at all. In addition, some interviewees were indifferent towards spirituality and religion entirely. As one interviewee expressed, "I just believe in taking care of my family and friends and being nice, kind. But I don't really think I have any spiritual overarching guidance in my life to put it generally" (18- to 24-year-old man).

Under the biopsychosocial-spiritual model of human health, certain domains may stand out as more pressing concerns for clients in various healthcare settings. Although some interviewees expressed spiritually related feelings of depression, the previous interviewee primarily used mental health counseling as an outlet to work through panic attacks, which I would argue relate more to biological and psychological health. My survey data also indicated that interest in spirituality did not correlate with significantly higher satisfaction with outcomes in mental health counseling.

Of the total respondents in figure 5, 39% indicated "strongly agree" and 33% answered "agree" when asked if they felt their mental health improved through counseling. Also, 48% of respondents with a "a great deal" of connection to a higher power and 51% with "somewhat" of a connection also indicated "strongly agree" to the mental health outcome question. Even among the 16 people who indicated they "never" felt connected to a higher power, only 38% indicated anything aside from "strongly agree" or "agree" to mental health improvement through counseling. My data indicates that spirituality does not serve as a strong indicator of satisfaction with mental health outcomes, unsurprisingly given the biopsychosocial-spiritual model's ability to see health needs as multifaceted.

64 Advaita Vedānta refers to the classical school of Indian philosophy which teaches that the nature of one's own self is identical to *brahman*—nondual, and pure consciousness. The school's primary exponent, *Śaṅkara*, taught such a metaphysical view alongside means of practice and self-knowledge to recognize one's own eternal and infinite nature of brahman (Dalal 2021).

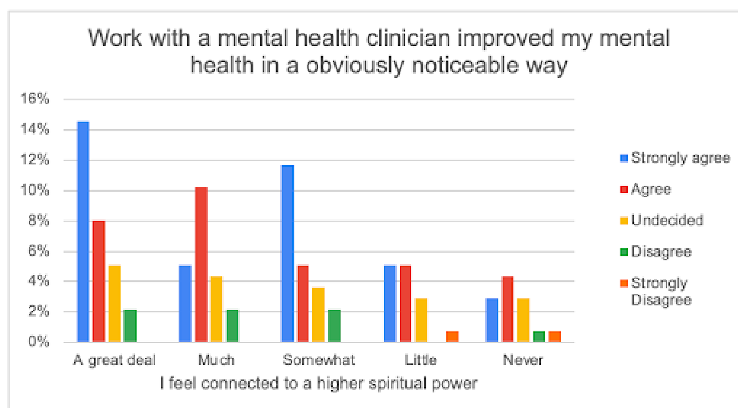

Figure 5. Percentage of survey respondents who did or did not agree that counseling improved their mental health, compared with the degree to which they feel connected to a higher power. Both questions were answered by 137 respondents.

VII. Conclusions and limitations

Through compelling personal narratives and survey data, backed up by extensive existing research, I have argued spirituality and religion can impact lives in a transformational way by alleviating existential crises, providing support through grief, addiction, and other traumatic events, and supporting well-being and resilience through worldview and spiritual practices. Furthermore, I believe that these benefits of spirituality deserve more attention in research, especially in mental health counseling theory and practice because of spirituality and religion's capacity to contribute to the process of healing from trauma and making existential meaning in life. For many of the respondents that I intentionally focused on, spirituality and religion were essential for navigating through their biggest challenges, but also provided long-term well-being and resilience. Although certainly not a panacea and best combined with biopsychosocial approaches, spirituality and religion occupy an essential role for a portion of clients seeking mental healthcare, making it difficult to consider and discuss their well-being and mental health without giving serious attention to the role and benefits of spirituality and religion.

Furthermore, my data indicates that the journey toward integrating spirituality and religion into mental healthcare is far from complete. Especially for those with a very strong interest in such matters, I believe that the mixed spectrum of experiences points to a general lack of standardized competence and sensitivity towards spiritual and religious concerns. This is not to say that all clients or clinicians ought to focus on such concerns—especially given varied personal preferences and backgrounds—but that the overall standard of competence may be raised in order to better meet the collective needs of clients seeking mental healthcare. As my interviews demonstrated, clients might desire to address spirituality later in counseling after working through more urgent and traumatic issues. To me, this indicates that in the best scenario clinicians welcome a spiritual conversation when appropriate for each client.

In the most macroscopic sense, I also would strongly suggest for our collective conception of health to consider the spiritual domain, one in which we can either thrive or struggle existentially. In my literature review, I highlighted how spirituality and religion appeared infrequently in journals on counseling psychology, which points to a cultural deficit in conversations about spiritual health. More attention in research and practice towards spirituality and religion can validate spiritual crises as a genuine health concern, while also assessing the benefits I have thoroughly covered. Furthermore, if more mental health clinicians explicitly acknowledge their capacity to offer conversations on spirituality or religion, I believe that this might offset clients' hesitancy to discuss such topics. As one interviewee expressed, "I think a part of me is almost scared to tap into that [spirituality] within myself and really explore that with myself because it's just, extremely overwhelming." This opens up a broader conversation about the limits of mental health counseling in its scope and intent. Clinicians may struggle to make room for more positive approaches like building resiliency, making meaning, and thriving alongside treating and coping with more acute conditions such as depression and anxiety. However, in the spirit of the "both-and" principle, I would argue that both symptom treatment and resilience and positive well-being development can coexist as two goals in counseling.

Lastly, in terms of concrete steps and tangible change, I would first encourage clients to consider the needs and concerns they have in seeking mental health counseling. Also, they can explicitly ask their potential clinician how they feel about spirituality and if they are comfortable addressing such concerns. Of course, not everyone seeking mental health treatment has the privilege and flexibility to seek out a specific and personalized clinician through private practice. In order to address spiritual and religious concerns in more accessible settings, such as community mental health clinics, I would encourage the adoption of spiritual and religious assessment in intakes or screening tools, increased training and visibility in graduate programs, internships, and continuing education, and the application of more psychospiritual modalities of therapy when appropriate.

A. Limitations

Given the limitations of undergraduate research, there are a number of areas I would like to improve on in future research. First off, my demographic generally leaned toward a more Christian background, as many spiritual but not religious interviewees were also Christian in their upbringing. Also, I would recruit more men, especially of an older age group. Every man that I interviewed was in the 18–24 age range, so I would like to hear the stories of men with more lifelong faith associations or spiritual journeys. It was particularly difficult to recruit older respondents for interviews because I used an online survey, email, and Google Meet as my recruitment tools. I would like to interview more older individuals by searching for interviewees through in-person groups, like meditation meetings, Alcoholics Anonymous, or spiritual talks or events. Also, I would aim to find a more representative sample of the overall US population, which is not represented by the highly educated and overwhelmingly liberal Bay Area.

Also, given my survey's title of "An Assessment on the Integration of Spirituality into Psychological Counseling" as well as the method of snowball sampling, it is quite possible that my data sample represented a more spiritually active and interested portion of the population than is reflected in reality. People more inclined towards spirituality might have been more interested in those who identify as agnostic or atheist and lacked spiritual interest, and the latter category might have avoided the survey altogether thinking it was not designed for them (although I clearly listed that anyone can take the survey in its description). Also, I asked people to share the survey in their own networks with anyone interested, but it might have been snowballed only to people who were known by the original survey recipient to have a pre-existing interest in spirituality.

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