

## Issues of Spirituality and Religion in Psychotherapy Supervision

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**Abstract:** *Objective:* We note gaps between the basic science of psychotherapy and the spiritual dimensions of religious life; between the beliefs and practices of patients and those of therapists; and between evidence for the influence of spirituality on health and the lack of its integration into psychotherapeutic training. We attempt to provide a framework to bridge this gap in supervision. *Method:* We reviewed the literature on the roles of spirituality and religion in mental health and illness; on the place of religion in psychotherapy; and on the pedagogy of spirituality. *Results:* Issues requiring attention include definitions of terms; awareness of personal beliefs; consideration of the boundaries between religiosity and pathology; and distinction between religious structures and personal beliefs. A format for addressing these issues in supervision includes: assisting the trainee with self-awareness; providing tools for spiritual assessment of the patient; providing developmental schema for spirituality; and maintaining awareness of the intersubjectivity of the patient-therapist field and the trainee-supervisor field. *Conclusions:* Existing literature provides usable frameworks for integrating religion and spirituality into psychotherapy supervision. We offer suggestions on how this may be accomplished.

### Introduction: Context

Contemporary psychotherapy has several problems dealing with religion and spirituality. From the outset, therapists as a group differ from their patients in the weight and significance of spiritual matters in their own lives. For example, when given the statement, “My whole approach to life is based on my religion,” the percent agreeing among respective groups in the United States was elicited (1). In contrast to the general public, 72% of whom endorsed this statement, rates among mental health professionals were far more modest: Psychiatrists, 39%; Clinical psychologists, 33%; Clinical social workers, 46%; Marital and family therapists, 62%; All mental health professionals, 46%. Israeli psychotherapists differ at least as much from the general population as do their U.S. counterparts, endorsing significantly lower levels of religiosity than their potential patients (2).

Further, much of traditional psychotherapy springs from a history of antagonism toward religion. Sigmund Freud, in “The Future of an Illusion,” dismissed all religion as “comparable to a childhood neurosis,” and expanded:

Our knowledge of the historical worth of certain religious doctrines increases our respect for them, but

does not invalidate our proposal that they should cease to be put forward as the reasons for the precepts of civilization. On the contrary! Those historical residues have helped us to view religious teachings, as it were, as neurotic relics, and we may now argue that the time has probably come, as it does in an analytic treatment, for replacing the effects of repression by the results of the rational operation of the intellect (3).

While Freud’s views on this, as on many other topics, no longer carry their original weight, there remains a significant current of negative views of spiritual beliefs and religious practices among practicing psychotherapists. Fundamentally, authors and teachers of psychotherapy are invested in defining the field as scientific and the endeavor as a clinical procedure. These views bear particular relevance for psychiatrists, whose field remains under skeptical assessment from fellow physicians and the general public (4, 5).

Psychoanalyst Gerald Epstein epitomizes those who have abandoned any effort at integration because he believes that, fundamentally, spirituality and psychotherapy are irreconcilably antithetical. In his view, the basic tenets are so far apart that they cannot be mixed; the language of one field cannot be used to define the other (6).

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## Reasons to Make the Effort

But the majority of those who analyze the problem see a need to arrive at integration for several reasons:

1. A significant body of evidence now links religiosity and spiritual life to mental health. Positive spiritual beliefs and religiosity have been correlated with longevity (7), diminished levels of stress (8), healthier blood pressure and other dimensions of physical health (9), as well as lower risks for suicide and drug abuse (10). Setting aside the nature of the complex causal chains, the associations are undeniable.
2. Patients want and expect that their spiritual lives be addressed (11). For many, religious beliefs and identities are core parts of the core “self,” providing fundamental schemas that structure meaning in life. To develop an integrated Self in psychotherapy would require that these schemas be included. Psychotherapy is an intimate experience, aimed ideally not just at symptom remission but at introspection and personal growth. Spiritual assessment can improve the treatment alliance (12).
3. The patient’s religious community can serve as a resource to augment therapy. The patient is better able to make use of such resources, such as pastoral counseling or support groups, if he/she is able to believe they are accepted by the therapist as part of his/her recovery (13).
4. Religious, spiritual or existential elements are not uncommonly part of the presenting clinical situation (14). On the one hand, pathological religious preoccupations may be a symptom of a mental disorder. Alternatively, a patient with a life-threatening illness may suffer from existential anxiety (12). The DSM-IV includes “Religious or Spiritual Problem” (V62.89) as an acknowledged potential focus of therapeutic activity (15).
5. Religious beliefs may constitute a resistance to committing to psychotherapy (14). The presumed secular nature of psychotherapy, or anticipated values of unrestrained behavioral freedoms, may run contrary to beliefs the patient brings to the treatment (5, 16).

The supervisor who reaches the conclusion that

his/her trainees should get some grounding in assessment of patients’ spirituality and integration of religious and spiritual beliefs into therapy will find little guidance in the literature on how to reach this end. A Medline search for the terms (*religion or spirituality*) *and* (*supervision or training*) *and* (*psychotherapy*) for the years 1990 through 2006 resulted in only 62 citations; of these just five actually described or reported elements of religion and spirituality in psychotherapy supervision, and only two were in the context of psychiatric training. At the same time, a large body of literature exists on the place of spirituality in psychotherapy, and a substantial compendium on teaching spirituality in other settings. Reviewing trends from both realms can provide a framework for addressing our challenge.

## Educational Objectives

Like most other educators, we have found that training curricula are most successful when they start with an identification of objectives (17, 18). From the introductory analysis above, it makes sense to identify the following basic knowledge and skill objectives for the integration of religion and spirituality into psychotherapy supervision. At a minimum, the trainee should be able to define, describe and/or demonstrate:

1. A clear definition of terms, particularly “religion” and “spirituality.”
2. A usable outline for the investigation of these issues in his/her patients.
3. A framework of spiritual development comparable to the more familiar cognitive and psychosocial schemata.
4. Distinctions between religious beliefs and behaviors and psychopathological ones.
5. Self-awareness about religious and spiritual issues, including elements of personal history and countertransference.

## Proposals

*Definitions of terms* — Trainees generally do not begin with clear distinctions among the concepts of spirituality, religiosity, religious belief and religious

practice. An initial confusion of terms makes comprehension difficult (19). Many experts have previously crafted useful definitions (4, 14). While supervisor and trainee may wish to research and create their own, the authors offer these summaries from the cited sources:

- **Spirituality**, at its broadest, is a person's attempt to make sense of his/her world beyond the tangible and temporal. It strives to connect the individual with the transcendent and transpersonal elements of human existence. It may, but need not, include religion.
- **Religion** is an organized system of beliefs, practices and rituals. Usually, it is shared with others, but each individual creates his/her own version.
- **Religiosity** and **faith** are descriptions of the extent and depth to which a person holds the beliefs of his/her religion.
- **Religious behavior** is the action one takes in the conduct of religion, including such elements as prayer and other observance.

*Outline for investigation* — Trainees who have no reticence about inquiry into a patient's sexual history and practice may become paralyzed at the prospect of investigating the same patient's religious life. One of the skills that can be conveyed in supervision is a framework for spiritual assessment. Such a structure can override the anxiety born of the trainee's uncertainty. A number of such tools have been described (5, 20), but the fundamental issue is opening the window for investigation into the patient's beliefs and practices (14, 21). Most schemas include the basic elements outlined by Koenig and Pritchett (22):

- a. Faith: How important is religion or spirituality in the patient's life? This inquiry may lead to further investigation about specific beliefs and practices.
- b. Influence: What role has faith played in the patient's life, now and in the past? This question may unveil particular spiritual experiences, and can frame the way therapist and patient describe the psychiatric disturbance.
- c. Community: What is the social or structural context of the patient's beliefs? Awareness of a religious support network gives the therapeutic pair a tool for recovery.

- d. Address: How does the patient want to have these issues addressed in the therapy? Knowing the patient's limits and boundaries, as well as his/her hopes and expectations, lets the therapist fit further inquiry and intervention into a shared frame.

The supervisor should advise the trainee that some clinical circumstances may point toward the importance of spiritual issues even if they are not raised by the patient, and should arouse the therapist's curiosity. These include:

- a. Spiritual manifestations of a psychiatric disorder, such as religious delusions or compulsive pursuit of religious ritual.
- b. Religious factors influencing the clinical problem, such as prohibition of a potential abortion, or the opposition of clergy to psychiatric treatment.
- c. Existential issues, particularly over loss, death or suffering.
- d. Guilt about perceived moral failings, as a patient may identify his/her illness as a deserved punishment.
- e. Protective function of religion or spirituality, allowing and even encouraging the patient to use resources of personal faith and religious community to augment therapeutic recovery (12).

When spiritual issues are identified, the therapist can use a format such as that of Josephson and Wiesner (12) to clarify. Again, the use of such a framework makes the ambiguous task of investigating faith more tangible, and the act of asking these questions opens a deeper therapeutic conversation:

- a. Developmental history: What was the patient's religious upbringing and education? What role did faith play in the family of origin and at times of crisis or life transitions?
- b. Community: What is the community environment of the patient's beliefs? Who are the important individuals and what are the structures?
- c. Does the patient believe in a higher power? How does he/she describe that deity? What does the patient strongly believe? What does he/she most doubt?

- d. Ritual and practice: In what specific religious activities does the patient engage? What value or detriment do they provide?
- e. Spiritual experience: Whether within or aside from organized religious practice, what spiritual experiences, if any, has the patient undergone? How does he/she understand them?
- f. Psychopathology: How does the patient understand the meaning of his/her psychological distress? What, if anything, is its spiritual context (5)?

*Developmental framework* — From medical school, and from classroom education in psychology, social work and related disciplines, trainees are generally much more familiar with psychosocial and cognitive schemata of development than they are with comparable outlines of spiritual growth. Residents may benefit from understanding the diversity of ways in which people understand spiritual and religious concepts. Over the years numerous meta-psychologists, including Assigioli (23), Frankl (24), Jung (25, 26) and Maslow (27), among many others, have offered perspectives that include spiritual and religious dimensions in their understanding of the psyche and in the conduct of psychotherapy. Yalom's concerns in existential psychotherapy, touching on themes such as meaninglessness, alienation, despair, and fear of death, similarly deal with issues usually subsumed under spiritual concerns (28). Following on life-span development models of Erik Erikson (29), Jean Piaget (30), and on Lawrence Kohlberg's (31) writings on the stages of moral development, among others, perhaps the most well known perspective on the development of "Stages of Faith" stems from the work of James Fowler, whose work in theological ethics and applied theology at the Harvard Divinity School led to his formulations accounting for people's life-long development of faith. According to Fowler (32), regardless of where one finds them, or from what religious context they emerge, the "Stages of Faith" are reasonably consistent and uniform. Because they are highly representative of such developmental theories, we present Fowler's six stages in summary for those who may not be familiar with these works:

- a. Stage one, "Intuitive-Projective faith," usually occurs between the ages of three and seven, and is characterized by the psyche's unprotected exposure to the unconscious, imagination sans logic. The child's imagination can be "possessed" by enforced taboos and indoctrination.
- b. Stage two, "Mythic-Literal faith," sees the early integration of one-dimensional symbols and ritual, permitting only literal interpretations of myth and symbol. Found mostly in school children (although one can maintain this state for life), linear thinking becomes normative. Individuals strongly believe in the justice and reciprocity of the universe and that cosmic powers are almost always anthropomorphic.
- c. Stage three, "Synthetic-Conventional faith," found in the majority of the population, usually begins in adolescence and serves to secure a complex pattern of socialization and integration in which faith inseparably helps to order one's world. This stage is characterized by conformity, where one's identity aligns with a certain perspective, and the individual does little to reflect critically on these views. This ideology often leads to perceiving those who differ in opinion as "the Other," as different "kinds" of people. Certain situations, such as contradictions between religious authorities, revelations of authoritarian hypocrisy, and lived experiences that contradict one's religious convictions may foster feelings of despair, or may lead some to the next stage.
- d. Stage four, "Individuative-Reflective faith," characterized by angst and struggle, requiring one to face difficult questions regarding identity and belief — a "dark night of the soul" in some instances — can begin as early as age 17, but is usually a phase of early adulthood. Here the individual gradually detaches from the defining group from which he/she formerly drew his/her identity and becomes aware of him/herself as an individual, having to take personal responsibility for his/her beliefs and feelings. In this de-mythologizing stage, what was previously unquestioned is now carefully scrutinized and examined. Many individuals start to sense the world as far more complex than their previous perspectives allowed, and may start seeing it as probably still more



complex and numinous than simple agnostic rationality.

- e. Stage five, "Conjunctive faith" moves beyond the rationalism of stage four to acknowledging paradox and transcendence. Here, we see "regression in the service of transcendence" (33). Individuals begin to grasp a sense of reality behind the symbols of his or her inherited systems, and are also drawn to and acknowledge the symbols of other's systems, and experience mystery and the unconscious, fascinated by the power behind the metaphors while simultaneously acknowledging their relativity. Whereas in stage four the world was demythologized, in stage five it's "re-sacrilized," brimming with vision and a sense of "the bigger picture" and inclusivity that erodes the walls built between ourselves and others by culture and tradition.
- f. Stage six, "Universalizing faith" involves dissolution of any lingering apprehensions and becoming an activist for the unitive vision, universalizing compassion and living self-less lives, seemingly achieving the ultimate aims of transpersonal psychology or the very higher stages of "enlightenment." Here are the Dalai Lamas, Mahatma Gandhis and Mother Teresas of the world, whose surpassing moral and religious actuality give their actions and words an extraordinary and often forceful quality.

Fowler's scaffold, though widely known, is hardly the last word on the topic. Others have elaborated differently. Streib (34), for one, goes beyond the narrow cognitive dimensions of Fowler to delineate a typology of religious styles influenced by the life history of the individual.

Rizzuto (35), coming from a psychoanalytic perspective, integrates spiritual development with notions of defensive operations and object relations that are familiar to therapists in training. She starts with the most basic notions common to all psychoanalytic theories:

- The psyche exists in a dynamic process, aiming to accommodate internal wishes or needs and those of the social environment.
- Defenses function to make emotional life viable.

- Cognition attempts to organize experience into the comprehensible.

Following on Fowler, Rizzuto maintains that faith is an active process, an essential form of relatedness, beginning in Eriksonian basic trust. Upon it, psychic life and love are founded. Religious faith is one particular and powerful manifestation of it. Faith development requires the presence of human beings and a social fabric of beliefs and symbols. The psychoanalytic perspective emphasizes the personal perception of the real elements of the environment. The accumulation of experiences in the object world forms the thread of a personal narrative. In turn, events, both positive and negative, are interpreted in light of this narrative and further shape it. Hers is but one example of how the familiar schemata of ego psychology, object relations and self psychology can encompass, and be enriched by, a view that includes spiritual development.

In an exhaustive review and analysis of the psychology of religion and coping, Pargament (36) describes instances where under stress religion and coping converge, where religious or spiritual beliefs appear to provide orienting systems that help distressed individuals navigate various crises. These beliefs may foster avoidance, provide comforting explanations and help conserve significance, provide rituals that aid tension reduction, help reframe events in acceptable and comforting ways, provide transcendent perspectives that may take an individual's preoccupations away from a small "self." However, some forms of religious coping adopted under conditions of extreme stress may ultimately prove maladaptive. Conversely, for some individuals, under extreme stress, spirituality-religion and coping may diverge, and individuals may lose their faith.

In an application of attachment theory, several authors have postulated parallels between the nature of an individual's attachment style to parents (e.g., secure/insecure, or secure/avoidant/anxious-ambivalent), and his/her attachment to religion or to God (37, 38). The clinical implication is that trainees must attend to each individual's separate conception of spirituality and religion, and the role that his/her beliefs play in the origins and maintenance of the psychopathological problems he/she brings to psychotherapy, a "microreligious" assessment. Ques-

tions that broadly ask about the patient's beliefs regarding the "big picture," meaning systems, ultimate explanations, and how his/her difficulties may be tied into those beliefs, such as those enumerated above, may tap into the spiritual dimension.

*Religiosity and pathology* — While DSM-IV guidelines are fairly specific and objective about signs and symptoms of particular mental disorders, the evaluation of religious ideas and behaviors is much more confusing. A behavior that constitutes culturally normative conduct for one person may be a compulsive ritual for another. Observant Muslims pray at regular and frequent intervals daily; Orthodox Jews pay meticulous attention to diet; religious Catholics count the rosary. It is a challenge to determine what behaviors and attitudes fall outside the bounds of the normative within a religious community (5, 11). Furthermore, individual and micro-cultural issues combine in interesting ways: some previously irreligious individuals with obsessive-compulsive tendencies may become ultraorthodox in their practices (e.g., "born again" or "ba'al teshuva") and incorporate religious rituals more rigidly than individuals born into those communities in the first place (39, 40). For patients who are overtly religious, questions regarding the nature and extent of their belief in God, God's purpose for them, God's will and their relationships with God may help delineate these beliefs. The clinician must deftly assess the extent to which a patient's beliefs may be helpful and supportive or counterproductive and maladaptive, respecting those areas where beliefs are benign and adaptive, and compassionately helping the patient reflect on how some of his or her beliefs may be self-sabotaging.

Similarly, the trainee may make assumptions about a patient's beliefs based on the therapist's prior knowledge about the patient's religion. It does not necessarily follow, however, that every individual fundamentalist Christian believes in a literal hell awaiting sinners, nor that every Muslim abstains from alcohol. This problem is likely worse when patient and therapist share a religion. Assumptions about patients' beliefs stifle curious investigation. The supervisor can encourage the trainee to approach each patient with "skeptical credence" to avoid over-pathologizing religiously normative be-

havior on the one hand, or missing genuine psychopathology masquerading as faith (11, 13, 14, 41, 42).

*Self-awareness* — Most supervisors are aware of the nature and power of countertransference, and have a model for identifying, confronting and managing the impact of the trainee's unconscious processes in the therapy. Inevitably, this process involves the trainee's awareness of his/her behaviors, thoughts and feelings. Therapists also bring to the treatment their own experiences and prejudices around religious issues. Some beliefs may stem from scientific and medical education; others may be the result of personal history. Unelucidated, such ideas and emotions can only sabotage treatment and training (2, 14, 16).

The presumption of scientific rationality about psychotherapy may breed negative attitudes about spirituality (1, 43). The conformity mandated by many religions may feel incompatible with the trainee's efforts to increase his/her patients' autonomy (1). Formal Western religions are inherently judgemental, classifying aberrant behavior with various definitions of sin or transgression; psychotherapy is inherently nonjudgemental, identifying misbehavior as, at worst, maladaptive and as psychopathology (5). The scientific roots of psychotherapy mandate an empirical foundation for assessment and treatment, while spiritual traditions value intuitive sources equally or more heavily (14, 21, 44).

The supervisor should encourage the therapist to examine his/her own beliefs and the personal and professional history that shaped them. The therapist who attempts treatment without awareness of his/her prejudices does a disservice to the patient and to his/her own learning. The task of looking inward is, however, one explored only delicately in supervision. The issues at hand are much like those involved in countertransference: Unconscious elements of the therapist have some effect on the therapy, but the supervisor does not have the license to delve too deeply into the trainee's unconscious. Here, the supervisor cannot go too far in examining the role of the trainee's parents, private experiences with spirituality and religion, or beliefs instilled by respected figures from the trainee's prior education. A

useful approach, then, parallels what a supervisor ideally does in teaching about countertransference:

- Look for any evidence that prejudice (positive or negative) is playing a role in the trainee's conduct in the therapy.
- Point out the evidence to the trainee.
- Invite discussion about whether such bias exists, and engage in nonjudgemental inquiry.
- Avoid direct involvement with the trainee's spiritual life and identify topics best taken to someone in a better position to promote the resolution of such issues, such as clergy or confidant.

Supervision would be inadequate if it identifies the problems of grappling with religion as solely those of the patient. In this context, we draw attention to the complex layers of intersubjectivity (45) that exist with respect to spiritual and religious issues, not only between the patient and the trainee, but in even more complicated fashion in the three-way interactions of patient, trainee and supervisor. In this three-way field, each person brings his or her own particular intrapsychic beliefs and prejudices about spirituality and religion, as well as his or her own interpersonal transactional predispositions, all of which play out in sometimes unexpected ways in the tri-dimensional uneven playing field of power relationships among patient-trainee-supervisor. An honest self-appraisal on the part of therapist and supervisor of where they stand and how their personal spiritual and religious beliefs and values may impact their perceptions and actions with the others is critical for a healthy conduct of therapy and supervision, where these issues can be openly discussed.

Pargament points out how attending to the "helper's" orientation to religion is of paramount importance. He describes potentially destructive outcomes when therapist (or supervisor) embody "religious rejectionism," disregarding or derogating spiritual and religious dimensions. Equally damaging is "religious exclusivism," where the spiritual or religious beliefs of the therapist or supervisor demand that God or some other spiritual belief be a central part of the clinical reality and an integral part of any solution. In Pargament's view, two "helper" orientations that may better serve the clinical situation are "religious constructivism" and "religious

pluralism." In religious constructivism, all beliefs (or disbeliefs) in God or other spiritual concepts are constructed realities of the individual, based on individual experiences, relationships and micro-social context. Religious constructivists may be secular and have no belief in a higher power. In contrast, "religious pluralists" believe in a God or higher power, but insists that there are many ways to approach it. Neither the religious constructivist nor the religious pluralist have to share the individual's religious or spiritual views — but they are respectful of their traditions, symptoms, imagery and methods, and can at least to some extent enter their patients' worlds (36). Each, however, may inherently limit the extent to which the therapist or supervisor can actually empathetically enter the inner experience of a patient whose strong faith and beliefs are very different from their own.

The American Psychiatric Association has prepared "Guidelines Regarding Possible Conflict Between Psychiatrists' Religious Commitment and Psychiatric Practice" (46). It holds that psychiatrists should maintain respect for their patients' beliefs, which must begin with an assessment of those beliefs; and it prohibits the practitioner from forcing his/her religious agenda into the therapy. This guideline should be presented to the trainee as an ethical framework for investigation and therapy.

## Conclusions

The traditions of Western psychotherapy may have had their origins in the magic and spirituality of ancient healers, but psychotherapy trainees may see contemporary philosophies of therapy and its pedagogy as incompatible with faith and religion. Most therapists and trainees exhibit less belief and religious practice than their patients. Yet patients do believe and practice, and undeniable evidence substantiates the important role of spirituality in mental and physical health. Psychotherapy supervisors are thus obliged to help their students learn to address these issues as they learn all other aspects of psychotherapy.

Among the issues that should be addressed by the supervisor-trainee pair are:

- The definition of terms used by patient, therapist and supervisor;
- The tools available to the developing therapist for investigating the spiritual lives of patients;
- Frameworks of religious and spiritual development that are compatible with familiar cognitive and psychosocial schemata;
- The perceived relationship between religiosity and psychopathology;
- The therapist's self-awareness regarding these issues, and a similar awareness within the supervisor-supervisee pair.

By examining the literature describing the place of spirituality in psychotherapy, and the literature on spiritual pedagogy, the authors have outlined a recommended format for including religion and spirituality in the curriculum of psychotherapy supervision. Our framework emphasizes self-awareness and attention to intersubjectivity, and provides organized schemata for spiritual assessment and the understanding of spiritual development. The supervisor who is able to integrate these features will add an important dimension to his/her trainees' comprehension and wisdom.

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