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An Exploration of the Therapeutic Use of Spiritual Disciplines in Clinical Practice

Brian E. Eck
Azusa Pacific University

This article explores the use of spiritual interventions in psychotherapy by identifying the ethical, cultural, and professional practice contexts for their use. Issues related to the client, therapist, clinical setting, and professional practice that effect the use of spiritual interventions are identified. A framework to assess for the appropriateness of these interventions is provided. A review of the literature on spiritual disciplines and practices is provided and it is suggested that these spiritual interventions address disordered cognitions, behaviors, and relationships. Beginning points are offered for the therapist seeking to integrate these interventions into their work with religious clients. Research related to the clinical use of spiritual interventions is reviewed and future directions are discussed.

Over the past several years, there has been an explosion in the literature on integrating religion and spirituality into clinical practice. Bergin (1988, 1991), Fukuyama & Sevig (1999), Lovinger (1984, 1990), Miller (1988, 1999), Propst (1988, 1996), Shafranske (1996) and others (Fleischman, 1990, Koenig, 1998; Shafranske & Malony, 1996) argue for the inclusion of religion and spirituality into treatment. Within the Christian psychological community there has been a shift from a theoretical, conceptual integration to a practice oriented, applied integration (Brokaw, 1997; Bufford, 1997; Hall & Hall, 1997; McMinn, 1996; McMinn & McRay, 1997; Moon, 1997; Moon, Bailey, Kwasny, & Willis, 1991; Worthington, 1986; Worthington, Kurusu, McCullough & Sandage, 1996). Research in the larger secular psychological community has contributed to a growing recognition that psychotherapy that includes religion and spirituality may lead to better clinical outcomes (Payne, Bergin, Bielema, & Jenkins, 1991; Propst, 1980).

There has also been an increasing recognition that the values and practices of religious clients, their ethno-religiosity, deserve the same level of respect and sensitivity as any other ethno-cultural aspect of a client's life (Bergin, 1980; Bergin, Payne, & Richards, 1996; Fukuyama & Sevig, 1999; Payne, Bergin, & Loftus, 1992). The concept that religion and spirituality are relevant to clinical practice and are as much a part of a person's orientation to life as their ethnicity, gender, and culture is becoming a standard within the therapeutic community. Even managed care companies now let their clients identify if they wish to work with a therapist of their own faith.

Unfortunately this emerging standard of care does not seem to have become incorporated into the education, training, and practice of psychotherapists, even for those within the Christian community (Jones, Watson, & Wolfram, 1992; Moon, Willis, Bailey, & Kwasny, 1993).

This article will explore the use of spiritual interventions in psychotherapy by identifying the ethical, cultural, and professional practice contexts for their use and suggesting starting points for more fully integrating spiritual disciplines and practices into clinical treatment with religious clients.

Ethical, Cultural, and Clinical Contexts

Use of spiritual disciplines in clinical practice takes place in the broader ethical and cultural context of psychotherapy. Each of these contexts help to define the parameters of appropriate therapeutic care.

Ethical Context

The first context for the use of spiritual disciplines in psychotherapy is ethical clinical prac-

Correspondence regarding this article should be addressed to Brian E. Eck, Ph.D., Department of Psychology, Azusa Pacific University, 901 E. Alosta Ave., Azusa, CA 91702-7000. E-mail at beck@apu.edu

tice. Contemporary ethical practice has shifted from exclusion of religion in psychotherapy to requiring that therapists respect religion as an orienting framework in the client's life. The American Psychological Association's (APA's) Ethical Principles, Principle D (1992), says in part, "Psychologists are aware of culture, individual, and role differences, including those due to age, gender, race, national origin, *religion* [italics added], sexual orientation, disability, language, and socioeconomic status" (p. 1599). This principle challenges the therapist to properly assess, become aware of, and respect the spiritual and religious dimensions of a client's life.

Second, the APA's Ethical Principles and Code of Conduct for psychologists, Section 1.08 (1992) states that, "Where differences of age, gender, race, ethnicity, national origin, *religion* [italics added], sexual orientation, disability, language, or socioeconomic status significantly affect psychologists' work concerning particular individuals or groups, psychologists obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals" (p. 1601).

This standard challenges every practicing therapist to obtain the training necessary to demonstrate competence in understanding the role of spirituality and religion in their clients' lives. Just as one must take coursework on cultural, ethnic, racial, and gender diversity, therapists should also obtain training in religious and spiritual diversity.

A final professional ethical statement of relevance is the APA's Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (1993). This states in part that, "Psychologists respect clients' *religious and or spiritual beliefs and values, including attributions and taboos* [italics added] since they affect worldview, psychosocial functions and expressions of distress." (p. 461). Ethical practice as a psychologist recognizes the central role religion plays in a client's life and requires that the therapist demonstrate an awareness, sensitivity, and respect for the client's religious beliefs, values, and practices.

To summarize, APA ethical codes require a therapist to assess, understand, and respect the religious and spiritual beliefs, values, and practices of their clients, and to obtain the training and experience necessary to sensitively and appropriately address this aspect of a client's life in their clinical practice.

The standard of care in psychology is to be culturally competent in responding to a client's life context. Just as there is a need to be sensitive to cultural, racial, ethnic, and gender aspects of a client's life, there is a corresponding need to be sensitive to the religious aspects of the client's life when making therapeutic interventions. Clinicians need to be culturally and religiously competent. In support of this, the American Psychological Association has in recent years published several major books on integrating spirituality into treatment. Shafranske's (1996) *Religion and the clinical practice of psychology*, Richards and Bergin's (1997) *A spiritual strategy for counseling and psychotherapy*, Miller's (1999) *Integrating spirituality into treatment*, and Richards and Bergin's (2000) *Handbook of psychotherapy and religious diversity* are essential resources for the clinician seeking to develop ethno-religious competency. There have also been an increasing number of articles published in recent years to increase clinician understanding of the effects of spiritual and religious issues in specific areas of therapy including coping (Ashby & Lenhart, 1994; Baugh, 1988; Bickel, Ciarrocchi, Sheers, Estadt, Powell, & Pargament, 1998; Gartner, Larson, & Allen, 1991; Hathaway & Pargament, 1990; Pargament, 1996; Pargament, Smith, Koenig, & Perez, 1998; Wong-McDonald & Gorsuch, 2000), forgiveness (DiBlasio, 1992; DiBlasio & Benda, 1991; McCullough & Worthington, 1994; Worthington & DiBlasio, 1990), and health (Bearon & Koenig, 1990; Chamberlain & Hall, 2000; Hill & Butter, 1995; Koenig, 1997; Larson, 1994; Larson, Swyers & McCullough, 1997; Martin & Carlson, 1988; McIntosh & Spilka, 1990; Propst, 1980).

Cultural Context

Given that religion and spirituality are being more widely recognized as part of a person's orientation to life, what might a therapist expect to see walk through the clinic doors? How frequently might one encounter a religious client?

Religious practice is actually quite pervasive in the United States. From a number of studies (Gallup, 1994; Greeley, 1989; Hoge, 1996), 95% of Americans report that they believe in God, 93% identify with a religious group, 88% report they pray and 87% report that God answers prayers, (apparently one percent pray, but don't believe that God answers prayers). Of relevance to clinicians, 84% try to live according to their religious beliefs, 82% report they pray for health

or success, 80% report that religion is very or fairly important in their lives, or that they consider themselves to be a spiritual or religious person. This research would seem to indicate that eight or nine out of every ten clients who show up in the waiting room would report that religion is important to them. At the lowest level of reported religious practice, 58% feel the need to experience spiritual growth. What this research would seem to indicate is that somewhere between fifty and ninety percent of the clients that are seen in therapy have a spiritual or religious orientation that is important to them. One would think that such a significant part of a client's orientation to life should be a part of the growth therapy is trying to facilitate.

Clinical Context

If eighty to ninety percent of Americans identify religion and spirituality as important to them, how many of them would like this area to be included in their psychotherapy? Research seems to indicate that clients prefer therapy that includes their belief systems with Quackenbos, Privette and Klentz (1985) reporting that 78% of clients feel that religious values should be discussed in counseling. Clients who identify themselves as religious, report the preference for the use of prayer, scripture, and explicitly religious themes in their counseling (Worthington, Dupont, Berry, & Duncan, 1988).

If clients prefer that therapists include their religious and spiritual values in treatment, why don't more clients bring them up in therapy? It may be difficult for clients to initiate talking about their religion for a number of reasons. First, religion has in large part been removed from the public square. Clients don't necessarily expect it to be part of their public lives. American Christians often seem to separate sacred from secular and thus may talk to a priest or member of the clergy about spiritual concerns and a therapist if they perceived it to be a psychological problem. This kind of intrapersonal splitting prevents a more holistic, integrated approach to treatment. Therapists routinely encourage clients to talk about their ethnic and cultural background, personal and family backgrounds, history of substance use, and past history of sexual, physical, or emotional abuse. Why not also invite them to incorporate their spiritual life in therapy? This silence on the therapist's part may be due to therapist-client collusion in which clients don't talk about their spirituality or religion and therapists don't ask them about it (the therapeutic equivalent of don't ask, don't tell). If religion is uncomfortable or irrelevant to the therapists they may be resistant to engage it as a clinical concern. As clinicians are trained to deal with collusion in other aspects of therapy perhaps clinician training should include the collusion of silence in the area of spirituality and religion.

It may also be difficult for clients to bring up religious issues due to fear of religious coercion. Religion was removed from the public square in part due to concerns that religion can become coercive. Research reports that most clients want to talk about their spirituality, not hear about the therapist's religion (Worthington et al., 1988). Therapists should respect, honor, and be sensitive to the boundaries that make religion a safe topic in therapy.

Given these client and cultural contexts, why hasn't spirituality and religion become better incorporated within our clinical models, training, practice, and protocols? A final issue related to religious silence in psychotherapy may be due to bias in our own profession (Gibson & Herron, 1990). In contrast to the eighty to ninety percent of the general population who identify religion as important to them, only forty-eight to sixty-five percent of psychologists identify religion as very or fairly important (Bergin & Jensen, 1990; Shafranske, 1996; Shafranske & Malony, 1990).

Therapists need training in the area of religion and spirituality so that they can competently engage the 80% to 90% of their clients for whom this is an important area of their lives. Appropriate education and training would ensure that therapists practice within the scope of their training and experience and provide them with the skills necessary for engaging a client's ethno-religiosity as easily as any other issues in a client's life.

General Practice Issues for Spiritual Intervention

A second context for the use of spiritual disciplines in clinical practice involves the standards of professional practice. These would include issues of therapeutic appropriateness related to the client, therapist, and clinical setting.

Client Issues

Before introducing spiritual interventions into clinical practice, the therapist should assess whether such interventions would promote the overall welfare of the client. A thorough assess-

ment of the client's life situation, developmental history, and spiritual or religious involvement help to insure that interventions are congruent with and respectful of the client's beliefs, values, and religious practices.

Therapeutic interventions should be consistent with a client's goals and desires. If the client does not want therapy to engage their religious or spiritual life, the therapist may probe and interpret the exclusion of this area from therapy as they would the exclusion of any other area of the client's life, but the use of spiritual interventions should be based on client assent and informed consent (Lewis & Epperson, 1991). It is essential that the client explicitly understands and consents to the use of each spiritual intervention. This helps to ensure that the client does not experience the use of spiritual interventions as either religious manipulation or coercion.

A final client issue would be an assessment of the fit between a spiritual intervention and the client's diagnosis. Clients with certain disorders such as schizophrenia or a personality disorder may contra-indicate the use of certain forms of treatment including spiritual interventions. The therapist needs to assess whether the use of a spiritual intervention would foster increased defensiveness, manipulation, dependency, emotional repression, or increased pathology. If uncertain about the use of any intervention, including a spiritual intervention, the therapist should consult with experienced colleagues.

Therapist Issues

The therapist is responsible for facilitating client growth and maintaining ethical practice. The therapist should be sensitive to any conflicts that might occur between a client's spiritual and religious practices and their own (Bergin, 1991; Bergin, Payne, & Richards, 1996). If a conflict exists, the therapist should discuss it with the client and if necessary make a referral. This does not mean that a therapist cannot explore, interpret, or confront client behavior, but it does mean that it is the therapist's responsibility to sensitively talk about these issues as they arise.

The therapist is also responsible for using interventions, including spiritual interventions, that are within the scope of their training and experience. Before utilizing spiritual interventions in treatment, one must obtain the necessary education, training, and supervised experience. For spiritual interventions, this may require the therapist to get supervision or consultation from a qualified peer, clergy member, or priest.

A final issue for the therapist is that spiritual interventions must be properly documented and that arrangement for reimbursement for the use of a spiritual intervention is clarified before it is used. Spiritual interventions may or may not meet the parameters for reimbursement by third parties, and as such, part of a client's informed consent relates to fee arrangements for any non-reimbursable interventions (Chappelle, 2000).

Working with Spiritual Issues in Psychotherapy

How then does one begin working with spiritual issues in psychotherapy? A starting point is the realization that for the majority of clients, religion and spirituality are important to them and that they would like to be able to talk about this area of their lives in therapy. Therapists should facilitate this by creating a setting of openness, trust, and respect for client spiritual expression. Therapists should invite clients to share their spiritual or religious concerns, issues, and values in the same way they share any other area of their life.

Beyond the creation of an environment accepting of the client's religion and spirituality, there are several suggested guidelines for using spiritual interventions in therapy (Chappelle, 2000; Miller, 1999; Richards & Bergin, 1997; Richards, Rector, & Tjeltveit, 1999; Tan, 1994). As a general overview, it includes a thorough assessment of the client's spiritual and religious life, an evaluation of the therapist's ability to appropriately utilize spiritual interventions, and an awareness of the limits set by the therapeutic setting and treatment modality.

Client Assessment

Assessment of the client permits the therapist to understand the client's belief system, values, and religious practices. Without this knowledge, the therapist cannot engage the client in a way that is ethno-religiously congruent and that does not potentially violate their religious tradition and practices. There are many models for assessing religion and spirituality in clinical practice (Conners, Tonigan, & Miller, 1996; Hall, Tisdale, & Brokaw, 1994, Lovinger, 1996; Miller, 1999; Richards & Bergin, 1997; Tan, 1996a), and what follows provides a basic outline of an assessment protocol.

Assessment of the client's religion and spirituality begins with the initial intake assessment. In addition to a good developmental and family history, the intake form or interview can include a number of open-ended questions about a person's spirituality and religion. These would inquire about current concerns such as what gives the client's life meaning and purpose, whether they consider themselves to be a spiritual or religious person, and whether they participate in any religious practices or organizations. The therapist should also inquire about the personal and family history of religious experience and if the client's religious practices have changed, it would be important to assess what has led to those changes.

An additional aspect of this initial assessment could include the use of standardized measures of spirituality or religion. These could include Richards and Bergin's (1997) Religious-Spiritual Assessment Questionnaire, measures of intrinsic/extrinsic religiosity, measures of spiritual well being or maturity, measures of God image, measures of spiritual/religious practices and beliefs, or measures of spiritual or religious values or lifestyle.

If in the first assessment the client identifies that religion or spirituality is important to them, this should lead to more specific questions about the nature of their religious life. Spilka, Hood, and Gorsuch (1985) have identified multiple approaches for conceptualizing the religious dimension, but Glock's (1962) five dimensions of religious experience can perhaps best serve the clinician as a framework for this assessment. These dimensions include (1) ritualistic practices and behaviors, (2) ideological or formative doctrines and beliefs, (3) personal-experiential components, (4) cognitive based intellectual knowledge and teachings, and (5) consequential-relational including ethical living and community life.

This second level of client assessment should include questions concerning the client's religious or spiritual rituals, beliefs, or practices, their participation in a religious community, their level of religious knowledge, any supportive connections to priests or clergy, and their guiding values and ethical positions.

As part of this second level of client assessment the therapist should look for areas of strength or dysfunction within the client's religious or spiritual life and how, if at all, the client believes that their religion or spirituality is involved in their current life circumstances. It should also include a general assessment of whether the client's spiritual development is age appropriate and consistent with other areas of development, and if there is congruence between the client's religious beliefs and lifestyle. The nature of the client's image of God, religious motives, and ways of incorporating religion and spirituality into their coping or problem solving behaviors should be explored. These assessments could include information from one of the standardized instruments and/or a clinical interview.

The purpose of this client assessment is for the clinician to become aware of how religion and spirituality function in the life of the client and whether it serves a healthy and constructive or dysfunctional and destructive role. Spiritual interventions would be contra-indicated or used with caution with clients who present with a dysfunctional or poorly formed religion or spirituality, have been wounded by past religious abuse, or for whom spiritual interventions would exacerbate existing pathology.

Therapist Assessment

In addition to an assessment of the client, the therapist must perform a self-assessment to determine if spiritual interventions are appropriate and compatible with their role and scope of practice. Depending on the nature of the therapeutic relationship, their therapeutic modality, and the therapeutic contract, the therapist should decide whether to use implicit or explicit spiritual interventions (Tan, 1996a). Implicit spiritual interventions are not brought overtly into the clinical setting and can include such things as the therapist praying for the client outside of the session. Explicit interventions bring religion and spirituality directly into the therapeutic process. To do this, the therapist must determine that the spiritual interventions are compatible with the therapeutic setting, treatment modality, and are in the best interests of the client. Explicit interventions that arise out of the therapeutic alliance are least likely to violate the client's values and most likely to facilitate client growth.

Part of a therapist self-assessment should also be to determine whether a spiritual intervention is within the scope of his or her training and experience. As with any therapeutic technique, the therapist must be properly trained, supervised in its use, and able to practice the technique safely. The therapist should also be self-aware enough that their own personal values, beliefs, conflicts, and biases do not hinder their service to the client or

impose practices that violate the client's own beliefs and values. Spiritual interventions outside the scope of one's own religious experience or for which one has not had the education, training, or supervision should not be utilized until such training and experience have been obtained.

Clinical Setting Assessment

A final professional practice context is assessing the clinical setting itself. Spiritual interventions should be congruent with the rules and protocols governing the clinical setting. Therapists in public funded agencies and clinics or those in research and training settings must carefully assess the appropriateness of the use of spiritual interventions in their work settings (Richards & Bergin, 1997). Therapists who are reimbursed by third parties must also work within the parameters of their contracts and any required conditions such as medical necessity. Spiritual interventions may therefore not be appropriate with some settings or therapeutic contracts. Agency approval, written informed consent and prior client agreement to any spiritual interventions may help to address some of these concerns.

Utilizing Spiritual Intervention in Therapy

After assessing the client's spirituality or religion and determining that it is consistent with the use of spiritual interventions, after obtaining client consent for the use of each spiritual intervention, and after determining that the use of spiritual interventions takes place within ethical practice guidelines, the therapist should seek to identify which spiritual interventions might best meet the client's needs. Interventions should be appropriate for the client's spiritual or religious tradition, diagnosis, level of spiritual development, treatment modality, and clinical setting without fostering defensiveness, inappropriate dependency, increased manipulation of the therapeutic setting, or increased pathology.

Spiritual or religious interventions should be congruent with and address the client's needs related to their cognitions (beliefs and knowledge), behaviors (practices and lifestyle), or interpersonal relationships (social support, belongingness, and attachment). All of the major religious traditions have developed rituals, disciplines, and practices to address the ills of humanity. Within the Christian tradition there has been a resurgence of interest in reclaiming the disciplines and practices of the faith as means for facilitating change and transforming the human condition (Bass, 1997; Foster, 1988; Mangis, 2000; Ortberg, 1995, 1997; Tan, 1996b; Tan & Gregg, 1996; Willard, 1988).

Nature of the spiritual Disciplines

Spiritual disciplines and practices have been utilized over the centuries as a means to help people of faith reorder their lives. Their purpose is to address disorder, dysfunction, and disconnection by reorienting how one thinks, behaves, and relates to God and one's community. Willard (1998) says that sin is a "psychological reality" where, "The inner resources of a person are weakened or dead, and the factors of human life do not interrelate as they were intended by their nature and function to do" (p. 104). He goes on to state, "In this condition the mind is confused, ignorant, and misguided. The emotions are simultaneously dominant of personality and conflicting. The body and the social environment are filled with regular patterns of wrongdoing and are constantly inclined toward doing what is wrong" (p. 105).

These sound like a client's presenting problems. Their thinking, feeling, behavior, or relationships are, "defective and connected wrongly with reference to life as a whole" (Willard, 1998, p. 105).

In utilizing the spiritual disciplines to address this condition Willard writes that, "The disciplines are activities of mind and body purposefully undertaken, to bring our personality and total being into effective cooperation with the divine order" (1988, p. 68). In a later article he writes that, "a discipline is an activity within our power—something we can do—which brings us to a point where we can do what we at present cannot do by direct effort: (1998, p. 106).

Among other key figures writing on this topic, Ortberg states that, "a disciplined person is someone who can do the right thing at the right time" (1997, p. 54). Foster states that "the spiritual disciplines are intended for our good. They are meant to bring the abundance of God into our lives" (1988, p. 9). Bass writes that Christian practices, "... have practical purposes: to heal, to shape communities, to discern," and that one incorporates Christian practices, "... not just because it works, but because it is good" (Bass, 1997, p. 7).

At their heart spiritual disciplines and practices are activities that help one to live the life God intended rather than a life of brokenness, sin, and disconnection. Spiritual disciplines are activities that allow the person to do what they presently cannot do for themselves. Willard says that the

aim of the spiritual disciplines is, "the renewal of the whole person from the inside, involving differences in thought, feeling, and character" (1998, p. 107). Spiritual disciplines, in other words, work toward the same goals as the therapeutic process, change in human functioning.

Use of spiritual disciplines and practices must also take place in a context which recognizes that, "true character transformation begins and is continually assisted by the pure grace of God" (Willard, 2000, p. 20). Spiritual disciplines are not barometers of spirituality or a way to earn God's merit, forgiveness, and goodwill. They are not to be used as soul killing legalistic practices performed from guilt and coercion (Ortberg, 1997, Tan & Gregg, 1997). They exist for humanity's sake, not God's. They work to mold and shape the embodied human person through activities that open one to more of God's life and power (Foster, & Yanni. 1992; Tan & Gregg, 1997; Willard, 1988). The use of the spiritual disciplines and practices in the clinical setting must remain true to this grace filled, God empowered focus as a means of grace and mercy and not as a legalistic or coercive process.

Guidelines for Using Spiritual Disciplines and Practices.

There are three key issues that need to be addressed in the use of spiritual disciplines in clinical practice. First, the disciplines should be used in a way that is consistent with and shows respect for their religious intention. Even though research has demonstrated that non-religious therapists can have better outcomes when they incorporate religion and spirituality into therapy (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992), the specific use of a spiritual discipline or practice should not be ripped from its spiritual heritage. Therapists need to respect the religious tradition and intention of the discipline, the context in which it was developed and the context in which it has historically been used.

For a therapist of faith, a second issue involves the role of the Holy Spirit in the therapeutic process. There have been several discussions of this in the literature (Decker, 2002; Dodds, 1999; Ingram, 1996; Kunst & Tan, 1996). The therapist of faith should be sensitive to and aware of the Holy Spirit's guidance in themselves and the client, using spiritual interventions only in concert with the leading and guiding of the Holy Spirit.

Third, there needs to be a better integration of spiritual disciplines and practices into our treatment models, theories, and clinical practice. This would require the development of a more systematic way of thinking about how spirituality and the use of spiritual disciplines can become part of each clinical modality.

There also needs to be more ongoing research identifying the best practices for integrating spiritual disciplines and practices into treatment. This would include research identifying which spiritual interventions are most efficacious with which disorders or client populations. An excellent example of this kind of research is McCullough and Larson's (1999) review of the literature on prayer in which they report that in chronic pain patients petitionary prayer decreases level of functioning while the use of a more contemplative prayer style improves coping.

Spiritual disciplines and practices should become incorporated into standard clinical practice in an ethical, appropriate, and effective fashion congruent with the overall goals and modalities of therapy. In recapturing this rich spiritual heritage, psychotherapy with a client of faith can be more integrated and effective in addressing the needs of the whole person as body, mind, and spirit.

Therapeutic Use of Spiritual Disciplines in Clinical Practice

How would one integrate spiritual disciplines and practices into the therapy hour? A beginning point, as with all therapy, is with the goal of treatment. When choosing a spiritual discipline to practice, Ortberg (1997) recommends beginning with understanding the goal of a Christian life and identifying the barriers that keep one from living the life desired. The choice of which spiritual discipline to use is, as in therapy, determined by the problem definition and need of the person. The choice of a discipline should respect the freedom of the Holy Spirit, the uniqueness of the client, and the barriers they want to overcome (Ortberg, 1997; Tan & Gregg, 1997). Every client is a unique person in various stages of spiritual development for whom one or more of the disciplines can be critical in helping them to grow.

Each of the spiritual disciplines address particular deficits, distortions, or dysfunctions in the human condition and, as Willard says, assists one to do what cannot presently be done on one's own. Although each of the spiritual disciplines and practices may address multiple areas of a person's life, each seems to address in a primary way a particular type of dysfunction.

		Richard Foster Disciplines (1988)	Dallas Willard Disciplines (1988)	Tan & Gregg Disciplines (1997)	John Ortberg Disciplines (1997)	Bass, et al. Practices (1997)	Worthington et al. (1988)	Ball & Goodyear (1991)	Moon et al. (1991 1993)	Jones et al. (1992)	Richards & Bergin (1997)
Cognitive	1. Meditation	Inward		Solitude	Guidance		1		2	1	2
	2. Listening			Solitude	Guidance						
	3. Scripture				Core		4	1	2	2	2
	4. Study	Inward	Engagement	Solitude	Guidance		1	1			1
	5. Prayer	Inward	Engagement	Solitude	Guidance		2	1	4	2	3
	6. Discernment					Practice			1		
Behavioral	1. Simplicity	Outward		Service					1		
	2. Frugality		Abstinence			Practice					
	3. Fasting		Abstinence	Surrender	Celebration				1		1
	4. Chastity		Abstinence								1
	5. Body Care					Practice					
	6. Saying no/yes					Practice					
	7. Slowing				Core						
	8. Sabbath				Celebration	Practice					
	9. Solitude	Outward	Abstinence	Solitude	Slowing				1		
	10. Silence		Abstinence	Solitude					1		
	11. Secrecy		Abstinence		Core						
	12. Service	Outward	Engagement	Service							1
	13. Servanthood				Core						
	14. Sacrifice		Abstinence								
	15. Suffering				Core						
	16. Dying well					Practice					
Interpersonal	1. Confession	Corporate	Engagement	Surrender	Core		2		1		1
	2. Repentance			Surrender					1		1
	3. Forgiveness					Practice	3	1	1		1
	4. Submission		Engagement	Surrender							
	5. Humility				Servanthood						
	6. Worship	Corporate	Engagement	Surrender	Guidance				1		1
	7. Eucarist					Practice					1
	8. Singing					Practice					1
	9. Celebration	Corporate	Engagement		Core						
	10. Fellowship		Engagement	Service							1
	11. Community					Practice					
	12. Hospitality					Practice					
	13. Healing				Confession	Practice	1	1	1	1	
	14. Witnessing			Service							
	15. Testimony					Practice					1
	16. Intercession			Solitude			1	1	1		
	17. Guidance			Solitude	Core						

#'s indicate the number of sub-categories for a spiritual discipline that was identified by a researcher.
A blank indicates that the discipline was not incorporated in the study.

Figure 1.
39 Spiritual Disciplines and Practices

Key authors in this literature have identified thirty-nine different spiritual disciplines or practices (see Figure 1). In the chart of spiritual disciplines and practices, each author identifies specific disciplines and assigns them to particular categories. Foster (1988) identifies nine disciplines that he divides into inward, outward, and corporate. Willard (1988, 1998, 2000) identifies 15 disciplines divided into engagement and abstinence, while Tan and Greg (1997) identify 17 disciplines that are divided into solitude, service, and surrender. Ortberg (1997) talks about 18 disciplines divided into guidance, core, slowing, servanthood, and confession, and finally Bass (1997) identifies 13 practices of the Christian faith.

As a starting point for clinicians interested in integrating spiritual disciplines into clinical practice, it is suggested that one begin by targeting the dysfunction in the client. Willard's (1998) identification that the disciplines target the disordered mind, body and relationships due to sin suggests that some of the disciplines and practices address disordered thinking, disordered behaviors, or disordered relationships. Although client concerns may include multiple issues, by incorporating spiritual disciplines into the cognitive, behavioral, and interpersonal/psychodynamic modalities in clinical practice, it seems that clinicians targeting disordered thoughts or employing cognitive interventions could integrate those disciplines which target disordered thinking. Clinicians working with disordered behavior and lifestyle patterns could utilize those disciplines targeting excessive or deficient behaviors while those targeting disordered relationships or utilizing interpersonal interventions could use the more relationally oriented disciplines.

Cognitive Oriented Disciplines

Those disciplines and practices which most seem to address a disordered thought life would include meditation, listening, scripture, study, prayer, and discernment. Research has already investigated the clinical use of meditation (Carlson, Bacaseta, & Simanton, 1988), and prayer (Ashby & Lenhart, 1994; Byrd, 1988; Dossey, 1993, Duckro & Magaletta, 1994; Finney & Malony, 1985; Magaletta, 1998; McCullough, 1995). Research (see Figure 1) also indicates that almost all of the disciplines is this group are already being used by Christian therapists (Ball & Goodyear, 1991; Jones, et al., 1992; Moon, et al., 1991; Moon, et al., 1993; Worthington, et al., 1988). Therapists working with the destructive self-talk evidenced in depression or the anxiety disorders, clients impaired by excessively negative or grandiose self-appraisal, or any destructive pattern of thought may seek to incorporate with their religious clients the disciplines that address disordered thinking.

Behaviorally Oriented Disciplines

The second group of disciplines and practices is the largest group. They address either excessive or inadequate behavioral patterns and lifestyles practiced in everyday living. Bass's 1997 concept of the discipline of saying yes and saying no is already well explored in the literature on boundaries (Cloud & Townsend, 1992, 1999). Many of the disciplines listed in this section would support a client's development of appropriate boundaries and limits for a healthier life. The research would seem to indicate that these are the least frequently used by Christian therapists (see Figure 1).

Disciplines that address excessive behaviors would include simplicity, frugality, fasting, chastity, body care, and saying yes and no. These disciplines address behavior that is out of control and lifestyle excesses such as materialism, gluttony, and promiscuity. Therapists frequently work with clients struggling with addictions and lack of self-control while those involved in life coaching and case management help their clients budget, manage money and practice better self-care. Integrating spirituality into treatment has already proven helpful in several of these areas (Johnson, 1993), and the use of spiritual disciplines to support self-limiting practices should be encouraged.

Other disciplines in this group relate to managing stress, controlling an excessive pace of life, and assisting clients caught up in pursuing material success. Disciplines such as slowing, Sabbath, solitude, silence, and secrecy, help clients find balance and meaning in life outside of compulsive activity, or the pursuit of money and power. These disciplines help to re-center the person and remind them that they are more important than what they do or can achieve. Solitude and silence have received some coverage in the literature (Van Meter, McMinn, Bissell, Kaur, & Pressley, 2001) and one article reported how a Jewish couple was assigned the homework of keeping Sabbath by their marriage counselor. They reported that by taking a day away from computers, yard work, and shopping, in order to be together as a couple, they were able to rebuild and deepen the depth of communication and the spiritual foundation of their marriage (Chase, 1997).

A final set of disciplines in this group target self-absorption or an inadequate understanding of the struggles of life. Disciplines such as service, servanthood, sacrifice, and suffering help one transcend a worldview of narrow self-interest or one that does not appreciate the relationship between struggle and growth. These disciplines address distortions of the self and facilitate greater generativity and personal growth. Within this group of disciplines there is a significant amount of literature on religion and coping (Baugh, 1988, Hathaway & Pargament, 1990; Pargament, 1996, 1997; Pargament, Ensing, Falgout, Olsen, Reily, Van Haitsma, & Warren, 1990). There is more limited literature on obedience (Wong-McDonald & Gorsuch, 2000), acceptance and hope, (Brody & Semel, 1993; Farran, Herth, & Popovich, 1995; Snyder, 1994) and suffering (Allender, 1999). Therapists should be encouraged to help their clients transcend their life circumstances by incorporating the spiritual disciplines that assist them to find life's meaning in something greater than themselves.

Interpersonally Oriented Disciplines

The final group of disciplines identified in Figure 1 address relational problems. These disciplines focus on repairing damaged relationships, creating interpersonal connections, healing spiritual disconnection, and facilitating mentoring relationships. About half of these disciplines and practices are reportedly being used by Christian counselors (see Figure 1).

The disciplines of confession, repentance, forgiveness, submission, and humility focus on repairing relationships. Therapeutic use of these disciplines would assist those clients of faith, seeking to rebuild broken relationships to restore both the interpersonal and spiritual dimensions of the relationship. Research on these has focused primarily on the use of forgiveness in therapy (DiBlasio & Benda, 1991; DiBlasio & Proctor, 1993; McCullough & Worthington, 1994; Worthington & DiBlasio, 1990). Trust and faith in one's partner are essentials for openness and vulnerability in relationships and reestablishing these inherent spiritual attributes are essential for healing relational brokenness.

The disciplines of worship, eucharist, singing, celebration, fellowship, community, hospitality, and guidance focus on the horizontal and vertical connections of a client's life. These are the means for overcoming an isolated and lonely existence by connecting one to community. Of all of the spiritual disciplines, it seems strange that these are virtually unexplored in the clinical research literature and are not widely used by Christian counselors (see Figure 1). One of the most basic issues humans face is disconnection and isolation. Helping people find community in a loving supportive church may provide the client with the extra support necessary for pursuing personal growth and change. Clients may also be helped through the development of mentoring relationships that provide them the experience of caring, connection, and guidance necessary to take the risks required for growth.

The disciplines of healing, witnessing, testimony, and intercession address areas of spiritual concern or brokenness. When the problem the client is facing is at its core a spiritual problem and the client is seeking spiritual renewal as part of their personal growth, these disciplines most directly address these concerns. Healing and intercession are reportedly used by Christian counselors (see Figure 1), however there is little in the clinical literature on their use in treatment. Because of their foundational spiritual focus, these disciplines might best be incorporated into treatment by pastoral counselors or by referring the client to their own priest or minister.

Current Status and Future Directions

Research on the actual use of spiritual interventions indicates that some therapists have begun to incorporate spiritual interventions into therapy (Ball & Goodyear, 1991; Jones, et al., 1992; Moon, et al., 1991; Worthington, et al., 1988). This research indicates that the use of spiritual disciplines in treatment varies greatly with Jones, et al. (1992) reporting that 23.2% to 30.6% of Christian counselors self-report the use of spiritually oriented techniques with their clients. Use also appears to have an inverse relationship to the therapist's level of education and their affiliation with professional clinical associations like the APA (Moon, et al., 1993). Doctoral prepared therapists who are members of their national professional association are the least likely to use spiritual interventions.

The spiritual interventions therapists report using most frequently in these studies are implicit techniques like praying for clients outside of session and the implicit teaching of biblical concepts. Among the more explicit techniques therapists report using are discussing the client's faith, praying with the client in session, instruction in repentance and forgiveness, explicit quoting or interpreting of scripture, assigning religious homework, using guided religious imagery, teaching

religious meditation, and confronting the client over sinful life patterns (Jones, et al., 1992; Moon, et al., 1993). Worthington, et al. (1988) found that the techniques which clients report were the most helpful in treatment were encouraging them to forgive others, forgive God, and to have been assigned religious homework.

Future Directions

This article has identified some beginning places for therapists who wish to integrate spiritual disciplines into clinical practice. A future direction for the use of these disciplines and practices would be the establishment of research protocols that identify which disciplines and practices are most effective in the treatment of specific disorders. Even as research has begun to identify the differential effects of petitionary versus contemplative prayer in chronic pain patients (McCullough & Larson, 1999), further research is needed to better understand and validate the efficacious effects of all of the identified spiritual disciplines and practices. By revisiting the historical guidelines for the use of spiritual disciplines and practices throughout the history of the faith and by empirically validating the conditions under which they can best be used in the contemporary therapeutic setting, these interventions can become part of the standards of care for religious clients. Any widespread integration of spiritual interventions into standard clinical practice with religious clients will need to be guided by future research in this area.

A second direction for the future is the development of a set of "best practice" treatment models that integrate spiritual disciplines and practices into the major treatment modalities. Although existing literature most frequently integrates spiritual interventions into directive treatment approaches (Hawkins, Tan, & Turk, 1999; Johnson & Ridley, 1992; Miller & Martin, 1988), there is a growing openness to integrating spiritual perspectives with the non-directive therapies (Finn, & Gartner, 1992). The goals of psychotherapy and those of the spiritual interventions are the same—change in human functioning. More work needs to be done to develop integrated theoretical models for treatment intervention so that spiritual interventions for religious clients become fully integrated into every therapeutic change modality.

A final future direction is to increase the education and training therapists receive on spiritual interventions with religious clients. The fact that even Christian therapists are reluctant to engage the religion and spirituality of their clients reflects deficiencies in their education and training. As with all other areas of cultural diversity, an educational and training curriculum needs to be developed that clearly identifies the role of religion in our society, the orienting framework it provides in the client's life, its proper clinical assessment, and "best practice" models for making spiritual interventions a standard part of treatment.

By clearly identifying the primary spiritual disciplines and practices and suggesting beginning places for the therapist interested in integrating these spiritual interventions into their clinical practice, it is hoped that a greater number of therapists will utilize them when working with religious clients. More needs to be done with regard to clinical research and theoretical model building; however, if each therapist is challenged to at least assess for religion and spirituality in the life of their client and is trained in how to incorporate this essential area of their religious client's life into treatment, psychotherapy could begin to address the whole person, body, mind, and spirit. It is hoped that this wold lead to not only a more holistic therapy but also to better treatment outcomes.

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Author

Brian E. Eck, Ph.D., is Professor and Chair of the Psychology Department at Azusa Pacific University. He holds a Ph.D. in Clinical Psychology from Rosemead School of Psychology and is in private practice in Covina, California. His research interests include the integration of psychology and Christianity, psychology of religion, faith development, and the integration of faith and learning.