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Putting Research into Practice:
Toward a Clinical Psychology of Religion and Spirituality¹

Hisham Abu-Raiya / Kenneth I. Pargament

Summary: In this chapter, we identify five recent key developments in the field of psychology of religion and spirituality and draw out their clinical implications. Our core recommendations can be summarized as follows. First, mental health professionals should invite psychotherapy clients into a “spiritual conversation” by explicitly inquiring about the place of the sacred in their lives. Second, clinicians should avoid spiritual reductionism by viewing spirituality as representing a significant distinctive dimension of life. Third, we encourage mental health professionals to help their psychotherapy clients draw on positive religious coping methods to deal with stressors. Fourth, we recommend that clinicians assess for religious doubts and struggles, normalize them and encourage clients to draw on spiritual resources to address spiritual struggles. Finally, we recommend that mental health professionals assess for spiritual integration and encourage their clients to develop a broader and deeper spirituality.


1. Introduction

Research in the psychology of religion has grown dramatically in the past two decades, and researchers and practitioners have gained multiple insights about this important topic. It is clear that religious and spiritual practices and beliefs are prevalent in many countries around the world and are associated with indices of health and well-being (Koenig & Larson 2001; Hood et al. 2009). It is also clear that religion and spirituality serve as valuable tools for individuals dealing with life stressors (Pargament 1997; Pargament & Abu-Raiya 2007).

However, our goals as psychologists of religion do not end with describing, explaining and understanding religious/spiritual phenomena. Our ultimate goal, perhaps, is converting abstract knowledge to practical applications that can be bene¹ Portions of this chapter are drawn from Pargament (2007), Pargament & Abu-Raiya (2007) and Abu-Raiya & Pargament (2010).
cial to people in their communities. Toward this end, researchers and practitioners have recently begun to translate this body of knowledge into religiously or spiritually integrated psychotherapy with clients, with promising results (Pargament 2007; Richards & Bergin 2005; Pargament, Murray-Swank & Tarakeshwar 2005; Freedman & Enright 1996; McCullough & Worthington 1994; Smith, Bartz & Richards 2007).

Following suit, in this paper we identify recent key theoretical and empirical developments in the field of psychology of religion and spirituality and draw out their clinical implications. To set the stage for discussion, we start by defining the main constructs of our paper, namely religion, spirituality and spiritually integrated psychotherapy.

2. Definition of Main Constructs

Social scientists and theologians have offered numerous definitions of religion, but have failed to reach a consensus, which led sociologist J. Milton Yinger (1967, 108) to conclude, “any definition of religion is likely to be satisfactory only to its author.” Here we offer a definition of religion that is relevant to the phenomenon of interest – health and well-being. According to Pargament (1997, 32), religion is a “search for significance in ways related to the sacred.” This perspective is tailored to the psychological venture, excluding ontological concerns about the reality of the sacred that go beyond the province of the field.

This definition includes two important elements: search and sacred. The search refers to a process of discovery of significant ends in life, conservation of those values once they have been found, and transformation of significance when internal or external pressures require a change (Pargament 1997; 1999). The search can also be understood in terms of the multiple pathways people take to reach their goals and the goals themselves. Religious pathways encompass a variety of dimensions: ideological, ethical, ritual, emotional, and social. These pathways can lead to diverse goals, including personal ends, such as meaning in life and self-development, and social ends, such as intimacy with others and justice in the world. However, the function most central to religious life is spirituality itself. “It is the ultimate Thou whom the religious person seeks most of all” (Johnson 1959, 70). The definition of spirituality, “a search for the sacred,” captures this critical function (Pargament 1999, 12).

Given that religion and spirituality play a central role in the lives of many people, several researchers have argued for the utilization of spiritually or religiously integrated psychotherapy (e.g., Pargament 2007; Richards & Bergin 2005). Spiritually integrated psychotherapy is “an approach to treatment that acknowledges and addresses the spirituality of the client, the spirituality of the therapist and the process of change” (Pargament 2007, 176).

3. Key Developments in the Psychology of Religion and Spirituality and their Clinical Implications

With Pargament’s definitions of religion, spirituality and spiritually integrated psychotherapy in mind, we now identify 5 recent key theoretical and empirical devel-
opments in the field of psychology of religion and spirituality and draw out their clinical implications.

3.1. The Many Faces of the Sacred: Address both Traditional and Non-Traditional Spiritual Expressions

According to Pargament’s definitions, the sacred is the heart and soul of religion and spirituality. For many people, the sacred is equivalent to higher powers or divine beings. However, the sacred expresses itself in the lives of people in non-traditional forms. Many view the sacred in a broader sense, one that encompasses any variety of objects be they psychological (e.g., identity, meaning), social (e.g., community, love), time (e.g., Sabbath), people (e.g., leaders), and place (e.g., nature, churches). Pargament and Mahoney’s (2005) definition of the sacred reflects these two perspectives. They define the sacred in terms of divine beings, higher powers, God, or transcendent reality, as well as other aspects of life that take on extraordinary significance by virtue of their association with the divine.

Theoretical speculation and empirical findings alike testify to the importance of the sacred to many people. The sacred, for example, elicits spiritual emotions such as awe, wonder and reverence (Otto 1928), mystical experiences which are characterized by feelings of unity, openness and totality (Hood 2005) and gratitude, which has been linked to significant emotional and physical benefits (Emmons & McCullough 2003). Once discovered, the sacred also becomes an organizing force in life and serves as the “ground of everything that is” and the “integrating center of the personal life” (Tillich 1957, 108). Further, the sacred can be a resource that can be accessed throughout life. For example, research has shown that couples who sanctify their marriages to greater degree report that they derive greater personal benefits and satisfaction from their marriages (Mahoney et al. 1999) and college students who view the act of sexual intercourse as sacred experience greater pleasure and satisfaction from their sexual act (Murray-Swank, Pargament & Mahoney 2005).

Given the centrality of the sacred to many people, mental health professionals should invite psychotherapy clients into a “spiritual conversation” by explicitly inquiring about the place of the sacred in their lives. During this conversation, it is important to attend to what is sacred to clients and what they organize their lives around, and to be alert to both traditional and nontraditional forms of the sacred. This invitation into spiritual conversation should be offered in the assessment phase, but it may be re-offered at other points in the course of psychotherapy. Three questions are particularly useful in the intake session: 1. Do you consider yourself a religious or spiritual person? If so, in what way? 2. Has your problem affected you religiously or spiritually? If so, in what way? 3. Has your religion or spirituality been involved in the way you have coped with your problem? If so, in what way? These three questions assess the salience of religion and spirituality to the client, to the problem, and to the solution, respectively (Pargament 2007).

By inviting clients to engage in a spiritual conversation, therapists open the door to a deeper and potentially more meaningful therapeutic dialogue, one that may have important implications for clients’ psychological health and well-being. Conversely, sidestepping this issue in treatment may lead to an incomplete and even dis-
torted picture of the lives of many clients. Furthermore, by overlooking the spiritual/religious dimension, therapists may be overlooking vital issues and valuable resources for effective treatment.

3.2. The Multiple Functions of Religion: Avoid Spiritual Reductionism

“How unique is religion/spirituality?” This question has concerned psychologists and other social scientists for a number of years. This question is far from an intellectual exercise; the answer to it has important implications for the ways that psychologists study, understand, and approach religion/spirituality (Pargament et al. 2005).

In an attempt to clarify the workings of religion, many researchers are examining questions about potential mediators of the relationship between religion and well-being. For example, can the relationship between church attendance and lower rates of mortality be explained by the social support members receive from the church or the sense of meaning received from religious doctrine? Can the relationship between religious struggles and negative outcomes be explained by the degree to which the individual is able to work struggles through or the extent to which the individual’s community accepts these struggles? Explaining how religion and spirituality work at the psychological and social levels is part of our job as researchers and practitioners. Nonetheless, there is an important difference between explaining religion and explaining religion away.

The classic approach to religion and spirituality was reductionistic in nature. Many renowned social scientists have argued that there is nothing unique about religion. For them, religion is merely an expression of more basic psychological, social or physiological processes. For example, Leuba (1933) maintained that mystical experiences could be ultimately explained by physiological processes. Freud (1927/1961) asserted that religion is a set of illusions designed to reduce anxiety and satisfy childish wishes. Durkheim (1915) viewed religion as an expression of basic social needs. More recently, Funder (2002, 214) expressed a similar point of view: “The psychological processes by which religion affects subjective well-being and psychological and physical health are interesting and important, and research on them is easily justified—but they have very little to do with religion per se, and there is nothing that necessarily leads from an interest in these processes to a focus on religion.” Each of these theorists tried to integrate and explicate religious phenomena within his specific theoretical framework. None saw the need for special concepts, theories, or methods tailored to religious life.

These types of reductionistic explanations of religion have received only limited empirical support. Numerous studies have testified to religion’s distinctiveness with respect to several dimensions: motivation and personality (Allport 1961; Emmons 1999; Piedmont 1999; Pargament & Mahoney 2002; 2005; Tarakeshwar, Swank, Pargament & Mahoney 2001), mortality and health (McCullough, Hoyt, Larson, Koenig & Thoresen 2000; Hummer, Rogers, Nam & Ellison 1999), coping (Mickley, Pargament, Brant & Hipp 1998; Tix & Frazier 1998), and distress (Richard & Bergin 2005; Trenholm, Trent & Compton 1998). Consider the following examples.
Piedmont (1999) examined spirituality as a “motivational trait,” one he described as an intrinsic, stable dimension of personality. Working with a college sample, he constructed the Spiritual Transcendence Scale (STS) that assessed prayer fulfillment, universality and connectedness. Piedmont showed that STS predicted outcomes (e.g., social support, interpersonal style, stress experience) above and beyond the effects of personality (the five-factor model of personality).

McCullough, Hoyt, Larson, Koenig & Thoresen (2000) conducted a meta-analysis of data from 42 independent samples examining the association of a measure of religious involvement and all causes of mortality. They found that religious involvement was significantly associated with lower mortality, indicating that people with higher religious involvement were more likely to be alive at a follow-up than people lower in religious involvement. Moreover, McCullough et al. (2000) examined whether potential mediating and confounding variables (demographics, health behaviors, social support) could explain the relationship between religiousness and mortality. Smaller, but still substantial, association between religious involvement and mortality remained even after controlling for these variables.

Working with a sample of 150 family members of loved ones undergoing coronary artery bypass surgery, Pargament et al. (1999) found that religious problem-solving strategies for gaining control (e.g., collaborative, deferring, self-directing coping) were uniquely associated with coping efficacy, anxiety and depression, and spiritual well-being after partialling out the effects of demographics and nonreligious methods of coping.

Thus, empirical studies such as these suggest that religion/spirituality may not be fully reducible to presumably more basic processes. The most parsimonious explanation of these findings may be that spirituality has some direct and unique effects on well-being. To put it another way, spirituality represents a significant dimension of life that stands on its own ground. Though additional research is needed that examines potential mediators between religion and health more comprehensively, it is highly unlikely that religion will be “explained away.” Religion certainly interacts with other basic human processes. Yet, extensive theoretical and empirical evidence suggest that religion is a distinctive dimension.

Spiritual reductionism has serious problematic clinical implications. Psychotherapists who reduce spiritual and religious concerns to presumably more fundamental problems might, for example, interpret anger at God as a sign of anger at the father and spiritual emptiness as merely a symptom of depression. Thus, when spiritual concerns arise in therapy, they may receive little direct attention from the therapist. Treat the “underlying” problem, it is assumed, and the spiritual problem will be resolved as well. Further, it is assumed that there is no need to assess religious or spiritual problems, for they are merely signs of a presumed deeper distress that represents the more appropriate target for treatment.

Based on theoretical and empirical grounds, spiritually integrated psychotherapy operates from a different frame of reference. Spiritually integrated psychotherapists take spirituality seriously in its own right rather than reduce it fully to a psychological function or explain it away. This approach to therapy assumes that spirituality is often interwoven into the problems of the clients, and that the spiritual dimension of problems calls for clinical attention. Teasing apart the interconnections between
psychological and spiritual problems is not always easy. Spiritual problems can be understood as a cause of psychological problems or the end result of psychological problems.

We believe that in order to perform such intricate clinical analyses, therapists should have the right attitude towards clients who raise spiritual concerns in psychotherapy. This attitude is manifested in four essential qualities. First, spiritually integrated psychotherapy calls for knowledge about spirituality that transcends any particular set of spiritual teachings, beliefs and practices. Spiritually integrated psychotherapy also involves more than knowledge about spirituality and knowledge about therapy; it rests on wisdom about how to integrate the two together.

Second, therapists should display openness and tolerance toward religious and spiritual concerns. Armed with openness to learning, the therapist can expand his or her understanding of spirituality over time. Education can come not only from readings and personal experience but from clinical work itself. Every client has the potential to teach the therapist something new and valuable about spirituality. An openness to learning also calls for tolerance of diverse spiritual expressions. The therapist must be able to communicate genuine respect for the many ways people understand and relate to the sacred.

Third, there is, of course, the potential of coercion in any form of psychotherapy; psychotherapy integrated psychotherapy is no exception. After all, client and therapist are not equal partners in the therapy room. By virtue of their training, education, and experience, therapists are in a position of greater power and authority than their clients, and as a result, may, knowingly or unknowingly, infringe upon their client’s autonomy and right to choose. One antidote to this danger is spiritual self-awareness, insight into the therapist’s own spiritual worldview and the way it may shape the therapeutic process.

Finally, therapists should portray authenticity in their work with clients. Authenticity means speaking to the truth as one comprehends it. Authenticity also entails a willingness to share one’s own understanding of life in ways that are respectful of the client’s values and autonomy. Authenticity involves self-disclosure in careful, measured ways that advance the clinical relationship. And, authenticity creates the conditions for communication at the most profound levels. It is an essential element of spiritually integrated psychotherapy.

Spiritual knowledge, tolerance, self-awareness and authenticity are all critical ingredients of spiritually integrated psychotherapy. Armed with a broad, deep, flexible and coherent perspective on spirituality, an appreciation for the richness and diversity of spirituality, an awareness of the role of spirituality in the lives of clients and the process of therapy; and a willingness to share oneself authentically in treatment, the spiritually integrated therapist becomes another powerful resource for the clients, a resource capable of facilitating profound change.

3.3. The Distinctive Character of Religious Coping Methods:
Help People Access Religious Resources

Empirical studies have shown that positive religious coping plays a beneficial role in the lives of people coping with major life stressors (Smith, Pargament, Brant
& Oliver 2000; Tarakeshwar & Pargament 2001; Narin & Merluzzi 2003; Smith, McCullough & Poll 2003; Ai, Peterson & Huang 2003; Meisenhelder & Marcum 2004; Ano & Vasconcelles 2005; Abu-Raiya, Pargament, Mahoney & Stein 2008; Aflakseir & Coleman 2009). According to Pargament et al. (2000), positive religious coping methods reflect a secure relationship with God, a belief that there is a greater meaning to be found, and a sense of spiritual connectedness with others. Below we draw attention to some of the recent relevant studies.

Smith, Pargament, Brant & Oliver (2000) examined the relationship between religious coping by church members and psychological and religious outcomes following the 1993 Midwest flood. They found that positive religious attributions and coping activities predicted better psychological and religious outcomes both 6 weeks and 6 months post-flood, after controlling for exposure and demographics.

Ai, Peterson & Huang (2003) collected information about religiousness, war-related trauma, religious-spiritual coping, optimism, and hope from a sample of Muslims who escaped from Kosovo and Bosnia and settled in the United States. Testing a path model, they found that higher religiousness was positively associated with positive religious coping, which in turn was related to higher optimism.

Working with 841 ministers in the Presbyterian Church, Meisenhelder & Marcum (2004) examined posttraumatic stress, religious and nonreligious coping in relation to positive religious outcomes following the tragedies of 9/11. They found that looking to God for strength, support, and guidance was the most frequently used strategy; the second was increased prayer. They also found that more frequent positive religious coping was related to less severe stress symptoms, numbness, avoidance and higher positive religious outcomes.

Ano & Vasconcelles (2005) conducted a meta-analysis of 49 studies testing the efficacy of religious coping for people dealing with stressful situations with a total of 105 effect sizes. The results of the study generally supported the hypothesis that positive religious coping was related to positive psychological adjustment to stress.

Finally, using a factor analysis with an international Muslim sample, Abu-Raiya, Pargament, Mahoney & Stein (2008) identified the Islamic Positive Religious Coping...
ing & Identification as one of 7 factors of Islamic religiousness. They found also that greater levels of Islamic Positive Religious Coping & Identification were consistently and strongly linked to greater levels of desirable outcomes (general Islamic well-being, purpose in life, satisfaction with life) and lower levels of undesirable outcomes (symptoms of physical health, alcohol use).

Helping clients identify and draw on their own resources is one of the most important services that therapists can offer. Spirituality is another critical resource that can be accessed in psychotherapy. Spiritual strivings, knowledge, experience, practices, relationships and coping methods are invaluable “tools” while working with therapy clients. Clinicians should pay close attention to these resources and help their clients to identify and draw on them in the process of dealing with life stressors. Table 1 presents examples of positive spiritual coping methods that have been shown to play a beneficial role in the lives of people coping with major life stressors.

3.4. Religious Struggles as a Fork in the Road:

Address Religious Struggles in the Counseling Process

If religion can be a source of support, strength, and comfort, it can also be a source of strain and religious struggles. Religious or spiritual struggles are “expressions of conflict, question and doubt regarding matters of faith, God and religious relationships” (McConnell et al. 2006, 1470). Researchers have identified three types of spiritual struggles: divine, intrapsychic and interpersonal (Pargament 2007). Divine struggles refer to tension in the individual’s relationship with the divine. This tension might be manifested in questions about the benevolence and power of God, feelings of divine abandonment and anger toward God. Intrapsychic spiritual struggles are characterized by questions and doubts about spiritual beliefs and issues, such as the belief in the afterlife, and conflicts between religious teachings and human impulses and appetites. Interpersonal spiritual struggles include spirituality-related conflicts with family, friends and institutions.

Empirical studies have linked signs of religious struggle to poorer mental health and even psychopathology (Fitchett, Rybarczyk, DeMarco & Nicholas 1999; Exline, Yali & Lobel 1999; Pargament, Zinnbauer et al. 1998; Smith, Pargament, Brant & Oliver 2000; Sherman et al. 2005; McConnell, Pargament et al. 2006; Abu-Raiya, Pargament, Mahoney & Stein 2008). Below we draw attention to a few examples.

Sherman et al. (2005) examined general religiousness and two modes of cancer-specific religious coping, drawing closer to faith (positive) and struggling with faith (negative), among 213 multiple myeloma patients evaluated at the same point in treatment, during their initial work-up for autologous stem cell transplantation. The outcomes assessed included standardized measures and clinician ratings of depression, general distress, physical functioning, mental health functioning, pain, and fatigue. After adjusting for relevant control variables, negative religious coping was associated with significantly poorer functioning in the areas of depression, distress, mental health, pain, and fatigue.

McConnell, Pargament et al. (2006) investigated the relationship between spiritual struggles and various types of psychopathology symptoms in individuals who had and had not suffered from a recent illness. Participants completed self-report
measures of religious variables and symptoms of psychopathology. Spiritual struggles were assessed by a measure of negative religious coping. As they predicted, negative religious coping was significantly linked to various forms of psychopathology, including anxiety, phobic anxiety, depression, paranoid ideation, obsessive–compulsiveness, and somatization, after controlling for demographic and religious variables. In addition, the relationship between negative religious coping and anxiety and phobic anxiety was stronger for individuals who had experienced a recent illness.

Abu-Raiya, Pargament, Mahoney & Stein (2008) identified religious struggle as one of two negative types of religiousness among Muslims. Greater levels of Islamic religious struggle were linked consistently and strongly with greater levels of negative outcomes (angry feeling, alcohol use, depressed mood) and lower levels of positive outcomes (positive relations with others, purpose in life).

It seems that religious struggles are the symbol of the “dark night of the soul” (Flower 1987). Their negative impacts are found across different religious groups and cultures. Initially, these findings surprised us. After all, from Abraham to Moses to Buddha to Jesus to Muhammad to Mother Teresa, illustrious religious figures have experienced their own religious struggles only to come out the other side steeled and strengthened. How can these findings be explained?

Table 2: Signs of Religious/Spiritual Struggles

<table>
<thead>
<tr>
<th>Divine Struggles</th>
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</thead>
<tbody>
<tr>
<td>1 I feel I am being punished by God.</td>
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<tr>
<td>2 I feel angry with God for what has happened.</td>
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<tr>
<td>3 I feel like God has abandoned me.</td>
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<tr>
<td>4 I wonder whether God really loves me.</td>
</tr>
<tr>
<td>5 I wonder whether the devil has something to do with the situation.</td>
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<td></td>
</tr>
<tr>
<td>Intrapsychic Struggles</td>
</tr>
<tr>
<td>1 I am having doubts about my faith.</td>
</tr>
<tr>
<td>2 I am not sure what I really believe anymore.</td>
</tr>
<tr>
<td>3 I know what’s right but I keep doing what’s wrong.</td>
</tr>
<tr>
<td>4 I do not know why I am alive.</td>
</tr>
<tr>
<td>5 I feel guilty about the way I think, feel, or act.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Interpersonal Struggles</td>
</tr>
<tr>
<td>1 I feel my church has abandoned me.</td>
</tr>
<tr>
<td>2 I disagree with what my church wants me to believe.</td>
</tr>
<tr>
<td>3 I disagree with family and friends about spiritual matters.</td>
</tr>
<tr>
<td>4 I feel like my family or friends are spiritual hypocrites.</td>
</tr>
<tr>
<td>5 I argue with my family or friends about whose side is God really on.</td>
</tr>
<tr>
<td>6 I hope God will have his vengeance on the people who hurt me.</td>
</tr>
</tbody>
</table>

*Source: Pargament (2007)*

One key may be whether the individual is able to resolve his or her struggles. Some recent analyses suggest that this may be the case; it appears that those who are unable to resolve their struggles over time are at greater risk of poorer mental and physical health, while people who experience these struggles temporarily do not face the same risk (Pargament, Koenig, Tarakeshwar & Hahn 2004). Another key may be
the degree to which religious struggles are socially acceptable. In this vein, Pargament & Abu-Raiya (2007) hypothesized that expressions of religious struggles may be unacceptable in different cultures, if there is a lack of models of individuals who acknowledge and work through their religious struggles. As a result, individuals who experience religious struggles may be especially vulnerable to stigma and loneliness, which may lead to depression, anger, or alcohol use. Promising as these explanations might be, it is important to recognize that they are still speculative. Future studies are needed to explicate the mechanisms that mediate between religious struggles and negative outcomes.

Because religious struggles are so robustly tied to mental and physical health, it would be inappropriate to overlook them in psychotherapy. How can mental health professionals address potentially problematic methods of religious coping in their work with clients? First, we recommend thoroughly assessing for the presence of religious or spiritual struggles. Table 2 presents signs of spiritual struggles (Pargament 2007). We encourage therapists to be alert to the manifestation of these and/or similar signs in their clients.

Second, it is important to avoid passing judgment on clients who are struggling by suggesting that their struggles are signs of a weak faith or religious/spiritual immaturity. Rather, we recommend supporting clients by normalizing these processes and creating opportunities to discuss them. In the process of normalizing spiritual struggles, it might be helpful to refer to individuals from different traditions (e.g., Moses, Jesus, Abraham, Muhammad, Mother Teresa) as models of esteemed figures who experienced such struggles. Consider for example the words of Mother Teresa who experienced profound feelings of divine abandonment as she worked with homeless children and dying people in the slums of Calcutta: “I am told that God lives in me – and yet the reality of darkness and coldness and emptiness is so great that nothing touches my soul. . . I want God with all the power of my soul – and yet between us there is terrible separation. . . Heaven from every side is closed” (The Toledo Blade, 2003, 6A). Or, consider Moses, who shattered the tables containing the Ten Commandments after witnessing the people of Israel worshipping a golden calf. Or Mohammad, who struggled immensely in trying to spread the message of Islam and at times would have doubts about the successful completion of his mission. Directing the attention of clients who deal with religious doubts and struggles to the fact that even such well-regarded figures experienced such struggles could help normalize these struggles and offer hope that they can lead to growth and transformation.

Third, we encourage clinicians to encourage clients to draw on spiritual resources to address spiritual struggles. Struggles can be resolved more effectively within the context of a broader and deeper spirituality. For example, Nicole Murray-Swank (2003) developed an eight-session spiritually-integrated program, “Solace for the Soul,” to address the spiritual struggles of women who had been sexually abused as children. Many of these women suffer from harsh, controlling images of God. “Solace for the Soul” has helped women to see God in a more loving light. In one exercise, participants are asked to imagine God’s love as a waterfall within themselves: “Picture God as a waterfall within you... pouring down cool, refreshing water... the waters of love, healing, restoration throughout your body... a cool, refreshing water-