The Challenge of Psychotherapy for Religion and Spirituality

Michael Utsch

Summary

Although early psychoanalysis was suspicious on religious belief, a growing interest in spirituality can be found in nowadays psychotherapies. The increase in volume and quality of scientific research in the psychology of religion is remarkable. This article reflects on this tendency. It is stated that psychotherapy cannot have claims on religious truths. But nevertheless psychotherapy and religion can have overlapping concerns and can be differentiated from one another. Some remarks are made on the integration and exclusion of spiritual interventions in psychotherapy.

Key words: Psychology of Religion, Psychotherapy, Spirituality

Introduction

In Western Europe, the Christian churches are changing at a large scale. Two examples may illustrate the new situation: In France, a traditional catholic country, until the 1960s the belief in God remained stable around 75 %. In 2006, only 52 % of the population indicate that they trust in God. While in the 1990s around 80 % attended worship services regularly, today only 51 % do so. In the Netherlands, in 1960 30 % of the population was a member of a protestant church. A new prognosis estimates that in 2020 only 4 % will belong to a protestant church. Then, only 28 % will be in contact with a Christian church at all. According to this study, in the Netherlands only two religious groups will remain on the long run – the Roman Catholic Church and Islam.

The main idea of the following text is that only a personal faith will give Christianity the power to survive in society reigned by secularisation. Psychotherapy can help people to internalize Christian values into a personal faith by giving faith an individual face. The young discipline psychotherapy in its turn can learn a lot of the old tradition of spiritual direction (Schreurs, 2002; Benner, 2004; Moon & Sperry 2004).

A historical sketch

Psychotherapy is the very young daughter of religious soul care. In ancient times, healing of the mind and soul was a religious matter. The religious community and pastoral care served as psychotherapy in former centuries. The physicians were part of the priests, and still in the

Middle Ages the medical profession was a holy office. Before modernity brought a radical transformation to every culture, medical science was grounded on a religious cosmology: healing (*Heilung*) was dependent on sanctification (*Heiligung*). Within shamanism and other traditional folk religions, health is part of a broad and complex meaning system – physical and psychological wellbeing are corresponding with the salvation of the soul. The religious professionals developed methods of spiritual counselling long before scientific concepts of psychotherapeutic treatment appeared (shamanism: Frank, 1961; Hinduism: Kakar, 1982; Buddhism: Epstein, 1995; Goleman, 2003; Trungpa, 2005; Christianity: Benner, 1998).

The Enlightenment movement and a countless number of technological revolutions caused a separation of the salvation of the soul – religion – from secular approaches to healing – medicine and psychotherapy. The scientific and the religious interpretation of the world became incompatible. In psychology, the best example is the strict behavioristic model of the human mind, which is based on a functional, mechanistic and deterministic world view. In this model of mind, there is no room for transcendent influences and therefore no need for transpersonal investigations.

When the Human Potential movement, the New Age era and a 'New Spirituality' permeated Western cultures, religious issues reappeared in an unexpected way.

While traditional meaning systems became old and 'dry', Western societies opened themselves for exotic techniques to extend their 'poor rationalistic' thinking. Shamanistic rituals, neohinduistic satsangs, Buddhist meditation retreats, and even Pentecostal healing events and other ways to enter a trance state of consciousness today are very popular. Para- psychological and transpersonal phenomena are used as an empirical proof for the existence of the spiritual reality (Lorimer, 2001; Dossey, 2002; Sheldrake, 2003).

On the field of counselling and psychotherapy, there is a shift between practical approaches of spiritual interventions and the lack of an empirically proven efficacy. The beginning of the 21st century shows many unsolved political conflicts based on religiously justified violence and a frighteningly growing fundamentalism in main world religions such as Christianity, Islam and Hinduism. This reminds the profession of psychology that the topics of religiosity and spirituality have been badly neglected (Tarnas, 1991; Kurtz, 1999; Pargament, 2002).

The shift from psychological critique to spiritual therapies

Psychotherapy tends to be suspicious of religious beliefs in which power is given to a 'higher reality' instead of to self control. Yet, the radical critique of religion of early psychoanalysis which tried to eliminate such 'childish' beliefs has changed into psychotherapies integrating the spiritual dimension. Moreover, in transpersonal psychotherapies healing effects of altered states of consciousness are propagated.

Starting with the human potential movement, much psychotherapies are explicit by aiming religious goals such as meaning giving, self-assertions and life-orientation (Utsch, 2002). While Freud and the early psychoanalysts treated religiosity from a biased perspective (Parsons, 1999), later developments such as the object-relations theories draw attention to parallels between psychoanalytic and religious change processes. In particular the British school of object-relations theory and theories of the self in the last years have contributed much to the understanding of the psychological functions of religious beliefs (Spezzano & Gargiulo, 1997; Britton, 1998; Eigen, 1998; Ferro, 2002; Schermer, 2003; Lehmann, 2004; Ostow, 2006).

Many other psychotherapists such as Jung, Frankl, Assagioli, have also developed thoughtful models of the religious dimension (Mahrer, 1996). Furthermore, the humanistic-transpersonal tradition of psychotherapy (Allport, Maslow, Grof, Wilber) which focused on extraordinary states of consciousness, have explored ways to combine spiritual traditions with modern psychological insights (Vaughan, Wittine, & Walsh, 1996). The new approach of Positive Psychology features the powerful resource of a stable meaning system (Shapiro, Schwartz, & Santerre, 2001; Pargament & Mahoney, 2001).

Presently many patients are seeking purpose, wholeness, and meaning in life (Bolletino, 2001). Confronted with life-threatening illness, traumatic experiences or feelings of deep depression and meaninglessness, they raise existential religious questions. However, to deal with questions such as justice, suffering, truth, death, destiny or meaning in life, the therapist does not need any extra professional psychotherapeutic competence. He needs the ability to work within a specific worldview.

Nevertheless a psychotherapist who methodically focuses on the clients' point of view cannot ignore the question of truth. Are the subjective (religious) meaning systems and the 'spiritual dimension' products of the human mind, or are they effects of a power independent of human activity? For the science of psychology, the crucial questions are: How can the subjective experience of a secret relationship between mind and body, consciousness and brain, spirit and soul become object of a psychological investigation or be part of a therapeutic intervention (Andresen & Forman, 2000; Cardena, Lynn & Krippner, 2000)? Still, the deep longing to handle and control existential powers by using a 'spiritual technique' produces a dilemma: by which method the Absolute can be managed? There is some evidence that the spiritual dimension follows paradox rules contrary to all rational insights (Cole & Pargament, 1999). Concepts of a 'spiritual intelligence' (Emmons, 1999) or 'spiritual transcendence' (Piedmont, 1999) as a single trait of personality offer a new way of description which takes into account the paradoxical nature of spirituality.

Research on religion in psychotherapy

Empirical research relevant to understanding the influence of religion and spirituality on psychotherapy has progressed but is still quite limited. A main finding says that clients' religious or spiritual values can be viewed as a potential resource in psychotherapy (Richards, Rector & Tjeltveit, 1999). Worthington and his team (1996) published a ten-year review of empirical research on religion in psychotherapeutic processes. They found a tremendous increase in volume and quality of scientific research. According to the findings of the 148 articles which they examined, religious people cannot be assumed to be mentally unhealthy. But only a few studies have focused on the influence of therapists' religious and spiritual values or the convergence and matching of clients' and therapists' religious values.

McCullough (1999) conducted a meta-analysis of five outcome studies that compared the efficacy of standard approaches to counselling for depression with religion-accommodative approaches. Findings suggest that the choice to use religious approaches with religious clients is probably more a matter of client preference than a matter of different efficacy. In Germany, relevant research on religious-accommodative approaches has started only recently (Utsch, 2005). Within the protestant churches, Christian counselling is dominated by the psychoanalytic paradigm.

Hickson, Housley, & Wages (2000) investigated the attitudes of 147 licensed counsellors in two south-eastern states of the USA concerning spirituality in the therapeutic process. The main results are: 94% of the counsellors indicate the significance of their self-awareness of spiritual beliefs, 90% consider the spiritual self as a powerful change agent within the counselling process, and 89% ask for better skills to discuss spiritual issues.

Rose, Westefeld & Ansley (2001) surveyed clients (N = 74) at six mental health centres in the USA. Nearly 40% of the participants reported no current religious affiliation. This is atypical: recent national surveys indicate that 71% are members of a church or synagogue. More than half (55%) of the clients indicated a desire to discuss spiritual or religious concerns in counselling. Clients who reported higher levels of prior spiritual experiences preferred to discuss spiritual or religious matters. Only 18% did not want to discuss spiritual or religious issues.

In a similar study in Germany, Demling, Wörthmüller and O'Connolly (2001) surveyed religious issues in psychotherapists' practice in Southern Germany. Less than 30% (29% of the physicians, 28% of the psychologists) reported no religious affiliation. Almost 20% of the psychologists prayed for their clients. The study did not find more agnostic therapists among the psycho-

analytical or behavioral trained professionals. A large number of the therapists would agree to co-operate with Christian counsellors. The results indicated that Roman Catholic psychotherapists were more open to religious experiences than the group of the Protestants and the group without a religious confession.

Bilgrave and Deluty (1998) examined the relations between religious beliefs and psychotherapeutic orientations in a sample of 237 psychologists (members of four divisions of the APA: clinical, counselling, therapeutic and humanistic psychology). Of the delivered surveys, 51 % were returned. 66 % of these psychologists believed in the transcendent, 72 % asserted that their religious beliefs influenced their practice of psychotherapy, and 66 % claimed that their practice of therapy influenced their religious beliefs.

In a similar study in Germany, Ludwig and Plaum (1998) sent a questionnaire on existential and religious beliefs to all psychotherapists working in Munich. Of the delivered surveys, only 31 % were returned. 93 % believed in something that goes beyond the findings of the empirical sciences, 74 % believed in a 'transcendent reality (personal or not personal)', and 65 % asserted the significance of this reality for their therapeutic work.

In an explorative study of a group of therapists, Sorensen (1994) explored the influence of developmental representations of God and their experiences as candidates in a psychoanalytic seminary with their preferred way of working with religious issues as therapists. He found that the students' own experiences of how their therapists handled religious issues were a stronger predictor of their approach to the religiosity of their clients than were the students' God representations.

In a recently published explorative study, Hundt (2003) used biographical interviews to find out why psychotherapists turn towards a spiritual way, and how they integrate spiritual values and methods in a Western concept of therapy. The therapists argued that spirituality as a central healing factor is necessary for the therapeutic process. The therapists reported that they deal with spiritual issues only on a clients' demand. Nevertheless, the study indicated a mixing between the therapeutic goal of the client and the spiritual meaning system of the therapist.

Religion and health

Health has become one of the most popular values in Europe. In Germany, the folk wisdom says 'Hauptsache gesund', which means that health is the most important thing in life. The search for better health also promotes the economy. You only have to look at the increasing drugstore business and the prices people are willing to pay for better health. All over Europe you will find busy wellness industries promoting improvement for body and soul. Since we know that the mind-body-connection is highly relevant for health and healing, many efforts are made to improve mental states. That's why faith, spirituality and religion have become a prominent research subject in medicine. But let us keep in mind that such a use of faith and spirituality is very narrow and limited. A concept which only looks for the efficacy and outcomes tends to reduce the complex structure of spirituality.

There is some research evidence that religious involvement is associated with better physical and mental health and longer survival (Koenig, McCullough & Larson, 2001). In a meta-analytic study, 147 investigations were examined whether religiousness is associated with less depressive symptoms (Smith, McCullough & Poll, 2003). Having analysed the data of almost 100.000 participants, the investigation indicated that greater religiousness is mildly associated with fewer symptoms.

The strong religion-health-connection has become suspect, however, especially in Europe. Religion and spirituality are culturally shaped. Therefore it is not possible to transfer the results of studies made in the predominantly religious United States directly to the much more secular Europe. Moreover, there are angry voices in Europe which assume for example that all studies with financial support by the Templeton Foundation cannot be taken serious because they are biased. It is true that the direction of a question influences the answer. The credo of Sir John Templeton 'A spiritual world is a better world' may have highlighted the beneficial aspects of

spirituality and neglected its harmful aspects. It must be highly acknowledged, however, that this foundation (and others) is pushing the research forward in a significant way.

Nevertheless, there is an ongoing battle among researchers promoting spirituality as a health resource like Harold Koenig from Duke University on the one hand and sceptical voices like Richard Sloan from Columbia University on the other hand. By the way, both are financially supported partly by the John Templeton Foundation. In his Field Analysis for the Metanexus Institute Sloan is posing a clever question: 'Given the significant place that religion holds in the US and the substantial ethical issues that arise in connection with religion and health, what, precisely, is the larger objective of studies that seek to examine connections between religious practices and health?' Here, we reach the critical point of the presuppositions of every psychological investigation in religion and spirituality: either by reduction (psychologically, religion is nothing else but – psychology as religion) or by apologetics defending religion psychologically (religion as psychology). While Koenig tries to protect religion, Sloan is attacking irrational beliefs. Because of the social and financial consequences, the question of religion and health is highly political. It is not helpful if a battle over the right or wrong worldview – for example the old fight between a scientific and a spiritual explanation of the world – is the motivation for empirical research. What are the aims of researchers conducting studies on religion and health? It seems important to me that each researcher answers this question for himself and that he also communicates the intention of his research.

In their survey, George, Ellison and Larson (2002) have identified four potential mediators of the religion-health-relationship:

1. Health practices,
2. Social support,
3. Psychosocial resources, and
4. Belief structures such as a coherent meaning system.

If we compare these mediators with the profile of a regular church visitor, we will find:

Ad 1. Church members normally smoke less and don't abuse drugs and alcohol – all significant health practices.

Ad 2. The social support through the local church community is also identified as an important health factor by several studies. One main finding from the numerous studies of Koenig and colleagues is that attendance at services is the most powerful predictor of health.

Ad 3. It is the upper middle class which attends religious services the most. Normally, a member of this milieu owns a set of psychosocial resources which empowers him to manage times of crises.

Ad 4: Religious faith offers a coherent meaning system that provides hope, security and comfort.

That's why the item 'regular attendance of religious services' does not tell us much about the factor religiosity or spirituality if we assume that this is really a separate and distinct factor. Is it possible to isolate the factor spirituality solo and alone? In the New Testament, Paul is saying: 'We have this treasure in earthen vessels'. That means that the gift of Christian faith and hope is covered by a weak body and a vulnerable soul. Spirituality must be incarnated by the personal history, the genetic and social disposition.

The mechanisms by which religion benefits health are still quit unclear. The thoughtful research review by George, Ellison and Larson (2002) concluded: 'We are far from understanding the mechanisms by which religious involvement promotes health.' The five conclusions which Pargament (2002) drew from his review of the empirical literature, are very helpful. He points out:

1. Some forms of religion are more helpful than others. For example, well-being has been linked positively to a religion that is internalized, intrinsically motivated, and based on a secure relationship with God and negatively to a religion that is imposed, unexamined, and reflective of a tenuous relationship with God and the world.
2. There are advantages and disadvantages to even controversial forms of religion, such as fundamentalism.

3. Religion is particularly helpful to socially marginalized groups and to those who embed religion more fully in their lives.
4. Religious beliefs and practices appear to be especially valuable in stressful situations that push people to the limits of their resources.
5. The efficacy of religion is tied to the degree in which it is well integrated in the individual's life.

Over all, the harmful effects of spirituality are often neglected. When the literature on religion and health is reviewed, the potential negative effects of religion are rarely discussed. In my opinion, this is what will happen if you only measure the frequency of church attendance. This factor is not very informative about the subjects' spirituality. Apart from the many demonstrated links between religiosity and well-being, some people are turning to religion with feelings of disappointment, mistrust and anger. According to some few preliminary data, the predictors of anger toward God seem to mirror the predictors of interpersonal anger and unforgiveness. Anger toward God is more likely when people believe that God directly caused severe suffering through malevolent interventions or will punish them.

Some other studies have analyzed the factor of religious doubt. Religious doubt as a feeling of uncertainty toward and questioning of, religious teachings and beliefs can be necessary for spiritual growth. On the other hand, the outcomes of a few studies suggest that religious doubt is associated with more symptoms of depression and less satisfaction with health.

The following table 1 shows some conjunctions with positive and negative effects on both sides:

Similarities and differences between the religious and the psychotherapeutic attitude

Psychotherapy and religion are overlapping in quite a lot of areas. Both are trying to build up better conditions for the human community, to answer personal needs and to help developing persons' potentials. But their differences are obvious: While psychotherapy as a complex scientific method is a modern enterprise, the religious interpretation of 'destiny' is as old as the world. Therefore, let us consider the differences between both realms:

- Psychotherapy is a profession based on scientific insights and empirically proven facts, while true religion lies beyond human control. True religion leads to letting go and devotion, while psychotherapy is a systematic training system of self direction. Every authentic religious experience transcends a causal-psychological analysis.
- While psychotherapy intends to rebuild the psychic and social functions, religious exercises are aimed to deepen the relationship to God or a transcendent power.
- Different psychotherapeutic schools have developed a variety of theories and tools to help people who suffer from depression or neurosis. But a serious psychotherapy never can promise happiness or well-being. The main factors which determine life satisfaction lay outside psychological control.

Table 1. *Conjunctions with positive and negative effects on integrative approaches in religion and in psychotherapy.*

	A religious tradition integrating therapeutic insights	*Medicine and psychotherapy integrating religious traditions*
Positive effects	Transformation of a dogmatic statement into personal truth	Using the power of rituals and symbols
Negative effects	Religious abuse of therapeutic techniques (group pressure, mind control)	Therapeutic promises with religious claims (e.g., salvation, enlightenment)

Integration or exclusion of spiritual interventions?

Religious or spiritual interventions are techniques imported from formal religious traditions and used as an addition to counselling or psychotherapy in the treatment of religious or spiritually-minded clients. Yet until recently, working with the spiritual dimension of human experience has been largely absent from professional training, and thus many clinicians are looking for greater competence in the psycho-spiritual realm. Since the initial impulse of Bergin (1980) there has been an ongoing discussion about the influence of values and the worldview as significant therapeutic variables. Recent publications show significant improvement in this field. They also indicate that a lot of work still has to be done (Shafranske, 1996; Richards & Bergin, 2000; 2005; W. Miller, 1999; Johnson & Sandage, 1999; West, 2000; Worthington & Sandage, 2001; 2002; Sperry, 2001; Schreurs, 2002; G. Miller, 2003; Utsch, 2005). The issue of the 'Journal of Clinical Psychology' (63/2007) dealing with spirituality in psychotherapy documents the ongoing research.

Some main achievements are:

- The development of a more culturally sensitive diagnostic manual which does not judge religiosity *per se* as pathological.
- The precise description of shapes of religiosity that help people to cope with their problems and to gain inner strength.
- The indisputable significance of religious faith for patients who struggle with existential questions and traumatic stress.

Some main desiderata are:

- The awareness of one's personal belief system and the readiness to notice and tolerate different ones.
- Which form of religiosity is helpful to which type of character, which one unhealthy?
- How to prevent that people seeking security in existential matters fall prey to fundamentalist sects?

More and more therapists are voting for integration (Sollod, 1993; Karasu, 1999). Only a few reject this (Corveleyn, 2000) and some others try to balance therapeutic and spiritual interventions (Lomax, Karff & McKenny, 2002). Obviously there is an urgent need for intrapersonal integration: all counsellors and therapists need to recognize their own value systems and beliefs about suffering, health, wellbeing and meaning in life (Tan, 1996; Miller, 1999). Explicating one's models of reality may not be an easy process for mental health professionals, but such explication is needed. Otherwise, there is a real risk that they will act as therapeutically unethical and religious leaders.

In a thoughtful analysis, Zinnbauer and Pargament (2000) have identified four helping orientations of the counsellor to religious and spiritual issues in psychotherapy. The constructivist and the pluralist approaches are advocated as best suited to work with diverse clients and religious beliefs, and flexible enough to deal respectfully, ethically, and effectively with a variety of religious and spiritual issues in therapy and counselling.

Our democratic culture assigns equal rights to people with a variety of worldviews, which may be incompatible if not downright contradictory. As a result many people with a vague religious longing or ambivalent religious commitment are seeking a personal identity. They confront psychotherapists with a new challenge: to support them in their search for a satisfying religious orientation (see table 2).

This raises the question whether we should meet this callenge and give our patients support in their spititual search? If our answer is yes, as I think it should be, than we must be aware of some conditions and restrictions:

1. We need to acquire some key competences of spiritual care.
2. We need to acknowledge that we cannot exercise professional spiritual directions (unless we are prepared to become fully-qualified theologians). Our help in that area will necesserily be limited.
3. We need to keep our role as therapist apart from the role of provider of spiritual support. As table 2 shows, the diffences between the two are fundamental. Mixing them would be utterly confusing for the patient and unethical fot the therapist.

Table 2. *Differences in psychotherapeutic and religious attitude.*

	Psychotherapeutic attitude	*Religious attitude*
Goal	Behaviour Control, Functioning	Confidence in a Higher Power
Method	Focusing on solutions	Openness, letting go
Relationship	Professional Distance	Leader, Master, Guru
Consequence	Ability to cope with stressors	Surrender and Devotion

4. The religious insights of therapist and patient should not contradict each other, and neither should they differ too much from each other. Otherwise authentic communications and support are impossible (see table 2).

To benefit from the powerful health effects of religious beliefs and practices, a careful integration of religious or spiritual interventions requires a corresponding worldview of client and therapist.

Literature:

Andresen, J. & Forman, R.K.C. (Eds.) (2000). *Cognitive Models and Spiritual Maps. Interdisciplinary Explorations of Religious Experience*. Thorverton: Imprint Academic.

Benner, D.G. (1998). *Care of Souls. Revisioning Christian Nurture and Counsel*. Grand Rapids: Baker.

Benner, D. G. (2004). Intensive Soul Care: Integrating Psychotherapy and Spiritual Direction. In L. Sperry & E. P. Shafranske (Eds.), *Spiritually oriented Psychotherapy*. Washington: APA.

Bergin, A.E. (1990). Psychotherapy and Religious Values. *Journal of Consulting and Clinical Psychology, 48,* 95-105.

Bilgrave, D.P. & R.H. Deluty (1998). Religious Beliefs and Therapeutic Orientations of Clinical and Counselling Psychologists. *Journal for the Scientific Study of Religion, 37 2,* 329-349.

Bolletino, R. C. (2001). A Model of Spirituality for Psychotherapy and other Fields of Mind-Body-Medicine. *Advances in Mind-Body-Medicine, 17,* 90-107.

Britton, R. (1998). *Belief and Imagination. Explorations in Psychoanalysis*. London: Routledge.

Cardena, E., S.J. Lynn & S. Krippner (Eds.) (2000). *Varieties of Anomalous Experience. Examining the Scientific Evidence*. Washington: APA.

Cole, B. & K. I. Pargament (1999). Spiritual Surrender: A Paradoxical Path to Control. In W. Miller (Ed.), *Integrating Spirituality in Treatment. Resources for Practitioners*. Washington: APA.

Corveleyn, J. (2000). In Defense of Benevolent Neutrality. Against a 'Spiritual Strategy'. *The Journal of Individual Psychology, 56, 3,* 343-352.

Demling, J.H., M. Wörthmüller & T.A. O'Connolly (2001). Psychotherapie und Religion. Eine repräsentative Umfrage unter fränkischen Psychotherapeuten. *Psychotherapie, Psychosomatik, medizinische Psychologie 51,* 76-82.

Dossey, L. (2002). *Healing Beyond the Mind. Medicine and the Infinite Reach of the Mind*. Boston: Shambala.

Eigen, M. (1998). *The Psychoanalytic Mystic*. London: Free Association Press.

Emmons, R. A. (2000). Is Spirituality an Intelligence? Motivation, Cognition and the Psychology of Ultimate Concern. *The International Journal for the Psychology of Religion, 10, 1,* 3-26.

Epstein, M. (1995). *Thoughts without a Thinker. Buddhism and Psychoanalysis*. New York: Harper Collins.

Ferro, A. (2002). Some Implications of Bion's Thought. *The International Journal of Psychoanalysis, 83,3,* 597-607.

Frank, J.D. (1961). *Persuasion and Healing. A Comparative Study of Psychotherapy*. Baltimore: John Hopkins University Press.

George, L.K., C.G. Ellison & D.B. Larson (2002).

Explaining the Relationships between Religious Involvement and Health. *Psychological Inquiry, 13, 3,* 190-200.

Goleman, D. (2003). *Healing Emotions. Conversations with the Dalai Lama on Mindfulness, Emotions and Health*. Boston: Shambhala.

Hickson, J., W. Housley & D. Wages (2000). Counselors' Perceptions of Spirituality in the Therapeutic Process. *Counselling and Values, 45,* 58-66.

Johnson, E. L. & S.J. Sandage (1999). A Postmodern Reconstruction of Psychotherapy: Orienteering, Religion, and the Healing of the Soul. *Psychotherapy, 36,* 1-15.

Hundt, U. (2003). Psychotherapie und Spiritualität. Eine qualitative Studie über die Integration spiritueller Konzepte und Methoden. *Journal für Psychologie, 11, 4,* 368-386.

Kakar, S. (1982). *Shamans, Mystics, and Doctors*. New York: Alfred A. Knopf.

Karasu, T.B. (1999). Spiritual Psychotherapy. *American Journal of Psychotherapy, 53, 2,* 143-162.

Kendler, K.S., X.-Q. Liu, C.O. Gardner, M.E. McCullough, D. Larson & C.A. Prescott (2003). Dimensions of Religiosity and Their Relationship to Lifetime Psychiatric and Substance Use Disorders. *American Journal of Psychiatry, 160, 3,* 496-503.

Koenig, H.G., M.E. McCullough & D.B. Larson (2001). *Handbook of Religion and Health*. New York: Oxford University Press.

Kurtz, E. (1999). The Historical Context. In W.R. Miller (Ed.), *Integrating Spirituality into Treatment. Resources for Practitioners*. Washington: APA.

Lehmann, S. R. (2004). *Minding Spirituality*. New York: The Analytic Press.

Lomax, J.W., S. Karff & G.P. McKenny (2002). Ethical Considerations in the Integration of Religion and Psychotherapy: Three Perspectives. *Psychiatric Clinics of North America, 25,* 547-559.

Lorimer, D. (Ed.) (2001). *Thinking beyond the Brain. A Wider Science of Consciousness*. New York: Floris Books.

Ludwig, M. & E. Plaum (1998). Glaubensüberzeugungen bei Psychotherapeuten. *Zeitschrift für Klinische Psychologie, Psychiatrie und Psychotherapie, 46, 1,* 58-83.

Mahrer, A.R. (1996). Existential-Humanistic Psychotherapy and the Religious Person. In Shafranske (Ed.), *Religion and the Clinical Practice of Psychology*. Washington: APA.

McCullough, M. E. (1999). Research on Religion-Accomodative Counselling. Review and Meta-Analysis. *Journal of Counselling Psychology, 46,* 92-98.

Miller, G. (2003). *Incorporating Spirituality in Counselling and Psychotherapy. Theory and Technique*. New Jersey: John Wiley.

Miller, W.R. (Ed.) (1999). *Integrating Spirituality into Treatment. Resources for Practitioners*. Washington: APA.

Moon, G. W. & L. Sperry (Eds.) (2004). *Spiritual Direction and the Care of Souls. A Guide to Christian Approaches and Practices*. Philadelphia: Intervarsity Press.

Ostow, M. (2006). *Spirit, Mind, and Brain. A Psychoanalytic Examination of Spirituality and Religion*. New York: Columbia University Press.

Pargament, K.I. & A. Mahoney (2001). Spirituality. Discovering and Conserving the Sacred. In C. R. Snyder & S.J. Lopez (Eds.), *Handbook of Positive Psychology*. New York: Oxford University Press.

Pargament, K.I. (2002). The Bitter and the Sweet. An Evaluation of the Costs and Benefits of Religiousness. *Psychological Inquiry, 13, 3,* 168-181.

Parsons, W.B. (1999). *The Enigma of the Oceanic Feeling. Revisioning the Psychoanalytic Theory of Mysticism*. New York: Oxford University Press.

Piedmont, R. L. (1999). Does Spirituality represent the Sixth Factor of Personality? Spiritual Transcendence and the Five-Factor Model. *Journal of Personality, 67,* 985-1014.

Richards, P.S. & A.E. Bergin (Eds.) (2000). *Handbook of Psychotherapy and Religious Diversity*. Washington: APA.

Richards, P.S. & A.E. Bergin (2005). *A Spiritual Strategy for Counselling and Psychotherapy*. Washington: APA.

Richards, P.S., J.M. Rector & A.C. Tjeltveit (1999). Values, Spirituality, and Psychotherapy. In

W.R. Miller (Ed.), *Integrating Spirituality into Treatment*. Washington: APA.

Rose, E.M., J.S. Westefeld & T.N. Ansley (2001). Spiritual Issues in Counseling: Clients' Beliefs and Preferences. *Journal of Consulting Psychology, 48, 1,* 61-71.

Schermer, V. L. (2003). *Spirit and Psyche. A New Paradigm for Psychology, Psychoanalysis and Psychotherapy*. London: Jessica Kingsley.

Shafranske, E.P. (Ed.) (1996). *Religion and the Clinical Practice of Psychology*. Washington: APA.

Shapiro, S.L., G.E.R. Schwartz, & C. Santerre (2001). Meditation and Positive Psychology. In C. R. Snyder & S.J. Lopez (Eds.), *Handbook of Positive Psychology*. New York: Oxford University Press.

Sheldrake, R. (2003). *The Sense of Being Stared At and Other Aspects of the Extended Mind*. London: Hutchinson.

Smith, T.B., M.E. McCullough & J. Poll (2003). Religiousness and Depression: Evidence for a Main Effect and the Moderating Influence of Stressful Life Events. *Psychological Bulletin, 129, 4,* 614-636.

Sollod, R.N. (1993). Integrating Spiritual Healing Approaches and Techniques into Psychotherapy. In G. Stricker & J.R. Gold (Eds.), *Comprehensive Handbook of Psychotherapy Integration*. New York: Plenum Press.

Sorensen, R.L. (1994). Therapists' (and their Therapists') God Representations in Clinical Practice. *Journal of Psychology and Theology, 22,* 325-344.

Sperry, L. (2001). *Spirituality in Clinical Practice. Incorporating the Spiritual Dimension in Psychotherapy and Counselling*. Philadelphia: Brunner-Routledge.

Spezzano, C. & G.J. Gargiulo (Eds.) (1997). *Soul on the Coach. Spirituality, Religion, and Morality in Contemporary Psychoanalysis*. Mahwah: The Analytic Press.

Schreurs, A. (2002). *Psychotherapy and Spirituality. Integrating the Spiritual Dimension into Therapeutic Practice*. London: Jessica Kingsley.

Tarnas, R. (1991). *The Passion of the Western Mind*. New York: Random House.

Tan, S.Y. (1996). Religion in Clinical Practice: Implicit and Explicit Integration. In Shafranske (Ed.), *Religion and the Clinical Practice of Psychology*. Washington: APA.

Trungpa, C. (2005). *The Sanity We Are Born With. A Buddhist Approach to Psychology*. Boston: Shambhala.

Utsch, M. (2002). *Psychotherapie und Spiritualität. Unterschiede zwischen wissenschaftlicher und weltanschaulicher Lebenshilfe*. Berlin: EZW-Texte 166.

Utsch, M. (2005). *Religiöse Fragen in der Psychotherapie. Psychologische Zugänge zu Religiosität und Spiritualität*. Stuttgart: Kohlhammer.

Vaughan, F., B. Wittine & R. Walsh (1996). Transpersonal Psychology and the Religious Person. In Shafranske (Ed.), *Religion and the Clinical Practice of Psychology*. Washington: APA.

West, W. (2000). *Psychotherapy and Spirituality. Crossing the Line between Therapy and Religion*. London: Sage.

Worthington, E. L., Jr., T.A. Kurusu, M.E. McCullough & S.J. Sandage (1996). Empirical Research on Religion and Counselling. A Ten-Year Update and Prospectus. *Psychological Bulletin, 119,* 448-487.

Worthington, E.L. & S.J. Sandage (2001). Religion and Spirituality. *Psychotherapy, 38, 4,* 473-478.

Worthington, E.L. & S.J. Sandage (2002). Religion and Spirituality in Psychotherapy. In J.C. Norcross (Ed.), *Psychotherapy Relationships that Work*. New York: Oxford University Press.

Wulff, D.M. (2000). Mystical Experience. In E. Cardena, S.J. Lynn & S. Krippner (Eds.), *Varieties of Anomalous Experience. Examining the Scientific Evidence*. Washington: APA.

Zinnbauer, B.J. & K.I. Pargament (2000). Working with the Sacred. Four Approaches to Religious and Spiritual Issues in Counselling. *Journal of Counselling and Development, 78,* 162-171.

Personalia

Dr. M. Utsch is theologian and psychologist. He is as a psychotherapist allied to the Evangelische Zentralstelle für Weltanschauungsfragen in Berlin. Correspondence: EZW, Auguststraße 80, 10117 Berlin, Germany. E-mail: utsch@ezw-berlin.de