

(v2); Couple and Marital Counseling (v1); Family Counseling (v1); Therapist Techniques/Behaviors (v2)

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SPIRITUALITY/RELIGION

Traditionally, the word *spirituality* has been used for concepts and experiences that either are religious or are analogous to it. More recently, there has been controversy concerning the meaning and application of the term *spirituality* as it is differentiated from *religion* and *religiosity*. Inasmuch as the largest body of research relevant to issues in counseling and religion has concentrated on what can be defined as “religion and mental health,” this entry begins in that context and then addresses other understandings of spirituality.

The relation between religion and mental health can be divided into two separate, but related issues: the influence of religion on mental health and the place of religion in the counseling session.

The Influence of Religion on Mental Health

For centuries, some of the most brilliant minds in the world’s cultures pondered the nature of the human condition in the context of religion. In general, these individuals took religion as a given, and presumed that the best life was that which conformed to the dictates of the religion with which the individual identified. Religion was generally presumed to be required for the good ordering of society, its function being to promote virtue and condemn vice, at least for the masses. When psychology began to emerge as a distinct discipline at the midpoint of the 19th century and sever its ties with philosophy, there was a general reconsideration of religion and its relation to human welfare. This process continued into the twentieth century, and a number of the founding fathers of the fledgling field of psychology essentially rejected religion out of hand (e.g., Sigmund Freud, John B. Watson, B.F. Skinner) as a remnant of unsophisticated and superstitious thinking.

As the specialties of clinical and counseling psychology developed after World War II and were influenced by behavioral and psychoanalytic theories, psychology continued with the presumption that religion was the vestige of an earlier, irrational mentality, and that it was detrimental to optimal functioning. Items with religious content were included in the first edition of the Minnesota Multiphasic Personality Inventory (MMPI) because therapists had heard such phrases from their clients, and associated them with their clients’ disorders. Positive correlations between the Marlowe-Crown Social Desirability scale and measures of religiousness were taken as evidence that religious individuals had a strong “approval motive” and thus their answers on other measures were suspect. Albert Ellis, one of the most prominent therapists of the second half of the 20th century, promoted rational-emotive therapy (RET), which took for granted that religion was irrational and thus a detriment to mental health.

Over time, evidence grew that the presumption of a general negative impact of religion on mental health was untenable. A large-scale factor analysis of the MMPI discovered that its religion-related items loaded on a factor orthogonal to those measuring disorders. These items were removed from the MMPI-2. Other research found that religious and nonreligious

individuals differed in their response patterns to certain items on the Social Desirability Scale. When these items were removed, there was no correlation between the remaining items on the Social Desirability scale and measures of religiosity.

The 1990s saw continuing research on religion-related topics, as well as impressive meta-analytic reviews of the area supporting a positive view of religion. Harold Koenig, Michael McCullough, and David Larson's *Handbook of Religion and Health* is among the best sources for summary data on research on religion and mental health. They found that across a wide range of disorders—depression (118 findings surveyed), suicide (114 findings), anxiety disorders (80 findings), schizophrenia and other psychoses (22 findings), alcohol and drug use (99 findings), delinquency (41 findings), marital instability (42 studies)—religiousness was associated with lower rates of risk in the majority of cases.

Koenig and colleagues were careful to note nuances:

- Depression is more common among Jews and unbelievers than among Christians and Protestants.
- Depression and anxiety display a stronger negative relation to activity in a religious community than simple religious belief. They also have a stronger negative relation with intrinsic (religion as an end to itself) rather than extrinsic (religion as source of social support and networking) orientations toward religion.
- There is no clear linkage between any particular denomination and suicide, although rates are lower among conservative Protestants and Muslims, and generally lower among the religiously committed.
- There are no prospective studies involving religiousness and schizophrenia, so causal statements are largely unwarranted.
- In contrast, there is evidence that early religious involvement in youth may be protective factor against later delinquency.
- Religious homogamy (both spouses being of the same religious background) may be a factor in the negative relation between religiousness and marital instability.

Thus, far from supporting the view that religion is somehow pathogenic, the empirical evidence is that religion may be an influence for reducing the likelihood for a variety of disorders. However, it is neither ethical nor practical to try to inculcate religion into all clients to make their lives better.

Religion in the Counseling Session

As noted earlier, Ellis considered religion irrational and therefore essentially antithetical to the therapeutic process. Others, however, were engaged in a body of theory and research that would integrate the involvement of religious principles in the therapeutic process. An increasing number of researchers studied aspects of religion (e.g., religious coping, forgiveness) and their roles in clients' lives. In 2000, the American Psychological Association (APA) prominently featured works on integrating religion/spirituality and psychology in its publications catalogue and later that same year, Ellis himself published an article admitting that even conservative religion can have positive mental health influences. Currently, both the American Counseling Association (ACA) and APA acknowledge religion as a form of diversity that requires the same level of attention as gender, racial/ethnic background, and sexual orientation.

How should such issues be addressed in the counseling session? Several sources addressing the integration of religious beliefs and therapy recommend the taking of a religious/spiritual history of the client. The following questions might be asked: "Has religion or spirituality played a major force in your development?" "Were you raised within any religious tradition?" "How would you describe yourself now?" Regardless of the answers to these questions, they may provide insights that will be profitable in ways that are not immediately evident.

Two aspects of therapy with the religious client are most important. The first are the "cultural" aspects of religious affiliation. Clients from denominations with strict behavioral constraints (e.g., Mormons, Seventh-Day Adventists) can sometimes be provoked to terminate therapy prematurely when presented with seemingly innocuous questions (e.g., "Would you like a cup of coffee?"). Similarly, the intense degree of religious involvement in more conservative denominations, or for the more conservative members of some of the main denominations, may seem aberrant to the uninformed therapist when in fact they simply reflect a standard level of commitment in that context. Clinical psychologists, who have been shown in surveys to be far less likely to be actively involved in religious settings than the general population, need to be trained, as a part of their competence in cultural diversity, in the cultures and practices of various religious traditions.

The second aspect of religion that brings unique characteristics to the counseling and therapy is religious coping. This is the great strength of religion-accommodative therapy. It joins the insights of psychology to those of theology and religion. If both therapist and client find it acceptable, strategies of invoking God, Jesus, a beloved saint, or an honored ancestor to be present while imaging a traumatic event; engaging in prayer at the beginning or end of a given session; or contacting a minister of the person's denomination to suggest a form of religious practice that may be effective for that individual may be employed. Any of these actions can have profound, unique effects in the therapeutic setting.

Of course, not all forms of religious coping are good. Kenneth Pargament and his colleagues noted that one characteristic of negative religious coping could be evidenced by a change or "reappraisal" of long-held religious understandings. For example, a change by a client from a traditional image of a loving God to one who actively punishes wrongdoing, and is punishing the client specifically, is associated with greater depression.

Spirituality

Traditionally, the term *spirituality* has had two primary meanings. One was to describe the way in which one is religious, as in Eastern versus Western spirituality or Franciscan versus Jesuit spirituality. The second was to describe the heights of human experience, after the manner of Abraham Maslow's "peak experiences."

More recently, however, spirituality has become quite popular in the psychological literature. Spirituality first became a *Psychological Abstracts* keyword in 1988. Between then and the end of 2005, some 2470 entries were classified with that keyword, nearly as many as those that have been associated with Religion (2621). Of course, these numbers reflect cross-listings; fewer than half of the Spirituality entries (1212) are related only to that keyword; without also being cross-listed with some more traditional, religion-related keyword (the name of a specific denomination, religion, or religiosity or specific religious practices). Thus, much recent use of the word *spirituality* has been used to focus attention on the unique, personal, experiential characteristics of religiousness. Often this is defined as an individual's personal experiences of and relationship to the divine, which may or may not be specifically framed within a particular religious institution or tradition.

Although spirituality and religion do overlap, there is an ongoing interest in the counseling field in a spirituality that is largely disconnected from religion. Rheta L. Steen, Dennis W. Engels, and W. Tom Thewett III quote the Association for Spiritual, Ethical, and Religious Values in Counseling (ASER-VIC)—publisher of the journal *Counseling and Values*, a forum for much of the current discussion of the function of spirituality in counseling—as having defined *spirituality* in the following way:

Spirit may be defined as the animating life force, represented by such images as breath, wind, vigor, and courage. Spirituality is the drawing out and infusion of spirit in one's life . . . a capacity and tendency that is innate and unique to all persons. [It] moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness. Spirituality includes one's capacity for creativity, growth, and the development of a value system. [It includes] experiences, beliefs, and practices. Spirituality is approached from a variety of perspectives, including psychospiritual, religious, and transpersonal. While . . . usually expressed through culture, it both precedes and transcends culture. (p. 109)

Most striking about this definition is the near complete absence of any reference to religion. In a similar vein, the writings of Daniel Helminiak seek to disengage spirituality from religion, asserting that spirituality is innate in the human condition and has no necessary connection to concepts of God or the supernatural, and that such connections are almost invariably prescriptive (linked to religious doctrine and privileging certain perspectives). An approach like Helminiak's is a minority view, and there is thus relatively little research connecting it to therapeutic outcomes, given the lack of clear operational definitions. Furthermore, the common concatenation of the terms *religion* and *spirituality* threatens to further confuse matters, as spirituality becomes associated with both traditional religious practices and measures and less traditional "scientific" (to use Helminiak's term) understanding.

On the positive side, the broadening of the understanding of the human condition to include not only problems in living but also struggles with more overarching issues concerning knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness is certainly an

advance for the practice of counseling. Ethical standards for counselors increasingly mandate that counselors be open to such spiritual concerns when they are raised by their clients, be aware of them as diversity issues, and be willing to refer their clients if they don't feel prepared to deal with the type of spirituality that the clients presents. The *Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR)* defines such circumstances under the V-code 62.89 as "distressing experiences that involve loss or questioning of faith . . . conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution" (p. 741). The acceptance of such issues into the therapeutic process can only ultimately result in enriching the definitions of health and wholeness.

Current Literature

The current literature suggests that (a) there is strong evidence that employing both the cultural and spiritual aspects of traditional religious frameworks can strengthen a therapist's understanding and the effectiveness of his or her clients; (b) knowledge of the client's religious background, as well as knowledge of religious coping styles, can inform the therapist both of possible additional coping mechanisms available and of potentially maladaptive uses of religious concepts; and (c) there is as yet no significant body of evidence for the healing power of a "spiritual, but not religious" approach. Although advocates claim that religious beliefs confer psychological benefits and critics argue that some aspects of religious doctrine are psychologically harmful, there is little convincing evidence to substantiate these beliefs when religion, per se, is distinguished from behaviors justified on the basis of religious beliefs.

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See also Coping (v2); Espiritismo (v3); Forgiveness (v2); Jung, Carl (v2); Religion/Religious Belief Systems (v3); Spirituality (v3); Spirituality and Career Development (v4)

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STRESS

Stress is an unpleasant state of emotional arousal that people experience in situations that they perceive as dangerous or threatening. It is accompanied by physiological, behavioral, and cognitive changes. Although stress signals danger and thus has a protective function, the experience of chronic stress is a causative factor in physical illness as well as poor life adjustment and psychiatric disturbance.

Individuals differ in their propensity to experience stress and in their ability to cope effectively. Effective coping ultimately involves effective problem solving although emotion-focused strategies are useful in the short term and in uncontrollable situations. When stress and poor coping are experienced chronically the resultant physiological changes may contribute to the onset