Integrating spiritual resources from Christianity with Adlerian Psychology in clinical practice

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Abstract

Recent research supports the positive contribution that religious faith and spirituality (R/S) makes in helping people deal with significant life-altering events. Difficult life events and experiences such as bereavement can be life-altering, difficult to manage and can seriously challenge one's sense of meaning and purpose in life. Research supports that a majority of Americans have some type of religious belief or value system. This paper explores ways to integrate a Christian worldview with Adlerian psychology to effectively treat clients. Part of this literature review includes application to client care in the area of grief and loss, and the significant stress of spousal loss. Adler's Individual Psychology, as a holistic and practical method, can be effective with people of faith in making life adjustments. This thesis will identify current research findings regarding counseling the bereaved and connect key concepts from Individual Psychology with corresponding Christian spiritual and religious values and beliefs to provide an additional clinical resource for therapists.
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Integrating spiritual resources from Christianity with Adlerian Psychology in clinical practice

Recent research has supported the positive contribution that religious faith and spirituality (R/S) makes in helping people deal with significant life-altering events. Difficult life events and experiences such as bereavement can be life altering, difficult to manage and seriously challenge one's sense of meaning and purpose in life. In these situations, recovering people often rethink and form a renewed reliance on the sources of meaning and purpose in life.

Why have spiritual and religious interventions become an important and relevant area of study for therapists? First, these interventions represent a way of incorporating the clients’ spiritual beliefs and values into therapy (Hodge, 2011). Further, recovery often requires both psychosocial interventions to help people gain control of their lives, and religious or spiritual understanding to help them discover the limits of their control (Bussema, 2000).

There has been a mutual skepticism in the relationship between religion and science. Historically, mental health professionals have held ambivalent positions concerning the role of spirituality and religion in psychotherapy and clients have had concerns about the theories, beliefs, and methods of mental health professionals. This author, coming from an evangelical Christian worldview, explores an integrative approach to therapy in which one integrates a Christian worldview with the science and practice of psychology. This approach recognizes that the Christian faith has something important to contribute to psychology. A therapist can draw on the resource of God’s answers to basic life questions as a foundation for how to engage the science of psychology and to structure a practice in the profession. In the healing professions science has provided us with intellectual and practical tools for understanding and improving the human condition. It can help us understand things we want to know, for example, about child development, the human personality and schizophrenia or depression. There are many topics that
scripture does not address—how neurons work, how the brain synthesizes mathematical or emotional information, the types of memory, or the best way to understand personality traits (Johnson, 2010, p. 116). But our human experience is more than the basic elements of behaviors, neurons firing, or cognitive processing. Religious faith contributes perspectives on meaning, values, significance, ethics, and morality.

A fundamental stance as a Christian therapist is to embrace what God has told us about what it means to be fully human first; then that is our framework for engaging psychology as a social science in the world of learning (Johnson, 2010, p. 183). In the same way different denominations hold different emphases and understandings on many matters but still agree on fundamentals, therapists can be challenged to pursue the most effective use of their beliefs and education. Research indicates that many practitioners desire to use spiritual interventions in counseling but have received minimal training on the subject during their graduate studies (Hodge, 2011).

**Purpose and Significance of the Study**

The information collected by this research is relevant to counselors who have an interest in using religious faith and spiritual interventions in clinical counseling. Data presented in this research report will show historical trends, intervention strategies, bereavement research, the relationship between Adlerian Psychology and Christian principles, and a need for continued study of integrative trends. This paper explores a collaborative and integrative model of psychology with which to incorporate religious and spiritual interventions to effectively and ethically treat clients dealing with life-altering events such as the emotional affects and symptoms of bereavement.
Regardless of the worldview used to assess evidence, a goal of some therapists is to understand how R/S can affect the treatment outcome of clients in a particular population. Considerations for therapists coming from the Christian tradition include choosing a theory or model of psychotherapy to use in their practice, how that theory aligns with their personal beliefs and value system, and how to incorporate R/S in counseling clients. This paper explores the theory of Adlerian Psychology as a framework to provide clinical structure from a Christian perspective.

Assumptions and Limitations

This paper contains assumptions and limitations. First is the assumption that most graduate-level programs do not offer religion and spiritual interventions as part of their curriculum. Another assumption is that spiritual interventions can be effective in the treatment of mental and emotional disorders. This study explores the use of spiritual interventions to treat psychological problems resulting from spousal bereavement. Limitations include the lack of conclusive relevant research regarding psycho-spiritual interventions; and research methods used to measure R/S are often assessed in ways that do not assess differences that exist between faith traditions.

Literature Review

Few events in life affect adults more than the death of a spouse. It is considered to be one of life’s most difficult stressors and exposes the bereaved person to a higher risk for physical and mental complications (Fry, 1998; Ott, 2003). With the emotional turmoil that the death of the loved one brings, there are a wide variety of responses to this loss. Some individuals experience acute and long-lasting psychological distress while others do not. Religious and spiritual beliefs
represent one way people create a structure of meaning that helps provide order and purpose to their existence and to death (Golsworthy & Coyle, 1999).

For many people including therapists, spirituality is the foundation and main source of their value system. Numerous studies have shown that a majority of Americans have some type of religious or spiritual belief system. According to research by the Princeton Religion Research Center (Rose, Westerfeld, & Ansley, 2008), more than 90% of Americans report some religious preference, 92% of Americans report a belief in God or a universal spirit, and 56% state that religion is very important in their lives (Russinova & Cash, 2007). With these robust statistics, there is no clear understanding about how to incorporate these beliefs and values in the practice of counseling.

This data is important for therapists since for many clients religion and spirituality are important aspects of their sense of self, worldview, and belief system (Barnett & Johnson, 2011; Watts, 2000) and many clients prefer to incorporate their beliefs into therapy (Gockel, 2011; Hodge, 2011). According to Grizzle, for a therapist not to understand a client’s spiritual perspective is like “operating without a vital value system and possibly even a member of the family, God, left at home and ignored” (as cited in Watts, 2000). Much research indicates that people use religion and spirituality in situations of bereavement for seeking comfort, coping resources, and the sense of meaning the framework of religion can provide (Pargament, Koenig, & Perez, 2000; Wortmann & Park, 2008). Spirituality is an essential therapeutic factor for many clients.

A new approach to psychology, positive psychology, considers virtues, strengths and personal values critical to psychological health and well-being. Religious involvement and spirituality are recognized as important factors that give value and purpose to individuals’ lives.
INTEGRATING RELIGIOUS AND SPIRITUAL RESOURCES FROM

(Sperry & Shafranske, 2009). This widening of the behavioral science lens allows for a more holistic approach to psychological assessment and intervention. This research paper includes examples from spousal loss and how Adler’s “holistic” Individual Psychology can integrate with R/S for effectively treating clients coping with bereavement complications.

Definitions

**Therapist.** The word “therapist” refers to individuals who have earned at least a master’s level degree who is licensed in counseling, psychotherapy, or a related helping profession.

**Spirituality and religion.** To define spirituality and religion is a difficult task since they share characteristics. There are many interpretations of the terms. Professional and academic literature does not agree on the definitions. Boundaries between the terms spirituality and religion are often blurred. Both are thought to relate to the scared nature; spirituality as a subjective experience, more personal, and religion as a set of beliefs or institutional doctrines (Morrison, Clutter, Pritchett, & Demmitt, 2009) more broadly defined as that which is organizational, ritual and ideological (Walker et al., 2004). Griffith & Griggs, (2001) quote from Schneiders (1989) that "spirituality is the experience of consciously striving to integrate one's life in terms not of isolation and self-absorption but of self-transcendence toward the ultimate value one perceives" (p. 684).

Others refer to spirituality as a process that provides direction and meaning to life. The Association for Spiritual, Ethical and Religious Values in Counseling, (1998 p.1) states that it is "the drawing out and infusion of spirit in one's life, which involves an innate capacity for creativity, growth, and development of a value system" (Morrison et al., 2009). Spirituality may also include personal experiences such as feeling compassion, hope and love, receiving
inspiration, feeling enlightened, being honest and congruent and having a sense of meaning and purpose in life (Richards, Bartz, & O’Grady, 2009). According to Fallot (2001), authors believe spirituality is the larger concept and may not include religion and may refer to a broad search for meaning and belonging in connection with core values (Koenig, 1994). In other words, *Spirituality* can be defined as “the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred” and *sacred* refers to a “divine being, divine object, Ultimate Reality, or Ultimate Truth as perceived by the individual” (Hill et al., 2000, p. 66). Spirituality may or may not occur in the context of religion.

There is a wide spectrum of Christian perspectives. From an evangelical tradition Christians view spirituality more specifically and personal. It involves personal intimacy with God. Some basic beliefs include:

- God is a personal being who created humans for relationship with Him and others.
- God took on human form (the incarnation) to become a sacrifice for personal sin and offers forgiveness for sins through faith in Jesus Christ.
- The Bible is the divinely inspired Word of God, and is the fundamental guidebook for learning spiritual truths and how to live in relationship to others.
- The church is a body of Christ’s believers who are called to worship, love one another, and minister to a world of people (Watts, 2000, p. 318).

Religion generally is thought of as relating to an organized church or religious institution and is usually defined by a set of beliefs (or doctrines), rituals, practice and an identifiable community of believers (Fallot, 2001). It can also be defined as the “feelings, thoughts, experiences and behaviors that arise from a search for the sacred and may include a search for non-sacred goals (e.g. identity, belongingness or wellness) within the context of the sacred
search. Hill views religion as occurring within a formally structured religious institution and spirituality is often perceived to be based on personal experiences and meaning-making (Hill et al., 2000, p. 66).

A common thread in the definitions refers to the presence of the innate part of human nature that draws a person toward a set of beliefs and values from which to live by. For this study, the terms religious faith and spirituality (R/S) may be used interchangeably. The terms have become somewhat controversial and each represents a large theme. Due to increasing cultural and religious diversity these terms may have new and profound meanings, but it is not in the scope of this review to cover those trends.

**Religion and Spirituality in Psychotherapy**

There has been a long history of mutual skepticism, if not antagonism, and there continues to be debate in the scientific community about religion and science (Fallot, 2001). One of the nation’s premier scientific organizations, The National Academy of Sciences, stated in 1984 that religion and science are separate and mutually exclusive realms and to place them in the same context leads to misunderstanding in both scientific study and religious belief (Barnett & Johnson, 2011).

Psychology is both a profession and a science. Most of the human service professions have become respected and trusted disciplines that rely on scientific methods. Science typically proceeds in an intellectual, goal directed manner. Data is collected for specific research purposes and hypotheses are tested for solving problems. Psychology observes and documents factual characteristics of the human personality and develops theories to understand it. As a profession psychology derives legitimacy from psychological science (Johnson, 2010, p. 105). In contrast, religion operates on a different level of human purpose, meaning and valuing in a way that
science does not. An integrationist from a faith perspective draws on Biblical resources and personal faith convictions to shape his or her scientific and professional practice. But this does not mean that everything we want to know can be found in the Bible, for example what we want to know about child development, the human personality and mental illnesses like schizophrenia or depression (Johnson, 2010, p. 110).

Just as a physician treats a patient’s wound by cleaning and stitching it; the doctor does not actually heal the wound. There is only so much that the doctor can do. In medicine or psychotherapy any cure partly relies on forces of recovery that are out of the provider’s control. The doctor puts his or her faith in innate forces to provide the healing. This writer believes that science alone cannot provide healing. There is something more than modifiable behaviors intrapsychic conflict and chemical imbalances. However, contemporary psychotherapists continue to debate the appropriate boundaries between psychotherapeutic and spiritual or religious interventions.

**Historical perspective.** Historically, there has been little agreement between medical and mental health professionals and religious organizations. As a result, for years both communities have maintained an indifferent or even antagonistic relationship (Jones, 1994; Pardini, Plante, Sherman, & Stump, 2000; Weaver et al., 1997).

Before psychology became a profession, religious and spiritual leaders included counseling as part of their duties and helped people with spiritual and mental health problems. There has been an evolving relationship between psychology and R/S. There were attempts to integrate R/S with psychology since psychology was established as an independent discipline in the mid-nineteenth century (Vande Kemp, 1985). Both were concerned with understanding the purpose of life and the nature of human relationships (Polanski, 2002).
Some forefathers in psychology such as Carl Jung, William James and Gordon Allport were interested in the relation of religion and psychology, but most professional and scientific psychology over the past century avoided connecting the two (Plante, 2007, p. 892).

William James, one of the fathers of American psychology and author of *The Varieties of Religious Experience* published in 1903, over 100 years ago, believed that religious experiences can and should be studied empirically. He discussed the positive and negative influences of spiritual phenomenon, including faith, conversion, saintliness and mysticism, and believed that regardless of what you think about them, they are important parts of human existence which demand investigation (Blanch, 2007). Although there was widespread opposition to his beliefs, some of the same opposition exists today. For example, clinical psychologists rarely receive religious or spiritual training (Shafranske & Malony, 1990).

Issues relating to spirituality and religion in psychology were not only ignored but influenced by psychotherapy pioneers such as Sigmund Freud, B.F. Skinner, John Watson, and Albert Ellis, who found little if any value in the study or practice of religion. Watson (1923/1983) referred to religious interests as “neurotic” (Plante, 2007). Freud considered religion to be a collective neurosis and believed religious practices offered clients illusionary protection against human frailty. He referred to those who were religious as deluded, not psychologically healthy, but neurotic (Plante, 2007; Barnett & Johnson, 2011; Fallot, 2001). Cognitive-behavioral psychotherapy pioneer Albert Ellis claimed that psychotherapy should have “no truck whatever with any kind of miraculous cause or cure, any kind of god or devil, or any kind of sacredness” (Ellis, 1973, p. 16).

Psychology in the 20th century was influenced by science and phenomena that were observable and measurable. It tended to avoid things that were of a spiritual or religious nature in
order to maximize the scientific approach in research and practice. Practitioners that wanted to integrate faith and psychology were apt to do so quietly. It wasn’t until after World War II that conservative Protestants began to think seriously about how their faith relates to the sciences and art. It was in the 1950’s that evangelicals started to engage psychology in a meaningful way. Training programs began to emerge associated with evangelical Protestant churches that freely embraced R/S integration (Plante, 2007).

The Catholic Church has for centuries understood the importance of spirituality and emotional healing evidenced in monastic life and spiritual direction, while contemporary Protestant counselors often overlook or lack understanding of the value of spirituality in counseling (Johnson, 2010).

**Current trends.** Since the 1980’s, the integration movement has become more relevant and practical. Consideration is given to how theories of counseling can be modified or enhanced by Christian values and empirical studies have been reported that help build a scientific base for these claims (McMinn, 2011).

Research has provided insight into the positive relationship between R/S and psychological functioning (Baetz & Toews, 2009, p. 292). For example, a review by Gartner, Larson, & Allen, (1991) of over 200 studies on religion and mental health showed a strong correlation between religious commitment and improved rates of mental health, physical health and social functioning, and lowered rates of mortality, suicide, drug and alcohol use, delinquency and divorce. A study in 2000 also showed a positive correlation between R/S and many positive mental and physical health outcomes such as lowered rates of depression and suicide, fewer health risk behaviors such as substance abuse, better coping skills, higher levels of self-esteem, life satisfaction, resistance to stress and an optimistic outlook on life (Pardini et al., 2000).
According to Richards & Bergin, the alienation that existed between mental health professionals and religion for most of the 20th century is ended and spirituality is being discovered anew (Richards & Bergin, 2000). By the end of the 20th century, beliefs in the fields of psychology and science concerning integration of spirituality have changed. The use of scientific methods such as double-blind randomized clinical trials (where neither the subject nor the researcher know the critical aspects of the trial) have been used to examine important questions relating to psychology and religious integration (Plante, 2007, p. 892; Plante & Sherman, 2001; Miller, 1999; Miller & Thoresen, 2003). The influence and benefits of religion and spirituality upon mental and physical health and wellness is being studied and receives professional and public support (Koenig, McCollough, & Larson, 2001; Plante, 2007). Counselors are beginning to understand the importance of religious faith and spirituality to psychotherapy and positive client change.

Much quality research supports the benefits of faith to health (Plant, 2007; Koenig, et al, 2001). There are more texts addressing the subject than ever before and psychiatry has formally endorsed a “bio-psycho-social-spiritual model,” and a category of “religious or spiritual problem” is included in the DSM-IV (Blanch, 2007).

There has been much investigation of the relation of R/S to the recovery process. Pargament, 1997, cited in (Webb, Charbonneau, McCann, & Gayle, 2011, p. 1162) states that religion may provide a constructive means of coping. It lends guidance, support and hope and offers a cognitive framework for understanding, predicting, and managing events that may otherwise seem overwhelming. Spiritual activities such as prayer and meditation have been demonstrated to provide a stress buffer. Faith communities provide social supportive networks where individuals can express needs.
McMinn, 2011 believes that there is a need for intradisciplinary integration or that which occurs within the disciplines of counseling and psychotherapy or in other words, how do I integrate religious values and beliefs into the treatment of clients? He further states the importance of understanding spirituality and the process of spiritual formation.

**Positive psychology.** Some of the futuristic thinking of today focuses on what humanistic and existential thinkers have been discussing for years including Seligman’s positive psychology. In the past when moral philosophy was part of psychology, virtue and character were important elements. But as psychology strove to become more scientific and value free, those characteristics became unimportant. Recently, there has been a movement to return to these virtues in the scientific field of psychology. A key component to positive psychology is that strengths and virtue build character and can act as a buffer against misfortune and expressions of psychopathology. These character-building virtues appear to be instrumental in developing psychological resilience. Research is underway on virtues such as self-control, love, hope, humility, patience, wisdom, courage, gratitude and forgiveness (Sperry & Shafranske, 2009, p. 311). This author finds it an interesting concept that science is now studying these concepts as ones that can be proven to be helpful in the practice of psychological counseling when these are concepts that have been taught in the Holy Scriptures for centuries.

**Adlerian and Christian principles.** Alfred Adler (1870 – 1937) was one of the founding theorists in psychology and human development. Adler was a young practicing physician when he was invited to join Freud’s psychoanalytic circle. He was an active member of Freud’s group until Adler’s different theories of life and human nature caused him to break with Freud in 1911. He became the subjective social scientist in opposition to Freud, the objective natural scientist (Ansbacher & Ansbacher, 1956).
Adlerians attempt to understand the client from the client’s “subjective” viewpoint, also known as the phenomenological view. This view pays attention to the way a person perceives the world. It includes the individual’s perceptions, thoughts, feelings, beliefs, convictions and conclusions. Behavior then is understood as originating from this “subjective” perspective. It is how we interpret and attach meaning to our experiences that explains behavior (Johansen, 2010, p. 31).

Holism. Adler’s Individual Psychology can better be described as indivisible psychology in reference to the indivisible nature of individuals and the need to understand them in a holistic sense. Adler believed there was more to understanding human nature than biological and cultural factors (Polanski, 2002). Holism refers to the idea that “the whole is greater than the sum of its parts, and that unified, the parts constitute a new and unique whole” (Griffith & Powers, 2007, p. 55). All dimensions of a person are interconnected. These parts are unified by the individual’s movement toward a life goal (Corey, 2009, p. 99). Adlerian principles focus on understanding the whole person. People function as complete units in which each part (body, thinking, feeling, acting, conscious and unconscious, in every expression of his personality, within their social and environmental settings) represents the interactions of the whole person (Ansbacher & Ansbacher, 1956; Griffith & Powers, 2007; Johansen, 2010).

The personality becomes unified though development of a life goal. The individual’s thoughts, feelings, beliefs, convictions, attitudes, character and actions are expressions of his uniqueness, and all reflect a plan of live that moves toward a self-selected life goal.

Adler believed in the interaction between the mind and body, emotions and health. He is recognized as the founder of modern psychosomatic medicine (Sperry, 2011). Today, psychosomatic medicine is described as a method to assess psychological factors contributing to
illness. It is based on a biopsychosocial (biological, psychological and social environment) model of patient care; it involves specialized interventions to combine psychological therapies in the treatment, rehabilitation and prevention of medical conditions (Sperry, 2011).

**Organ inferiority.** A central Adlerian concept is that of organ inferiority. The term refers to an inherited defect, weakness or deficiency of an organ or system (e.g. nervous, cardiovascular, and endocrine). Adler recognized that some people experienced organ inferiorities but all people experience some form of psychological inferiorities. He studied the relation of medical illness and psychological inferiorities. His formulation of psychosomatics (i.e., organ inferiority) was the first to recognize that the mind can actually bring on physical symptoms by initiating physiological pathology as it reacts to situations it interprets as favorable or unfavorable (Sperry, 2011, p. 78).

**Christian perspective of human life.** From a Christian perspective, individuals are multidimensional. How many parts are there to man? Most people sense that they also have an immaterial part--a “soul” that will live on after their bodies die (2 Cor. 5:8). There is a difference in theological teachings regarding the soul and spirit. Some believe in a trichotomy (body, soul and spirit). Others have said that the “spirit” is not a separate part of man, but simply another term for “soul,” and that both terms are used interchangeably. The view that man is made up of two parts (body and soul/spirit) is called dichotomy. In this view, man is described as having both “inner” and “outer” aspects, but these function as an essential unity. Further, the “inner man” itself is understood as an essential unity. Cognition, emotion, and will are understood as aspects of the spiritual activity of the “heart” rather than discrete psychological functions (Smith, 2000, p. 22)
The Greek word for soul is *psuche* and denotes “the breath, the breath of life” and is used many times in the New Testament. The soul is the immaterial part of a person from which flow the actions, thoughts, desires, reasoning, etc. It is separate from the physical body. It is the part of the person that makes a person what he is, alive, aware, able, etc. It is the essence of personhood.

Spirit is a difficult word to define. It is the part of the conscious person, that aspect of awareness that animates our bodies. Biblically it is sometimes used synonymously with soul (Job. 7:11; Isa. 26:9). It is often used in reference to a person’s most inward thoughts (1 Cor. 2:11). The spirit does not have flesh and bones (Luke 24:39). The spirit of a man is created by God (Zech. 12:1) (www.carm.org, Christian Apologetics & Research Ministry). Which ever view is taken, scripture clearly teaches that there is an immaterial part of man’s nature and the emphasis of Scripture is on the overall unity of man as created by God (Grudem, 2004, p. 472-482). The body, soul and/or spirit are all part of the human life; all parts interact with each other and affect the “whole” person.

**Striving.** From Adler’s perspective, God is an idea that humans are constantly striving toward some goal as if it existed. Adler viewed God as the ultimate representation of this final goal (the concept of perfection) and that people are constantly moving from a position they feel is inadequate (a felt minus) toward a position of adequacy (a felt plus). He also thought of religious and spiritual experiences and practices as a way of striving to overcome and find a place in the group, and God as a goal that leads to harmonious social living (Johansen, 2010).

**Social interest.** Individual Psychology is a relational psychology. Social interest is one of the most important concepts in Adlerian psychology, and the strongest area of common ground with Christian spirituality. Social interest means a “feeling of community,” the feeling of having
something in common with others, a feeling of belonging and connectedness to one’s community (Johansen, 2010). Adlerians measure mental health in terms of a person’s degree of social interest: a willingness to participate in the give and take of life in an effort to solve life’s problems and to cooperate with others. Those who help others will look outward instead of inward and show concern for others. These are characteristics of good mental health. Social interest is the opposite of self-focus and placing one’s interest ahead of others. Seeking to elevate oneself shows a lack of social interest (Carlson, Watts, & Maniaci, 2008; Johansen, 2010).

Christian spirituality is relational. At the heart of Christian spirituality is a healing relationship with God. Watts, 2000 describes biblically based Christian spirituality as specific and personal. He quotes Collins, 1998 that this spirituality “involves personal intimacy with God, a process of being conformed to the image of God for the sake of others… and compassion oriented reaching out to those in need”. Other characteristics from a survey cited in Collins, 1998 include: (a) trusts in God’s saving grace and believes in the humanity and divinity of Jesus Christ; (b) experiences a sense of personal well-being, security and peace; (c) integrates faith and life, seeing work, family, social relationships and political choices as part of his or her religious life; (d) seeks spiritual growth through study, reflection, prayer and discussion with others; (e) seeks to be a part of a community of believers in which people give witness to their faith and support and nourish one another; (f) hold life affirming values, including commitment to racial and gender equality, affirmation of cultural and religious diversity, and a personal sense of responsibility for the welfare of others; (g) advocates for social and global change to bring about greater social justice; and (h) serves humanity, consistently and passionately, through acts of love and justice (Watts, 2000, p. 319). There is common ground between the basic assumptions of Christianity and Individual Psychology regarding humankind. Both discuss human
functioning from cognitive, psychodynamic, and systemic perspectives. Both share a concept of humans as creative, holistic, socially oriented, and teleologically (goal-directed) motivated; and both emphasize the equality, value, and dignity of all humans.

The most important contribution of Individual Psychology is the concept of social interest. Christian spirituality is relational. A focus of the Bible is on relationships, it affirms humans’ responsibility to God, others, and to themselves. According to the Bible, the most disruptive factors in relationships (individual, family, society) are selfishness and pride (Watts, 2000, p. 321).

The tasks of life. Another major emphasis of Adlerian philosophy is the concept of the tasks of life. As we grow and mature in life we all must face challenges with which we must cope and find solutions. Adler identified three major life tasks: work (society’s expectation that members will be productive), friendship/social (get along) and love (form bonds). Adler alluded to two additional tasks, self and spiritual. However, the two additional tasks of “coping with oneself” and the “spiritual” task were added later by Adlerians who worked closely with Adler’s work, Rudolf Dreikurs & Harold Mosak (Johansen, 2010). Mosak and Dreikurs (1967) presented the fifth task “the spiritual or the search for meaning” (Baruth & Manning, 1987). They argued that questions of God, faith and meaning are important to psychology. Spirituality should be a task one engages in whether or not one believes in the existence of God. Questions regarding the search for meaning in life still need to be addressed. Mosak and Dreikurs discussed five aspects of the spiritual life task and are briefly stated here:

1. The person’s relationship to God includes an acceptance and description of a superior being. Adler’s perception of God was the “concretization of the idea of perfection, the highest image of greatness and superiority (Adler, 1964, p. 275);
2. The importance of one’s religion is reflected by his or her involvement in it;
3. The individual’s perceptions of his or her place in the universe;
4. The person’s belief about immortality and the existence of an afterlife; and
5. What does the person perceive to be the meaning of life?

There are many questions the therapist can ask a client to determine how well the client is functioning in the spiritual task. Adler’s definition of religion is unclear but his positive feelings toward religion and its worth are communicated in Individual Psychology. Adler explained that his conception of God was a “human idea,” an idea that cannot be proven scientifically but must be accepted as a “gift of faith”. To Adler, any meaning the individual places on life that causes movement in the direction of connecting with and caring for the welfare of others is considered a useful and worthwhile interpretation of the meaning of life (Johansen, 2010).

From a Christian perspective God has a purpose for each human being he has created. God didn’t create “nobodies.” Each person has purpose and meaning and can understand God’s purpose and meaning for his or her life. Through a relationship with Jesus, God’s son, through scripture and prayer one can have a relationship with God, lead a meaningful purposeful life and successfully complete the tasks that one was created to do.

There is much common ground between Individual Psychology and basic Christianity regarding mental health and humanity. Both see humans as creative, holistic, socially oriented, and goal-directed and both emphasize the equality, value and dignity of all human beings. In addition there is the shared relational aspect. Most of the factors that contribute to mentally healthy Christianity as described by Benson and Eklin, and cited in Collins (1998), share the relational emphasis of Individual Psychology.
Grief and Bereavement

**Characteristics.** Reactions to bereavement vary from individual to individual characterized by a range of feelings, thoughts and behaviors of which grief and sadness are the most typical. Other expressions include a yearning and pining for the deceased, shock, numbness, hallucinatory experiences, anger, guilt, depression, health problems, irritability, a sense of meaninglessness, as well as feelings of relief and hope. It is sometimes difficult to distinguish between normal and pathological responses.

The DSM-IV-TR has listed bereavement under the category of “Additional Conditions That May Be a Focus of Clinical Attention” and lists symptoms that may be more than normal grief reactions which may be characteristic of a major depressive episode if symptoms persist for more than two months after the loss. These symptoms include:

1. Guilt about things other than actions taken or not taken by the survivor at the time of the death;
2. Thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person;
3. Morbid preoccupation with worthlessness;
4. Marked psychomotor retardation;
5. Prolonged and marked functional impairment; and
6. Hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person (*Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*; American Psychiatric Association, 2010, p. 741)).
A common emotional reaction to separation and loss is anger that results from a sense of insecurity and frustration at the loss of a major source of support (e.g. physical, emotional, and financial). The intensity of the anger depends on how well the person can make sense out of the situation (Kim, 2009). Sustained anger can contribute to depression. Depression is common for all age groups that experience bereavement. It is sometimes difficult to determine if it is a normal reaction or clinical depression.

**Clinical bereavement depression.** In the normal bereavement process individuals generally respond to comfort and support. It is also normal to experience anger and relate depressed feelings about the loss. They may experience physical complaints, loss of self-esteem, have feelings of guilt over some aspect of the loss, and experience feelings of emptiness and sadness. However, they can still experience times of enjoyment in life.

The clinically depressed often do not accept support, have many complaints and may express irritability and experience inward anger. They do not experience enjoyment in life, feel helpless and hopeless with generalized feelings of guilt. The bereaved who are clinically depressed usually experience physical complaints and loss of self-esteem for a longer duration (Wolfelt, 1988).

Other symptoms of clinical depression are: medical illness, hospital admissions, drug use, change in sleeping patterns, loss of social contacts and decreased social functioning. Weiss (1995) reports major depressive symptoms which include: disturbed sleep, temporary cognitive impairments such as slowed thinking and memory problems, weight loss and a general loss of interest in daily living. It is common for the bereaved to experience increased anxiety including panic attacks and agoraphobia. However, a morbid preoccupation with feelings of worthlessness,
functional impairment and suicidal ideation may indicate the occurrence of a major depressive disorder.

Because of the stigma of receiving mental health services, grief related illnesses often go untreated until symptoms are reported as somatic illnesses or interpersonal problems. Adults who suffer from major depressive symptoms due to grief and loss could benefit from professional mental health counseling.

**Complicated grief.** Studies described by Prigerson et al., 1995-1996 as cited in (Rosenzweig, Prigerson, Miller, & Reynolds, 1997) have revealed that certain symptoms of grief (e.g. yearning, searching for the deceased, intrusive thoughts, being stunned by the death and a preoccupation with thoughts of the deceased) are different from symptoms of bereavement related depression (listed above) and anxiety (e.g. nervousness, irritability, diaphoresis, palpitations). According to Ott, 2003, some researchers characterize these complications of bereavement as “pathological” with subtypes of inhibited, delayed or prolonged, and use the term complicated grief (CG).

CG defined by Jacobs, 1999 as a “disorder that occurs after the death of a significant other. Symptoms of separation distress are the core of the disorder and amalgamate with bereavement specific symptoms of being devastated and traumatized by the death” (Ott, 2003, p. 250). Unlike symptoms of bereavement related depression, complicated grief has been found to continue despite the passage of time and causes continuing dysfunction even with the use of antidepressant medications. At the time of a study by Rosenzweig, elderly participants that were given a selective serotonin reuptake inhibitor (Paroxetine) for the symptoms of CG showed a 50% improvement within three months (Rosenzweig et al., 1997). The hypothesis of that study is that CG is a variant of posttraumatic stress.
According to Ott’s research, (Ott, 2003, p. 250) the etiology of CG is thought to be due to insecure childhood attachments resulting from a history of abuse, conflict, inconsistent parenting or neglect, and/or death of a parent. These attachment deficits in combination with a personality style characterized by poor affect can lead to enmeshed adult relationships in which dependency or compulsive care-giving are characteristic. For these people, the loss of a spouse or exclusive relationship that was stabilizing can result in intense separation anxiety and psychological trauma even though the loss did not occur under traumatic circumstances (Ott, 2003; van Doorn, Kasl, Beery, Jacobs, & Prigerson, 1998).

**Bereavement and spirituality.** Bereavement, like many other challenging events in life, is a circumstance that may initiate re-evaluation of basic beliefs about one’s future, what to expect from others, reasons why things happen, one’s purpose in life, and other assumptions the bereaved has held. Their beliefs and philosophy of life may be challenged leaving them bewildered and unsure about how to continue in this new life.

Often the loss of a significant person such as a spouse may present challenges to an existing worldview provoking questions about the individual’s spiritual and religious understandings. Bereavement can also raise questions about one’s own mortality and priorities in life. For some people, death and re-examination of beliefs can lead to a loss of faith and meaning, anger, and other psychological stressors such as depression and complicated grief. For other persons the crisis of bereavement and grief can lead to deeper and more satisfying spiritual life. Considerable research indicates that people turn to R/S in times of bereavement (Wortmann & Park, 2008, p. 704).

**Stages and progression of spousal grief.** Many theorists describe a process which individuals go through during bereavement over the loss of a spouse. The normal process of grief
has been compared to the stage models of death and dying known as the "grieving process". They try to gauge how the individual is doing according to that process (Corr, Nabe, & Corr, 2000). Others assign tasks which the grieving person must accomplish. Some examples of the stage and task models are:

1. Normal grief compares to the emotional stages of death and dying from Kubler-Ross’s *On Death and Dying*, (denial, anger, bargaining, depression, and acceptance) (Kubler-Ross & Kessler, 2005).

2. Morgan, 1994 states the “grieving process” that follows a loss generally includes three overlapping stages:
   a. An initial period of shock, grief and disbelief;
   b. An intermediate period of acute discomfort and social withdrawal; and
   c. A culminating period of resolution.

3. The psychoanalytic, or “grief work” model, views the “task” of mourning to be a gradual detachment of the libidinal bond with the deceased and transferring this energy to other persons or objects. They do this by first dwelling on the relationship and their memories until they gradually diminish, after which they are able to transfer the bonds (Hartshorne, 2003, p. 146).

4. Bowlby’s attachment model, a phase model which views the loss of an attachment relationship as the start of an instinctive motivation to re-establish contact with the deceased which takes place in stages:
   a. Shock
   b. Yearning and protest
   c. Despair; and
d. Reorganization of the person’s image to the world to seek new affectional bonds (Weiss, 2001).

5. Psychosocial transition models include social constructivist and cognitive-behavioral approaches. They view the task of grief as one of “meaning reconstruction in the face of challenges to life constructs” (Murray, 2002, p.49). This process assists the client in making sense out of what has happened and allows them to seek new affectional bonds.

6. Worden (1982) has suggested the following tasks of the grieving process:

   a. Accept the finality of the loss;
   b. Experience the pain of grief, identify and express feelings;
   c. Adjust to the new environment without the deceased, continue living; and
   d. Withdraw emotional attachment to the deceased and reinvest oneself in the world through new or enriched attachments and activities.

Other theorists suggest even more stages and tasks to be a part of the normal grieving process. In American culture there is a belief that individuals should pass through the “grieving process” in approximately one year. At the completion of the process and the final stage of acceptance of the death, the bereaved should return to a pre-loss level of functioning. Working through the process is a huge task for anyone but it is especially hard for an older adult coping with the loss of a loved one, particularly a life-long partner and friend.

Traditional beliefs in the “stages and tasks” of the “grieving process” have been challenged by researchers. Alternative research suggests that the levels of grief may not change in time for at least two or three years following the loss. Even if CG symptoms subside within two to three years there are distinct gender differences in symptoms displayed in three to five
years post loss. Men have higher overall complicated grief scores (especially in anger and bitterness over the death) in the three to five years following the death of a spouse. Bereaved women have considerably lower levels of symptoms during the same time period (Bierhals, Prigerson, & Fasiczka, 1996; Rosenzweig et al., 1997). Some theorists have identified fluid-like phases that vary from person to person.

Ruth Davis Konigsberg argues that stages of grieving is a myth and not supported by scientific data. Grieving should not be formatted into a strictly regimented process. Some people do experience some of these stages and the emotions are valid, but the overall structure that describes a sequential progression is in reality much less orderly (Konigsberg, 2011). For example, a widow may feel down and depressive one day, only to feel lighthearted and cheerful the next. The emotions of grief are like waves in the ocean, calm at times then suddenly rough and turbulent.

Konigsberg cites Bisconti’s research with grieving widows and states that swings in emotions might occur several times a day but gradually would diminish in intensity and frequency. She states that grief is anything but linear. It moves with consistent ups and downs, which is in conflict with the “stage theory” (Konigsberg, 2011, p. 72).

Lund’s research of 292 recently bereaved men and women over the age of 50 found 75% of respondents reported finding humor and laughter in their daily lives. Lund argues that the stage theory prioritizes negative emotions over positive ones that might occur, for example, from a happy memory of the deceased spouse; and it is positive emotions that are the most healing (Lund, Utz, & Caserta, 2008).

George Bonanno, in his book The Other Side of Sadness, quotes C.S. Lewis describing grief as “a bomber circling round and dropping its bombs each time the circle brings it
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Bonanno states “it is that respite from the trench of sadness that makes grief bearable. It is the marvelous human capacity to squeeze in brief moments of happiness and joy that allows us to see that we may once again begin moving forward” (Bonanno, 2009, p. 43).

Since there are many concepts of what to expect of the client who is experiencing spousal bereavement it may be difficult to know how well the client is progressing. Two questions arise: “What is the course of the grieving process for the typical person?” and “How does my client compare with the typical person?”

In a study of 118 recently widowed participants, Ott and Lueger report findings from a psychotherapy “phase model” (Howard, Lueger, Maling, & Martinovich, 1993) that can be used in clinical intervention to measure progress (Ott & Lueger, 2002, p. 387). This model reports changes in a person’s mental health status during the first two years of spousal bereavement and allows the practitioner to evaluate progress in three areas: subjective well-being, distressing symptoms and functioning in life roles. Study results indicated that interventions result in rapid improvement early in therapy followed by a plateau at which time further gains require more intense interventions with progress occurring at a slower rate (Ott & Lueger, 2002, p. 389).

Phase one observes well-being in the first 2 to 4 months following the death. A process of demoralization occurs in some people after a traumatic event such as the death of a spouse. The person may experience a decreased ability to cope with the situation, resulting in a sense of hopelessness, helplessness and severe distress. A variety of supportive interventions early in therapy help to mobilize coping strategies and begin the remoralization process with increased hopefulness and well-being. Findings seem to indicate that older widows showed less symptoms of demoralization and were able to return to a state of hopefulness and self-efficacy sooner but that older widows may experience a slower decline in grief symptoms than younger widows.
The second stage ranges from 3 to 4 months or longer and is focused on the alleviation of symptoms. For those individuals who are not able to engage their own coping resources effectively, distressing symptoms develop. There is a focus on improving coping skills to alleviate distressing symptoms such as anxiety, depression, phobia, adjustment disorder, compulsiveness and substance abuse. Studies indicate that different symptoms of tearfulness, anger, guilt and depression declined at different rates over time. Symptoms of depression were the most persistent at 32% the first year and decreased to 10% by the fourth year.

The last phase of this model concentrates on life functions and rehabilitation and has been confirmed by substantial psychotherapy research (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988; Lueger, Knobloch, McGinnis, Rolling, & Howard, 1996; Ott & Lueger, 2002, p. 391). It focuses on learning new coping strategies targeted at resuming former roles or assuming new ones. The process of this change is very gradual and can last anywhere from months to years depending on the particular area of problematic functioning (i.e. work, school or household functioning roles; intimacy, social, family, health or self-management). In terms of bereavement individuals in this phase learn how to live with the loss, develop a new relationship with the deceased, then shift focus from self to the outer world (Rando, 1993).

This application of psychotherapy correlates with the Adlerian life tasks model that assesses how the client is functioning in the basic tasks of life. It also correlates with Adler’s concept of social interest that measures mental health by the degree of social interest evidenced by the griever. These concepts are both mentioned earlier in this report (p.17, 19).

**Risk factors.** It has become well-documented that there can be adverse physical and mental outcomes of bereavement (Baetz & Toews, 2009). Studies of spousal bereavement have confirmed the increased risk of mortality in the surviving spouse compared to their married
counterparts. A study of 12,522 spouse pairs followed for 14-23 years found a significant increase in mortality rates, other factors being equal. In addition, the highest rate was found to be 7 -12 months following spousal loss (Rosenzweig et al., 1997). Depression was clearly found associated with late-life bereavement as well as increased rates for anxiety, and increased uses of alcohol, sedatives, and tobacco. Higher rates of suicide and cirrhosis were also found in bereaved persons (Conwell, Schneider, Reynolds, & Lebowitz, 1994; Jacobs, Hansen, & Kasl, 1990).

There are well documented findings for bereavement related depression, but other morbidity and mortality factors related to bereavement are less documented. According to the Prigerson Inventory of Complicated Grief research, complicated grief symptoms at approximately six months from spousal death correlated with negative health outcomes such as cancer, hypertension, anxiety, depression, suicidal ideation, increased smoking and sleep impairment (Prigerson, Frank, & Kasl, 1995).

Results suggest that it may not be the stress of the bereavement that puts these individuals at risk for long-term impairment but rather the psychiatric sequences of bereavement (e.g. complicated grief, depression) that determine which individuals will be at risk for poor outcomes (Rosenzweig et al., 1997, p. 425). While it is not within the context of this review to address the biophysical changes that transpire in the body following extreme stress, it is known that the magnitude of stress following spousal loss outranks all other stress. The most common DSM diagnoses seeking mental health treatment in outpatient therapy include: (a) adjustment disorder, (b) anxiety, (c) depression, (d) bipolar disorder, (e) obsessive-compulsive disorder, (f) phobias, and (g) substance use (Ott, 2003).

Pharmacotherapy for treating CG is a new area of exploration but studies show the use of pharmacology and therapeutic techniques help alleviate the pain, conflict and poor adjustment
that often accompany the grieving process. The adjustment of cognitive distortions associated with insecure attachment styles that influence complicated grief may be a meaningful focus of treatment. Adlerian concepts and tools of counseling as well as R/S resources can be of great assistance to counselors who treat spousal loss.

**Considerations on spousal loss.** One factor to consider is the person's social support. Social status changes with the death of a life-long partner. For the person who has been accustomed to being in a "couples" world, his or her status is now changed to widow or widower. The death of a spouse brings other painful changes and losses e.g., the loss of a partner in managing the household, maintaining involvement with the children and other social contacts, and the loss of a sexual partner. The person may have financial concerns and decisions to make, need assistance with health and basic physical needs, and suffer loneliness and isolation.

If the person has intact mental facilities, the counselor can help them work through the process of grief. For an older adult who faces memory loss such as in dementia the process is more complicated. It requires additional counseling to help the patient cope with the dual loss of their ability to process thoughts and the loss of their loved one.

**Goal of Counseling**

A basic goal of Adlerian therapy is to help clients experience new information that will reveal faulty thinking and provide the opportunity to create perceptual and growth-enhancing alternatives (Watts, 2000). The ultimate goal is to develop the client’s sense of belonging and to assist in the adoption of behaviors that increase social interest and community feeling. There are criteria to assist meeting that goal:

- Relieve symptoms;
- Decrease feelings of inferiority;
• Increase functioning;

• Increase clients’ sense of humor; and

• Produce a change in the client’s perspective (Carlson et al., 2008, p. 130; Johansen, 2010, p. 40).

In line with Adlerian psychotherapy, these goals have a relational orientation.

**Role of the counselor.** The counselor can be viewed as one who treats specific symptoms with techniques to aid in healing. The counselor helps create a climate that enables clients to freely examine their thoughts, feelings, and actions and where the counselor assists in helping individuals find answers to problems consistent with their own values (Corey, 2009).

Adlerian counselors educate clients in new ways to view themselves, others, and life. They help clients see with a new “cognitive” map a way to understand the purpose of their behavior, to challenge mistaken beliefs and assist them to change unhealthy perceptions. Mosak and Maniaci (2008) have listed several goals in the educational process:

• Foster social interest;

• Help clients overcome feelings of discouragement and inferiority;

• Modify client’s views and goals – that is, changing their lifestyle;

• Change faulty motivation;

• Encourage the individual to recognize equality among people; and

• Help people become contributing members of society.

A Christian counselor is one whose spiritual life influences interactions with others. Relationship building is an essential ingredient for counseling effectiveness from both a Christian and Adlerian perspective. Many clients are looking for a therapist not only for the techniques they offer but whose values they respect.
According to Polanski, 2002, the process of developing competence in using spiritual interventions in therapy involves exploring and understanding one’s personal religious and spiritual beliefs in order to establish ideological consistency within a personal model of counseling. In interdisciplinary integration, the counselor reflects a character that comes from years of training in spiritual disciplines such as prayer, worship and the study of the scriptures (Foster, 1988).

**Treatment planning.** Adlerians give much attention to assessment. Adlerians perform both an assessment to focus on how the person is presently functioning and a diagnostic interview to see what makes this person sick and how he or she has come to see and operate in the world. A five-axis psychological diagnosis using the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* should be considered on a case by case basis and may be necessary for insurance reimbursement. The treatment plan will naturally follow after the assessment and diagnosis have been made. Treatment plans have five basic components:

1. Crisis management;
2. Medical/somatic interventions;
3. Short-term goals;
4. Long-term goals; and
5. Ancillary services

Adlerians see psychotherapy as a collaborative effort and engage the client to participate in establishing the goals of treatment as much as possible and are in charge of the process.

**Adlerian Therapeutic Concepts**

Although grief and mourning are natural experiences in life, our understanding of the effects of grief, how people cope, and how to assist individuals through grief, is still developing.
Adlerian concepts and techniques can prove to be helpful in the process of assisting clients through bereavement and loss.

Adlerians generally practice brief psychotherapy. Their approach is directive, frequently using psychoeducation. It is future-oriented and eclectic. Adlerians frequently combine other approaches such as cognitive-behavioral, existential, person-centered and solution focused models while remaining consistent with Adlerian theory and techniques (Johansen, 2010, p. 38).

Phases of therapy. A basic overview of Adlerian psychotherapy recognizes four primary phases:

1. Establish a therapeutic relationship;
2. Assessment;
3. Provide self-understanding and insight; and
4. Reorientation.

The first stage focuses on developing and maintaining an empathetic and egalitarian relationship between the therapist and the client in which the client feels safe and free to express feelings and beliefs. The roles of the client and therapist are understood to be that of equal co-workers in therapy. The therapist does not place him or herself in a superior or inferior position but allows the client to understand his or her responsibility for change. The therapist helps the client with the process while building a strong and trusting relationship. Carlson, et al, 2008, describes the behaviors required to develop and maintain an effective therapeutic relationship which includes:

- Encouragement. This includes reassuring clients; active listening; reflecting feelings; and recognizing client’s strengths and competencies.
• **Informing.** Therapists should provide information about the process of therapy and structure of individual sessions and clear up any misunderstandings.

• **Discovering.** Explore the client’s behaviors by asking reflecting questions for information about the client’s thoughts, feelings, and behaviors while providing reflective feedback.

• **Interpreting.** Interpreting includes seeking clarification of client’s meanings, while offering tentative-hypotheses regarding the purposes of clients’ behavior while offering tentative interpretations.

• **Confronting.** Confront client’s behaviors and discrepancies in order to recognize what is happening in the “here and now,” while challenging destructive emotions and behaviors.

• **Considering.** Collaborating and reflecting helps clients create and explore perceptual, emotional, and behavioral alternatives.

• **Proposing.** Ask clients to consider alternatives they have suggested.

• **Evaluating.** Hold clients accountable for homework tasks and provide feedback on progress.

According to Dreikurs (1967), the therapeutic relationship is a crucial one characterized by mutual trust and respect. The therapist offers empathy, warmth, and acceptance; and the client feels accepted, understood, and hopeful that their life can be different (Carlson et al., 2008, p. 77).

The second stage of therapy includes assessing and understanding the client’s history, social context, and movement within that context. Adlerians place much importance on the assessment process. A thorough clinical assessment addresses six areas: identifying information,
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the presenting problem, background data, current functioning, treatment expectations and a clinical summary.

There are two types of interviews in assessment. The initial interview focuses on how people are functioning in the here and now in their current world. It involves active listening in order to understand the client’s presenting issues. Dreikurs states, “In interviewing patients for the first time, we let them talk about their condition, their discomfort and dysfunctions; this is the subjective condition. We then know how they feel, what they experience within themselves, what they came for” (Mosak & Maniaci, 1999, p. 134).

Adlerians then examine the “objective situations” of the client. They concentrate on how the client has come to see and operate in their world, and focus on what is making the client sick. Adlerians attempt to develop a complete and holistic understanding of the client’s beliefs, feelings and perceptions (Johansen, 2010, p. 39), and seek to gain a better understanding of how the client meets the tasks of life and functions in the world.

Diagnostic information is gathered from the client’s medical and social history and when Adlerians believe the client’s lifestyle is contributing to the presenting problem, a formal lifestyle interview may be performed. Valuable information about the client’s belief system and understanding of his or her world and unique style of living can be obtained with a lifestyle assessment. This assessment is generally organized in two parts, the family constellation and early recollections. The therapist gathers information about the client’s history and family of origin. Early recollections are single, specific incidents in childhood that the individual is able to remember. These recollections point to the client’s current beliefs and attitude toward life.

To illustrate this technique we could think of a chronically depressed woman who enters therapy. After a lifestyle assessment the following basic mistaken beliefs are discovered:
She has convinced herself that nobody could really care about her.

- She rejects people before they have a chance to reject her.
- She is quite critical of herself and expects perfection.
- She has expectations that things rarely work out well.
- She is burdened with guilt about herself because she is letting everyone down.

This woman may have developed these beliefs as a child but still hangs on to them as “rules for living” even if she isn’t consciously aware of these thoughts. Her depression fuels a self-fulfilling prophecy. The therapist will seek to challenge the structure of her private logic that says “I am unlovable, people are unloving, and I must keep to myself so I won’t get hurt.”

Based on the way individuals interpret life differently, we can expect grief responses to vary between individuals. One person may respond to the death of a spouse with optimism and courage while another person responds with anger and hostility (Hartshorne, 2003, p. 146). Based on the Adlerian lifestyle model, the need to process grief in a certain emotional way or time is not universal. The response comes from the perceptual framework of the individual.

The third stage of Adlerian psychotherapy includes increasing a client’s understanding through psychoeducation and by providing insight into his or her diagnosis and assessment. The therapist helps clients understand themselves by what is revealed in the assessment process, how mistaken beliefs and ideas have contributed to their actions, and how to make changes to correct the presenting problem and prevent additional problems.

Reorientation, the final stage of therapy, helps the client put newly discovered insights into practice. Clients who are ready to implement change are also ready to increase social interest, which is a goal of Adlerian psychotherapy. Encouragement is part of all phases of Adlerian therapy. Mosak (1995) described the therapeutic process in terms of the Christian
values of “faith, hope, and love.” These values are communicated to the patient as the therapist sustains faith and hope that things can and will improve, displays empathy, unconditional positive regard and sincere caring (Johansen, 2010, p. 40). In addition to encouragement, Adlerians use a variety of techniques to move clients toward the goals of therapy including decreasing feelings of inferiority, relieving symptoms, and promoting social interest.

**Goal directedness.** According to Adler, all behavior has a purpose. This is the primary focus of goal-directedness. Once the goal of the behavior is understood, the behavior makes sense.

According to Adlerian theory, mourning includes a set of behaviors and emotions that are goal-directed. In order to help a client with unhealthy reactions to loss, the therapist needs to understand the goals, concerns, appraisals, social environment and ways the client self-regulates. Adlerian theory asks, what is the purpose of sadness and grief? Adler suggests one possibility is that it could be an expression of injustice or superiority: “I do not deserve to have lost this person” or “People as superior as I should not have this happen to them.” Grief could also be a means of demonstrating to others what a sensitive and fine person I am (Hartshorne, 2003, p. 149).

Shaver and Tancredy (2001) suggest another purpose may be that as the person focuses on memories and events to organize them in the mind; it helps to make sense of what has happened. People modify their worldview as they adjust to a major change in their social field. In the Adlerian perspective, this is the process of making adaptations to one’s lifestyle. A third possibility for grief may be to maintain connection with the deceased in order to be reminded of the significance that the deceased person had in the griever's life.
Symptoms of complicated grief also need to be reviewed in the context of goal-directedness. Researchers have tried to understand the nature of complicated grief (Maercker, Bonanno, Znoj, & Horowitz, 1998; Piper et al., 2001). For example, Piper cited in Ott, 2003 found that ambivalence was not a contributing factor but affiliation and dependence may contribute to symptoms of complicated grief. Intervention would involve understanding the purpose of the symptoms in each individual case. Grievers experience and express grief in a variety of ways depending on their cultural background, but all those who suffer loss have something in common. From an Adlerian perspective how the individual perceives loss is related to lifestyle and social interest. Grief must be understood in terms of the expectations of society and the private logic that each person brings to the experience. Individual psychology affirms that individuals develop a lifestyle to match their perception of the world. Lifestyle reflects movement, and grief should be viewed in that context. Grief, like other forms of behavior, always has a purpose, and understanding the purpose helps the therapist assess the way the individual is coping with grief (Hartshorne, 2003).

Integrating spirituality and psychotherapy. Fallot (2001) offers reasons to include religion and spirituality in mental health services:

- Religion and spirituality are central to the self-understanding of many consumers. There are a large percentage of people who rated high in surveys concerning belief in God and who considered themselves highly religious.
- R/S may be central to the recovery experience. It may also function as a resource for personal and social strength.
- It enhances cultural sensitivity of services. In many cultural and ethnic groups, R/S is a vital source of meaning and structure as well as healing.
- It relates positively to psychosocial well-being. It has been found to be related to more positive mental health outcomes: religiousness is found to be connected to lower rates of suicide, drug and alcohol use and depression.

To include religious and spiritual discussions in psychotherapy can be helpful for a client’s self-discovery and recovery. Psychotherapists can be sensitive to the religious and spiritual dimensions of their client while focusing on psychological assessment and treatment goals.

Lens Sperry, a physician and psychiatry professor has introduced an integrative spirituality oriented psychotherapy model that combines the developmental and pathology model of health and well-being for use with difficult to treat clients. This model views growth and recovery in holistic terms including the biological, psychological, social and spiritual dimensions. Assessment includes strengths and weaknesses from a psychological perspective as well as moral and spiritual development (Sperry & Shafranske, 2009, p. 307). Spiritual considerations include relationship to God, God-image or representation, core psychospiritual values and spiritual practices including involvement in a spiritually supportive community. In this capacity, the counselor listens attentively for both psychological and spiritual meaning. The biopsychosocial model is a holistic perspective for understanding the unity of the biological, psychological and social forces that influence health, illness and well-being (Sperry & Shafranske, 2009, p. 308). A model called the biopsychosociospiritual perspective includes the spiritual dimension. Using this model requires specific knowledge, skills and supervision. Care should be given not to blur the roles of psychoanalyst and spiritual guide.

Another theory that has been the subject of research in relation to spirituality is the God image and attachment theory. Attachment theory states that an individual’s emotional
relationship with others is influenced by early attachments with their parents. If there is a faulty relationship with parents or in particular the father, it could be that the God-image would be influenced in the same manner. However, neurobiological research has indicated that although early attachments influence brain structure, effective psychotherapy or other life-changing experiences can change these neural networks (Siegel, 1999). Recent research on attachment reveals that God is an image that demonstrates clearly all of the characteristics of an attachment figure to whom individuals can turn to for safety and security. A recent clinical outcomes study cited in Sperry & Shafranske, 2009, found that clients’ images of God positively changed over the course of psychotherapy (Cheston, Piedmont, Eanes, & Lavin, 2003; Sperry & Shafranske, 2009, p. 310).

There are certain assumptions that can be made when considering integration of the spiritual dimension into counseling. The first is that the spiritual dimension has predominance over the other parts of the biopsychosociospiritual model because it provides meaning and direction in life. In grief therapy this is often a consideration for people experiencing spousal loss. Second, from a spiritual perspective, a goal for change or growth can surpass the range of growth in traditional psychotherapy. Third, spiritual transformation is considered an outcome of the spiritual journey. In the Christian tradition, this implies that both a self-transformation and a social transformation of the community and world under the reign of God (Sperry & Shafranske, 2009). A fourth assumption in this integrated model is a comprehensive approach that customizes treatment modalities and therapeutic approaches to meet the individual client’s unique needs and treatment expectations.

The overall purpose of psychotherapy is to help clients understand, cope with, and resolve their presenting problems in order to promote healing, growth, and long-term well-
being. Biological interventions can be used such as, medical referrals for evaluations or medications, diet or exercise referrals, and other stress-management strategies.

For some clients it is important to focus on religious and spiritual issues during treatment. Various R/S interventions that can be integrated in the counseling practice include:

- Exploring the client’s religious and spiritual background, for example, helping the client with identity and worth as a creation of God, or detect faulty self-conceptions from their spiritual background by use of a lifestyle analysis;
- Recommend religious and spiritual support groups;
- Cognitive restructuring of dysfunctional religious beliefs;
- Psychospiritual interventions including: spiritual discussions, mindfulness, spiritual journaling, altruism and discussion about gratitude, guilt and forgiveness;
- Spiritual practices as prayer, fasting, meditation reading spiritual or inspirational texts, participation in a religious community, stewardship practices.

Since religion and spirituality are important components of many clients' lives, it would be a disservice to omit discussing them in the counseling session. One way to evaluate the client's emotional needs is to include spirituality in the routine assessment process. Additionally, spirituality can be explored in the counseling session, incorporated into the treatment plan and spiritual interventions used. According to Walker et al., (2004), therapists can use explicit/overt methods such as dealing with religious issues in therapy, reading scriptures, prayer and referrals to church or use an implicit/covert approach that does not directly use spiritual resources like prayer and scripture readings but bases therapeutic values on theistic principles from an organized religion. Still another form of integration is intrapersonal which refers to the therapist's
use of his or her personal religious or spiritual experience in counseling such as silently praying for a client during a session. Before a spiritual intervention is used however, it should be explained to the client and informed consent established.

One reason counselors may choose not to incorporate spirituality in therapy is a lack of education and training for this type of counseling. Using spirituality inappropriately however may lead to ethical concerns. In a survey 73% of licensed professional counselors surveyed stated that they believed spiritual interventions in therapy were important but were not confident addressing the subject. Only 25% of the respondents reported receiving adequate training in addressing spiritual concerns (Morrison et al., 2009). There are few approved religious graduate training programs in clinical psychology that are accredited by the American Psychological Association (Walker et al., 2004).

A client from an in-depth study by Rose et al. (2008), states, "I had been in therapy for years and could only heal to a certain level. It wasn't until my present counselor approached me about spirituality that I could receive healing at a deeper level." Another client said, "Your counselor works with the whole you. It's a package deal." When discussing interventions with clients, the focus should remain on solving the client's problems.

**Ethical Considerations and Possible Negative Consequences**

It is understood that counselors, to some degree communicate their values to their clients (Corey, Corey, & Callanan, 2011; Goldsworthy & Coyle, 2001). For many therapists religion and spirituality is the basis and primary source of their value system and will be used in assessing and treating clients. Also, many clients are seeking to address spiritual concerns in the therapy session (Morrison, Clutter, Pritchett, & Demmitt, 2009). According to a Gallop poll, the majority of Americans state they believe in God or a higher power and believe that their faith is a
central guiding force in their life; respondents indicated they would prefer to see counselors with similar values and beliefs (Morrison et al., 2009).

It is important for counselors to remember that it is unethical for those who work in nonreligious settings to promote, proselytize or attempt to persuade clients, covertly or overtly, to their religious beliefs or traditions (Richards & Bergin, 2005, p. 201).

The American Psychological Association Ethics Code supports religion as a diversity issue. It states that psychologists should consider religion and religious issues like any other diversity issue which requires sensitivity and training (Plante, 2009).

**Competence.** Most graduate and postgraduate training programs do not include spiritual and religious integration in counseling in their professional training; as a result professionals need to obtain training in other ways. The AAMFT Ethics code addresses competence by stating that therapists take steps to ensure competence and protect clients from possible harm. They do not diagnose, treat or advise on problems outside of the recognized boundaries of their competencies nor hold themselves out as competent beyond their scope of training or education (Sub principles 3.1, 3.7, 3.11, 4.4 and 8.8).

A therapist may define themselves as a spiritual person and an active member of a particular faith tradition but that is not the same as being an expert in that tradition or having the ability to accurately integrate spirituality and religion into counseling practice. There should be caution not to blur boundaries.

**Blurred boundaries and dual relationships.** Blurred boundaries can evolve when a professional has two roles and the client may not be clear about which role the professional is in during the relationship. An example of this could be a clergy member who is also licensed as a mental health professional and counsels with a parishioner. Depending on individual state law,
mandated reporting rules may be required in the counselor role but not in the clergy role. In Minnesota, both professions are mandated reporters. Listening to a confession in the clergy role may be treated differently than when it is heard as the licensed counselor. The client should always understand which role the counselor is taking (Plante, 2007). Another possible problem is getting referrals from the clergy's congregation. This can create a conflict of interest and a boundary issue.

An additional concern is that the goals of therapy may focus on religious goals rather than therapeutic goals. For example, spiritual interventions may be used instead of medication or other psychological treatments. A result is that reimbursement from a third party may be inappropriate (Morrison et al., 2009).

**Spiritual and religious bias.** Many professionals that are interested in the integration of spirituality and counseling come from an active faith community. The desire to be in the helping profession relates to their compassion and caring. Individuals already engaged in service in their own faith tradition may not be familiar with issues and beliefs of other faith traditions. Therefore it is important to become informed about the traditions and beliefs of the client coming from a different faith perspective.

The client may be better served if the counselor collaborates with a member of the clergy for the individual client's needs. If the counselor is unable to prevent bias in treating the client he or she should seek supervision and possibly refer the client to a therapist more qualified to help that individual.

**Destructive religious beliefs and behaviors.** Some religious beliefs condone destructive and harmful behaviors. For example some religions withhold medicine from sick children, condone punishment of women and children, allow circumcision on adolescent girls
and deny women and children adequate education and medical services. In cases where clients come to counseling with radical beliefs, the counselor may be exposed to legal and ethical decisions. The professional's concern for the welfare of others mandates the therapist to act when religious and spiritual beliefs cause clients or others to be at risk (Plante, 2007).

**Countertransference.** It is important for the clinician to understand his or her own worldview. When working with individuals from a different spiritual worldview it is possible for the therapist's unresolved issues to unconsciously affect the interaction with the client, forming a "spiritual countertransference" (Hodge, 2011). The practitioner's unresolved personal issues may negatively affect interactions with clients. For example, the practitioner may verbally or nonverbally communicate disapproval about the client’s views and damage the relationship.

In summary, the use and integration of spiritual and religious interventions during counseling or therapy can be advantageous to both the counselor and the client, but care must be given to stay within the ethical and moral boundaries of the profession. The therapist must be aware of the vulnerabilities of clients who experience psychological bereavement issues.

**Summary, Conclusions and Recommendations**

There has been sufficient research about the positive impact that religious faith and spirituality has on one’s mental and physical health. The majority of Americans report religious preferences believe in God and state that R/S is an important value in their life. Spousal loss is considered to be one of the most stressful events in a person’s life. Based on the findings presented a therapist, when considerate of the client’s value system, can effectively treat clients with complications of bereavement or spousal loss by integrating religious faith and spirituality within the Adlerian Individual Psychological approach. A holistic approach to psychology and Christianity understands that people function in the physical, mental, and spiritual dimensions.
INTEGRATING RELIGIOUS AND SPIRITUAL RESOURCES FROM

Counselor can be sensitive to their clients’ spiritual concerns regarding questions raised during bereavement and address these concerns during the assessment and treatment process. Some clients prefer to work with a therapist who shares his or her value system and would favor the use of spiritual interventions such as prayer, meditation, Christian support groups, and Bible reading. Counseling can assist the bereaved toward movement of new life goals. Encouragement is a vital theme of Adlerian psychology and Christian values.

Historically, life and death are some of most thought and talked about topics of discussion. Typically families rejoice over the birth of a new life and grieve over the death of a family member. It is a particularly difficult time for individuals who have lost a spouse and lifelong partner through death. Age old questions people ask are why am I here? What is the purpose of my life? Where am I headed? Is there life after death? These are all critical questions and require much reflection and study. Religion and spiritually for many people provides answers to life’s basic existential questions.

It is important to include a spiritual assessment during the initial interview in order to identify what is important to the client and what his or her beliefs and expectations are in regard to incorporating R/S into the therapy process. Adlerians place importance on acquiring an understanding of a client’s lifestyle and what makes a person “tick.” From a Christian perspective, spirituality is part of the whole person.

Although the terms “religion” and “spirituality” mean different things to different people, a therapist has the responsibility of honoring the client’s belief system and working within that system. If the therapist does not understand or cannot work within that system he or she should refer the client to a more appropriate mental health professional.
Current trends in psychology recognize the therapeutic importance of incorporating R/S techniques and interventions that facilitate insight, hope and change as important elements in the counseling process. The influence and benefits of R/S upon mental and physical health is receiving increasing professional and public support.

Adlerian Psychology and the Christian faith share common ground, and both perspectives can be integrated into clinical therapy. Both discuss human functioning from cognitive, psychodynamic, and systemic perspectives and both recognize humans as creative, holistic, socially oriented and goal directed. Adlerian holism refers to the indivisible nature of individuals. There is more to understanding human nature than biological and cultural factors. The “whole” person cannot be studied as separate parts but all dimensions of a person are interconnected and unified by the individual’s movement toward a life goal. Christianity believes that humans are created multidimensional with both “outer” (body) and inner” (soul/spirit) aspects. The soul is that part of a person from which actions, thoughts, desires, and reasoning’s flow. The spirit which is often used interchangeably with the term soul is often used to reference a person’s most inward thoughts. The inner person (soul/spirit) is accountable to God and will live into eternity. All parts comprise the total person. Both perspectives (Adlerian psychology and Christianity) emphasize the equality, value, and dignity of all human life and a common theme is relationships.

Organ inferiority refers to a weakness or deficiency of a body part or system. When organ inferiority is combined with a psychological disturbance, the result can lead to psychosomatic symptoms. Scriptures teach that as a person thinks, so he becomes. In other words a person’s bad thinking can have negative effects on the person’s health and well-being. Adler believed that a person’s reasons for thinking, feeling and behaving was related to the
person’s *private logic* or the unconscious bias idiosyncratic thinking that is unique to his or her lifestyle. In our *private* worlds we may have thoughts, attitudes, beliefs, and convictions that can cause us difficulty in adapting (Mosak & Maniaci, 1999, p. 121). A goal of Adlerian counseling is to increase the client’s awareness of his or her private logic in order to create healthy thinking and behaviors in order to meet life’s tasks.

Adlerians measure mental health in terms of the degree of a person’s relationships or *social interest*, how well the person cooperates with and contributes to others in society. Christian spiritually is relational therefore belonging to a community of believers and making a contribution to the world are defining values.

The five Adlerian *life tasks*: work, friendship, love, self and spirituality correlate with the Christian faith. The Bible teaches that believers are given spiritual gifts which are to be used in fulfilling their unique life’s mission or purpose; people are expected to work, develop friendships and care for self and others.

Grief reactions vary from individual to individual. Since Kubler-Ross introduced the five stages of death (which became translated into the five stages of grief and mourning,) it has been widely accepted that grief is experienced in specific stages. A person is believed to progress through the stages and eventually come to an acceptance of the loss and then return to normal functioning. This theory of the “grief process” has been challenged and there are alternative theories worthy of consideration. One particular idea is that grief cannot be labeled and put in neat stages or tasks but symptoms and emotions fluctuate and can last longer than normally assumed.

There are a range of symptoms that generally accompany grief, and in particular spousal loss. However, some individuals develop complicated grief or depression. Care should be taken
when making an assessment of the client’s presenting problems. Integrated care may include pharmacology, biomedical psychotherapy and spiritual support.

Many bereaved with spousal loss may challenge their thinking about spiritual and religious beliefs. Counselors should pay attention to the client’s spiritual reactions as the client seeks to conform to a new way of belonging in the world. Grieving spouses may not conform to traditional “stages of grieving”; symptoms may vary periodically and there may be differences in gender reactions and emotions.

The counselor’s relationship-building skills are important to the therapeutic outcome. The client and counselor become co-collaborative partners in the process and the client needs to sense a strong and trusting environment in which to share his or her innermost feelings, thoughts, and concerns. Encouragement on the part of the therapist is crucial at each stage of the therapy. Besides empathic listening the counselor needs to be able to discern and understand the client’s worldview and lifestyle in order to provide insight about mistaken beliefs that contribute to the presenting problem.

Adlerians generally practice brief psychotherapy. Their approach is directive, psycho-educational and future-oriented. Other methods and models of psychology can successfully be integrated into Adlerian therapy. Each client’s treatment is individually tailored to best fit that client’s needs.

In conclusion, the practice of Adlerian psychology is a useful model to use to integrate religious faith and spiritually into psychotherapy and will be beneficial in treating the complications of grief and loss. Each case needs to be assessed on an individual basis, and care needs to be exercised so ethical boundaries are not crossed when using an integrated approach.
Recommendations for Future Research

Additional research is recommended to measure and more clearly define the relationship between R/S and the adjustment to bereavement in both normal and pathological grief. The terms religion and spirituality are often used interchangeable and nonspecific to various religions and forms of spirituality. Research is recommended to distinguish between the multidimensional aspects of these terms and the how various approaches affect spousal bereavement recovery. Certain dimensions could include the content of beliefs, how one understands suffering, one’s view of God and the afterlife, forgiveness of self and others and the justice of God.

Another topic of further discussion is the development of faith or struggles with God based on resolution of previous life events that challenged one’s beliefs. It could be that the perceptions of God are related to the individual’s past or present involvement in social supportive networks in the faith community.

Resources

Christian counselors have come from around the world to discuss counseling techniques and methods. The American Association of Christian Counselors (AACC) publishes *Christian Counseling Today*, a periodical with many practical counseling ideas. Other Christian integration journals include: the *Journal of Psychology and Theology* and the *Journal of Psychology and Christianity*. 
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