

SPIRITUALITY AND RELIGIOSITY IN PSYCHOTHERAPY

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Welcome ladies and gentlemen. I would like to give you an overview of the contemporary state of developments, including the open questions, concerning the integration of the spiritual and religious dimension into psychotherapeutic treatment.

Before addressing the subject and presenting my present state of knowledge and considerations regarding the place of spirituality and religiosity in psychotherapy practice to you, I would first of all like to ask you to pause for a moment and to ask yourselves the following questions – thereby presupposing that many people in the audience are themselves psychotherapists or are studying and aspire to such a profession in the future.

Here are my questions:

1. Are you of the opinion that, on the part of the psychotherapist, specific qualities, skills or knowledge are required to adequately deal with spiritually or religiously oriented clients and their problems? And if so, which specific qualifications would those be?
2. Are there, from your point of view, any Do's and Don'ts in dealing with these clients and issues? If so which would these be?
3. What do you personally consider the possibilities and potentials of including the spiritual dimension in the context of psychotherapy? And where would you see the possible limits and pitfalls associated herewith?
4. If you yourself are spiritually or religiously oriented, in which way does this affect your practice of psychotherapy?

With these questions we are already at the core of our subject. And I suspect that the possible spectrum of your individual answers to these questions will be quite different. At least this is the case in the pertinent specialized literature.

But, first of all, I would like to give you a brief outline of my presentation:

1. I will start with some definitions that will give a baseline for the positioning of our subject.
2. Then I will briefly sketch some of the points that are important for the understanding of the background and further developments of the topic.
3. This is followed by a presentation of findings from a national representative survey of German psychotherapists on “Spirituality and Religiosity in Psychotherapy Practice”.
4. Then I will turn to naming some of the components which have to be considered in the process of the development and implementation of integrative approaches.
5. Next I will exemplarily describe some of the contemporary approaches of an inclusion of the spiritual and religious dimension within the framework of psychotherapy, and I will also discuss the potential pitfalls associated herewith.
6. In conclusion, I will summarize the present state of the art and close with some thoughts about the further implications.

Now let’s proceed with the definition of the terms spirituality and religiosity:

For our purposes spirituality and religiosity can together be described as the relationship of a person with a higher reality that transcends the individual personality. This higher reality can be conceived of and named differently, dependent on the respective religio-cultural contexts.

Even if wide variety of definitions of the terms “spirituality” and “religiosity” can be found in the literature, a general trend can now be observed:

Spirituality (spiritual) is increasingly associated with a personal, individual and experiential approach to the transcendent dimension, and related to feelings of a fundamental interconnectedness as well as the search for purpose and existential meaning.

Whereas **Religiosity** (religious) is more and more confined to the formalized, traditional and institutionalized forms of reference to an ultimate transcendence.

For the term Psychotherapy we find quite different definitions, too. As an example I would like to quote the following definition from the European Association for Psychotherapy, which reads as follows:

“The practice of psychotherapy is the comprehensive, conscious and planned treatment of psychosocial, psychosomatic and behavioural disturbances or states of suffering with scientific psychotherapeutic methods, through an interaction between one or more persons being treated, and one or more psychotherapists, with the aim of relieving disturbing attitudes to change, and to promote the maturation, development and health of the treated person. It requires both a general and a specific training/education.”

(Source: <http://www.europsyche.org/contents/13219/definition-of-the-profession-of-psychotherapy>)

It is important for our context that the area of professional psychotherapy is differentiated from religiously and ideologically based health-and healing provisions in the centrality of its scientific-theoretical foundation, and the empirical validation of its claims.

At present in the field of academic psychology and in the health care professions in general, a strong trend towards a stronger inclusion of the spiritual and religious dimension in clinical practice can be observed. This becomes evident from a quote from Post and Wade in a survey article on “Religion and Spirituality in Psychotherapy” from 2009.

They write:

“The practical question for clinicians is no longer *whether* to address the sacred in psychotherapy with religious and spiritual clients, but rather, the questions are *when* and *how* to address the sacred.” (Post & Wade, 2009, p. 132)

This formulation shows that a change has taken place here and that this has not always been the case.

At the beginning of the 1990s, at the latest, an increasing impetus towards a stronger incorporation of the religious and spiritual dimension into the context of clinical-psychotherapeutic treatment was driven forward by a number of clinicians.

I would like to briefly consider some of the central arguments they provided as justification for the vital necessity of such an endeavor.

One important point that was repeatedly emphasized was the striking increase in interest from the general population in individual forms of spirituality, but also the continuing importance of traditional forms of religiosity. According to some scholars, this growing interest from the general population in turn necessitates a stronger consideration of the respective issues in the field of professional psychotherapy. The following quote from Richards and Bergin is typical of such a position. They state:

“This spiritual energy [of the general population] has created a powerful cultural demand for psychotherapists to be more aware of and sensitive to religious and spiritual issues. Unfortunately, very few psychotherapists are adequately trained or prepared to deal effectively with such issues. Because of the alienation that has existed historically between the behavioural sciences and religion, the religious faith and spiritual concerns of clients have long been neglected in the psychotherapy profession.” (Richards & Bergin, 2002, p. 6)

In a similar way, the German theologian Hans Küng spoke as early as in 1979 of the

“...current explosion of religiousness all over the world in every possible form (mythical, cultic, and mystical; Christian, Indian, and Far Eastern; progressive and conservative)” which “...believes the thesis that religion is dying, but is looked upon by psychologists and theologians alike with mixed feelings.” (Küng, 1990, xiii / orig. 1979)

A further important starting point of our subject lies in the increasing criticism of the academic disciplines of psychology and psychiatry concerning their dealings with the issues of spirituality and religiosity. These disciplines were accused of ignoring, marginalizing and even pathologizing the religious and spiritual dimensions of human life in theory, research, education and practice (eg. Lukoff, Lu & Turner, 1992; Richards & Bergin, 2002).

In this sense the theologian Hans Küng spoke of a repression of religion in psychology, psychiatry and psychotherapy in an invited address to the members of the American Psychiatric Association, and declared religion the final taboo of these professions. (Küng, 1990, p. 126f)

In this context he asked:

“Shouldn’t psychiatrists in particular and indeed educated people in general, ask whether a phenomenon of repression may not be at work here and whether this repression of religion might not be just as worthy an object of investigation as its explosion in other societal strata and subcultures?” (1990, p. 134)

The specific reasons for this historically grown neglect of spiritual and religious issues in the academic fields of psychology and psychiatry are plentiful, and I will merely specify a few by way of example:

- There is the strong natural scientific, biologist and positivistic orientation of these disciplines
- Their principal priority is of biological over cultural factors

- Their striving to become recognized as scientific disciplines and to distinguish themselves as independent from the fields of theology and philosophy
- Their strong self-understanding as representatives of enlightenment, replacing religious beliefs as guiding principles, and regarding scientific and religious belief systems as possible resources of knowledge about the world as being mutually exclusive
- The religion-critical stance of prominent representatives of psychotherapy such as Sigmund Freud or Albert Ellis.

In addition to the arguments mentioned previously, further scientific and practical reasons have been pointed out which imply the relevance of spiritual and religious issues for psychotherapeutic practice:

- Firstly, the empirical evidence that shows that spirituality and religiosity are significant health-related variables
- Secondly, the relatively frequent addressing of spiritual and religious topics by the clients, which had also been documented in different US-American studies
- Thirdly, the revision of the APA ethical guidelines in 1992, which demand a more culturally sensitive approach to psychotherapy. Psychotherapists are, according to these ethical principles, explicitly requested to be aware of, to respect and to include religiosity and spirituality as possible cultural factors and frames of reference. Some authors have suggested that religion and spirituality are among the most important cultural factors that shape the presentation, interpretation and definition of health and illness
- The latter point is confirmed by the frequent observation that the clinical problems of the clients are often inextricably intertwined with their spiritual worldviews and orientation.

The spiritual or religious life-orientation of an individual is – even in our secular, compartmentalized and specialized societies – generally deeply and pervasively interwoven with all aspects of life, human values, actions and objectives. James Fowler pointed out this integrative function of faith some time ago when he stated:

“Faith, classically understood, is not a separate dimension of life, a compartmentalized speciality. Faith is an orientation of the total person, giving purpose and goals to one’s hopes and strivings, thoughts and actions... as such, faith is an integral part of one’s character or personality.” (Fowler, 1981, p. 14)

Accordingly – such is the reasoning – the spiritual and religious dimensions deserve the same attention as other important aspects of human nature and have to be granted their rightful place in psychotherapy.

It should be also borne in mind that, despite the apparent differences in the ideological foundations and the functions of scientific-secular psychotherapy and religious institutions and traditions, there are also considerable overlaps between the issues and tasks with which the representatives of these fields are confronted.

Accordingly, C.G. Jung, who is known to have been engaged in these kinds of questions at an early stage, said that “you cannot tear the human being into two pieces, to delegate one part to the physician and the other to the theologian.” (Jaffe & Adler, 1972, p. 132, transl. LH)

Psychotherapy, as well as religious traditions and institutions, try to provide answers and guidelines to vital questions in life and to overcome human suffering. Bilgrave and Deluty (2002, p. 245f) have drawn up the following common characteristics of religious ideologies and psychotherapy.

They both provide frameworks “a) that possess some degree of internal coherence; b) that claim to accurately reference reality; c) that may reach a high degree of abstraction and so are potentially capable of influencing an extensive range of perception, evaluation and action; and

d) that can help to understand the human condition, to diagnose both personal and social problems, and to offer remedy.”

In line with this, different authors have emphasized that modern psychotherapy has its historical roots in religious contexts, beginning with the early shamanic traditions – and they have made it clear that psychotherapeutic and religious systems, even if they may be characterized by different surface-forms, are nevertheless functionally and often even structurally very similar on a deeper level (Bilgrave & Deluty, 2002; Frank, 1991). Hence the long-standing taboo status and the marginalization of these issues within academic psychology and psychiatry is, on one hand, quite understandable in its historical development, and there were good reasons for it. Ultimately, such an approach does not really seem to do justice to the subject matter and a respective rethinking seems long overdue.

Largely confirming all these thoughts, 63% of the surveyed religiously or spiritually oriented clients in a study undertaken by Rose, Westefeld and Ansley (2001) thought it appropriate to address religious or spiritual concerns in psychotherapy. As reasons for their wishes to include their religious or spiritual orientation, they indicated the following:

- they believed that spirituality and religion were important to their healing and growth
- spirituality or religion was personally important to them
- they believed spirituality or religion to be central to human personality, behaviour and worldview
- they believed their current problems were related to spiritual or religious issues (p. 67)

However, irrespective of all these good arguments for an inclusion of such topics, there are indications that their long and routine marginalization in clinical-psychotherapeutic contexts has clearly left its marks. This concerns the self- and outside perception of the psychotherapeutic profession.

Findings from different studies suggest that unspoken prejudices, inhibitions and uncertainties, among the clients as well as the psychotherapists, do impede the addressing of

spiritual or religious contents in connection with a scientifically and secularly based psychotherapy. For instance, in a study conducted by Mayers, Leavey, Vallianatou and Baker (2007) about the process of seeking psychotherapy, the spiritually or religiously oriented participants reported that, before the beginning of their therapy, they were afraid that a secularly oriented psychotherapist would be insensitive towards spiritual or religious issues or would not address them at all.

In a German study undertaken by O' Connolly, Demling and Wörthmöller (2002, p. 116), the participating psychotherapist reported the following reasons for their scant regard of patients' religious orientation as a possible psychotherapeutic resource:

“.. fear of contact or insecurity in addressing the subject; ... lack of knowledge of the subject (and lack of emphasis on it in continuing education); the opinion that the subject is not pertinent, irrelevant for therapy or unscientific, ... indifferent and uninterested attitudes of therapists; “historical” reasons; as well as critical opinions on the stance held by official religious institutions with reference to religious questions, which is found to be too dogmatic and harmful to therapy.”

Herewith I would like to come to an end with my coverage of the historical background and context of our topic.

In the meantime a lot of changes have taken place, as the introductory quotation from Post and Wade has impressively demonstrated. Clinical-psychotherapeutic issues, related to spirituality and religiosity, are receiving increasing attention within the academic fields of psychology, psychiatry and even in medicine.

This is demonstrated by a strong increase in the respective literature in specialist databases such as Psychlit, Psynindex or Medline. Issues and approaches of this kind have in the meantime especially been taken up in the applied fields, such as clinical psychology, psychotherapy, counseling, rehabilitation and in the caring professions.

This has been made evident by a series of handbooks on the subject area of spirituality and religiosity in clinical practice which have been published in recent years by professional

organizations like the American Psychological Association and other academic publishers. (Shafranske 1996; Richards & Bergin, 2000, 2002, 2003; Miller, 1999; Sperry, 2001; Sperry & Shafranske, 2005; Plante, 2008; Bhugra, 1996; Boehnlein 2000).

This development can also be observed, with some delay, in the German language literature (Utsch 2005; Bucher, 2007; Quekelberghe, 2007).

In these volumes, a broad spectrum of clinically relevant issues are discussed, and possible models of an inclusion of spiritual and religious factors in the clinical dialogue are presented.

Of primary interest are questions regarding

- the relation between spirituality and religiosity, and physical and mental health
- the possibilities of using the spiritual or religious orientation of the client as a resource for their stabilization and recovery
- the possibilities of an implementation of diverse spiritual and religious interventions and their clinical efficacy, and
- if and how ideologically based variables, such as worldview, view of man, values, and concepts of health and illness, influence the choice of the psychotherapeutic setting, of the therapist as well as the process of psychotherapy itself.

But what about the attitudes of the psychotherapeutic practitioners themselves? To answer that question let us take a look at some central empirical findings from a national representative survey of psychological psychotherapists from Germany which I conducted under the supervision of Prof. Harald Walach (Hofmann, 2009; Hofmann & Walach 2011).

The sample consisted of 895 psychological psychotherapists.

We first of all found a surprisingly high relevance of the spiritual and religious dimension in the personal lives of the psychotherapists:

65% affirmed a belief in a higher, transcendent reality

57% declared their belief orientation as spiritual (36%) or religious (21%)

65 % estimated the importance of spirituality or religiosity in their own life as moderately, quite or very high, and

63% reported having had their own significant religious or spiritual experiences.

These findings are actually quite remarkable and were not necessarily expected considering the high degree of secularization of German society and the secular-scientific training of the psychotherapists. However, it is in keeping with Smith and Orlinsky (2004) who found similar figures for psychotherapists from the USA, Canada and New Zealand, and interpreted these as evidence that psychology, as a discipline, is secular, but psychotherapists as individuals often are not. Nevertheless, it has also to be kept in mind that in a wide variety of studies it has been shown that the majority of the psychotherapists describe themselves as spiritual rather than religious. Even if they are open to and appreciate the numinous dimension of life in general, psychotherapists seem to have a more critical stance toward traditional religion than is the case in the general population.

Secondly: The majority of our psychotherapists advocate a greater consideration of spiritual and religious issues in the context of academic education and postgraduate psychotherapy training.

67% assert that clinically relevant questions related to spirituality and religiosity should be given more regard in graduate education

81% stated that such issues were rarely or never discussed in psychotherapy training

(this latter finding is remarkable in itself, and it is also consistent with studies from the US)

43% report that dealing with these issues in psychotherapy training barely or did not at all meet their needs as psychotherapeutic practitioners

63% estimate the possible benefit of further training concerning this special subject as moderate to very high.

What is interesting in this connection is the following: while only **18%** said that clinically relevant questions relating to spirituality and religiosity had been dealt with at a moderate

to very high level in the course of psychotherapy training, all together **55%** reported that they had concerned themselves with these questions at a moderate to very high level. The discrepancy between these values suggests that, concerning their dealings with spiritual issues, in the expansion of their respective knowledge base and their deepening of competence, the psychotherapists draw on sources other than that of curricular psychotherapy training.

With these findings regarding education and training, a statement made by Edward Shafranske, editor of the standard work “Religion and the Clinical Practice of Psychology” seems to be proved right, when he writes:

“The development of competence in understanding the contributions of religion and spirituality to mental health as well as in the applied psychology of religion, in the near term, is likely to rest on unique training experiences rather than on systematic attention throughout all levels of graduate education and clinical training. To a great extent the personal faith commitment of the clinician will continue to serve as a salient feature of motivation and determine the extent to which a psychologist obtains expertise in this area.” (Shafranske, 2005, p. 506)

A third major finding of our study was that spirituality and religiosity especially seem to play an important role as an influencing factor on the part of the psychotherapists. More than half of them reported that their personal spiritual or religious orientation has had an effect on their practice of psychotherapy to a moderate (27%), quite (21%) or very high degree (8%). This is also consistent with US-American studies. In a survey conducted by Bilgrave and Deluty, 72% of the psychotherapists surveyed said that their religious convictions had had an influence on their psychotherapeutic practice.

However, our subsequent in-depth survey showed that, according to the psychotherapists, this “influence” rarely comes explicitly into effect, as, for example in the form of applying specific spiritual or religious interventions or even by means of exerting ideological

influences. It finds its expression rather implicitly, in the sense of a specific attitude towards the patients and their problems as well as via specific psychotherapeutically supportive qualities which the therapists have cultivated in the course of their own spiritual orientation and practice. The psychotherapists reported that their own spiritual or religious practice had contributed to the development of qualities such as equanimity, acceptance, trust, optimism, empathy, appreciation, tolerance, respect, non-judging, compassion, love, gratitude, mindfulness or being present. These qualities would not only have a positive effect on their psychotherapeutic work, but also prove useful as a resource for their own wellbeing (Hofmann, 2011).

Now I would like to shift the focus again and proceed with the necessary preconditions and foundations of professional approaches to incorporate spirituality and religiosity into psychotherapeutic treatment. The necessary steps and components are primarily the development of

- consensual practice standards
- the establishment of the respective ethical guidelines
- the development of informed-consent procedures
- and the development of models of integration.

Currently in the literature a broad spectrum of possibilities of incorporating the spiritual and religious dimension into clinical practice is being discussed. The spectrum ranges from

- integrating spirituality and religiosity as possible thematic subjects and as clinically relevant variables in all phases of the treatment process, to
- using concepts and principles derived from spiritual traditions, such as the principles of mindfulness, acceptance or forgiveness, in an entirely secularized form, under conventional clinical-therapeutic treatment goals, up to

- comprehensive approaches that are explicitly based on a spiritual conception of man and which try to foster and support the spiritual development and formation of the person.

It can be single aspects and interventions that are loosely interwoven with conventional treatment, or complex approaches which systematically include the spiritual and religious dimension.

As examples of such comprehensive approaches we find Richards and Bergin's "spiritual-theistic strategy for counseling and psychotherapy" (Richards & Bergin, 2002), the "adapted cognitive-behavioural therapy for the religious client", as proposed by Rebecca Probst (eg. Probst, 1996), to "mindfulness and acceptance based treatment approaches" with exponents such as Jon Kabat-Zinn or Marsha Linehan (Kabat-Zinn, 1990, 2003; Linehan, 1996) and up to the different forms of Transpersonal and Integral Psychotherapy (eg. Walsh & Vaughan, 1993; Wilber, 2000; Assagioli, 2004).

Richards and Bergin (2002) and Harris, Thorensen, McCoullough and Larson (1999) have compiled a wide range of spiritual and religious interventions in their surveys. For example, spiritual / religious assessment, recommendation of spiritual or religious literature, forgiveness interventions, different forms of meditation, prayer with the client, religious bibliotherapy, imagination with a spiritual focus, the use of religious metaphors, twelve-step programs, and others.

These examples impressively demonstrate how broad the spectrum of available interventions and approaches is. Furthermore, it can be seen how different the individual forms are, as well as how different the extent of integration of conventional psychotherapeutic procedures and concepts, and those that derive from religious or spiritual traditions actually are. The extent of the theoretical foundation and empirical validation of these approaches differs considerably as well.

As welcome as the present opening up of the profession concerning such issues may be, there are also certain risks involved when applying the respective approaches. Those have also been discussed under the keypoints of “ethical issues” and “fields of competence of the profession”.

Predominantly in the area of mindfulness-based approaches, for instance, the following pitfalls have been debated:

- usurpating and violating the integrity of the traditions of origin
- a lack of in-depth understanding of the underlying paradigms
- a purely technicistic approach, functionalization and misappropriation of spiritual practices for the purposes of a health technology which is focused on efficacy and goal attainment.

(e.g. Walsh 1980, 1988; Heidenreich & Michalak, 2006)

Mostly, but not exclusively in the context of the spiritual-theistic approaches, the following concerns have been expressed:

- the trivialisation of the numinous or sacred
- abusive and encroaching practices
- imposing spiritual or religious worldviews and values upon the client
- practicing outside the boundaries of professional competence
- the holding of dual religious and professional relationships
- the displacement or usurpation of religious / spiritual authority
- violating the boundaries given by the worksetting
- the raising of utopian expectations in clients as a result of the combination of medical or psychotherapeutic and spiritual authority.

(Richards & Bergin, 2002, p. 143ff.; Utsch, 2005; Sollod, 2005)

Quite well known and frequently cited in this context are the general ethical guidelines for psychiatrists which have been issued by the “Religion and Psychiatry” Committee of the American Psychiatric Association in 1990 in order to avoid possible conflicts between the psychiatrist’s religious commitments and clinical practice.

They include, among others, the following points:

- psychiatrists should maintain respect for patients’ beliefs
- psychiatrists should seek to obtain information on the religious or ideologic beliefs and orientation of their patients so that they may attend to them in the course of treatment. Empathy for the patients’ sensibilities and particular beliefs is central.
- psychiatrists should not impose their own religious, antireligious or ideological agenda on a patient, nor should religious concepts or ritual be offered as a substitute for accepted diagnostic concepts or therapeutic practice.

(summarized after APA, 1990, p. 542)

With regard to all these pitfalls, recommendations and practical procedures have been formulated which serve to minimize and adequately address them. But due to time constraints I regrettably cannot discuss these here in more detail.

I would slowly like to come to an end with my presentation and summarize the present state of the art. Thereto, I would like to quote Richards and Bergin once again, the authors of the famous APA standard work “A Spiritual Strategy for Psychotherapy and Counseling”. In their introduction to this volume the authors state: “During the past 15 years, a broad-based, ecumenical, interdisciplinary effort has been under way to develop a spiritual orientation for psychotherapy and psychology.” (2002, p. 9)

Since then, a multitude of handbooks describing the possibilities of an inclusion of the spiritual and religious dimension in all stages of the psychotherapeutic process have been made available. Furthermore, a broad spectrum of individual interventions, as well as

sophisticated models of an encompassing inclusion of the spiritual and religious dimension, have been elaborated and presented. By now professional practice standards, informed-consent procedures and ethical guidelines are at our disposal. However, regarding these procedures, neither has a consensus been achieved, nor has this resulted in an incorporation of respective binding guidelines and practice standards in psychotherapy training curricula.

Concerning the further development of these approaches, we have to be mindful of the possible benefits as well as of the risks involved in the attempt to include and integrate these areas into a psychotherapeutic setting.

With this special area we are entering relatively new and hitherto uncharted grounds in the history of academic psychology, which is anyhow rather short. The engagement with these topics and the development and implementation of the respective approaches require a high sensitivity, a specific professional expertise, and, not least, personal experience with respect to the underlying traditions and practices. Issues of this kind require interdisciplinary approaches, reflection on the areas and boundaries of professional competence, the reflection on epistemological questions, and, last but not least, a scientific-empirical investigation and validation of the procedures applied.

A stronger consideration of religious and spiritual issues in psychotherapy training could help the psychotherapists feel more confident in dealing with such topics if they become an implicit or explicit theme in client presentation. It could also help them to address such topics more competently and effectively. And it could support them in making the best possible use of the potential that is inherent in the inclusion of spiritual or religious factors in psychotherapy.

After all these reflections concerning an increasing professionalization and standardization of integrative approaches, I would like to counterbalance and close my presentation with a quotation from C.G. Jung. And in doing so, I would like to encourage you to develop yourself

equally in a holistic way and to have trust in your very personal experiences, insights and standpoints, concerning the integration of spirituality and religiosity into treatment.

Jung states:

“Every psychotherapist not only has his own method: *he himself is that method.*

‘Ars totum requirit hominem’ says an old master. [The art requires the whole person]. The great healing factor in psychotherapy is the doctor’s personality, which is not a priori given; but rather represents performance at its highest, but not a doctrinaire blueprint. Theories are unavoidable, but mere auxiliaries.....”

(C.G. Jung, C.W. 16, p. 94, transl. LH)

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