# Competency Addressing Religion & Spirituality in Couple & Family Therapy Workbook

Hi there! We are Dr. Jen Ripley and Dr. Jim Sells, Co-directors of the Charis Institute at Regent University.

## WELCOME!

Welcome to the learning series titled Family and Couple Therapy Competencies Addressing Religion and Spirituality, or *Family CARS*. This is a community-of-learning continuing education experience to apply principles from diversity education and family systems theory to addressing religious and spiritual issues in couple and family therapy.

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# THE ROAD AHEAD

## 01 Cultural Comfort

An overview of awareness of R/S competency in couple & family therapy. What is your comfort with R/S? What is your Expertise? Working within your competency and maintaining ethical boundaries.

## 02 Research in Family CARS

Research basics in religious coping, sanctification of family relationships, forgiveness & humility, and prayer in families. Applying prayer to therapy.

## 03 Assessment in Family CARS

What are the family's R/S identities? How prominent is R/S? What role does R/S play in their concerns? How would they include R/S in therapy?

## 04 Systems application

Applying 4 systems principles to clinical work: Non-anxious presence, Multi-directional partiality, Differentiation in R/S, and Exclusions & Embrace.

## 05 Application to a case

Apply the CARS principles to a family case.

Family CARS

Competencies Addressing Religion/Spirituality


## Family CARS: Comfort, Assessment, Research & Systems

1. Reflect on R/S in your **Comfort** for each case (CECE)
   a. What is your Cultural **Comfort** with R/S?
   b. What is your **Expertise** with their R/S tradition?
   c. Work within your R/S **Competency**, and
   d. Always maintain **Ethical** boundaries
2. R/S family **Research** concepts are usually positive, but can be negative (Can Someone Find Peace?)
   a. Religious **Coping**
   b. **Sanctification** of family relationships
   c. **Forgiveness** & Humility
   d. **Prayer** in families
3. **Assess** 4 key R/S Assessment questions (IPRI)
   a. **Identity**: What is the religious/spiritual tradition or beliefs for you and your family?
   b. **Prominence**: How prominent is R/S in your family's daily life together?
   c. **Role**: What role does R/S have with your current concerns?
   d. **Inclusion**: Would you like to include your R/S practice into therapy?
4. What **Systems** therapist concepts help address spiritual tensions? (Nuns & Monks Dance Everyday)
   a. **Non-anxious** presence
   b. **Multi-directional** partiality
   c. **Differentiation** around R/S issues
   d. Engage in both **Exclusion and Embrace**

# C.E. LEARNING OBJECTIVES

Module 1: Introduction to CFR/S (introductory level)

(a) accept R/S as a diversity variable,
(b) understand the influence of personal beliefs or biases,
(c) learn how relational and family language is essential in R/S constructs

Module 2: Translating basic science of CFR/S for therapy (intermediate level)

(d) translate basic science on R/S in families to therapy (e.g., the sanctification of marriage, religious coping in parenting),
(e) negotiate when R/S is viewed as a threat to functioning,
(f) apply research on prayers as exemplar religious intervention utilized as part of treatment

Module 3: Assessment of CFR/S and their relationship with aspects of diversity (introductory level)

(g) discover basic assessment skills in R/S factors that both help the family function and potentially create tension within families.
(h) review the intersection of R/S with other diversity variables, especially LGBTQ+, race/ethnicity, family type, and life stage.

Module 4: Religious/spiritual intervention: Best practice and Ethics (intermediate level)

(h) integrate established systems theory, including relational ethic for diverse R/S contexts,
(i) review procedures to collaborate with religious leaders/communities.
(j) review ethical use of religious practices (e.g., prayer).

Module 5: Application to a Case Spiritually Integrated Parenting Focused Treatment (intermediate level)

(k) examine the integration of clinicians' theory of CF treatment with religious concepts.

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# MODULE 1: CULTURAL COMFORT

The first module will be about self-reflection of our comf
R/S in therapy.

The Four Great Ideas for Module 1 are (CECE):

- Explore our **C**ultural Comfort level
- Consider our **E**xpertise in Client's R/S
- Work within our **C**ompetency
- Maintain **E**thical boundaries

Your Mission:

1. Watch the Module One Video
2. Take Notes on What you Learned
3. Check out your Learning with the Content Questions
4. Engage in Peer conversation applying the ideas to a case

## Module 1 Video Notes

Froma Walsh said "Most families and couples who come for therapy or counseling are seeking more than symptom reduction, problem solving, or communication skills; they are seeking

d_____.

m_____ and

c_____ in their lives."

Group Discussion (~15 minutes): Note how comfortable or uncomfortable this topic is with peers and clients.

Are you more religious, spiritual, both or neither?

Are you more conventional, unconventional, both or neither?

Do you feel positively towards R/S experience? Are you a performer? audience member? no-thank-you?

If time:

Where are you in your personal R/S journey currently?

How might your personal experience impact your work with clients?

Notes on your Cultural Comfort Level

# FOUR GREAT IDEAS FROM FAMILY SYSTEMS

Great idea #1: A non-anxious _____ _____ wins over _____ when creating a non-_____ presence.

Great idea #2: Differentiation is the ability to maintain a sense of _____ in close relationships with others.

Great idea #3: Multi-directed _____. being partial to each _____. The contextual family therapist engages fully.

Great idea #4: Exclusion & _____. The basis for healthy therapeutic attachment is to embrace in spite of _____. Acknowledge that we are both different and valued, separated but _____.

Hint: "Nuns & Monks Dance Everyday" is mnemonic for Non-anxious presence; Multi-directed partiality; Differentiation; and Exclusion & Embrace

# MODULE 1 NOTES

# MODULE 1:
# CHECK YOUR LEARNING

___ Feelings that arise before, during, or after culturally relevant conversations

A. Cultural Humility

___ Meaning making and striving that is not focused on a religious tradition or history

B. Cultural Comfort

___ Being open and willing to reflect on oneself as an embedded cultural being and an openness to hearing about and striving to understand the cultural background and identity of others

C. Spirituality

Which of the following is NOT one of the four "great ideas" from systems theory to increase our competency addressing religion and spirituality proposed in this module?

A. Attend to each person in the room

B. Maintain a sense of self in close relationships with others

C. Acknowledge that we are different and valued, as well as separate but embraced

D. Ignore the religion and spirituality diversity factors that the client presents with

E. Create a non-anxious presence in the face of diversity issues

There is a scientific basis for understanding religion and spirituality in couples and families, just like other aspects of diversity.

True False

Answers: B; C; A; D; True

# MODULE 1:
# CASE

Dana is a therapist who has a case that presents for family therapy and talks about conflict over their 22-year-old son who is gay and recently announced he would like to marry his boyfriend. The husband in this family is a traditional religious follower and finds this to be a desecration of the family. The mother is the same religion but believes that there is no problem with being gay in their religion. She supports her son and believes the proper religious response is to actively support the son's relationship. You can tell the mother is worried about it although her worry is expressed subtly. The son isn't sure he wants to do family therapy, doubting it will be helpful.

Dana herself is nonbinary (she/they) and active in supporting gay rights. But Dana knows this conflict runs deep for this family. Dana decides to move on from their conflict about the marriage and instead focuses them to talk about general communication between them. Dana knows nothing about their religion and finds their religion and views on gay marriage confusing. Instead Dana decides to focus on their language and ethnicity as a family from Tuvalu in Polynesia to address diversity in the couple. After all she is busy as a clinician, and can't be an expert in everything.

## MODULE 1:
# SMALL GROUP DISCUSSION QUESTIONS

1. What does this case bring up in you? What is in your awareness of your reaction to the family's religion/ spirituality? How does your own experience with religion/ spirituality affect your reaction to a case like this one?

2. What principles from the teaching could Dana apply to this case?

3. Describe what Dana is missing. Why is it missing? And what would be a better response to this?

4. If Dana were to address religion and spirituality with this family, how could she address the family tension between the son's gay identity and the parents different beliefs about religion and gay identity using the training ideas from this module.

5. Share with the group some of your own spiritual identities (religious, spiritual, both or neither) and emotional reaction to R/S (performer 1 or 2, audience, or no thank you). Notice how sharing this personal (often hidden) information makes you feel. What anxieties do you notice arising when you consider sharing this information? How might your clients feel about sharing this information with you?

# MODULE 2: RESEARCH IN R/S IN FAMILIES

The second module will focus on the extant research on religion and spirituality in couples and families.

The Four Great Ideas for Module 2 are (Mnemonic: Can Someone Find Peace?):

- Religious **C**oping
- **S**anctification of Couples and Families
- **F**orgiveness & Humility
- **P**rayer

1. Watch the Module Two Video
2. Take Notes on What you Learned
3. Check out your Learning with the Content Questions
4. Engage in Peer conversation applying the ideas to a case

## Fill in the Blank Module 2 Video Notes

Religion/ Spirituality usually predicts _____

general health and _____ life.


Sanctification is the manifestation of God or imbued with

_____ qualities.

Divine triangulation would place one partner allied with
_____
against another family member.

Is Forgiveness Healthy?
_____

All major religions have encouraged their followers to engage

in _____ as an answer to the problem of

offenses in relationships.

Frank Fincham and Stephen Beach have conducted studies

that show that positive _____ increases couple

commitment, and forgiveness.

# MODULE 2 NOTES

## MODULE 2:
## CHECK YOUR LEARNING

___ A tactic that can be used in a family dyad to get one entity on their side to increase their power.

___ The manifestation of God or imbued with sacred qualities

___ joining with a Higher Power to pray for blessings for one's children or spouse.

A. Sanctification

B. Negative Triangulation

C. Divine Triangulation

According to research, which of the following could be associated with increased sanctification in a relationship?

A. Increased psychosocial adjustment

B. Less negative functioning

C. Positive communication

D. Lower infidelity

E. All of the above

All major religions have encouraged their followers to engage in forgiveness as an answer to the problem of offenses in relationships.

True False

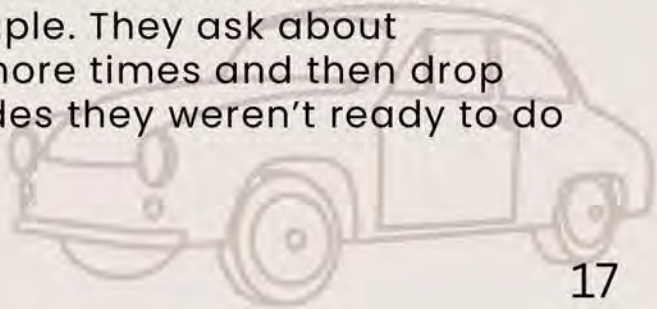
# MODULE 2:
# CASE

A couple presents to therapy where the husband is a Baptist pastor and the wife also works for the church. Their primary presenting issue is the husband has been using pornography which violates their values for sexuality. It doesn't appear to be affecting his ability to work, or self-care. But the couple is deeply affected by this. The wife caught her husband watching some pornography and brought the incident to another local pastor for advice. Consequently, the husband's position in the church is threatened by this discovery where he could be sanctioned but is unlikely to be removed from his position for a "first offense."

The wife is just aghast at the "whole affair." She is having nightmares, and can't sleep. The husband is contrite and apologetic but more likely to say it's a moral problem, not a psychological problem. The wife is convinced it's both. The couple is asking for a forgiveness intervention and want to use prayer to help them through this struggle.

The couple's therapist isn't quite sure how to respond to this couple. The therapist is agnostic and has had some negative experiences with Baptists in her community. She doesn't know much about forgiveness interventions and doesn't think the husband's relatively small amount of pornography use is a psychological problem. She wonders if she should perhaps refer them to a local religious therapist but is unsure if they would end up shaming the husband and creating more problems for the couple. It's a small town so there aren't but a few therapists who do couple therapy in the area.

She tells the couple that the pornography use wouldn't be considered a psychological diagnosis, but she could help the couple with communication issues. She offers to do emotion-focused couple therapy with the couple. They ask about forgiveness interventions a couple more times and then drop out of treatment. The therapist decides they weren't ready to do the work of couple therapy.



## MODULE 2:
## SMALL GROUP DISCUSSION QUESTIONS

1. What would you tell the therapist she should do with this case?

2. Is the therapist missing anything when she decided they weren't ready for therapy? Could anything from the couple's religion have helped the therapist build alliances, and use their religion as a resource?

3. If the therapist were to address religion and spirituality with this family, how could the therapist address the spiritual triangulation with the wife+ other pastor, and implied wife+God as she is wanting her husband to be labeled an "addict" but the husband doesn't see it that way?

4. How might you use forgiveness and prayer for a couple/family like this, or one that has a different religion/spirituality than you do?

# MODULE 3: ASSESSMENT OF R/S IN FAMILIES

The third module will focus on assessment techniques for religion and spirituality in couple and family therapy

The Four Great Ideas for Module 3 are (IPRI):

- Identity: What are the R/S identity/identities of the family?
- Prominence: How prominent is R/S in the life of the family?
- Role: What role does R/S play in the family's problems?
- Inclusion: Would they like to include R/S practice in therapy?

Your Mission

1. Watch the Module Three Video
2. Take Notes on What you Learned
3. Check out your Learning with the Content Questions
4. Engage in Peer conversation applying the ideas to a case

## Fill in the Blank Module 3 Video Notes

The first question for identity is: What is you and your family's

religious and spiritual _____ ?"


Be specific in their religious _____ and terminology, for example use "your Islamic tradition" if that is their term.

If the family is not engaged in formal religion or spiritual practices, you might instead ask about how they uniquely create____ _____ in life together as a couple/family or explore deeper questions about death, birth, love, marriage (if married) in their own way.

The video suggests to ask about #4 inclusion by using the phrase "How would you see your spiritual/ religious /faith practices _____ in your counseling?"

# MODULE 3: NOTES

# MODULE 3:
# CHECK YOUR LEARNING

Some clients prefer various terminology for their religious/ spiritual identity. Which term would be most specific in working with a family?

A. Your religion
B. Your faith tradition
C. Your Islamic tradition
D. Your spirituality

What question is important to ask for couples/families who have a high interest in spirituality or religion and see religion/spirituality as a part of their family's purpose or problem?

A. How might your spiritual practices help in your counseling?
B. How important is religiosity and spirituality in your life?
C. With what religion, faith, or spiritual label do you describe yourself?
D. All of the above

If a family is not engaged in formal religion or spiritual practices, what is something you might ask about instead of faith tradition or religiosity?

A. How the couple/family understands the influence of outside stressors
B, How the couple/family uniquely creates meaning in life together or explores deeper questions about death, birth, love, and marriage
C. How the couple/family communicates about their cultural backgrounds
D. None of the above

In therapy, you might have an open discussion with your clients about what language they use and acknowledge with them that, within their own family or religious group, there is a whole lexicon of terminology.

TRUE FALSE

Answers: C , D , B ; True

# MODULE 3: CASE

A single mom Carmella presents for treatment concerned about her only son Will, who is 15 and has been diagnosed with ADHD and bipolar disorder from a reputable local child psychologist. His teacher says he might need special education and referred the family for mental healthcare. The family is African-American. The mom lives on her own with the son, and relies heavily on her family for support and childcare. Will really loves spending time with his grandmother and cousins, and they seem to accept the odd behaviors that come with his diagnosis.

The family is heavily involved in a local Muslim community center with her brother and also the grandmother's African-Methodist Episcopal church. The two religious groups both engage in many local political and community activities including marches, and rallies which Carmella enjoys and finds meaning in being active in the political work.

The mom receives a good deal of her financial support for utility bills and food from these two religious groups. An older lady at the AME church asked if her son might be cursed by God or have "some kind of demonic influence over him" and states "I know that sounds kind of crazy, and I don't mean to sound that way, but he's just so unusual and odd. Sometimes he like sees ghosts when he's depressed. And he just seems sorta wild. Sometimes I wonder." You are the therapist and just met this family.

# MODULE 3:
# DISCUSSION QUESTIONS

What would you ask about the mother and son's religious/spiritual beliefs and practices? What would you actually say?

Reflect on what the religion or spirituality brings up in you? Is there any discomfort? Is her involvement in two religions bringing up any feelings in you? Reflect on how familiar you are with each of these religions.

How might the assessment IPRI (Identity, Prominence, Role, and Inclusion) ideas be applied to a case like Carmella and Will?

How would you conceptualize the role of religion/spirituality in your conceptualization of this case (use your own theory)?

# MODULE 4: SYSTEMS APPLICATION TO R/S ISSUES

The fourth module will focus on applying great ideas from family systems theory to religion and spirituality in couple and family therapy

The Four Great Ideas for Module 4 are (Nuns & Monks Dance Everyday):

- Non-anxious presence. Calmly and courageously sitting with families with R/S tensions
- Multi-directional partiality. Taking the interests surrounding R/S of each party.
- Differentiation. Applied to R/S issues
- Engage in both Exclusion & Embrace in R/S issues

Your Mission

1. Watch the Module Four Video
2. Take Notes on What you Learned
3. Check out your Learning with the Content Questions
4. Engage in Peer conversation applying the ideas to a case

## Fill in the Blank Module 4 Video Notes

In family systems, problems and solutions are found

_____ people.

The four big ideas are

1.Maintain a _____ presence

2.Use _____ partiality

3.Employ _____ around R/S issues

4.Engage in both _____ and _____

You can create _____ using multidirectional partiality.

Differentiation: Maintain a strong _____ of _____ while engaging curiously with those that are different.

Notes:

# MODULE 4: NOTES

## MODULE 4:
## CHECK YOUR LEARNING

Check which concepts from this training below relate to creating a systemic alliance with each person. Check all that apply.

___ A. Calm presence with religious tension

___ B. Treatment planning

___ C. Sacred Relationships

___ D. Prejudice

___ E. Exclusion and embrace

___ F. Multi-directed partiality

Instead of focusing on "IT" the religious difference between couples who present to therapy, what should the therapist focus on instead?

A. How other family members feel about the religious difference

B. Do actually focus on the religious difference for most sessions

C. Focus on and explore the recursive patterns established by family of origins

It is rare for a family member to sabotage the new systemic changes made in therapy (in this case around handling R/S tensions) so there's no need to prepare for this eventuality.

True False

Answers: A, E, & F; C; False

# MODULE 4: CASE

David is a Jewish young man, age 30. He has a young son with his grad school girlfriend and has weekend custody and the relationship with the ex is amicable. He works as a chemist in Boston and does not believe in God or practice his Jewish faith but appreciates the legacy and history of Judaism. He is engaged to Bindi, age 29, a Hindu woman who is a pharmacist. She does practice her faith with her family who also live in Boston.

Bindi's family came to the U.S. from Mumbai India before she was born. They are a proud family who have succeeded in the United States after the parents' investment and sacrifice. The family is quite respected in the Hindu community, as they are from the Brahman caste and the father was favored by a guru in the Boston area. The couple is living together for a year now and planning a wedding in another year.

The reason to seek counseling is that they have had some disagreements about the wedding planning, and about religion. David is glad to just have a Hindu wedding, since religion isn't important to him but his mother refuses to attend the wedding if it doesn't include some Jewish traditions. Words like sacrilege and desecration were used by the mother at a family meal recently.

Bindi states that she can't even sleep or eat out of anxiety over the problem. She feels as though she can't possibly handle the stress of the extended family tension. David seems to be minimizing the problem saying that none of their families even really believe in a God or gods, but Bindi finds this very offensive.

In individual meeting David confesses that he has thought about trying to reconcile with his ex due to the stress around religion and their families. Bindi just seems lost and deeply frightened of losing the man she has loved for several years.

# Module 4: Discussion Questions

1. Reflect on feelings that this case brings up in you about religious differences in families. What does it bring up to your awareness? Is there any discomfort?

2. How might non-anxious presence be helpful for this young couple's problems?

3. What could multi-directional partiality look like for a couple with different religions, like Bindi and David?

4. What kind of ego-differentiation would a therapist need to address the R/S differences in the couple in a professional way?
(Differentiation is the ability to maintain a sense of self in close relationship with others. It is the capacity to manage one's own anxieties and to resist reacting to anxiety in another. Well-differentiated people can recognize that they need others, but also stay calm and clear when there is conflict, criticism, and rejection. They can respond selflessly in the best interest of the family and not respond in over-conforming or pouty rebellious ways.)

5. In what ways is the couple excluded from each other's individual experiences, and yet can embrace each others religious identity and issues?

6. How might you use prayer with a couple like this, who are different religions?

# MODULE 5: APPLY TO A PARENTING CASE

The fifth module will focus on applying the great ideas from family systems theory to religion and spirituality in a parenting case. The 4 great ideas for this module are:

1. Reflect on our comfort in a parenting case with a religious problem
2. Assess the R/S needs of parents in treatment
3. Discuss Family CARS research concepts applied to the case
4. Apply family systems theory principles to a religious problem in family therapy.

Your Mission

1. Watch the Module Five Video
2. Take Notes on What you Learned
3. Check out your Learning with the Content Questions
4. Engage in Peer conversation applying the ideas to a case

## Fill in the Blank Module 5 Video Notes

For R/S assessment, this couple from Malaysia appears to be:

Identity: Eastern Asian _____
Prominence of R/S in their lives? _____
Role of R/S in problem? _____
Inclusion of R/S in treatment? _____

Working within Ethical Limitations of _____ _____ & Role is important.

_____ _____: When psychological problems impair the ability to practice one's faith/ religion/ spirituality.

For multi-directed partiality think of each partner's interests, in this case the father's interests are about the _____ and the mother's interests are _____.

Differentiation: Draw from _____ and _____ resources for treatment.

Notes:

# MODULE 5: CHECK YOUR LEARNING

Review: CARS stands for:

Module 2: Research in Family R/S "Can Someone Find Peace" stands for

C

S

F

P

Module 3: Assessment "IPRI" stands for

I

P

R

I

Module 4: Systems Theory "Nuns and Monks Dance Everyday"

N

M

D

E

What is a therapist's *first* job in considering the best way to address Religion and Spirituality issues?

A. Understand their R/S history, traditions and practices

B. Awareness - reflect and identify your cultural comfort, reaction and response to the client's religion.

C. Determine which R/S resource is best for the couple.

A therapist can help clients explore their religion/spirituality as a resource instead of point of tension.

True False

Answers: For mnenomics check page 4 for all; B; True

# MODULE 5: CASE

Trace has a new case. They are a Buddhist couple who practice meditative prayer and yoga practice. They are 2nd generation Malaysian, living in Washington DC., working in a family business, and quite supportive and loving with each other. They requested couple therapy to assist with adjustments with their 5-year-old daughter who is newly diagnosed with autism. The father is anxious about the diagnosis and worries he won't be able to keep up the business.

The couple would like to use prayer, meditation, and yoga practices to help cope with the stress of parenting and be more accepting of the diagnosis.

Trace is not that familiar with Buddhism but does practice mindfulness for his self-care. He asks the couple what they were thinking might work for them with the practices, and follows their lead. The wife begins to pursue her husband to engage in practices together, he withdraws, and they have conflict around the practices.

Trace isn't sure what to do. Trace brings ideas for conjoint prayer practices to the couple but this just seems to entrench them further in conflict around how to do the practices. Trace attempts standard communication exercises to help the couple listen to each other better, but they both reject the attempts.

# MODULE 5:
# DISCUSSION QUESTIONS

1.What does this case brings up in you around religion and spirituality? Does it bring up any new clinical experiences or discomfort?

2.What intersections of diversity do you notice in this case?

3.How might you use family systems approach to couple/family therapy to help the couple with this tension around religious practices?

4.How might Trace, as the therapist, use the couple's Buddhist religion as a resource while respecting the couple's different struggles with the autism diagnosis?

5.What would you like to share with this group has been most impactful to you?

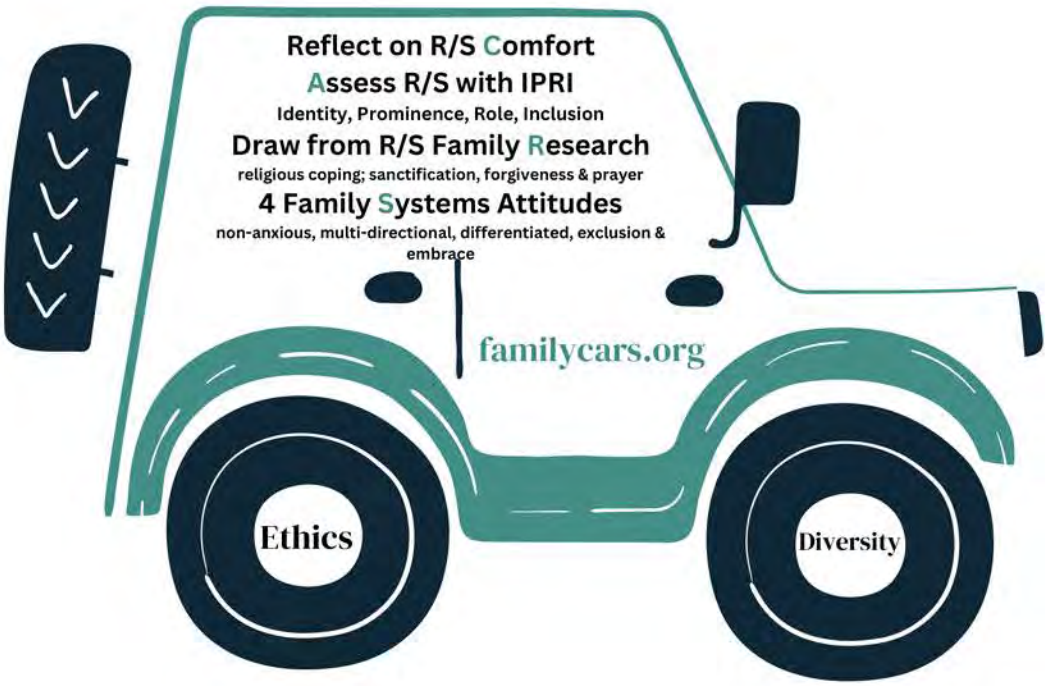
6.How central to your identity as a professional mental healthcare worker is being a competent religious/spiritual provider? Where does this fit with your overall personal style as a diversity-conscious clinician?

# MODULE 5: NOTES

# ONE PAGE ARTICLE SUMMARIES

**Clinicians are busy people!**

**Reading research articles is difficult to fit into a busy schedule, whether you are a student or practicing professional. But keeping up with research is important! We offer some key article single page summaries for research on religion/ spirituality in couples and family dynamics or therapy. What a deal!**



Carneiro, R. (2013). The impact of Christianity on therapy with Latino families. *Contemporary Family Therapy, 35,* 137–146. doi:10.1007/s10591-012-9209-3

Abstract:

Unquestioned patriarchal beliefs prescribed by religion often place women and racial and sexual minorities in positions of victimization. In the therapeutic framework, ''God'' represents unquestioned values that must be challenged and evaluated in order to have a transformative effect. As a result of the increase in the number of Latino immigrants to the United States, it is inevitable for therapists to work with Latino families, a highly religious population. The purpose of this paper is to explore, through a feminist perspective, the role of Christianity and the feminist movement in Latin America and the impact of Christianity on therapists' work with Latino families.

God and religion can be viewed through the lens of societal morals that a person has. It is important for therapists to understand the role of religion in the Latinx community as the number of the Latinx population is ever growing in the United States. The article explores the role of Catholicism in Latinx history and way natives were condemned by faith until the Liberation Theology Catholic movement in the 1960's. However, many who sought a more liberal or democratic church were excommunicated or killed. This influenced silence and mistrust in the Latinx community and this is an important aspect for clinicians to mindful of when working within a societal system that has often silenced minority perspectives and rights. The article states that as religion can mirror values of a society, worshipping a male God perpetuates a patriarchal agenda and can devalue female perspectives. Internalized oppression can be addressed in the family therapy process. In Latin America, strict gender roles and patriarchal structures can lead to resistance in gender equality which can be a factor that impacts therapy, particularly if spirituality is integrated.

Negative stereotypes can exist regarding gender equality which can be pervasive across life aspects and persist within families and family structures. Religion and spirituality are identified as separate concepts in this article with religion involving social and structural parts and spirituality involving the individual's role within a spiritual experience. As Christian religion was brought to natives in Latin America, there is an underlying theme of cultural mistrust and power that must be acknowledged. The article emphasizes the therapeutic alliance and the therapist is encouraged to analyze gender roles and power issues in families, and how it can relate to underlying Christian values and influences in the family. The article describes that therapists' internalized views of religious beliefs can have an impact on how clients are conceptualized. A therapist's role can be to empower clients to change any socially constructed internalized views of a punitive God to a view of a more loving God. A case vignette and analysis explored interpersonal issues with a Latinx female client with underlying with an intersection of religion, sexual orientation, and gender in unhealthy schemas impacting her life. The therapist acknowledging this intersection and having it be a focus in therapy, helped the client heal.

Crabtree, S. A., Chance A., Bell, D. A. R., Sandage, S.J. , Devor, N.G., & Stavros, G. (2020). Humility, differentiation of self, and clinical training in spiritual and religious competence. *Journal of Spirituality in Mental Health, 23,* 1–21.

Abstract:

Spiritual and religious (S/R) competence is an important yet understudied area of clinical multicultural competence. In a sample of clinicians who attended seminars on a specific S/ R group training model, we examined the roles of humility and differentiation of self (DoS) in predicting S/R attitudes and S/R self-efficacy, as well as perceived barriers to implementing this training model in clinical settings. DoS mediated the relationship between humility and S/R self-efficacy, but not between humility and S/R attitudes. Further, four barriers emerged to implementing the presented training model. A discussion of the findings and implications for training are included.

S/R is an appropriate multicultural competency to discuss and target in therapy and there can be negative therapy outcomes for the client if they perceive the therapist as avoiding or disregarding S/R. The article references a study stating that therapists only discuss S/R factors with 30% of clients. This could be due to biases of S/R in psychology. Clinicians need to be aware of their own personal commitments, biases, and experiences with religious as it can impact their approach to integration in therapy. Humility is discussed as being integral in approaching cultural differences and competency. Humility is defined as a virtue involving the capacity to view one's self accurately in a balanced way, practicing a receptive orientation with others and willing to learn and be taught, and the ability to regulate self-conscious and negative emotions. Humility for clinicians in the therapy room has shown for positive outcomes. Differentiation of self is also discussed as an important trait for clinicians to have. This involves self-awareness and self-reflection as well as the capacity to regulate intense emotions while acting with intention even with those emotions present, and to have the capacity to balance both independence with one's own needs to connect with others and the needs of others in the moment.

The present study examined whether humility and differentiation of self influence clinicians' self efficacy in implementing S/R competency with clients after attending a training on S/R competency as well as to see the feasibility of having a group training in S/R for clinical work. 48 Clinicians participated in the study and attended 5 group trainings on S/R which involved a day of training each with discussion and questions. Then participants completed a questionnaire including the following measures: Religious/Spiritually-Integrated Practice Assessment Scale (RSIPAS), Differentiation of Self Inventory-Revised-Short Form (DSI-SF), General Humility Scale (GHS), the single question "How comfortable do you feel participating in a group like this at your agency?" on a 5 point likert scale, and the single question "How likely do you think you are to participate in a SERT group at your agency?" on a 5 point likert scale.

The results from the meditation model analysis show an indirect relationship between humility and S/R self-efficacy through differentiation of self. Differentiation of self did not actually mediate the relationship between humility and S/R attitudes in psychotherapy. There was a direct relationship between humility and S/R attitudes. This shows that humility may be related to S/R attitudes and differentiation of self is more related to self-efficacy. A humble therapist may be more likely to sit in the room with a client in a nonjudgmental way while a differentiated therapist may be more confident in implementing S/R integration in session.

Daneshpour, M. (1998). Muslim families and family therapy. *Journal of Marital and Family Therapy, 24(3),* 355–368. doi:10.1111/j.1752-0606.1998.tb01090.x

Abstract:

Muslim immigrant families living in the United States may well come to the attention of mental health professionals. This article examines the applicability of the Anglo-American models of family therapy to Muslim immigrant families. The most significant differences in value systems between the Muslim and Anglo-American cultures is Muslim families' preference for greater connectedness, a less flexible and more hierarchical family structure, and an implicit communication style. Systemic thinking, which deals with the pattern of relationships, is valid for all families regardless of cultural differences. However, the preferred directions of change for Muslim families need to be integrated into the assessment and goals for family therapy.

Clinical Application:

The article starts by highlighting the basic premises of Islamic ideology regarding marriage and divorce. It should be noted that the Islamic community is diverse and that local ethnic, social, and historical factors affect how the Islamic faith is interpreted and applied. Overall, family structure is predominantly patriarchal and based on the extended family. The basic objectives of marriage in Islam are securing a comfortable atmosphere for the husband and wife and bringing up healthy, faithful, and virtuous children. Spouses choose each other of their own free will, however, consulting one's parents is encouraged. A husband is responsible for providing what is necessary for his wife's comfort and for running the household. The dowry is is seen as a means of showing respect to the future wife. While divorce is regarded as unpleasant and bitter, couples can divorce, and remarriage is common.

The dynamics of Muslim immigrant families are discussed within the framework of the Circumplex Model of Marital and Family Systems. The three basic concepts of this model are cohesion, flexibility, and communication patterns. While separateness usually takes precedence in Anglo-American families, Muslims value unity, harmony, and connectedness. Flexibility is valued highly in Anglo-American culture, and relationships tend to be egalitarian with a democratic approach to decision-making. In Muslim relationships, leadership is authoritarian, negotiations are limited, roles are strictly defined, rules are often unchangeable, and strictly enforced. Communication in Anglo-American culture is typically overt, explicit, and open. In contrast, indirect and implicit expression is common among Muslims and in many Eastern cultures, and particularly confrontations are disliked.

Lastly, the article highlights several strategies for approaching and helping Muslim families. These include awareness of the stereotypes and biases surrounding the Muslim religion, awareness that problems are typically dealt with in the family, and that acknowledging problems can be associated with a sense of failure. Recommendations include an emphasis on the joining process, a holistic ecological perspective toward intervention and the family system, as well as the use of a genogram. Additionally, concrete, immediate solutions to family problems are typically perceived as more practical and effective than future-oriented goals.

Dwairy, M., & El-Jamil, F. (2008). Counseling Arab and Muslim clients. In Paul B Pederson et al. (Eds) *Counseling Across Cultures.* (pp. 147-160) Sage Books.

This chapter gives attention to the complex theme of providing counseling services to Arab and Muslim clients. The author introduces the reader to the culturally unique lifeways and thoughtways of an ethnocultural population that has not received much attention in the multicultural psychological field until recently. The reader will learn that in general, Arab and the Muslim worlds share the ethos of tribal collectivism and Islamic values but are also influenced by their exposure to Western culture. The ethos and value orientation greatly influences the dynamics that occur within conventional counseling sessions. (PsycInfo Database Record (c) 2020 APA, all rights reserved)

Arabs are the descendants of Arabic tribes who once lived in the deserts of the Saudi peninsula, Iraq, and Syria and there are millions of Arabs living in 22 Arab countries. The Islamic religion appeared in one of the main Arabic tribes in the 7th century and has now been adopted by more than a billion Arab and non-Arab people worldwide. The Arab and Muslim worlds share the ethos of tribal collectivism and Islamic values. A clinician should bear in the mind that Arab clients may not necessarily identify as Muslim, just as there are non-Arab clients who are members of the Islamic faith.

The social systems for Arabs and Muslims tend to be collective and authoritarian. The individual and family are interdependent, and the family is ruled by a patriarchal, hierarchical authority. Within this collective system, many Arab and Muslim youth do not become psychologically individuated from their families. Their personalities continue to be collective and directed by external norms and values rather than by internal structures and processes. These Arabs and Muslims often come from traditional and religious families where collective values are highly enforced and the standards or expectations placed on males of the household differ from those placed on females. .

Counselors and therapists who work with these clients should be aware of the challenges of dealing with unconscious, personal, and/or repressed contents. It is important to acknowledge the importance and impact of the family belief system and the real restrictions that may be placed on the individual that influences self-fulfillment within the family culture. For Arab Muslim parents, traditions and values may be more important for decision making than their children's feelings. It is often difficult for Arab children to criticize their parents in conversations with foreigners, such as Western counselors, and they typically feel the need to emphasize that the intentions of their parents are good. The behavior of Arab children in the presence of their parents (external control) is often extremely different from their behavior when they are away from external control. Both behaviors represent two different yet real components of the children's personalities. When working with Arab and Muslim families, counselors should not seek to change or confront the family culture or the family structure. Instead, finding better solutions within the fabric of that culture and using the family's internal resources and strengths is recommended to change this situation for the better.

Arab Americans face the additional struggle of managing the demands of their families along with the demands of the culture of their host country. Understanding the client's Arabic and/or Muslim worldview is essential, as they can also influenced by their exposure to Western culture. Individuals often require assistance in allowing themselves to adopt new values from the host country without feeling that their cultural identity is being threatened. Throughout this process, clients' family members also require assistance in communicating their needs and fears to one another so that the family system itself does not feel threatened either. Therapists and counselors who work with Arab and Muslim clients should modify their therapies by incorporating cultural and religious norms and beliefs and by including the use of family therapy, metaphor therapy, and other indirect therapies.

Eppler, C., Cobb, R. A., & Wilson, E. E. (2020). Multifaith perspectives on family therapy models. *Journal of Family Psychotherapy, 31,* 1-35.

Researchers used thematic analysis with 37 participants to identify perceptions of the alignment between their faith traditions and family systems theory, structural family therapy, Bowen's multigenerational theory, and narrative family therapy. Thirty-seven participants from six faith orientations, including 20 denominations or sects, responded to a survey. Patterns across responses indicate that family systems theory concepts are compatible across diverse faith traditions. Structural family therapy's emphasis on restructuring boundaries and hierarchy is compatible across faith traditions as long as cultural and religious norms are carefully considered. Bowen's concepts of detriangulation and differentiation are compatible across faith traditions, but particular beliefs may contradict the transmission of family patterns. Core concepts of narrative family therapy are compatible across faith traditions as long as therapists honor intuitive processes, include stories from clients' faith traditions, and do not instill stories of false hope. Regardless of model, some clients may resist definitions of psychological dysfunction and understand illness and change as supernatural. (PsycInfo Database Record (c) 2021 APA, all rights reserved)

Understanding the faith-based beliefs of clients and incorporating their religious or humanistic spirituality into therapy enhances culturally attuned therapeutic practice. Faith traditions guide meaning- and decision-making, which affects presenting problems, and provide clients sources of resilience. Many clients prefer therapists who are aware of their religious or spiritual beliefs. However, many therapists report a lack of understanding regarding the alignment between clients' faith and clinical work, which can make discussions involving faith can be difficult for therapists.

Systemic therapy models, sometimes referred to as family therapy theories, are familiar and primary ways in which family therapists conceptualize clinical work. An enhanced understanding of the ways in which systemic therapies align with particular faith traditions may increase a therapist's ability to build rapport, support clients' strengths that are rooted in faith and/or spirituality, and incorporate other aspects of client centered, spiritually- integrated care.

Finding themes include:

(1) family systems theory's concepts seem compatible across diverse faith traditions;
(2) structural family therapy's emphasis on restructuring boundaries and hierarchy seems compatible across faith traditions as long as cultural/religious norms are carefully considered; (3) Bowen's multigenerational theory's concepts of detriangulation and differentiation seem compatible across faith traditions, but particular religious beliefs may contradict its emphasis on the transmission of family patterns; and
(4) narrative therapy's concepts of externalization, metaphors, and restorying seem compatible across faith traditions as long as intuitive processes are honored, faith stories are included, and the therapeutic stories do not promote false hope. It also seems true that regardless of the therapeutic theory, some religious clients may resist definitions of psychological dysfunction, resist prescriptions for behavioral change, and insist on understanding both illness and change as supernatural.

Overall, this research suggests that family therapy models are likely to be perceived as therapeutically helpful, particularly when applied with nuance and cultural sensitivity to specific faiths. The study highlights the importance of understanding clients' faith orientations and how their beliefs may relate to the therapeutic approaches that guide couples and family therapy.

Fincham, F. D., & Beach, S. R. (2014). I say a little prayer for you: Praying for partner increases commitment in romantic relationships. *Journal of Family Psychology, 28,* 587.

Abstract:

Partner-focused petitionary prayer (PFPP) has received little attention in the prayer literature. In two studies, we examine PFPP to see whether it is uniquely important in conveying relationship benefits, whether its benefits are transmitted through an effect on relationship satisfaction, and whether one's own or the partner's PFPP is central to beneficial effects. In Study 1, we examined PFPP in a sample of 316 undergraduate students who were in an "exclusive" romantic relationship, finding that PFPP was related to later level of commitment and that this relationship was partially mediated through enhanced relationship satisfaction. Study 2 examined PFPP in a sample of 205, married African American couples, finding that both partners' PFPP was consequential for commitment, with actor effects partially mediated through relationship quality, and partner effects fully mediated. Together the studies suggest the value of continued investigation of PFPP as a potentially important vehicle for enhancing relationship outcomes.

The studies put together suggest that engaging in individual Partner-Focused Petitionary Prayer (PFPP) is significantly related to later increased commitment to one's partner in romantic dyadic relationships and marriages for both younger Caucasian and older African American couples providing some support of the power of prayer to maintain relationships. However, not all prayers are the same as the same relationship was not found for petitionary prayer focused on the self. The focus of the studies was on colloquial, petitionary prayer, a form of prayer that invokes the deity's help in response to specific needs, using the individual's own language rather than a set or "memorized" prayer. In this article, the petitionary prayer of interest is other directed and focuses on the partner's well-being; namely, partner-focused petitionary prayer (PFPP). Commitment has also been described as the intentional choice to persist in the relationship and be emotionally attached, leading partners to become increasingly constrained and dedicated.

It seems that engaging in PFPP increases one's own satisfaction with one's relationship, which subsequently influences one's own commitment to the relationship positively. Indeed, it seems that relationship satisfaction was a significant, albeit partial, mediator of the PFPP commitment association. Also, there was a direct relation between PFPP and commitment that was not mediated by increased satisfaction. At the same time, it seems that engaging in PFPP increases one's partner's satisfaction with the relationship, and corresponding commitment (fully mediated by one's partner's satisfaction with the relationship). This suggests a primary pathway from PFPP to increased relationship satisfaction with ripple effects on potentially many other aspects of relationships, including commitment.

In practical contexts it suggests that individual PFPP is useful to relationships by increasing one's own relationship quality for self and partner and so can provide a helpful adjunct to other relationship enhancement activities and would be especially appropriate for religious/spiritual couples who already engage in prayer. Unfortunately, we do not know to what extent partners were fully aware of each other's PFPP activities, and the mechanisms through which PFPP impacts relationship satisfaction. In summary, the current set of results highlights the potential value of a relatively simple activity, PFPP, which has implications for satisfaction and, in turn, dedication commitment.

Gehart, D. R., & Paré, D. (2008). Suffering and the relationship with the problem in postmodern therapies: A Buddhist re-visioning. *Journal of Family Psychotherapy, 19,* 299-319.

Abstract:

This article explores ways that Buddhist psychology can enrich postmodern family therapy practice. The discussion focuses in particular on Buddhist ideas regarding suffering and the relationship with suffering. We propose that Buddhist practices of accommodation to suffering offer an alternative orientation to problems that in various ways can be incorporated into postmodern therapeutic practice—specifically solution focused brief therapy, narrative therapy, and collaborative language systems. The article compares and contrasts Buddhist and postmodern therapy ideas.

Ancient Buddhist psychological wisdom can be infused into post modern therapeutic practice to refresh and add newness to clinician's theory and practice in today's context. The pursuit of pleasure and the avoidance of suffering underlies the modern capitalistic cultures which results in many being ill-equipped to meet with suffering. In contrast, Buddhist ideas views suffering as inevitable, understood as byproducts of our expectations and attachments in the way we construct our world, which can be alleviated by reducing our attachments, and reducing the severity of our expectations. Buddhist ideas can be helpful perspectives to frame our approach to suffering and problems, many of which are unsolvable and difficult. Buddhists encourage an openness and curiosity to suffering, feeling and experiencing it in its richness, complexity and contradiction, without getting lost or overwhelmed by it, creating a sense of equanimity and peace in the face of good times and bad. When a person responds to suffering with curiosity rather than an immediate sense of needing to escape, the pause and openness changes how the problem is experienced, opening new possibilities.

Solution Focused Therapy (SFT) minimizes engagement with problems or its causes, as it's seen as a lost opportunity to construct solutions or to do something different, since it holds the view that solutions don't necessarily have anything to do with problems. This could discourage an engagement with suffering since suffering is closer to problems than solutions. A Buddhist enriched approach to SFT is of the view that all attachments lead to suffering, be it the client's attachment to the problem, and any rigid attachments of the client to the client's preferred solution.

Hence, loosening each partner's attachment to his or her respective preference would be one focus, which might help couples develop the ability to maintain their preference without demanding or rigidly insisting on it, and enhance the likelihood of moving towards a resolution that honors each person's preference, and increase their resilience when preferences are not met.

Hook, J. N., Worthington Jr, E. L., Davis, D. E., & Atkins, D. C. (2014). Religion and couple therapy: Description and preliminary outcome data. *Psychology of Religion and Spirituality, 6,* 94.

This naturalistic study examined religion and couple therapy. Participants were 44 therapists and 68 couples entering couple therapy with religious couple therapists. At three time points during therapy, clients completed measures of relationship satisfaction, working alliance with the therapist, and satisfaction with therapy. Clients also described the techniques (religious and nonreligious) that were used in therapy. Most religious techniques were used in about one half of the sessions, and the religious commitment of clients was positively related to the number of religious techniques used. Preliminary evidence revealed that clients in therapy with religious couple therapists improved over time in relationship satisfaction and working alliance, and reported a high level of satisfaction with therapy. This study is a first step in exploring issues related to religion in couple therapy, and we conclude by providing recommendations for future research in this area.

In this study, religious techniques such as discussion of faith, prayer in session, assignment of religious tasks, use of scripture, and forgiveness by God were utilized by the clinicians in about half of the sessions. All other techniques focused on solutions, emotions, thoughts, and behaviors, which is also very important in couple therapy. One takeaway from this study is that it seems appropriate to intersperse religious techniques with psychological techniques, rather than overload the couple with religious interventions, in order to keep the session on its projected course of treatment and honor the integrational goals of the couple.

Results of this study showed that the use of religious techniques in treatment was positively correlated to the couple's religious commitment, but that the therapist's religious commitment was not significantly correlated to the number of religious techniques used. Therefore, from the couple's point of view, the

therapists were respectful of the couple's goals and proactive in integrating Christianity into their sessions, regardless of their own religious and spiritual standing. So, an important suggestion would be for couple therapists to do their best to integrate, within their competencies, and couples will likely notice and appreciate the effort.

The couples in this study were found to improve in their relationship satisfaction, working alliance with the therapist, and overall satisfaction with therapy. Therefore, integrating religious techniques into treatment can be helpful for religious clients. However, couples with higher levels of religious commitment improved less over time in relationship satisfaction than clients with lower levels of religious commitment. This could be that couples with higher religious commitment may have more rigid belief systems or be less open to trying new things in couple therapy or with each other. High religious commitment could also impact the working alliance with the therapist, especially if the high religious commitment couple is paired with a nonreligious therapist. However, this was not studied as all clinicians in the study were Christian. Regardless, it is important for the therapist to accurately assess the couple's religious commitment at the start of treatment to set reasonable expectations for treatment outcomes.

Mahoney, A., Chinn, J. A., & McGraw, J. S. (2022). Positive psychology and religiousness/spirituality in the context of couples and families. In E.B. Davis, E.L. Worthington Jr., & S.A. Schnitker (Eds.), *Handbook of Positive Psychology, Religion and Spirituality,* Springer, In press.

In this chapter, we examine the intersections of positive psychology (PP) and religiousness/spirituality (R/S) in close relationships. Specifically, within Mahoney's (2010) relational spirituality framework, we focus on the maintenance stage of healthy relationships and explore helpful roles that R/S can play for diverse types of couples and families. We briefly summarize extensive evidence that global markers of R/S (e.g., religious service attendance) are associated with relational well-being. We also highlight that global markers of R/S confound relatively commonplace positive religious/spiritual processes with less common but potentially toxic manifestations of R/S. We then delve into four specific religious/spiritual strengths that are empirically tied to better relational functioning: sanctification, spiritual intimacy, prayer for partner, and positive religious/spiritual coping. Next, we offer guidelines consistent with available scientific research that religious leaders, chaplains, couple and family educators, and psychotherapists might consider when working in community or clinical settings. Finally, we suggest ways to advance science and practice on the roles of R/S, for better and worse, within intimate and family relationships.

This chapter found that greater religion and spirituality (R/S) can be a valuable resource for many types of couples and family relationships (i.e., unmarried couples, same-sex couples, and families led by single mothers) even though couples in traditional family units may participate in religious activities more frequently. In addition, greater R/S has been shown to be consistently linked to favorable relational outcomes in married and unmarried

opposite-sex couples. Due to the issues that can arise from only gathering global R/S, it is important for clinicians to assess and disentangle R/S strengths from other processes that may be toxic. Clinicians must remember that regardless of the couple's global R/S, every couple has a unique set of religious and spiritual practices that can impact interactions with their deity/Higher Power, each other, and the clinician. To accentuate only the virtues tied to R/S would be overlooking the possibly toxic forms of faith. Therefore, assessment is key in understanding the complexities of each couple's religious and spiritual standing, and it is important to illuminate both the positive and negative R/S processes.

This chapter suggests delving into four constructs (sanctification, spiritual disclosure/intimacy, prayer for partner, and positive religious/spiritual coping) within R/S couple therapy. Higher degrees of sanctification have been correlated with increased marital satisfaction and sexuality within intimate unions due to its focus on the relationship as "having sacred qualities and/or as being a manifestation of a deity's presence." By focusing on the couple's sacred union, couples may feel more adept at solving their problems as a team and focus on the greater goal of preserving, protecting, and strengthening their marriage/relationship. Engaging in intimate dialogues about R/S were shown to increase relationship satisfaction. Though many couples may fear sharing their innermost thoughts and feelings concerning R/S, clinicians can encourage couples to trust in the process and model acceptance and empathy. Benevolent prayer for one's partner has been shown to improve relationship quality, including , gratitude, and forgiveness of one's partner. Therefore, clinicians can encourage prayer and gratitude in or out of session to help couples "warm up" their feelings toward one another. Lastly, by encouraging couples to draw on their relationship with God and support from fellow believers, research has shown better psychological adjustment for individuals. Therefore, when discussing difficult topics in therapy, it will be important for couples (and clinicians) to practice R/S coping and self-care.

Pargament, K.I. & Krumrei, E.J. (2009). Clinical assessment of clients' spirituality. In J.D. Aten & M.M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination.* (pp.93-119). American Psychological Association.

Spiritual assessment measures a client's spiritual/religious functioning to best aid them in treatment planning and intervention. The foundation of spiritual assessment is understanding spirituality and how it relates to the client's conceptualization of their problems and solutions. Pargament and Krumrei (2009) posit that spirituality is neither inherently healthy or unhealthy, but it should be well-integrated into clients' lives. Well-integrated spirituality operates under the belief that the integration of spiritual components should act in harmony with one another. The article underscores several questions by which clinicians should assess a client's spiritual functioning: 1) where said client stands concerning spirituality, 2) where they are in their spiritual journey, 3) the content of clients' spirituality, 4) the context of clients' spirituality, 5) impact of spirituality and 6) the place of spirituality in treatment.

To assess these underlying premises of spirituality, the clinician must open the door to spiritual communication with the utmost respect and interest when engaging with clients. The initial spiritual assessment should take place during the intake session in which clients' should be assessed on the following components of spirituality: the importance of spirituality, their religious affiliation, the relevance of spirituality to their problems, and the relevance of spirituality to their solutions.

After initially inquiring about clients' spirituality, clinicians can use clinical judgment to decide if it would be helpful to follow through with an extensive spiritual assessment. An extensive spiritual assessment aids the clinician by gaining more information on their clients' spiritual functioning through spiritual storytelling, clinical exercises, and open-ended questions. Aside from explicit methods of spiritual assessment, implicit spiritual

assessment can likewise aid clinicians in indirectly understanding their clients' spiritual functioning. Pargament and Krumrei (2009) outline several ways clinicians can engage in implicit assessment: listening for implicit spiritual language, using psycho-spiritual questions, and attending to clients' emotions.

Spiritual assessment is a multidimensional process designed to better understand a client's spiritual functioning and where spirituality fits in their understanding of their presenting problems and potential solutions. The spiritual assessment begins with a brief inquiry about spiritual issues within the intake session. As the clinician sees fit, the clinician can move into an extensive assessment of the client's spiritual narratives and understandings of the world through session activities, open-ended questions, and story-telling narratives. If clients do not resonate with spirituality, clinicians need to attend to nonverbal cues or implicit methods of spiritual themes in therapy. Clinicians must approach spiritual themes with openness, respect, and interest to gain a holistic picture of a client and their treatment.

Ripley, J.S., Solfelt, L., Ord, A., Garthe, RC., Worthington, E.L. Jr., & Channing, T (2022). Short- and long-term outcomes of hope focused couple therapy. *Spirituality in Clinical Practice*, in press.

Hope Focused Couples Therapy (HFCT), a spiritually-integrated form of couple therapy, assists couples in restoring love, adjusting maladaptive areas of their relationships, promoting faith in one another, and regaining motivation to persevere in working on their relationship. The HFCT approach utilizes forgiveness strategies, embodying God's love, promoting faith, and using prayer or other relevant spiritual practices. Ripley et al. (2021) investigated the short-term and long-term effects for couples who completed short-term HFCT at a university-staffed community-based setting. The current study found that couples undergoing HFCT improved in their intimate relationships with moderate to large effect sizes immediately following treatment, 6 months after treatment, and 2-10 years after the completion of treatment. The long-term outcome for treatment demonstrated that the non-integrative treatment had slightly better outcomes than the integrative treatment. These results seem to indicate that spiritually integrative therapy does not produce better outcomes than the standard treatment.

Additionally, Ripley et al. (2021) found that partners scoring in the clinical range had the most improvement toward treatment goals compared to those scoring in the non-clinical range. A possible explanation could be that a non-clinical partner may not have the goal of increased relationship satisfaction but seek treatment for a more specific issue they are experiencing. The study also found that the married and engaged couples residing together had significantly better therapeutic outcomes than other couples, which might indicate that a variety of couples' needs need to be addressed. It is important to evaluate couples' purposes, success measures, and the need for couples' interventions. Ripley et al.

(2021) emphasized the importance of revisions being made to standard couples therapy (i.e., HFCT) so couples can meet their goals and distinct needs.

The complexity of needs in treatment is so varied and diverse, and clinicians must be able to identify when revisions need to be made to therapeutic approaches. Overall, this present study and prior studies underscore the idea that integrative couples therapy is efficacious in the short and long term. However, it is not more efficacious than standard couples therapy. Clinicians must remain flexible and open to each couple's unique needs. Therefore, clinicians must revise therapeutic approaches for the personal needs of each couple. Couples' spiritual and religious functioning in therapy can be an essential diversity variable to be considered and applied to treatment. The Hope-Focused approach is easy to learn and used as a revised method and a powerful change agent for couples seeking therapy.

Rizkallah, N., & Hudson, E. (2019). Circling the triangle: An EFT approach to working with Christian couples triangulating God. *Contemporary Family Therapy: An International Journal, 41,* 219–226. https://doi.org/10.1007/s10591-019-09496-8

The most recent research backs up the idea that there is an increased demand for therapists with a spiritual background and interventions that are more spiritually inclusive. This is especially important to keep in mind, given that the majority of Americans consider themselves to be Christian. The authors present a fresh way of thinking about therapy for Christian couples who triangulate God as a third party in their relationship. The most common form of treatment for triangulation is called structural therapy, which involves removing the third party as a potential source of conflict from a couple's relationship. Emotionally Focused Couples Therapy (EFT) serves as the basis for the authors' alternative conceptualization of an intervention that "circles" the triangle to make room for God to be included in the discussion. This literature reviews the existing research on working Christian couples who triangulate God, offers a rationale for why EFT is an effective model for spiritual inclusivity, and, as a final step, examines instructive EFT interventions and a case study for working with Christian couples who triangulate God.

Structural Therapy interventions address this triangular organization of families, in addition to other family structures. The process of triangulation takes these three and joins them in a way that violates a boundary. This third person or object is included in the spousal system in order to de-escalate or avoid conflict. In a coalition triangle, the spouses focus on blaming each other in order to win God's allegiance. Little to no work is done toward achieving a spousal subsystem with a clear boundary and ability to solve the present problem. Distance between the spouses increases as they shift into a process of manipulative triangulation. In a substitutive triangle a member of the dyad replaces intimacy with his or her spouse with a relationship with God. As confict

intimacy with his or her spouse with a relationship with God. As confict develops, either member distances from the other and substitutes spousal closeness with God, in order to manage anxiety. The operative experience is that of an overwhelming amount of anxiety with an attempt to defuse it by bringing in God. In triangulating God, spouses are trying to have their attachment needs met through manipulation (coalition triangle) or other emotional intimacy (substitutive triangle).

Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality, 5,* 129–144.

Polls show that most people value religion and spirituality. Nearly 20% of people are religiously unaffiliated, and more identify as spiritual but not religious. Religion and spirituality have been shown to improve psychological health and well-being, and clients prefer psychotherapy that addresses them. In response to this need, the authors developed a proposed set of spiritual and religious competencies for psychologists based on (1) a comprehensive literature review, (2) a focus group with scholars and clinicians, and (3) an online survey of 184 scholars and clinicians experienced in integrating spiritual and religious beliefs and practices and psychology. Survey participants suggested the wording for each item, and 105 licensed psychotherapists with expertise in spirituality/religion and psychology rated clarity and relative importance of each item as a basic spiritual and religious competency.

The outcome is a set of sixteen fundamental spiritual and religious competencies (attitudes, knowledge, and skills) that the authors recommend all licensed psychologists display. (1)Create a spiritually safe and affirming therapeutic environment for their clients, (2) have the ability to conduct an effective religious and spiritual assessment of their clients, (3) use or encourage religious and spiritual interventions, if indicated, to help clients access the resources of their faith and spirituality during treatment and recovery, and (4) effectively consult and collaborate with clergy and other pastoral professionals, and when necessary, refer to them. Similarly, Pargament (2007) identified four essential qualities of therapists who wish to practice spiritually integrated psychotherapy: (1) knowledge about religion and spirituality and how to integrate them into treatment; (2) openness and tolerance of diverse forms of religious and spiritual expression; (3) self-awareness of the psychotherapist's own spiritual attitudes and values; and (4) authenticity and genuineness in relating to clients about their spirituality.

Worthington, E. L., Jr., Sandage, S. J., Davis, D. E., Hook, J. N., Miller, A. J., Hall, M. E. L., & Hall, T. W. (2009). Training therapists to address spiritual concerns in clinical practice and research. In J. D. Aten & M. M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination.* (pp. 267–292). American Psychological Association. https://doi-org.ezproxy.regent.edu/10.1037/11853-012

This book chapter discusses how therapists can address spiritual concerns in their practice and research. It is more common for religious-affiliated counseling programs to teach integrating faith into therapy. However, that means that students from secular programs are not always as adequately trained in this area. Some schools consider religious/spiritual beliefs to be a part of multicultural diversity. Research indicated that secular schools had mixed beliefs regarding the relevance and appropriateness of including religious and spiritual training in their programs. This posed a problem that counselors were often not equipped to ethically integrate beliefs into counseling when requested by clients.

This chapter proposes ideas for how to solve this problem. One way to achieve this would be to train counselors to be more confident to address new issues such as personal beliefs and to provide tools to address that. Counselors in training also need to be aware of the discomfort they might experience with R/S ideas brought up by clients, including the possibility of countertransference. A goal for educators would be to help their students feel more comfortable with these topics. A suggestion for helping students achieve competence would be to provide space for a supervised environment to learn to handle the topic.

The remainder of the chapter discusses in detail the following suggestions for how counseling students can achieve the aforementioned goals. Those sources of learning are coursework, interaction with peers, advising and mentoring, research, personal therapy, practicum experiences, predoctoral internship, and post-degree training. Three training models were suggested for training programs to incorporate to assist with integrating spirituality and religion. To conclude the chapter, a research agenda to learn more about the problem and solutions.