Integrating Spirituality, Religion, and Faith into Psychotherapy

Integrating spirituality, religion, and faith into clinical practice is no longer the sole domain of clergy and pastoral counselors. Sacred-sensitive treatment is gaining prominence as an effective component of holistic health; its positive effects on mental and physical health are well documented (Koenig, McCullough, & Larson, 2001). Yet remarkably few practitioners address the often perplexing religious and spiritual problems inherent in the psychological difficulties of their diverse clientele. While some clinicians ignore spiritual and religious issues altogether, others refer clients with such issues to clergy. With our increased understanding of neurobiological factors in the workings of mind, brain, and body, we need new practice methods, particularly methods that enhance holistic health.

This book addresses methods of integrating spirituality, religion, and faith into psychotherapy by using evidence-based expressive practice approaches to address common problems that clients bring to treatment. While some difficulties are easily enunciated by clients, such as conflict in a couple over religious values, other issues may not appear to be overtly connected to spirituality, religion, or faith, yet these dimensions of life are significantly affected. Furthermore, whether clients are religious or not, existential issues often surface, such as the quest to understand personal self-worth, and bereavement brings up questions about life after death. These concerns often tap into the humanistic and spiritual domains in life. It is under such circumstances that the expressive therapies are a useful starting point.
This book describes a number of expressive therapies and provides information on when and how to link them in a treatment sequence with more commonly used talk-therapy methods. The book is written for a multidisciplinary audience of clinicians and scholars in the psychotherapeutic professions, including clinical and counseling psychologists, clinical social workers, marriage and family therapists, nurse practitioners, expressive-arts therapists, psychiatrists, recreational therapists, pastoral counselors, and child therapists. This opening chapter presents a short history of the tenuous relationship between the religious and spiritual fields and psychotherapy, and reviews why these two fields are necessarily merging. After laying this foundation, this chapter introduces the reader to the expressive therapies as they can be used for spiritual and religious clinical problems, their importance to holistic health, and how they access mind, brain, and body. In addition, principal themes that run through the entire book are given so that the reader may understand how chapters are linked together.

BACKGROUND: A CHANGING WORLD, A DIVERSE CLIENTELE

Because our world is changing, the kind of help our clients want and need is changing. Globalization has been a central player in this process. In the last thirty years, the number of Asians in the United States has risen from 1.5 million to 12 million, and Latinos from 9.6 million to 35.3 million (Bhaskar, Arenas-Germosén, & Dick, 2010). In Los Angeles, people from 140 countries speak approximately 86 different languages. In Los Angeles and San Francisco, in Chicago, in the Boston-to-Washington corridor, and in other areas across the United States and Canada, statistics reveal our diversity. With the influx of immigration from the Pacific Rim, Latin America, the Caribbean, and other homelands throughout the world, who our clients are and how they see their world and even the universe in relation to themselves has changed dramatically. In the United States alone, 51.5 million are Catholic or Eastern Rite, 2.8 million are Jewish, 1.1 million are Buddhist, 0.8 million are Hindu, 1.1 million are Islamic, 103,000 are Native American, and 57,000 are Sikh. Mainline Protestant churches such as Baptist, Methodist, Lutheran, Presbyterian, and Episcopal have approximately 115.2
million members, most of whom identify primarily by their denomination (ARDA, 2010). The decline of these mainline Protestant churches, the rise of the megachurch, an increase in fundamentalist movements in public and political life, the burgeoning number of storefront single-ethnic-group churches, the rise of New Age, individually defined spirituality, and the swell of so-called Eastern religions in the Western world all tell of how the face of those living in the United States and Canada has changed.

Concomitantly, more people are seeking help for psychological services than ever before. The sheer diversity of this group is vast. People seek help or are referred from a variety of settings, including schools, the workplace, hospitals and health care facilities, primary-care physicians, mental health clinics, the military, places of worship, and private practitioners. People come to request psychotherapy for their children, for family members, and for themselves. They come because they have experienced a troubling or harrowing event, family or marital problems, job problems, physical health problems, or loss. Often they have suffered abuse; they are traumatized, depressed, anxious, addicted, or suffering from the fallout from life stress (Heo & Koeske, 2010). Amid this diversity of people and issues, practitioners in one study report that a full third of their general client load presented with issues that were religious or spiritual (Sperry & Shafranske, 2005). Moreover, this finding does not document other cases where spirituality, religion, and faith are not the focus of the presenting problem, but are secondary problems resulting from underlying issues such as abandonment, trauma, rejection from their religious community, marital discord, or feeling a lack of meaning in life due to moral injuries of war.

Discerning where to begin in addressing both primary and secondary issues can be challenging. Specific sacred-sensitive coping methods can be employed to attenuate presenting problems, and treatment strategies can be integrated into the client’s life perspective. Such strategies have the potential to create powerful elements of change because they are more likely to make sense to the client, as they enhance “goodness of fit” between client and treatment. Religion, faith, and spirituality are key protagonists in that which gives ultimate meaning to life for many people, whether through organized religion or through individually oriented spirituality. We have come to recognize the roles of science and
the spiritual in maintaining physical and mental health. No longer are people considered to be the sum of intrapsychic drives, modifiable behaviors, or simple neurotransmitter imbalances (Sperry & Shafranske, 2005). The greater whole is represented by the interaction with sacred meaning of events, and of life itself.

Now more than ever, those seeking help are vocal about what they want. Findings from recent studies tell us that clients prefer a clinician who is at least sensitive to their religious, spiritual, or philosophical perspective on life (Koenig, 2005). Because the needs of some groups of clients have not been addressed in a spiritually sensitive manner, religiously identified institutions, such as the Jewish Federation and Catholic Social Services, have developed services of their own. In addition, those who identify with Conservative and Orthodox Judaism and fundamentalist Christianity often seek counselors in the same religious tradition. Some studies suggest that clients from these traditions prefer more explicit forms of religiously oriented therapy that integrate spiritual resources such as sacred texts or scripture (Tan, 1996). The newly immigrated may be more likely to bring their sacred traditions into counseling because they have experienced enormous changes that accompany relocation, migration, prejudice, and the need for language adjustment, and because such traditions are an acceptable part of their culture. Hence, we have abundant evidence of the importance of spirituality, religion, and faith in the lives of many clients. Questions remain whether we, as practitioners, deliver the kind of psychotherapeutic help that is wanted and effective, and importantly, if we know how to employ sacred-sensitive methods that are best suited to diverse clientele. In fact, the literature indicates that few in the psychotherapeutic professions treat clients who present with issues related to both sacred and psychological matters (Sperry, 2001). This book probes the potential of uniting these two dimensions.

HISTORY OF PSYCHOTHERAPY: SCIENCE, SECULARISM, AND THE SACRED

Since its inception, the psychotherapeutic field has been moving toward reliance on science. Psychotherapy literature explains mental disorders not as being rooted in a character of laziness or immaturity, but as being
due to biological, psychological, and social conditions (Hepworth, Rooney, & Larson, 2008; Maxmen & Ward, 1998). The effort to use science for validation has flourished in our field, with positive results. Many now use the findings of evidence-based practice and best-practice models to address specific problems. Such evidence may range from practice theory and clinical wisdom to case studies, surveys, and randomized controlled trials. Only very recently have sacred-sensitive approaches been validated in the scientific literature (Richards & Bergin, 2004). Yet for some, including religious and spiritual issues in treatment is seen as biased, unscientific, lacking objectivity, or not based in measurement and replication. Indeed, the sacred is difficult to define, to operationalize, to measure, and to analyze. To attempt to do so, some may reason, is in itself unscientific. Yet if we examine historical trends, the expanding neuroscience knowledge of the human brain has recently given legitimacy to explanations and practices that were previously only theoretical in nature. The need for sustained and secure attachment figures, the negative effects of trauma on brain and body development, the powerful effect of the therapeutic alliance on treatment outcome, and psychotherapeutic methods of integrating mind, brain, and body (J. Schore & Schore, 2008) are but a few of the powerful findings that were once only theoretical and now have advanced the psychotherapeutic field through sustained research efforts.

Ethical, academic objectivity is also rooted in a tradition of secularism. When we enter the realm of the sacred, some may fear losing secular objectivity, academic freedom, and a sense of scientific control over process and outcome that gives legitimacy to our field. Separation of church and state is, after all, an ethos long embedded in American consciousness. Other private institutions, even schools that are religiously oriented, often do not provide information on the intersection of faith and specific mental health treatments across diverse groups of people.

Clinician reluctance to address spiritual and religious issues can also be due to feelings of inadequate skills acquisition (Pargament, 2007). When we are unschooled in an area, we are more likely to disengage from the treatment process. If we examine historical trends, however, institutions of higher learning were also slow to address factors in the treatment process such as the impact of client diversity related to gender, ethnicity, race, class, sexual orientation, and physical ability.
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Only recently has the importance of the intersection of spirituality, religion, faith, and psychotherapy been recognized in psychotherapy curricula.

Whether spiritual or religious content is spotted by the clinician or the client is another issue, as such content can be easy to miss. Relatively few clients approach psychotherapy stating that they wish to address a religious or spiritual problem. For some clients, existential issues may lie at the root of many of life’s problems, even when they are defined as problems of a religious nature. Such may be the case for clients who struggle with depression, bereavement, trauma, anxiety, and chronic physical illness. For others, their spiritual and religious life is affected by mental health issues. In some scenarios, these sacred forces play an essential part in problem resolution. In the end, it is up to the clinician to begin the process of examining where and how these sacred elements play out in the life of the client. As in the case of our historical insensitivity to sexism, the presence of sexual abuse, the coming-out process in gay men and lesbians, and the effects of racial prejudice on self-concept and opportunity, unless we are aware of the dynamics of sacred issues and their effect on the client, we cannot give help. If one cannot see the problem, one cannot conceive of a solution.

For some clinicians, addressing spiritual content may be a daunting task. Spirituality and religion, after all, touch upon our most personal, sensitive, and vulnerable spot: the relationship between the self and the sacred. Such a wide expanse may be experienced as overwhelming, and the number of questions in the mind of the clinician can extinguish an adequate treatment intervention. Concerns abound about how and where to enter the discussion, whether addressing religious and spiritual issues is truly part of psychotherapy rather than pastoral counseling, what qualifications are necessary to counsel in this area, whether having a faith orientation is necessary to address spiritual issues competently: many arguments can be made for avoiding the topic of treating psychospiritual and religious problems. Likewise, clients test the waters of therapy in an effort to understand acceptable content to discuss in the therapy room. Hence, the clinician has a powerful effect, either directly or indirectly, on the likelihood that issues related to spirituality, religion, and faith will ever surface in the treatment process (Pargament, 2007).
Often, the religious and spiritual life of the client is present in the treatment room, whether we as clinicians realize it or not and whether we choose to address the issues these forces involve. At times issues in the media, such as conflict over in vitro fertilization, gay marriage, and abortion rights, directly affect our clients’ personal life choices. Many times spirituality, religion, and faith play a crucial role in the client’s experience, yet they remain unvoiced by both client and clinician and thus unused in treatment. Recognizing these issues and how they operate for clients both inside and outside of the treatment room are the first steps in harnessing this powerful medium of change. Understanding how to spot particular psychological concerns related to spirituality, religion, and faith and the best methods for assessment and treatment of psychospiritual problems will go a long way toward using their healing force.

WHY WE USE EXPRESSIVE METHODS

Unifying Mind, Brain, and Body

Expressive therapies offer many strengths for clients who are struggling with issues pertaining to their sacred life. One reason may be that we experience both expressive therapies and the sacred realm largely through our senses rather than through abstract reasoning. We recall sacred images visually; we experience our sacred world through auditory memories of song, organ, bells, and chants. We may taste bread and wine. We smell incense and candles burning. We move our bodies in sacred rituals of prayer. Thus, sight, sound, and sensation provide avenues to information processing and healing by activating mind, brain, and body. Similarly, mind-body connections inherent in expressive treatment make them most applicable to issues of a religious or spiritual nature, as these approaches capitalize on the senses to effect change. In fact, expressive therapies rely on the senses for both problem identification and resolution. Thus, a cardinal link between spirituality and expressive therapies lies in the evocation of the senses. Focusing on relationships between client, therapist, expressive form, and sacred life, these treatment methods successfully enhance interpersonal, intrapersonal, and transpersonal well-being.
Recognizing When Talk Therapy Is Insufficient

Expressive therapies often can provide a route into the client’s world when words alone fail. Further, while some clients carry a strong faith tradition that can be verbally activated for coping with extant problems, others are burdened with significant difficulties that are less accessible to talk therapy. Neurobiological research indicates that such is often the case with those experiencing post-traumatic stress disorder (PTSD) resulting from abuse, rape, cult experiences, exposure to war, or terrorist attacks such as September 11th (Siegel, 2012). As a result, the spiritual life may suffer, leaving the client without hope or sense of meaning in life (Van der Kolk, 2003). Such is the case with soldiers returning from war with moral injury. Moral injury stems from having transgressed one’s moral identity or violated core moral beliefs in acts of war (Nakashima Brock & Lettini, 2012). While soldiers often feel that they have breached their moral code, too frequently they may not be able to construct enough of a coherent narrative to grasp, evaluate, or communicate their sense of moral injury. Perhaps this is so because such trauma and injury sits deep in the right brain where implicit memories are stored without the benefit of language. At other times, veterans feel that they no longer live in a meaningful world and that acts of war have robbed them of their basic human decency. For many, healing occurs through the expressive arts (Nakashima Brock & Lettini, 2012).

Expressive methods such as film production, writing poetry, journaling, acting, producing artwork, and engaging in movement can elicit affect and bind together feeling and reflective thought that had previously been unspoken or hidden from consciousness. Often an expressive-arts treatment such as guided imagery can be quite helpful in decreasing anxiety and increasing affect regulation. For others, such as those clients in palliative care or hospice programs, end-of-life concerns relate to anxiety about their relationship with the divine and the existence of an afterlife, yet they may find talking too exhausting (Oleniacz, 2008). Here, use of video imagery geared to the client’s perspective of the spiritual can be most comforting. Music from the faith tradition of the client can also provide solace. Those with complicated bereavement often have unresolved issues related to final conversations and the final resting place of their loved one. When traditional talk therapy is
difficult, the clients’ time might be more productively used in creating a memory box of their relationship, speaking to an empty chair representing their lost loved one, or writing a eulogy or letter to the one who has passed away.

Some clients might feel damaged by their faith traditions, or shunned by religious institutions; they may be unable to express their thoughts, feelings, and beliefs in a self-reflective narrative because language is a symbolic form of communication that is inaccessible or incoherent (Siegel, 2012). Under such circumstances, clients may find vicarious psychodramatic enactment useful in working through thoughts, feelings, and behaviors.

Sand-tray and art therapy may be more appropriate when clients have questions and concerns about their emotional and physical safety, or the existence of a God who could let abuse occur. Adolescents may find greater success in making an art treasure box that reveals their inner and outer life, in creating a photo diary, or in making a stained-glass window of their life. Many clients have difficulty finding the words to attach to religious and spiritual issues, especially to problems that are intertwined with mental distress. For these individuals, dance and movement therapy may be a better match for their problems, as involving the body is a more direct method to communicate inner struggles; moreover, it is less abstract than verbal discourse. Talk therapy is still the most commonly used method of communication in psychotherapy sessions, yet relying solely on talk as a method for communication and treatment has limitations when targeting problems such as those described above. Importantly, verbal discourse is often easier during reflection time after an expressive approach is used. In addition, not every client has the same expressive style. While some clients are quite verbal and make good use of talking, others are more visual, and still others more tactile or auditory in nature (Malchiodi, 2005). Thus, it makes sense to use expressive approaches that are geared to the client’s mode of information processing.

**Enhancing Affect Regulation**

Anxiety problems, post-traumatic stress, substance abuse, and borderline personality disorder are but a few of the disorders that have as a
hallmark difficulties with affect regulation (Solomon & Siegel, 2003). Many expressive methods are designed to enhance affect regulation (Malchiodi, 2005). Some of these include dance and movement therapy, guided imagery, music therapy, and writing therapy. Furthermore, expressive methods can simulate the placebo effect and are linked with relaxation and self-soothing mechanisms (Cozolino, 2010). Hence, expressive therapies offer a distinctive and valuable contribution to improving affect regulation through sacred-sensitive practice.

**Effecting Growth and Change**

Expressive traditions often provide a powerful medium to effect growth and change. Noted scholar of creative art therapies Shaun McNiff (1992) comments that expressive therapies have a unique contribution to make in a society that is often bereft of cultural and spiritual connections and roots. Expressive and creative arts draw on the connections and interrelationships between the arts, cultural practices, and healing. Clinicians using this approach help clients bring their whole self—body, mind, emotions, spirit, and soul—to the process of recovery (Estrella, 2005). Looking to traditions as diverse as those found in indigenous cultures and Rogerian client-centered psychotherapy, this psychotherapeutic movement proposes that active engagement in the imaginative realm reveals the transformative and mending powers of the psyche (McNiff, 1992).

**Finding Meaning through Expression**

Within the triangular relationship of client, expressive process, and therapist, the language of imagination can facilitate meaning making (Knill, 1994). Often quickly communicating pertinent material in ways that talk therapy cannot, expressive traditions have unique contributions to make to the field of spirituality and psychotherapy as they probe the untapped potential for change in the life of the client.

The strength of the expressive therapies lies in their unique position of communicating aspects of subliminal implicit memories and stories that may be unavailable to conversation but emerge through touching, hearing, or visualization (Rothschild, 2000). When individuals can
experience their sacred narrative through an activity, their story line has potential for becoming conscious, and for being broadened and deepened; thus, it becomes more meaningful. Further, the active participation of the expressive traditions encourages clients to take an empowered, dynamic role in their therapy. Self-expressive modalities help people to abreact feelings for cathartic purposes, and to contain feelings leading to reflection, greater self-understanding, resolution of conflicts, and emotional repair.

Perhaps one reason that expressive therapy is effective is its use of what Winnicott (1971) refers to as potential space. In this space lying between subjective experience and objective reality, connections can occur between mind, brain, and body. Boundaries are more fluid in potential space; hence, clients engage fewer defenses as they grow toward problem resolution. When expressive methods are used in this space, emotional limbic experiences are activated, and implicit memory becomes accessible to client consciousness. Emotional material actuated through an expressive medium is no longer held within but becomes available for examination. Subsequently, in reflective time with an empathic other, the therapist, clients can assign words and meaning to their experience. It may be that for these reasons, emotional concerns pertaining to the client’s sacred life can be addressed through expressive therapy.

Thus, it is often chiefly the expressive method that is thought to prime the pump of self-reflection. Perhaps that is why the National Center for Complementary and Alternative Medicine (2004) heralds many of the expressive therapies as effective treatments for trauma, depression, pain, and chronic physical illness. Importantly, as clinicians learn to use a variety of methods to address psychospiritual problems, the probability of accommodating diverse client backgrounds and styles increases, as does authenticity and the likelihood of effective treatment.

**SACRED-SENSITIVE EXPRESSIVE METHODS: AN OVERVIEW**

Among the first expressive treatment methods developed, art therapy is seen as a way to communicate both conscious and unconscious issues. This method expresses client thoughts, feelings, and experiences through art production, and its efficacy is supported by a significant
amount of research (Malchiodi, 2005). Through a variety of methods, art imagery and art production can be useful in accessing mind, brain, and body material to resolve conflicts around psychological and spiritual or religious struggles. Methods include assembling a collage, creating a memory box, drawing God imagery and God content, creating a spiritual treasure box, and making a stained-glass window of life. In addition, existing artwork can be used in assessment and treatment in pursuit of well-being.

In the research-supported tradition of music therapy, music is employed to access feelings, thoughts, and memories for clients who have difficulty with verbalization. Music therapy is used effectively to treat physical, cognitive, psychological, and social problems that may intersect with struggles of a sacred nature (American Music Therapy Association, 2013). Spiritual and religious song traditions are examined through text analysis to reveal life schemata and God imagery. Over time, negative content may be replaced with positive imagery garnered through music. Creation of a spiritual poem from song traditions provides another avenue for healing conflict. Music therapy focuses on how and when music can become a powerful method for accessing and integrating mind, brain, and body in the healing process. This approach can be paired with talk therapy, including cognitive-behavioral treatment and emotion-focused treatment.

A wide range of interventions is available within the context of writing therapy. Methods range from those supported by research, such as journal writing and bibliotherapy, to the use of letter writing, commentary, obituaries and eulogy writing, poetry, mantra writing, and autoethnography.

Psychodrama is a form of action group psychotherapy where clients play themselves and others in problem situations in their lives (National Drama Therapy Association, 2013). Diverse religious and spiritual issues can be addressed with this method; they include issues of loss, bereavement, feelings of being abandoned by God, struggles with self-acceptance, familial and religious intolerance, conversion struggles, guilt, and crisis situations. Psychodramatic methods include the use of the mirror, the double, the soliloquy, and the empty chair, a verbal, action-oriented intervention that uses a chair to represent aspects of the
self, others, or a deity (Perls, Hefferline, & Goodman, 2006). Evidence-based talk therapy can be linked to behavior rehearsal, cognitive restructuring, and insight-oriented approaches.

Dance and movement therapy (DMT) involves the psychotherapeutic use of movement to further emotional, social, cognitive, spiritual, and physical integration of the individual (American Dance Therapy Association, 2013). Dance and movement can be integrated into therapy as effective ways of expressing deep-seated issues that are not always accessible to dialogue. This approach has strong potential to provide individuals with an effective tool for accessing and expressing repressed thoughts, feelings, and emotions held in their bodies, minds, and brains. Using various methods of movement throughout the phases of treatment, this approach helps clients regain control of their mental health by reconnecting to memories, numbed emotions, distanced relationships, and lost spiritual life.

Sand-tray therapy, a medium applicable to all age groups, involves the client in creating a scene in a tray of sand with miniatures that represent issues and conflicts in real-world settings. This method is useful with spiritual, religious, and faith conflicts. The client may project life issues in the sand scene by selecting miniatures with religious symbolism. Conflict issues often include those that the client is fearful of addressing verbally with the therapist. Because spiritual and religious conflicts are at times difficult for clients to put into words, the sand tray is a particularly useful medium for many, especially those who are at an impasse in their treatment. Tactile and visual elements of the sand-tray therapy are particularly useful in accessing and integrating material in mind, brain, and body. This method can also be linked to evidence-based talk therapy, including emotion-focused therapy, cognitive-behavioral therapy, as well as to psychodynamic treatment.

Well supported by research, guided imagery uses aspects of relaxation therapy from the behavioral model. Using this method, the clinician helps the client imagine and tolerate situations that are otherwise incomprehensible. Guided imagery can be coupled with other expressive methods to induce relaxation. Used effectively for clients with physical problems and those with a trauma history, this intervention can employ aspects of sacred imagery in the service of affect regulation and
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of emotional and physical well-being (Maher, 2006). Therapeutic methods include systematic desensitization, interviewing the spiritual adviser, and use of God imagery in the healing process.

PRINCIPAL FEATURES OF EACH CHAPTER

This book provides clinicians with expressive methods that activate mind, brain, and body in the healing of psychospiritual problems. In addition, methods are given for linking expressive and talk-therapy approaches.

Chapter 2 provides distinctions and discussion of the different domains of spirituality, religion, and faith and offers new methods of assessing these sacred domains. It addresses the need to assess how each domain can affect the life of the client, both singly and as a totality, as well as how these sacred domains might operate and interface with the presenting problems of clients. The chapter emphasizes the necessity for framing treatment within a bio-psycho-sociocultural perspective and presents a new lens that draws attention to factors the clinician should seek to understand. Ascertaining which of these sacred domains predominates in the hierarchy provides clinicians with an operational framework from which to design treatment. The chapter presents methods for starting the conversation and accessing information in the opening interview, emphasizing close listening and attention to the client’s sacred narrative. Further, it provides methods for deepening the therapeutic conversation and examining how life-cycle issues and preexisting problems can interface with the sacred triad. Process issues such as pacing, timing, and addressing absented material is presented. A thorough discussion is given on interpersonal neurobiological development to attachment figures and assessment of God imagery for those whose religion is theistic. An appendix is given on areas to cover for a comprehensive sacred-sensitive assessment. Within this chapter implications for clinical practice and guidelines for pairing expressive methods with other talk therapies are given.

Chapters 3–9 discuss several expressive therapies for psychospiritual problems. Each chapter is organized in the same manner and has common themes. Each chapter opens with a short description of the expressive method and reviews historical developments of the method
and the background theory that undergirds practice intervention. Within each chapter information is offered on how the expressive method accesses the neuroscience of mind, brain, and body and its value for treating sacred-sensitive problems. Discussion addresses who is helped by the expressive method and relevant research findings.

The central focus of chapters 3–9 lies in the application of the method to spiritual, religious, and faith struggles within the psychological difficulties of clients. To familiarize the reader with the expressive approach, the description of the method includes any materials needed, common practices, and case studies. Each chapter offers procedures for integrating relevant diversity material from the client’s background. The cases present a diversity of religious and spiritual orientations, cultural-ethnic backgrounds, ages, and presenting problems. The importance of using core values in the client’s culture is integrated throughout. Each intervention is presented across the phases of treatment. Each chapter describes whether the particular expressive therapy is used principally in session and when it is applicable out of session and used as homework. When appropriate, suggestions for integrating expressive approaches with other talk-therapy methods are given. Also explored is the significance of using a client-focused approach with the expressive-arts tradition, rather than a therapist-focused stance.

Chapter 10 analyzes common themes across expressive interventions. The reader is introduced to a developmental model that is useful when practicing with expressive treatment approaches. This concluding chapter discusses how to select appropriate interventions for various client problems. Finally, the chapter describes the implications for future development of expressive methods and directions for research.

**CONCLUSION**

The challenge of the field of psychotherapy in the twenty-first century is to become a sophisticated, creative, and effective force in addressing the often complex problems presented by a diverse pool of clients. Our world has become a network of global communities housing residents with greatly varied cultural, religious, philosophical, and familial values. Risks associated with the fallout from serial war, the ever-growing economic gap between the wealthy and the poor, and the rapid pace and
chronic stresses of urban life yield problematic sequelae such as trauma, ill health, anxiety, depression, and alienation. The field must move forward to address these pressing challenges. Research results point to the increasing need to attend to the mind-body connection in health and mental health, and the important role of neurobiology in the intersection of brain and behavior. The psychotherapeutic field increasingly includes spirituality, religion, and faith as vital components of well-being. Often, sacred-sensitive interventions are the essential key to unlocking psychotherapeutic growth.

Expressive therapies focus on the recursive nature of process and product: they offer clients a chance to grow into greater awareness of their own potentials and resources. Some clinicians may not feel comfortable with the expressive therapies because they are a “both/and” rather than an “either/or” approach to psychotherapy. Kenneth Gorelick eloquently states that such therapy enacts both continuity and change, embracing and transcending conflict; it is individual and communal, and represents both thought and action. “It is large in its smallness” (Gorelick, 2005, p. 137).

Expressive therapies are well suited for integrating mind, brain, and body with spiritual and religious content, as they offer a breakthrough to recovery when talk therapies used alone are limited. Linking expressive methods with sacred-sensitive interventions yields a powerful approach that is comprehensive, balanced, adaptive, culturally competent, and rigorous in meeting the challenge that exists in the field today.

REFERENCES


