

# Respecting Religion and Spirituality in Evidenced-Based Practices

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Evidence-based practices (EBPs)—including evidence-based assessments and treatment interventions—are intended to ensure that clients receive services with measurable and demonstrated scientific proof of their effectiveness. The impetus for the use of EBPs in treatment has come from funders, lawmakers and the public at large to help ensure that programs and interventions are delivering the desired results.

EBPs typically have prescribed protocols that some clinicians describe as rigid, impersonal or otherwise not client centered. On the other hand, those who develop and advocate for evidence-based practices encourage clinicians to use the available EBPs to support, rather than supplant, the delivery of personalized client-centered care by integrating the client's strengths and values into protocols that help move them toward wellness. Despite the mixed reviews, EBPs have gained increasingly broader acceptance in the past two decades as clinicians, policymakers and protocol developers have worked to create greater synergy in their perspectives.

This series of articles considers one of the most challenging aspects of EBPs and client-centered care: cultural and individual sensitivity in the context of rather prescriptive delivery. When cultural differences are present, questions often arise about the validity of EBPs with population groups whose values, norms, interpretations, experiences and assertions may differ from those of the developers of the EBPs. Race, ethnicity, family lifestyle and many other aspects of social diversity can be potent but overlooked variables. While a client's ethnic or racial background is

sometimes obvious, there are typically many more unobservable cultural distinctions to consider when utilizing EBPs. One such distinction is that of religious and spiritual diversity.

The presence (or absence) of religious beliefs and spirituality can have the same degree of influence on a person as ethnicity and other aspects of culture. Literature suggests that spirituality and religion have a transcendent quality in the human experience. “Spirituality is not simply a special topic. Rather, like culture and ethnicity, it involves streams of experience that flow through all aspects of our lives, from family heritage to personal belief systems, rituals and practices, and shared faith communities” (Walsh, 2009). “Religious beliefs and activities can have a profound impact on our mental and physical well-being by reducing stress, improving resistance to diseases, enhancing memory and mental function and helping us to lead longer lives” (Newberg, 2011).

Morgan and Cashwell (2009) noted that there is a historical and logical “marriage” between addictions counseling and spirituality. “Long before the counseling profession began systematically paying increased attention to spiritual and religious issues in counseling, counselors who worked with addictions recognized the important role that spirituality played in the recovery process for many people.” While the spiritual and religious dimensions of life have been historically important in holistic approaches to the treatment of substance use disorders, these areas have posed challenges for outcome evaluations. “Spirituality and religiousness are concepts which are difficult to define and operationalize for study and research in the healthcare field in general, and in the AOD field in particular” (McGovern, 2006).

At the 2010 GAIN Cultural Sensitivity Summit, the question of cultural sensitivity with EBP was brought to subject experts, trainers and treatment providers from diverse backgrounds who came together for two and one-half days of discussions about cultural adaptations and implications when using the GAIN (Global Appraisal of Individual Needs). The GAIN is an evidence-based family of assessments used widely in the substance abuse treatment field in both the United States and Canada. Participants in the GAIN Cultural Sensitivity Summit, sponsored by SAMHSA’s (Substance Abuse and Mental Health Services Administration) Center for Substance Abuse Treatment (CSAT), worked together to answer the following question: “How can an evidence-based assessment like the GAIN most effectively address the various dimensions of diversity of clients with substance use disorders?” In part 6 of this series on lessons learned from the GAIN Cultural Sensitivity Summit, we continue with our expanded discussion on EBP by summarizing the main points for effectively using EBP in tandem with a client’s religious and spiritual values.

### **How Can EBP Effectively Address the Various Dimensions of Diverse Religious and Spiritual Cultures?**

The answer to this question largely depends on how well advocates of EBP are able to (1) share common definitions for the key concepts in such discussions and (2) recognize the spiritual and religious factors that can affect a person’s response to evidence-based practices. The first step in this process is to define some important terms. In the first article of this series (August 2011), we anchored our discussions for the entire series by presenting some key definitions. It seems fitting at this time to review these definitions and add others that are specific to this article.

- Culture: “The attitudes, habits, norms, beliefs, customs, rituals, styles and artifacts that express a group’s adaptation to its environment—that is, ways that are shared by group members and passed on over time” (McAuliffe, 2008).
- Cultural Diversity: “The existence of variety in human expression, especially the multiplicity of mores and customs that are manifested in social and cultural life” (McAuliffe, 2008).
- Cultural Awareness: Understanding of the ideas, influences and significance of diverse cultures.
- Cultural Competence: A skill involving the “translation of this [cultural] awareness into behaviors that result in effective assessment and treatment” (Paniagua, 2005).
- Cultural Sensitivity: The knowledge, resources and flexibility to meet the needs of diverse populations.
- Spirituality: The way in which an individual finds their freedom and meaning in life; it is largely a matter of values in decision-making.
- Religiousness: The degree to which an individual finds their freedom and meaning in life through alignment with faith-based institutions and shared beliefs; it is an expression of spiritually, not its opposite.

Our working definitions of spirituality and religiousness allow for conceptual overlap. A 2005 feature in *Newsweek* explored “Spirituality in America.” The study found that 88% of Americans identified themselves as either spiritual or religious (Adler, 2005). The article distinguished among those who described themselves as spiritual, those who self-described as religious, those who saw themselves as both spiritual and religious, and those who described themselves as neither. The very categorization of these four groups suggests that the expression of spirituality and religion are neither diametrically opposed for everyone, nor totally synonymous for everyone.

There is no single “religious culture” just as there is not a sole culture of spirituality. The purpose of this discussion is not to explore any of the many cultures of spirituality and religion. Our purpose is to affirm ways that clinicians can develop and broadly apply the highest standards of cultural sensitivity to the implementation of EBP.

Religion and spirituality often have a significant place in the value systems of those who seek counseling. These value systems regulate and direct the clients’ views, perceptions, decisions and judgments, which are also the focus areas of many EBPs. Therefore, the concepts of EBP and the constructs of religion and spirituality do not have to be competing forces. These resources can blend well, as long as clinicians are competent in upholding the validity and fidelity of proven practices while still honoring the values of the client—rather than making those values invisible. This may be the epitome of evidence-based client-centered care.

In the 2001 Columbia University study, “So Help Me God: Substance Abuse, Religion and Spirituality,” Joseph Califano noted, “Too often clergy and physicians, religion and science, are ships passing in the night. When we separate the worlds of medicine and spirituality, we deny a host of individuals the help that may aid their recovery and ease their pain. This is especially true with respect to substance abuse and addiction.” Califano was the Secretary of Health, Education and Welfare (HEW) under the Carter administration, and he went on to establish the National

Center on Addiction and Substance Abuse at Columbia University, an evidence-based research organization. He proposed that, “If ever the sum were greater than the parts it is in combining the power of God, religion and spirituality with the power of science and professional medicine to prevent and treat substance abuse and addiction.”

Affirming the universal importance of this topic for all users of EBP, the organizers of the GAIN Cultural Sensitivity Summit positioned this topic as a plenary session on the agenda, rather than as a break-out session alongside other specific cultural groups. A significant discussion point at the session was that clients may fear being judged for their faith or spiritual position just as much as they fear being judged because of race, economic status or sexual orientation.

As described in the earlier articles in this series, the GAIN Cultural Sensitivity Summit participants identified five competencies for treatment professionals who want to use evidence-based practices with diverse populations:

- Recognize the power of historical perspective
- Appreciate the impact of cultural explanations and stigmas
- Respect cultural variations, expectations and communication
- Create an atmosphere of cultural safety
- Show adaptability and flexibility

Cultural awareness is the responsibility of the clinician in all five of these competency areas, but the Summit presenters and participants noted that clinicians do well to begin with a “Teach Me” posture, allowing clients to share their beliefs in a way that empowers the client as the expert on their personal beliefs and opens the door for disclosure of spiritual and religious values.

### ***Recognize the Power of Historical Perspective***

Cashwell (2009) notes that because many addictions counselors have a personal history of being in recovery or having a close relationship with someone in recovery, they often have a specifically defined concept of spirituality—for example, 12-Step programs. Their definitions may be limited, or at least biased, based on personal beliefs and experiences. Summit participants noted that a counselor does well to avoid writing the prescription for others out of their own experience and to recognize the historical perspectives of the client’s own religious or spiritual foundation.

Psychotherapy and religion frequently work toward the same kinds of goals and strive to help people with many of the same kinds of questions, but with paradigms that use different approaches and perspectives. Counseling typically emphasizes growth through self-determination, while religion often emphasizes growth through self-sacrifice. Depending upon the client, self-sacrifice can represent the client’s greatest joy or their greatest burden. The challenge in using EBP, or any intervention, is to recognize that self-determination and self-sacrifice can both support greater self-actualization for a client if the intervention is used with sensitivity and awareness of the client’s perspective.

The differing perspectives of self-determination and self-sacrifice have contributed to what (J. Scott) Young terms a *historical tension* between religion and mental health professions (Rollins, July 2009). Rollins noted how subject experts readily acknowledge that "...clients who have strong religious beliefs generally cast a wary eye toward counseling, sometimes out of suspicion that practitioners will try to divest them of their faith, sometimes because they assume the counselor will judge them negatively for their religious views or even regard them as pathological for expressing faith in a higher power at all." He adds, "Even when religious clients don't sense any hostility toward their beliefs, they may question whether a secular counselor can truly grasp what drives their life."

The concern is a valid one. The Columbia University study cites the combination of lower religiousness among mental health professionals as one of several barriers to linking spirituality and treatment. Among the general population and family physicians there is a general belief that spirituality or religiousness is important to health and recovery. In contrast, mental health professionals—most notably psychiatrists and psychologists—report significantly lower rates of belief in God. Ninety-six percent of the general public expresses a belief in God, compared to only 73% of psychiatrists and 72% of psychologists. Whereas, 9 out of 10 Americans consider religion to be very important or fairly important, only 56.7% of psychiatrists and 48% of psychologists endorse those levels of religious importance (Sloan et al., 1999; Shafranske, 2000). The report cites several other studies that describe the same pattern:

- A survey conducted by Gallup found that only 40 to 45% of mental health practitioners report a belief in God.
- When mental health specializations are taken into consideration, 25 to 40% of each group report having abandoned the faith of their youth, opting for atheism or agnosticism (Muffler et al., 1992).
- In a study of mental health nurses, while both nurses and patients had similar levels of reported spirituality, nurses underestimated the importance of spirituality to mental health patients. (McDowell et al., 1996).

With a noted history of less religiousness, mental health professionals may be disinclined to value and integrate spiritual and religious considerations in the development and use of EBP.

From the clients' historical perspective, in many traditions it has been the priest, pastor, rabbi or other religious leader who occupied the role of counselor, offering guidance that is trusted because it comes from a religious or spiritual perspective that is consistent with that of the client's. The literature suggests that nearly 40% of religious members go to their clergy first when they face a mental health or addiction crisis. Problematic is the fact that only 12.5% of clergy members surveyed had completed any course work related to substance abuse while studying to be a member of the clergy, according to the Columbia report. The implication is this: historically, a respect for spiritual values may be more important than professional training when people from religious communities seek counseling.

***Appreciate the Impact of Religious Explanations and Mental Health Stigmas***

Religious explanations for behavioral health disorders can translate into “treatment resistance” unless the clinician is culturally astute relative to these issues. The client may have been taught that as a person of faith, their life should transcend their habits or struggles. One client expressed to a counselor that she was frustrated by her doctor explaining how a particular health problem “affects most people.” Her response, “I’m not most people; I’m a child of God” showed the counselor how important it would be to respect and address the client’s faith background. Medication noncompliance can be rooted in the belief that one’s religious or spiritual resources should be transcendent, accessible and strong enough to beat their disorder without taking a pill. Some clients may even worry that disclosing their struggles to a nonbelieving counselor will indicate a disservice to the reputation of their religious faith by subjecting their beliefs or behaviors to undue scrutiny. This can be further complicated if an individual has a concern about being criticized by their religious body for seeking “outside” help that may conflict with their religious values.

In some religious belief systems, a substance use disorder is viewed as a purely spiritual problem—a result of demonic activity or akin to witchcraft. Other religious beliefs may attribute addiction to a hex or curse. Clients and their families may struggle to accept interventions that are not understood in these terms. A parent may not even know if they want “treatment” for their child; but they know they want the child “set free and delivered.” The desired outcome of wellness is the same, but mutual skepticism results if a clinician has negatively prejudged the client’s beliefs. Some religious perspectives view substance use as a moral failure requiring a stronger willpower or determination. The outcry may simply be, “Why can’t I (or they) just stop?” When stand-alone religious approaches have not reduced use or prevented relapse, clients may see themselves as spiritually weak or damaged, adding more guilt, shame and hopelessness to their experience.

The client’s sense of self-efficacy and problem orientation can be affected in unique ways by their spiritual or religious orientation. In the GAIN interview, for instance, the Problem Orientation Scale includes items asking if the client believes that their problems are out of control and if they believe their problems are solvable. If the client’s interpretation of those items is influenced by a religious value system that ascribes a different meaning to these questions than was intended, then the scale score could be adversely affected or misinterpreted.

### ***Cross-stigmatization***

Earlier articles in this series focused on ways that behavioral health disorders may have been stigmatized in various cultural settings. In this article, we find it necessary to explore this topic as a problem of cross-stigmatization. Given the historical tension between psychotherapy and religion, it is important to recognize ways in which both disciplines may bear stigmatization by the other.

Stigmas related to mental health or substance use disorders are still widespread in American culture at large and even more so in some religious communities where, as we have noted, such an admission may connote spiritual weakness or moral failure. Mental health professionals are often not trusted, amid fears of clients being manipulated or having their faith systems judged negatively. In instances where religious leaders assert that a deeper faith or spiritual commitment

is the remedy for mental health or substance use problems, client engagement in secular counseling may be weak.

At times, however, the biases of clinicians contribute to the stigmatization of religious values. Therapy, by its very nature, focuses on individual and personal development. In clinical practice, the process often involves the exploration of identity and values that transcend beliefs ascribed by others. Therapists do well to use caution before dismissing the shared moral values and codes for living that may be inherently important to clients who are invested in faith-based institutions. Summit participants noted that therapists may unwittingly be dismissive of religion, even to the point of positioning spirituality as superior to religious affiliation. Those whose orientations are toward liberation from shared moral values and codes for living may clash with clients who find their personal strength in spirituality that is based upon shared belief systems within a shared community.

The treatment field has taken great care to caution against proselytizing for religion. However, addictions counselors often proselytize for spirituality and the 12-Step model and find it generally acceptable given there is no resistance from within the culture of the recovery community. “The counselor trainee or counselor in recovery may with good reason hold the strong conviction that he or she is alive because of the 12-Step model of recovery. Yet in the moment where the trainee or counselor begins to proselytize for the 12-Step model, this is simply another form of fundamentalism. The approach is still exclusivist in nature” (Morgen & Cashwell, 2009).

One way to help overcome cross-stigmatization is for treatment providers to establish working relationships with local clergy members to both educate clergy members about substance use and mental health disorders and to prepare themselves to better respond to clients needs and desires for a spiritual component in their recovery regimen. It’s incumbent on counselors to initiate outreach with faith-based institutions and houses of worship in the community. At Richmond Behavioral Health Authority (RBHA) in Virginia, staff from the Substance Abuse Services Division was involved in regular roundtable meetings with inner-city clergy members of all faiths. RBHA used the GAIN as an evidence-based assessment in conjunction with a CSAT grant for adolescent residential treatment. Recognizing that family members of adolescents often go to their clergy first when drug-related behavior is suspected, the staff of RBHA reached out to address treatment barriers, encourage early intervention and promote understanding of the local treatment services. Efforts such as these can help strengthen the religious community’s trust in the professional treatment system.

### ***Respect Cultural Variations in Communication, Expectations, and Norms and Values.***

How do counselors work with clients of similar and dissimilar views of their own? What are the effects of addressing or not addressing religious and spiritual values in EBP? How important is the inclusion of spirituality in the treatment of disorders—such as a substance use disorder—that is widely acknowledged as a bio-psycho-social-spiritual disease? The combined works of Lewis (1990, 2007) and Worthington (1996) show the significance of values to answer questions like these by identifying five distinct ways that people make personal choices and exploring how values differ through the spectrum of religiousness and spirituality. By recognizing how these

differences may be present in substance use treatment scenarios, clinicians can employ greater sensitivity in the administration and interpretation of evidence-based assessments and interventions.

### *EXTERNAL AUTHORITIES*

One path of decision making is to look to external authority sources, such as clergy, supervisors or those perceived as subject experts. The authority might be through an institution, such as an academic program, a church or denominational structure. The authority may also be God (through direct revelation, the Bible or the inspirational writings of others).

### *DEDUCTIVE LOGIC MODELS*

Other people may be inclined toward a second approach to decision making: deductive logic. This approach uses a variety of tests—with the goal of consistency in thought—to choose our values. Although the guidelines of logic may be relative, it is the person's need for consistency that sets their personal standard. People who take this approach will be prone to filter their decisions through one or more logic models and seek to minimize their experience of logical error as each successive premise flows out of and must be consistent with its predecessors.

### *PHYSICAL EXPERIENCES*

The third approach relies on the experiences of the five physical senses. The person's encounters of sight, sound, touch, smell and taste become the final authority. So, even religious or spiritual values would be filtered through their own physical experiences.

### *EMOTIONAL EXPERIENCES*

Fourth, people may make decisions based on emotions: seeking emotional harmony above the physical senses, deductive logic or external authority. The integration of transcendent factors is based primarily on what "feels" right.

### *INTUITIVE DECISION MAKING*

From this perspective, the logic that is applied utilizes simultaneous information processing and integration, rather than the more linear approach of deductive logic.

Lewis proposes that there is more personal power in intuitive reasoning, but more control and discipline in logical reasoning. For discussion in this article, we propose viewing Lewis' approach on a continuum. See Figure 1.

Figure 1 Decision Making Continuum				
Found in Traditional Spirituality or Religion		Found in Modern Spirituality		
++ <i>Control/Discipline</i>		<i>Personal Power</i> ++		
β-----à				
External Authority	Deductive Logic	Sense Experience	Emotional Harmony	Intuitive Reasoning

The intent of this linear representation is not to suggest a progression toward greater spirituality at either end, but rather to show the positioning of the decision models relative to various expressions of spiritual life. A client may sit along any of these decision-making points in their spiritual belief system and be either content or discontent with it. The same applies to the clinician. As if that is not enough potential for a clash, consider also that the theoretical underpinnings or orientation of any EBP may also be more congruent with the values on one point of the continuum more than others. If all three positions are not considered in the intervention, then the EBP’s effectiveness—and ultimately client care—may be sorely compromised. Responsible use of EBPs calls for attention to whether or not a specific protocol is culturally congruent with a client’s beliefs and preferences.

As we consider this model, some clients pursuing recovery from substance use disorders may lean more toward external authority and accountability (for example, A.A., having a sponsor, or practicing a traditional religion) to help provide structure for decision-making. Other clients may find external and structured approaches to be limiting or proscriptive, and might seek to claim (or reclaim) more personal power. For these clients, their priority may be to break free from any “dogma” imposed upon them by others.

The clinician’s own self-awareness and sensitivity to the client’s values must be approached with understanding for the clinician to remain objective as the client works to bring their own decision-making approach into greater awareness. Ultimately, the client may want to explore whether or not their present decision model will work well in the pursuit of their recovery goals.

At the GAIN Cultural Sensitivity Summit, participants noted that the Spiritual Social Support Index (SSSI) items on the GAIN can be used to generate meaningful discussion about how clients make decisions about using, recovery, treatment, relationships, and so forth, and can be a helpful tool—not for judging or influencing spiritual decisions—but for self-awareness and introspection in treatment.

### *Create an Atmosphere of Safety*

Clients may not realize that their religious or spiritual views can be discussed in the counseling office. Counselors who ask nonthreatening questions about a client’s religious background during the assessment open the door for clients to feel safe with discussions about their religious backgrounds. If a counselor assumes that clients will bring up important religious beliefs on their own, the counselor may miss the opportunity for significant content to be addressed in counseling. This can be done, even when using an evidence-based assessment. The GAIN

developers were intentional about incorporating a Social Spiritual Support Index with items related to spiritual development, including identification with an organized religious group, strength of spiritual beliefs, attendance at religious events, and so on. Higher scores on this index typically indicate stronger levels of spiritual support. The greater the level of spiritual (and social) support, the higher the client's tolerance for stress and the lower the risk that a given conflict may leave a client without any other sources for spiritual or social support. In turn, the risk of relapse can be reduced. Asking structured questions about religiousness or spirituality using an evidence-based assessment can help ease the angst a counselor may have about introducing religious or spiritual content. It can also make it safer for the client to share his or her religious values because the inquiry is understood as procedural instead of personal.

Clinicians must be intentional about building trust and assuring clients that the client's faith will not be dismissed or maligned. Several models proposed in the literature present various degrees of counselor engagement or comfort with spiritual and religious content in counseling. Some counselors may be largely dismissive: rejecting religion as irrational or delusional and even responding with hostility. Others may be fearful or avoidant about the topic and address the topic from a cursory and superficial stance. Some may ascribe to one model or perspective that they promote as superior to others, often because it worked for them. Ideally, however, a competent counselor works to develop a level of comfort in broaching and sensitively discussing the subject with awareness and control of their own biases.

To work effectively with religious clients who may be mistrusting of mental health systems, clinicians can use the information gleaned in an evidenced-based assessment like the GAIN to guide clients to their spiritual support systems. Perhaps most importantly, clinicians do well to allow the client's faith to ultimately guide him or her to wholeness, because wholeness as defined by secular counseling may be too self-serving for some religious clients to embrace.

### ***Show Adaptability and Flexibility***

When a counselor has multiple EBPs to choose from or is competent at making validity-enhancing adaptations, he or she has a greater likelihood of having the means to complement—rather than alienate—the client's value systems. Summit participants also noted that if a client asks for a natural healer, a root doctor, a medicine man or a minister to perform a deliverance service, the counselor would be dismissive of the client's spirituality or religion if that request was not taken seriously. Morgen (2009) states, "If you don't necessarily believe what your client believes it's important to get information about why that belief is important to them. Then, as counselors, we need to figure out why we have a problem acknowledging the benefits to the client."

In his article, "Connecting with Clients of Faith," Rollins (2009) cites J. Scott Young: "I just look at what this person is saying and ask if it's working for them. As counselors, we need to be intellectually curious with these clients and open to looking at the strengths their religious beliefs provide. Don't prejudge their beliefs harshly, and don't be rigid. If you have a hidden agenda in wanting to change something in somebody, it will never work. It will only sabotage the relationship."

## Conclusion

or many clients, spirituality and religion can be important companions to recovery and maintaining sobriety. Historically, a respect for spiritual values has often meant more to religious clients than the counselors' professional training. Yet, with a noted history of less religiousness, mental health professionals may be disinclined to value and integrate spiritual and religious considerations into the development and use of EBP.

Where stigmatization exists regarding mental health diagnoses or toward religious affiliation, the ability to effectively deliver an EBP can be compromised and treatment outcomes can be adversely affected. Therefore it behooves treatment professionals to work with clergy and faith-based leaders to learn about beliefs, engender trust and overcome treatment barriers. Equally important is the training of religious and spiritual leaders to learn about referral priorities, referral options and the benefits of various kinds of treatment. Jointly, the two disciplines must identify ways for religion and spirituality to work toward the prevention and treatment of behavioral health disorders.

Spirituality—whether sought in the external authority of traditional institutions, in the personal power of individual expression or somewhere in between—is largely a matter of values in a decision-making continuum. The clinician's awareness of the spectrum of client values is vital to help the client explore how their present decision model will integrate into the pursuit of their recovery goals and can help the clinician select and adapt an EBP that will likely work with the client's values. Most important is the development and implementation of EBP with general sensitivity in an effort to avoid the clash of highly prescriptive and contradictory approaches.

Treatment providers must create an atmosphere of safety by knowing how to recognize and broach the spiritual and religious factors that impact treatment. If those values are ignored in treatment, the rates of early termination may be higher. The result would be the reduced representation of these populations in treatment studies and outcome reports and possibly higher rates of unexplained or misunderstood treatment dropout or recidivism.

Finally, adaptability and flexibility are the foundation for client engagement. Evidence-based practices can be highly prescriptive. Religion can be highly prescriptive. Thus, the potential for a clash must remain at the forefront of the clinician's awareness. This entire series of articles on lessons learned from the GAIN Cultural Sensitivity Summit emphasizes that cultural sensitivity is not inherently found in any intervention or protocol but is the responsibility of the clinician utilizing the tool. More research is needed to evaluate the efficacy and increase the effectiveness of faith-based initiatives and treatment programs. With an area as deeply personal as spirituality and religion, clinicians must give special attention to client engagement and client-driven outcomes in the use of EBP.

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