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Spirituality and Counseling in Holistic Health: Toward Integration in Actualizing Full Potential

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SPIRITUALITY AND COUNSELING IN HOLISTIC HEALTH:
TOWARD INTEGRATION IN ACTUALIZING FULL POTENTIAL

MARY ANN KNIESS, B.A., M.A.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Art

1997

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DEDICATION

This paper is dedicated to John Thekkedam, PhD., LPh., co-founder of East-West Awakening with Linda Young and myself. John shares with me in the vision and the journey of holistic ministry and self-realization through the integration of spirituality and psychology both here in the United States of America and in India. Together through holistic ministry, we desire creating a global community with various denominations, faiths, and cultures by focusing on what we share in common rather than focusing on what divides us.

ACKNOWLEDGEMENTS

I am grateful for my parents and family where the seeds of my spirituality were sown by the witness of their faith and love.

I am grateful for the Sisters of the Most Precious Blood of O'Fallon, Missouri, my religious community for 24 years. We journeyed together as an extended caring family. The community provided me with a variety of enriching opportunities: prayer experiences, faith sharing, yearly retreats, professional and spiritual counseling, and a Master's Degree in Christian Spirituality. Through their loving support they nurtured the seeds of my faith, and allowed my spirituality to grow based on a solid foundation.
I am grateful for the indwelling of divine life and all the graces I continually receive as I allow God's way to be done within me on a path toward wholeness in relationship with others.

I am grateful for the expertise of my professors, the providers of my practicum, the flexibility of my employers, and the support of my classmates and friends. I appreciate the 80 clients and therapists who assisted me by participating in this project through completing a survey. Lastly, I also appreciate the time and energy of the committee, the readers of this project.

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ABSTRACT

The purpose of this study was to investigate the relationship between spirituality and counseling in holistic health. Forty clients and forty therapists, both male and female, from varying economic and educational backgrounds completed a one-page self-report attitudinal survey regarding the place of religion and spirituality in their life and therapeutic sessions. Each ranked issues such as forgiveness, prayer, healing in relationships, grief, death, and afterlife as to the frequency with which they arose in therapy. Participants who returned surveys on site or by mail from Missouri and Illinois were volunteers who attended Joseph Zinker's Gestalt therapy annual workshop, Edward Harris' Gestalt group therapist's training, John Thekkedam's workshop at the St. Louis Behavioral Medicine on the integration of spirituality and psychology from an East/West perspective, Life Crisis, and from Biobehavioral Health Institute. Survey results using chi-square analysis and correlation with an alpha significance level of .05 indicated a relationship existed between the variables. The literature review and survey results supported the alternative hypothesis.

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Chapter I

Introduction

In the field of American psychology a controversy has existed regarding the place of spirituality in counseling/therapy sessions. Developmental psychology has suggested the existence of a transcendent dimension in human experience (Reed, 1992). This dimension has been conceptualized in the theoretical work of authors such as Allport, Erikson, Frankl, Jung, and May (cited in Shafranske & Gorsuch, 1984). Moreover, the trend toward holism, an ancient Eastern concept, has accepted the integration and interconnectedness of human functioning. Within this philosophical framework, spirituality has equal footing with the physical, mental, and emotional dimensions. In a holistic model the interaction and effect of one component upon another have been understood and accepted (Westgate, 1996; see also Morgan, 1982; Rowan, 1990; Shafranske and Gorsuch, 1984).

However, Western perspectives of health based on the philosophies of elementalism and human analysis, separate the components of body (soma), soul (psyche), and spirit (pneuma). Because these parts are seen as functioning separately, mental health professions have tended to treat one aspect without much regard for the effect on the whole (Westgate, 1996). Western

psychology has focused on the study of the individual and has based its rationale in Newtonian physics. This form of physics provided a method for studying separate, discrete things. Nevertheless, Newtonian physics has been surpassed by relativity and quantum theory. This theory has emphasized a view of reality as an interlocking web of dynamic relationships working together as a whole (Welwood, 1979). Yet this theory has not made its influence sufficiently felt in the field of social and behavioral sciences.

Historically, clinicians have been biased against the topic of religion and reluctant to include it in their clinical discussions. The prevalent view in psychology has been to dismiss religious beliefs as neurotic and religion as unreasonable (Freud, 1975/1961). The Age of Enlightenment (c. 18th century) glorified reason making spirituality seem irrational and irrelevant (Westgate, 1996). This bias may have its roots in the early developments of the field of psychology. In an attempt to be accepted as an empirical science, psychology disassociated itself from philosophy. Freud's attitude toward religion and the behavioral approaches in psychology have contributed to the severance (Shafranske & Gorsuch, 1984). Porter (1995) stated:

From such a viewpoint, anything that

> resembled religion, such as spirituality, which is at the esoteric [sic] heart of religion, had to be rejected as anathema by psychologists aspiring to be scientists. For counselors to unreservedly embrace spirituality as a legitimate element in their practice is for them to place the discipline at odds with the foundational assumptions of mainstream psychology (p. 71).

Counseling has been approached more as a science than as an art. When therapy is approached as an art, therapists would be immediately engaged in the relationship with their client, allowing their senses and attention to be enveloped. The therapist would then reflect upon the experience, just as an art critic would reflect upon a painting or a symphony (Kelley, 1986). Spirituality is associated with art, not science.

The American Psychiatric Association (1994) in Diagnostic and statistical manual of mental disorders (4th ed.) included religious and spiritual problems (V62.89, p. 685) as a diagnostic category. Maloney (1972) stated that the first and second presidents of APA both studied for the ministry before becoming psychologists. Maloney cited a survey of the 1963-1966 APA directories by Vayhinger and Cox who found two

percent of the membership (392 members) had received theological degrees. 80% of them indicated an interest in the relationship of psychology and theology. The review of the literature indicated a movement both in the medical field (Reed, 1992) and in psychology toward integrating various dimensions of the person toward wholeness.

Purpose of the Study

The purpose of this study has been to look at the relationship of spirituality and counseling. Do spirituality issues have a place in the counseling/therapeutic setting?

Operational Definitions

In the literature review several authors distinguished the terms religion and spirituality. The terms overlap in meaning but are not synonyms (Dombeck & Karl, 1987; Ganje-Fling & McCarthy, 1996; Maloney, 1972; Peterson & Nelson, 1987; Porter, 1995):

Religion. The term religion is generally used to describe "an organized set of beliefs and the practices expressing or representing those beliefs" (Peterson, 1987, p.35). Dombeck and Karl (1987) define religion as an organized system "of thought and experience concerning the fundamental problems of existence"

(p. 35). Bonhoeffer reported (in Maloney, 1972) that many believing persons, including intellectuals and psychologists, have become impatient with organized religion. Ferguson found (in Porter, 1995) that increasing numbers of Americans have had difficulty with organized religion due to its hierarchical, authoritative structure and allegiance to what they perceive as an abusive and corrupt power structure. For this study religion was defined as an organized set of dogma, doctrine, and beliefs concerning the fundamental values and problems of existence with its expressive practices.

Spirituality. The word "spirit," associated with breath, fire or wind, has referred to the animating or vital principle that gives life to physical organisms (Merriam-Webster's Collegiate Dictionary, 1993). Breath has been the immediate sign of life looked for both at an infant's birth and on a loved one's death bed. Porter (1995) noted that it is the invigorating element of spirit that makes the biological fact of life more than mere chemical or physical processes. The presence of spirit has added spontaneity, vigor, energy, courage, and freedom to life. Dombeck and Karl (1987) stated that spirituality deals with the life principle pervading and animating a person's entire being, including the emotional and volitional aspects

of life.

Cartwright and Mori (1988) noted that the spirit is often believed to be the "essence" of the person existing before the person's birth and continuing to exist even after the person dies. Spirit has been defined as "soul" (Merriam-Webster's Collegiate Dictionary, 1993). Furthermore, the human capacity for self-awareness and reflection, the courage to look with-in (Shafranske & Gorsuch cited in Ganje-Fling & McCarthy, 1996) has given a sense of quality and depth to human experience not present in lower forms of animal life and not possible without the powerful, animating presence of spirit (Porter, 1995).

Merriam Webster's dictionary defined spirit as "a supernatural" or "incorporeal or immaterial being" proceeding from or under the influence of the Holy Spirit, the divine Spirit of God (Merriam-Webster's Collegiate Dictionary, 1993). Murray defined (in Peterson & Nelson, 1987) spirituality as "the transcendental relationship between the person and a Higher Being, a quality that goes beyond a specific religious affiliation, that stresses reverence, awe, and inspiration, and that gives answers about the infinite" (p. 35). Edwards defined (in Ganje-Fling & McCarthy, 1996) spirituality "as a concern with the existential" (p. 253). Gilchrist defined (in Ganje-

Fling & McCarthy) spirituality as "what individuals hold sacred in their lives, what is most important to them at the essence of their being. It is a context for understanding things" (p. 253).

Peterson & Nelson (1987) stated that persons are spiritual beings. Consequently the need for transcendence is a part of our personhood just as the physiological or psychosocial is. In the spiritual they included three components: a) the sense of meaning and purpose in life, (b) a means of forgiveness, (3) a source of love and relatedness. The Summit on Spirituality at the 1996 American Counseling Association Convention in Pittsburgh described spirituality as:

> ... a capacity and tendency that is innate and unique to all persons. This spiritual tendency moves the individual towards knowledge, love, meaning, hope, transcendence, connectedness, and compassion. Spirituality includes one's capacity for creativity, growth, and the development of a values [sic] system. (Chauvin, 1996, p. 3)

Rather than taking a person "beyond" the everyday world, May (1977) saw spirituality more as a "vision of" the usual world. A means of clearing away the distortions and confusions that normally cloud one's

sight. May also clarified the difference of "thinking about" spirituality through objectifying the concept which he noted can exclude one from the vital and dynamic energy of "being in" the experience.

Porter (1995) noted that conventionally persons found spirituality within an organized religion. He stated:

> For some people the thought of spirituality outside of an organized, institutional religion is unthinkable. For others, the thought of spirituality within the confines of a religious setting is intolerable. For still others, the concept of spirituality itself is unthinkable. (p. 70)

J. K. Thekkedam (personal communication, February, 1997) stated that religion, coming from the Latin term <u>re-ligare</u>--to tie back or reconnect--is the means a human being uses to reconnect with God or the Supreme Being and spirituality is the end. The human being is thought to be innately restless, and yearns for completion through union with a Supreme Being or God. St. Thomas Acquinas and Thomistic philosophers speak of the unlimited objective capacity of the mind (<u>capacitas objectiva illimitata mentis</u>) as one of the reasons for an infinite object such as God for whom the human spirit longs. Psychotherapy without the spirit is an

empty shell. When clients suffer from traumatic experiences, the spirit makes the difference between those who whither and die and those who flourish, allowing new life to emerge.

Each of the above definitions highlighted important aspects of the term, spirituality. Like the faces of a prism, the various definitions pointed to the richness involved in the meaning of the term. In this study spirituality is defined from the Judeo-Christian viewpoint as a transcendental relationship with God through the grace of the Spirit and facilitates union and communion with self, others, and the Supreme Being.

Null Hypothesis

H_0: Spirituality issues are independent of counseling.

H_1: Spirituality issues are not independent of counseling: Spirituality is a part of a whole person approach integrating mind, body, and psyche (soul), therefore, spirituality issues are integrated in counseling/psychotherapy.

Chapter II

Literature Review

Religious Beliefs

Pete and Bondi (1992) stated that religious beliefs are an aspect of a client's cultural background and should be considered an important element of multi cultural awareness in the counselor education curriculum. In a 1985 Gallup survey reported by Bergin and Jensen (in Pete & Bondi) of 29,000 persons, two-thirds responded that religion was a very important or the most important dimension of their life. Based on their review of the literature on religious beliefs, Kroll and Sheehan concluded (in Pete & Bondi) that 90% of the general public profess a belief in God compared with 43% of psychologists. Consequently, counselor education students need to be aware of the importance of religious beliefs in the lives of many of their clients.

Suyemoto & MacDonald (1996) found from their study that religious beliefs could have either a positive or a negative effect upon clients. From their data they noted it was clear that most persons personalize and choose religious or spiritual beliefs, and are not dependent on a particular theology. When beliefs were evaluated and consciously chosen, as with any value that has been individualized, selected, and integrated

into one's overall identity, such persons were likely to be more mature and healthy. Their data supported previous theories by Spilka, Shaver, and Kirkpatrick that religious beliefs "make matters meaningful and protect, maintain, or enhance one's self-esteem or self-concept" (p. 151). Their data also supported Kivley who stated (in Suyemoto & MacDonald) religious beliefs "create a relational orientation and help maintain a consistent world view" (p. 151).

Therapy addresses such issues as control, comfort, organization in life, understanding, and connection with others; Suyemoto and MacDonald (1996) cited Bergin and Spilka in noting that religious beliefs may serve many of these same functions. Peterson and Nelson (1987) referring to nursing care, stated that if the patient's spiritual dimension is primarily a strength, that could be used in their care plan. They also noted that some clients will have spiritual concerns as part of their illness, e.g., suicidal or depressed clients who may be lacking meaning and purpose in life. Conversely, for some clients religious beliefs contributed to an unhealthy psychological state. Koch (1995) stated that every human being who accepts Jesus Christ as a foundation for their life could correctly be called a "fundamentalist." However, the fundamentalist movement began in the United States of

America after the first world war (1914-18)in some of the Protestant churches in reaction against evolutionary theories (Cross & Livingstone, 1990). The term emphasizes strict and literal Biblical interpretation as fundamental to Christian life and teaching (Merriam-Webster's Collegiate Dictionary, 1993).

Stemming from an elementary anxiety about life and the will for power, Koch (1995) considered the fundamentalist approach to religious beliefs psychologically unhealthy in its black/white, good/evil mentality. Porter (1992) stated that when some persons are confronted with enormous uncertainty and ambiguity, they use fundamentalism "to reduce the messy and mysterious to the known and absolutely certain, a spiritual security blanket" (p. 77). Koch suggested not condemning or judging fundamentalists. He indicated that conversations with them need to occur on the mystical and not on the moralistic level.

Levin and Coreil (1986), surveying the sheer number of New Age organizations across the country, were surprised that social scientists virtually ignored New Age healing. They observed an explanation might be the relationship of New Age to religion, particularly the esoteric, occult, and mystical elements derided by materialist scientists. Porter (1995) stated that the

appeal of the New Age comes from its incorporation of ideas both from religion and from science. From religion New Age has resurrected the notion of the numinous side of life and from science New Age took the idea of evolution.

Jones and Block (1984) observed that due to an emphasis on cause and effect, the essential philosophy of this society is anti-spiritual as evidenced by accumulation and control of matter or material things. They appraised that persons believing in other energies affecting life events would take less responsibility for personal accomplishments and failures. To the extent that therapy is seen as a context for increasing or restoring personal control and efficacy in clients, Jones and Block noted that when working with clients of spiritual orientation, adjustments may be necessary. They questioned the goal of therapy that would decrease the impact of spirituality. Jones and Block suggested that such clients may externalize problems, but also noted that what might look like "denial" could simply be "belief."

Meadow (1986) cautioned therapists that when religion is put in the service of mental health goals, an inappropriate ordering of values could occur. If therapists use religious ideas and practices to accomplish the task of psychological healing, the

client's mental and emotional equilibrium could get tied to particular religious ideas. Instead, Meadow seems to be encouraging therapists to live according to their religious ideals, and thereby, allow healing to be a by product of living.

Chesner and Baumeister (1985) studied the effect of therapist disclosure when they wore religious symbols as well as the effect the symbols had on the intimacy of client disclosure. Their data showed client inhibition increased. Morrow, Worthington, and McCullough (1993) studied college students' expectations of counselors regarding religious beliefs. Results suggested that most college students expected counselors to support the client's religious beliefs or at least to attend to psychological material, rather than to challenge those beliefs.

Transcendence

Lehman and Witley (1931) noted the frequency with which scientists, when writing their biographical sketches, recorded their religious affiliations. Out of 1189 biographical sketches, 25% included information regarding religious denomination. Physicists and chemists most frequently designated their denominations; whereas, psychologists seldom did.

In writing on the topic of growth and the elderly,

Rogers considered (in Cartwright & Mori, 1988) a person being, in essence, a spiritual entity, whereby human powers moved beyond normal awareness to transcendent mental capacities. He stated: "I now consider it possible that each of us is a continuing spiritual essence lasting over time, and occasionally incarnated in a human body" (p. 185).

Erikson observed (in Bellah, 1976) that human communities reinforced a sense of identity which promised meaning for "the cycle of life within a world view more real than the certainty of death." These societies in combat or competition viewed death as heroic and lived the motto, "kill and survive." Other people accepted the finiteness of life and focused on ensuring their salvation through transcendence. These communities preferred self-sacrifice to killing and accepted the motto "die and become." Erickson stated that this way of identity is personified by the great religious leaders who represent "the naked grandeur of the I that transcends all earthly identity in the name of Him who is I AM" (p. 58).

A noted theologian and psychologist, Van Kaam (1986) wrote of his experience as a Christian counselor among the underprivileged in mills and factories, among juvenile delinquents who had suffered social injustice, and among the spiritually abandoned European and

American intellectuals and professionals. He observed that many manifested a faith, hope, and love sometimes in desperate situations. He noted their justice and charity was "a striking manifestation of an ever present formative grace in their lives which they themselves did not recognize as such." (p. 432) Van Kaam reported that a number of non-Christians expressed their experience "of the insufficiency of the merely secular positivist or human helping sciences" (p. 432). For these sciences could not give a meaning to their situation which would nourish their faith, hope, and love. Van Kaam noted that suffering, disappointment, loss, and danger had awakened these people to the transcendent dimension of their existence in which "the always present offer of grace" began to appeal to them. Van Kaam (1986) stated:

> Christian formation anthropology sees foundational human life forms as always already gifted with a transhuman formation potency. Every human form of life from its very inception gratuitously endowed with this undeserved transhuman, initially passive, form potency. Our formation journey is always already accompanied by the constant formative appeal of divine grace, that can be freely refused or affirmed, implicitly or

explicitly. (p. 441-442)

Novak (1984) noted: "Authentic spiritual life is born precisely when that unsettling and unshakable feeling of distance between our actual state and that which is ultimately possible penetrates our awareness" (p. 65). The twelve step Alcoholic Anonymous program was based on belief in a Higher Power, Universal Consciousness, or the God of one's understanding. Warfield and Goldstein (1996) saw spirituality as the key to recovery from alcoholism. They considered that the twelve steps were designed to confront a diseased ego and promote its transcendence through creation and maintenance of positive spirituality. They viewed positive spirituality shown by loving, accepting, and trusting relationships with the self, others, the world, life, and ultimately, with God, as one understands God. They stated: "The alcoholic is grounded in a destructive negative spirituality" (p. 203). They found a movement toward a joyful dependence on God far preferable to the destructive dependence on alcohol.

Ganje-Fling and McCarthy (1996) noted that the development of the client suffering from childhood sexual abuse is arrested at the age the abuse occurred. The child's spiritual development is also arrested. The primary obstacle encountered is mistrust. These

children learned not to feel safe with authority figures; consequently, their image of God (from a Christian perspective) tied in with their abusers. Such clients found surrendering control difficult. Carich (1984) found guided imagery with Scriptures on God's love facilitated healing of memories for Christian clients. He also integrated messages of God's love in hypnosis for inner healing of self-esteem.

Clients suffering from strong anxiety often withdraw into a limited mode of functioning where their creative powers do not develop. Tillich wrote (in McAllister, 1983) of the need for the "courage to be" in order to develop a healthy personality. Adams suggested (in McAllister) that the source of courage and the answer to fear is love. In the New Testatment Scripture the first letter of St. John (4:18) stated that love drives out fear. Adams noted that the love of God has provided humanity with an eternal answer to existential anxiety. He stated that love is to be the source of our courage in living life.

Stern (1987) cited Mott who quoted from Thomas Merton, a contemplative monk, on a desire for oneness with God: "And truly, we are so close to ourselves that there is really no 'relation' to this ground of our own being. Can we not simply be ourselves without

thinking about it?" (p. 4) Stern also cited Clissold on St. Teresa of Avila, who said, that after a mystic experience, one's soul is then not content with anything but God. G. Aschenbrenner (personal communication, summer, 1981) taught at Creighton University that at the core of a person's being is God and oneself; no evil can penetrate. Experiences, that come from one's core are profound, whereas, experiences that "skitter and scatter" across "the skin of one's soul" might be intense but never profound.

Westgate (1996) cited studies by Richards, Owens, and Stein, and Carson, Soeken, and Grimm suggested a relationship between transcendence and depression for Christian clients. Both studies defined transcendence as a belief in God. Richards et al. found improvement in depression levels following cognitive therapy with a religious-spiritual component. Carson et al. discovered significant correlations between belief in God and both state hope and trait hope. Westgate cited the work of Noble who studied transcendent experiences among a variety of populations. She documented higher levels of psychological well-being among those who have had transcendent experiences than among those who have not. Noble observed greater self-actualization, optimism, and integration, as well as positive relationships, guiding values, and life purpose among

participants who have had transcendent experiences.

Need for Meaning/Purpose

Grounds perceived (in McAllister, 1983) seven basic human needs: (a) need for meaning and purpose, (b) need for forgiveness, (c) need for courage, (d) need for love, (e) need for community, (f) need for the power to cope, and (g) need for hope. Grounds noted that when these needs are not satisfied, people will develop symptoms of maladjustment and unhappiness. Spirituality, in general, refers to the questions people ask and the answers they accept about life's meaning, purpose, and direction. Spirituality is related to the degree of satisfaction and to the extent of personal fulfillment people experience in living. It also is related to a sense of unity with the cosmos, and the perception of the source of one's fulfillment as internal or external (Gross, 1980).

Bergin (1988) did a survey on values. The results showed 68% of therapists agreed that they seek a spiritual understanding of the universe and one's place in it. Bergin suggested that a spiritual orientation re-emphasizes the importance of being open, specific, and deliberate about values. Bergin found that a spirituality helps therapists shed inhibitions about helping people activate values that can be used as

cognitive guides in their self-regulation and lifestyles. Wylie (1994) remarked that parents are muddled about their own values, and saw the new challenge for clinicians as assisting postmodern families in identifying their values, norms, and goals. McAllister (1983) observed that a sense of meaning facilitates integration in life. For Allport (in Westgate, 1996) intrinsic values provided the framework by which one's life is understood. He found they are stable, and guide a person's life regardless of external consequences.

Oates categorized (in Julian, 1987) psychiatric patients with five levels of religious concerns: superficial, conventional, compulsive, character-disordered, and authentic. Oates defined authentic as "seeking for a genuinely meaningful interpretation of the chaos" (p. 125) one is experiencing. Bloomington and Kory studied (in Gross, 1980) adult human development and mid-life crisis. They noted that several important spiritual issues surfaced: the inevitability of one's own death, the time remaining to fulfill creative desires, and the examination of one's personal power to fulfill one's deepest needs. Levinson explained (in Gross, 1980; see also Boelen, 1978) that a crisis during mid-life is not in itself pathological. In fact people who live through this

stage with minimal discomfort could be losing an opportunity for personal development. He stated that failure to address the above issues often results in increased incidence of physical illness, depression, and substance abuse. Maslow believed (in Westgate, 1996) that an intrinsic value system is the defining characteristic of human nature. He noted that intrinsic values are necessary "to avoid sickness and to achieve fullest humanness" (p.29).

Howe (1988) stated that for most people, the transition to genuinely new life is only by way of crisis. Howe encouraged persons to see crisis as opportunities for new life: Confronting crisis could be one's path to full humanness and the means of fulfilling one's destiny as a being created in the divine image. McAllister (1983) considered that because work often temporarily supplied meaning to a person's life, unemployment often triggered the search for meaning. Tillich studied (in Howe) the Christian gospel and interpreted it as the answer to basic existential questions. He stated that sincerity, planning, and hard work do not yield a lasting sense of meaning. He found that persons spend half their lives finding more and more impressive ways to justify themselves in the eyes of the world from the conviction that worth as a human being is a function of

achievement.

The process of working through chaos and crisis often result in conversion. Conversion implies change (Merriam-Webster's Collegiate Dictionary, 1993). In the Christian tradition conversion involved a fundamental decision to commit the whole of one's life to God. The maintenance and concrete realization of that decision requires continual choices through the phases of human growth and development (Rahner, 1975).

Kelley (1986) stated that pastoral counselors, by considering the concept of conversion, could gain valuable insights into their work. Lonergan explained (in Kelley) conversion as a transformation of the subject and his world. He viewed transformation as the key of his approach to conversion. He perceived conversion implied not just growth or development but radical change in the course and direction of one's life where one's relationships with self, with others, with a Supreme Being, and with the world are substantially altered (Rahner, 1975; Kelley). Lonergan distinguished three separate but not isolated transformations involving different types of conversion: intellectual, ethical or moral, and spiritual or religious. He explained intellectual conversion as not just a change in the way one sees the world, but as a substantial alteration in experiencing,

understanding, judging, and believing. Lonergan observed that occasional geniuses, (e.g., Saint Augustine, Galileo, or Einstein) "find themselves to be the first humans to reach particular crossroads of the intellect covered with leaves no step had trodden black" (p.362).

In addition, Hillman referred (in Porter, 1995) to Michelangelo as speaking of an inner genius, one's inner compass to meaning and fulfillment. Porter noted that a counselor needs to empower clients to acquire a new vision of themselves and the conditions of their life to be in accord with the image of the heart. Citing Van Kaam, Westgate (1996) stated that the therapeutic goal for clients is to become reacquainted with their own inner wisdom, which is of a spiritual nature. Meadow, (1986) a theologian and a psychologist, stated she is seeking underlying bases of agreement among world faiths, trying to discern the core value in their bases. She planned to evaluate those core values in the light of contemporary understandings of the human inner life, and offer them to the spiritually hungry who may wish to accept them as nourishment.

Holistic Health Toward Actualizing Full Potential

Holistic health. Smuts coined (in Gross, 1980) the term "holistic" from the Greek "holos" meaning whole "in the sense that a living entity is more than the sum of its parts" (p. 96). Holistic health has been attempting to overcome the mind/body duality of Western science and medicine. This concept involves an interdependent system where a change in one part of the system affects all the other parts of the system. Gross also noted that in holistic health the concept of "positive wellness" replaces the focus of "an absence of disease" and supports a "sustained joy in living" (p. 96).

Perls considered (in Bryd, 1993) the body, mind, and soul to be parts of the whole organism, acting interdependently to create balance for the person. Effective therapists see clients as whole persons, including the spiritual dimension which has been most often overlooked. Tested interventions in this area have been sparse (Ganje-Fling & McCarthy, 1996; Peterson & Nelson, 1987). Chauvin (1996) stated that it is not whether the issue of spirituality should be addressed in counseling, but how it can best be addressed by well-prepared and sensitive counselors.

Warfield and Goldstein (1996) observed that the abuse of alcohol damages a person physically, mentally,

emotionally, socially, and spiritually. Citing Chandler, Holden, and Kolander, Witmer and Sweeney, they stated, "The central element in holistic healing is spirituality" (p. 198). And yet they found, unfortunately for the alcoholic, the spiritual aspect was most often de-emphasized in treatment programs. Cognitive and behavioral changes are generally given central focus with little more than lip service to the spiritual component. Brown, Peterson, and Cunningham (1988) noted that the field of psychology has now made available behavioral "tools" which counselors can use to facilitate not only sobriety, but spiritual actualization. Jung observed (in Warfield and Goldstein) of one of his patients, "his craving for alcohol was the equivalent, on a low level, of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God" (p. 198). Interestingly, Burke and Miller (1996) also chose the above quotations in writing their article in support of an interactive approach to counseling clients with HIV/AIDS.

Levin (1986) maintained a place on the mailing lists of almost one hundred religious cults and sects, holistic health centers, communes, and alternative healing organizations. In a study by Levin and Coreil (1986) they observed the New Age approach to holistic

health to be both Eastern and Western. Their study showed cases tended to cluster into those emphasizing mental or physical health through self-betterment (body), those emphasizing knowledge through the study of esoteric teachings (mind), and those emphasizing spiritual growth through contemplative practice (soul).

Porter (1995) suggested that the healthiest attitude toward New Age spirituality may be one of hope; "a hope that despite the soul-deadening machinery of contemporary society, the inner longing for the spirit irrepressibly finds an outlet" (p. 75). Wilson observed (in Porter) that what may bother critics of the New Age the most is that it encourages people to think about and experiment with ideas and practices that are forbidden or taboo to either (and probably both) science or religion.

Levin and Coreil (1986) explained disease as the result of maintaining a position which is out of harmony with one's natural lifeward tendency. "The ultimate health and healing technique is to simply be" (p. 891). They believed mastery of the physical body is within one's reach. Todrioll stated (in Walker, 1987) that it is possible to recognize and cultivate health in one's own existence and in others. Levin and Coreil did observe that depending upon the practitioner/ therapist, New Age patients could be as

fragmented as some conventional patients.

McCue-Herlihy (1996) perceived that the wellness model focuses on maximizing potential and growth, rather than "exclusively depicting defects or negative behavior" (p. 170). A concern was that the illness model was likely ingrained in most students. Clients seen as "sick" often resulted in being seen as incompetent. McCue-Herlihy was concerned with the heavy emphasis in some educational programs on the diagnosis of mental illness rather than early training on the alternative concept of lifelong wellness and empowerment. Because the medical model shifted responsibility for one's behavior from patient to doctor, Shostrom (1976) found it had limited value. Van Kaam (1985) stated that no diagnostic category alone could do justice to the emergent disclosure of the unique call of a human life form in its personal formation field.

Kelsey discussed (in Erickson, 1987) the relationship between a Christian viewpoint and Jung's thinking as it related to Christian counseling. He considered that a path to healing and wholeness involved listening to the wisdom of one's unconscious, and included the "spiritual realm" (See also Murphy, 1963; Peck, 1978; Sanford, 1977/1978; Sugrue, 1973/1942; Weiss, 1988). Sanford (1978) showed how

various cultures gained knowledge of God and guidance in life by learning from the messages in their dreams (See also Halligan & Shea, 1991).

In a study by Goldstein, Jaffe, Sutherland, and Wilson (1987) 22 out of 30 respondents of Holistic Physicians reported religious and/or spiritual experiences shaping their feelings about medicine and their practice of it. Over half of them spontaneously cited experience in psychotherapy, encounter groups, and other structural personal growth settings as an important determining factor in their present orientation toward medicine. Fourteen out of 30 reported personal experiences with their own illness or that of close family members as influencing their life style toward more holistic living.

McCamy and Presley discussed (in Gross, 1980) nourishment and exercise as essential ingredients in holistic health. They found most food insufficient in nutrients and suggested one criterion: food be fresh and whole rather than processed with additives. They noted that vigorous exercise develops a reserve of circulatory efficiency that permits people to adapt to the stress of daily living. Furthermore, exercise promotes the growth of blood vessels, strengthens the heart, increases muscle mass and energy reserves, and restores and maintains elasticity of tissues and the

functioning of joints. (See also Diamond, 1985/1987; Simonton, Matthews-Simonton, & Creighton, 1978; Taub, 1994). Simonton et al. (1978) also showed how cancer is related to emotional problems.

Taub (1994) discussed how most people start doing yoga for physical exercise and stress management, and are pleasantly surprised to learn of the emotional and spiritual benefits. His patients noticed how yoga worked through the whole body, mind, and soul. Taub stated: "It engages your muscles, your thoughts, your feelings, and your attitudes. At the same time that it releases tension and tightness in the muscles, it releases harmful emotions and painful feelings that can lead to illness" (p. 70). One of his patients after practicing yoga for a month, wrote Taub:

> These stretching and flexing exercises are miraculous! The ache in my lower back is nearly gone, after years of causing me such pain I could hardly bend. But that's not the only miracle. I don't know what it is about the exercises, but since I started doing them, I feel an inner calm, like a spiritual presence that I've never had before. It's like my soul just opened up. (p. 69)

Yoga originated in India and is a Sanskrit word meaning "union." Hatha means "balance and determined effort"

that helps to create emotional, mental, physical, and spiritual union.

Bloomfield and Kory described (in Gross, 1980) a positively well person as (a) physically fit, (b) free of health-destroying habits, (c) getting sufficient sleep, (d) eating nutritiously on a daily basis, (e) doing meaningful and productive work, and (f) experiencing profound loving relationships. Simonton et al.(1978) included taking time for play.

Byrd (1993) stated that physical healing and spiritual growth are positively correlated. Byrd cited Yalom, who, while denying the true existence of an ultimate rescuer, observed those clients who did have faith and trust in a higher power experiencing lowered anxiety in facing loneliness and/or death. Byrd perceived that empowerment may come from belief in the power of a supreme being who can alter disabling conditions. He noted that when the spiritual well-being of the rehabilitation client is taken into account, further gains may be made in the medical and psychosocial treatment. Byrd remarked that it makes little sense to discourage the spiritual variable if one wants wholeness to have its best chance.

Leibin (1981) perceived that the human person exists as the dialectical unity of contemplation and activity. Human beings contemplate their world and

their being in the world, then reorganize the world and themselves. De Gouw, Westendorp, Kunst, Mackenbach, and Vandenbroucke (1995) studied the monastery records of 1,523 monks from 1900 through 1994. They observed that taken together, present and earlier data suggested that, among contemplative monks, a simple life style is associated with an extension of life.

Van Kaam (1986) was asked to establish a psychology department that would teach psychology not merely as a positivistic science but as a human science that would take into account the deeper spiritual formation of human life and the social justice implications. Van Kaam stated:

> I am concerned with the development--in cooperation with others--of a foundational formative spirituality that draws among other sources on the basic contributions of all schools of spirituality. We cannot use the metalanguage of Christian theology for a non-Christian audience. (p. 438)

Ganje-Fling and McCarthy (1996) suggested that including questions about the spiritual dimension at the initial intake interview might alleviate client confusion at a later time when spiritual issues surfaced. They noted that introducing the topic of spirituality in the assessment phase also communicated

to the client that this is a valid topic of discussion in the counseling setting. Dombeck and Karl (1987) and Westgate (1996) gave possible questions for use as an assessment of spiritual needs (see Appendix A).

Holistic health can be viewed as a process that utilizes the healing forces and energies within the individual for the integration of body, mind, and spirit (Svihus in Gross, 1980). Clients interested in holistic health create a life style conducive, not only to maintaining their health, but to one that will enhance their personal fulfillment (Pelletier in Gross, 1980).

Actualizing full potential. Van Kaam (1985) spoke of an individual's formation field without which he/she would be nothing potentially. Persons continually change the ways they receive and give form to their field. People form themselves by forming their field. For instance, caring for others results in growing in love, admiring the beauty of nature develops the depth of one's aesthetic sense. Van Kaam viewed formation counseling essentially as a process of assisting clients to be free for their own formation. He observed on-going formation which possibly begins at conception and continues throughout the person's life, influenced by interaction with others.

Shostrom (1976) illustrated how a self-actualizing

person experiences growth from within like a mustard seed rather than through an external authority's impositions which act like mustard plaster. Porter (1995) also noted that persons can program their own reality. He stated that the reality one creates for oneself can open up the person "to new potentialities and undreamed of spiritual vistas" (p.76).

Rogers considered (in Cartwright & Mori, 1988) openness to experience as the polar opposite of defensiveness. He described the client who is more able to live fully in and with each and all of one's feelings and reactions as becoming a more "fully functioning person" (p. 181). Such persons combine awareness of deep feelings of personal strength with acceptance of weakness in themselves and others. They also tend to experience feelings fully in the present moment. Shostrom (1976) defined self-actualizing as "an active process of being and becoming increasingly inner-directed and integrated at the levels of thinking, feeling, and bodily response" (p. 65). He considered a healthy person also outer-directed: able to make effective and appropriate intimate contacts with other persons in relationship. Shostrom related the development of an individual from dependence to independence with further development in interdependence in the actualizing person.

Bensley, a health professional, described (in Westgate, 1996) wellness as an integration of the various dimensions of human functioning, including social, mental, emotional, physical, and spiritual. Dunn, a physician, elaborated (in Westgate) that this integration was oriented toward maximizing the potential of which the individual is capable with the spiritual dimension, the seat of values and creativity, as the center by which integration and growth occur. For further development of the topic, actualizing one's full potential, see Abramowitz et al. (1974), Barnette (1989), Boelen, 1978), Bowen, Anderson, and Halliman (1987), Braaten (1989), Brennen and Piechowski (1991), Chang and Page (1991), Day and Mathes (1992), DeCarvalho (1989), Hattie (1986), Leenders and Henderson (1991), Leitschuh and Rawlins (1991), Ryan, Hawkins, and Russell, 1992, Schott (1992), and Sweeney and Witmer (1991).

Process of Discernment: Health or Pathology

Maslow theorized (Fahlberg, Wolfer, & Fahlberg, 1992) that human growth is a continuous process going beyond self-actualization to self-transcendence. Grof and Grof explained (in Fahlberg et al. (1992); Porter, 1995; Small, 1987) "spiritual emergence" as the movement of an individual to a more expanded way of

being, increased emotional, spiritual, and psychic health, and a more intimate connection with others, nature, and the cosmos. Mainstream Western psychology and psychiatry have focused on the physical world as real and knowable. With this approach, what is invisible has not been considered real. The new paradigm of self-transcendence allowed for expansion of human development. Fahlberg et al. developed a framework to distinguish between personal crises that are developmentally healthy experiences and those that are pathological. They observed that during the process of the crisis, the signs for both could look similar.

Allport and Ross; and Watson, Morris, and Hood refuted (both in Suyemoto & MacDonald, 1996) the belief that religion is invariably correlated with psychopathology. The group for the advancement of psychiatry stated (in Meadow, 1986) that one cannot always tell the difference between religious mysticism and certain psychopathological states. Most mental health professionals have a poor understanding of religious mysticism. Some look only at experiences, which admittedly do have some factors in common with some psychopathological states, and neglect to consider that religious mysticism implies a radical, life-pervading reorientation of an individual, not just some

"high" experiences. Many are incapable of considering certain altered states of consciousness other than in a context of psychopathology. Stern (1987) cautioned that diagnosis and treatment plans for spiritual concerns could obscure the complicated and dynamic nature of the healing power inherent in what is often a reluctant response to the deepest ground of one's being. Carretto perceived (in Stern) that the therapeutic task is a rigorous self-examination so that nothing may be obliterated in the journey, and that "when the flood of pain has passed over the soul, what remains alive can be considered genuine" (p. 11).

Julian (1987) noted that the discernment process is not an easy matter but requires careful balance of one's intuition, reason, knowledge, and experience. Julian stated that for centuries people have struggled with the issue of distinguishing authentic from pathological symptoms. Before psychodynamic terminology was developed, mental processes were conceptualized in terms of "spirits"--forces that could influence a person's thoughts, feelings, and actions. In the New Testament Scriptures the first letter of St. John (4:1-6) gives guidelines for distinguishing the spirit of truth from the spirit of error. St. Paul placed the discernment of spirits among the gifts of the Holy Spirit.

The word "discernment" comes from the Greek word, "diakrisis," and means "to separate apart" (Julian, 1987, p. 126). The task of discernment of spirits is to separate apart the various influences impinging upon a person, thereby distinguishing the authentic from the pathological. Discernment of spirits developed more fully several centuries after Christ. Christians began living in the desert as a way of returning to a more authentic, rigorous form of Christianity. This life of prayer was seen as a way of encountering evil forces in order to defeat them. St. Ignatius of Loyala, the 16th century founder of the Jesuit Catholic religious congregation, is well known for his contribution in this area. He gave the concept paramount importance in the area of spiritual life. He stated that spirits fall into three categories: a) from God, b) from the devil, and c) from one's own self. Discernment of spirits played a vital roll in his spiritual exercises, and a great body of knowledge developed on this topic (Ignatius, (16th century/1951; Fleming (1981); Julian, 1987).

A common method throughout the centuries for judging religious experience has been by the effect of the spirit upon a person's life. The New Testament of the Bible, St. Paul writing to the Galatians (5:22-23) spoke of the fruit of the spirit as love, joy, peace,

patience, kindness, goodness, and self-control. Generally the emotional effect of authentic religious experience will be noticed by their "fruits." Julian (1987) noted that experiences leading to agitation, fear, loneliness, and increased attempts to be more controlling are less likely to be of God. Divine revelation also strengthens one's relationship with others, whereas, psychiatric patients often become more isolated and separated from other people.

Voices and visions occur both in mental illness and with religious experience. Julian (1987) mentioned that St. Augustine (born A.D. 354) described hearing a voice as part of his conversion experience. St. Teresa of Avila (Teresa, 16th century/1976; see also Julian, 1987) noted that for one who has experienced God, love becomes the motivator for the person's actions. Setzer observed (in Julian) that recipients of genuine divine revelation become more loving, wise, and integrated, whereas, pathology has a disintegrative effect on the person.

Peterson and Nelson (1987) found that the common approach for nurses working in psychiatric facilities was to ignore the spiritual concerns of their clients and to assume that they were part of the client's pathology. They noted that assessment skills need to be used in determining whether a client is exhibiting

pathology or expressing legitimate spiritual concerns. They cited Clinebell who differentiated between spiritual health and unhealth (see also Welwood, 1986).

Meadow (1986, 1989) expressed concern about psychologists who acted as spiritual directors. She stated that most therapists are ignorant of the great traditions of the world's developed spiritualities and typically lack training in the profession of spiritual direction. In this area she encouraged psychotherapists to refer clients to spiritual guides or pastoral counselors (see also Spilka, 1986). Meadow (1986) noted one exception: forgiveness. She perceived that forgiveness could be expressed in psychological language and be used to complete a client's healing.

May (1977) viewed spiritual counseling as distinct from spiritual direction. Spiritual counseling encourages persons to speak of their spiritual needs and experiences. The counselor is present with an attitude of gentle openness to facilitate the client to explore and clarify the feelings, blocks, fears, obstacles, and longings. The assumption here is that the client will become increasingly aware and capable of responding to his/her own spiritual needs. On the other hand, May (1977) described spiritual direction as specific guidance on how to pray and on what to do to

acquire a life of greater religious meaning. May saw directors as needing to be quite advanced personally in spiritual matters. However, May stated that whether the counseling be more exploratory or directive, the growth and healing that occur come from God, not from the client, director, or counselor (see also Ganje-Fling & McCarthy, 1991; Gratton, 1986).

Need for Love, Self-worth, Connectedness, Community, Intimacy

Need for love. The need for love has been established as a basic human need (Grounds cited in McAllister, 1983). People deprived of love die (Chavez-Garcia & Helminiak, 1985). The good news of the Christian gospel is that God is love (1 John 4:8), that we are loved unconditionally by God, and that it is this love which constitutes our worth (Howe, 1988). Participating in the paschal mystery of death to life is a call to conversion, to become love in the image of God in whom we were created.

At the end of the third century men and women went to the desert of Egypt to restore their damaged image of God and to wrestle more directly with the inner passions that prevented their loving. The abbas and ammas served as counselors and spiritual teachers to facilitate healing. One main difference between modern

counselors and those of the desert was that disciples in ancient time lived several years with their counselor (Bondi, 1986)!

Van Kaam (1985) viewed the counselor's sustaining presence, a wholehearted being with the counselee, as a source of inner freedom. He stated that the client will sooner or later be affected by the absence of any forcing, imposing, or overpowering on the part of the therapist. The "interformative" disposition counselors bring to counseling forms both the therapist and the client in a way no other encounter (except the love encounter) can give form to the persons' lives. Zinker (1995) described presence as being fully here with all of oneself, one's body and soul. He stated that presence is a way of "being with," without "doing to." Zinker found that when a person is present, stirrings are evoked in the deepest parts of one's being. Presence provides an opportunity for a profound encounter with another.

Need for self-worth. May (1977) observed that human spirituality threatens self-identity by calling into question one's image of oneself, and consequently, is defended against in a variety of ways. May perceived that the question, "Who am I?" is a sensitive question where confronting spirituality issues becomes even more difficult than facing psychological or

interpersonal problems. Lemoncelli and Carey (1996) discussed self-identity and abused children. They showed how children with dysfunctional parents lacking inner safety and security may fantasize an all loving view of their parents at the expense of their own self-worth. These children develop self-blame by attributing the bad that occurs to themselves. Lacking a nurturing parent, they tend to develop a stronger internal critical parent that is oppressive, conditional, and controlling. Lemoncelli and Carey perceived that these children hate, and are terrorized by the sexual assaults, but long to be touched, held, and loved even when the love is pathological.

Lemoncelli and Carey (1996) observed that trust and faith, necessary for spiritual development, are lacking for the survivors of abuse. As a result their spiritual development is impeded. In the Judeo-Christian tradition the image of God as a parent is prevalent. For abused children their image of God could be distorted due to their experience of their earthly parents. Lemoncelli and Carey noted that it is critical for therapists to address the spiritual bond that perpetuates the abuse cycle. If it is overlooked, therapy could be impeded because a powerful reinforcer is not being addressed. They found that change tends to be slow and due more to a secure, healthy

relationship with the therapist, than to any particular theoretical approach. They noted that the healing factor both spiritually and psychologically is for survivors to experience unconditional acceptance of all their feelings, fears, and beliefs. Unconditional acceptance helps them to believe that God might be able to love them in that way.

Need for connectedness and community. Hill-Hain and Rogers (1988), focusing on "being present," described their experience of group therapy with a cross-culture group in Africa. Rogers asked of himself whether he might be ready for the unexpected. He wanted to be open to any little clue that might open up doors of new understanding. Gold reported (in Porter, 1995) that when people experience presence, they sometimes notice a sense of connectedness or unity with all things.

Franks in presenting the status outcome of research stated (in Propst, 1986): "Thus far, we have found that the most important determinants of psychotherapy success seem to be the personal qualities of the patient and the therapists, and their interactions rather than the therapeutic method" (p. 74). Frotzer perceived (in Bemak & Epp, 1996) love to be a necessary condition to be established in a group before members could achieve insight,

responsibility, and eventually, self-actualization. When a group therapist does not create a loving therapeutic climate, group members may become defensive, frustrated, and disappointed (see also Conyne, 1996; Genia, 1990; Yahne & Long, 1988).

Bemak and Epp (1996) stated: "Real potency of group work lies in the simple experience of love" (p. 125). They considered that Rogers may have been right in emphasizing that we cannot change, or move away from what we are, until we love and accept who we are. They observed that love expressed during group therapy may be an extension of Roger's work and might be the necessary environment for self-love and for change to work. Bemak and Epp found the complex emotion of love traditionally ignored by psychotherapists. They appraised love to be a powerful therapeutic tool that could aid group clients in the transition from a pattern of failed or unhealthy love relationships to greater understanding of love's reality. Bemak and Epp (1996) noted that due to the threat of stimulating sexual feelings, many clients and group therapists avoid authentic love. They stated that group therapists may need "to sever the cultural link between love and sexuality in the members' collective psyche" (p. 124). They saw the therapist's role as critical in assisting clients in understanding

the dynamics of love and in fostering love's healing power.

Warfield and Goldstein (1996) stated that if the human person were created for a positive purpose, satisfying one's basic needs would produce a state of well-being. They perceived that the most spiritual of one's basic needs is belongingness, and described it as enjoyment of loving, accepting, and trusting relationships with one's self, other people, nature, the world with all aspects of life experiences, life itself, and God as one knows God.

Wylie (1994) explained that community is not about having final answers but a way of expressing the heart of the human person's yearning for connection. Wylie noted that community consists of a sense of common purpose, mutual respect, and trust, and is built through dialogue. Taffel observed (in Wylie) the importance of creating "an empathetic envelope" consisting of the parents' values, expectations, and way of being with their children. In such an envelope children are "held by their parents in a safe and secure place" (p. 25).

Need for intimacy. Hart (1984) observed that clients came into his office for three basic reasons: (a) problems with self-worth, (b) problems with sexuality, or (c) problems in the transcendent

relationship. Hart suggested that psychology dialogue with the church to reverse its pervasive sense that sexuality is somehow negative. Society suffers under the weight of centuries of teaching in the negative vein. Chavez-Garcia and Helminiak (1985) noted that in Western civilization sexuality and spirituality are seen as antagonistic. However, both are dimensions of a fully human person, consequently, they are not antagonistic but complementary, interdependent, and inseparable. They noted that a negative response to one's human body puts one at odds with an important source of data and experience, integration ceases, and spiritual growth is blocked. Chavez-Garcia and Helminiak perceived that a fully developed spirituality implies a fully developed sexuality, and reconciling them is a process of integration of the human with the divine.

St. Teresa of Avila (cited in Stern, 1987) baptized her sensual torments until she experienced spiritual rebirth, for her the banal became the pathway to the holy. May (1977) perceived that integrated spirituality tends to move a person away from the importance of need-satisfaction, whereas, the human drives of sex or aggression tend to move the individual to want more gratification. Hart (1984) viewed the concept of "one flesh" not simply as the penetration of

the male organ into the female organ for that could be too exploitative and too one-sided. Rather, Hart perceived one flesh connotes some union of the couple's souls, minds, and hearts.

Hart (1984) noted that the Bible used the term "to know" to indicate sexual union. However couples often have sexual union without knowing the other at all. "But in sexuality, the capability of true intimacy and deep fellowship with the other is potentially there, a guide to real fellowship on the order that God has" (p. 71). May explained (in Selvey, 1977) that in a sexually intimate and spiritual encounter a person can have the direct feeling level experience of the ground of one's being where one is attuned to and in harmony with the universe, experiencing deeply meaningful and pervasive union with one another and with the transcendent being.

Healing: Grief, Forgiveness

Grief. Bowlby stated (in Worden, 1991) that much psychiatric illness is an expression of pathological mourning. T. McIntier, a grief therapist giving a workshop on complicated grief (personal communication, November 7, 1995) stated that one-fourth of the patients in mental hospitals are suffering from unresolved grief issues. Shostrom (1976), after 13 years of research with 200 different studies, noted

that clients interested in becoming self-actualizing can begin by accepting their loses. Loss may result from death or from a variety of other causes, such as, divorce (Spaniol & Lannan, 1985), amputation, unemployment, victims of violence (Sharma & Cheatham, 1986; Weenolsen, 1991; Worden, 1991), aging (Becker, 1986), changing locations.

Joy (1985) observed a significant number of women requesting counseling for depression were suffering from unresolved grief over a prior abortion. As the counseling progressed, clients experienced the full spectrum of emotional responses: sorrow, anger, guilt, yearning for the lost, and relief. Joy noted that forgiveness was critical in the resolution of the loss (see also Schroeder-Sheker, 1994). Wilber (1989) gave an account of one woman's experience of death in relationship to her spirituality.

Forgiveness. In the ancient Hebrew and Christian view, forgiveness of self, others, and God played an important role both in healing from losses and healing of life's hurts (Enright, Gassin, & Wu, 1992). Pettitt (1987) observed that a more forgiving person is associated with better healing, living, and dying. Shostrom (1976) noted the importance in spirituality of compassion and the ability to forgive oneself and others from the inevitable mistakes that occur in

living. Rogers (1992) saw unconditional regard as the necessary first step for forgiveness. Meadow (1986) stated that after suitable expression and understanding of one's emotions and cognitions, forgiveness of one's enemies is psychologically helpful.

Pettitt (1987) defined forgiveness as "the process of canceling the conditions in the mind that prevent the full flow of love and vitality through a person as a result of a life event" (p. 180). Pettitt noted forgiveness is not an external act of pardoning, but an inner action of the will in the mind and value systems of the person, an act of self-care. Forgiveness does not mean one permits oneself to be overridden, and does not stop the person from taking appropriate wise action. Pettitt explained a process of forgiveness, especially important for use with loved ones and fellow workers. He/she found forgiveness enhances self-esteem, building one's confidence. Pettitt stated: "For peace as well as health, we must bring ourselves into harmony with nature and with each other" (p. 182). By citing case reports this study confirmed that forgiveness cuts the need for drug usage.

DiBlasio and Proctor (1993) observed that without exception forgiveness is reported in the literature as restoring relationships, and healing inner emotional wounds. Hope (1987) described forgiveness as a key

part of psychological healing; and Fitzgibbons (1986) described it as a powerful therapeutic intervention. Forgiveness is reported to be highly beneficial for such problems as anger and depression, family of origin issues, personality disorders, self-guilt, healing broken relationships in marriage, and for problems within alcoholic families (DiBlasio & Proctor, 1993; see also Enright & the Human Development Study Group, 1996; Hebl & Enright, 1993; McCullough & Worthington, 1995; Pingleton (1989); Wurster, 1983).

Peterson and Nelson (1987) noted that the need for forgiveness is frequently observed among mentally ill clients. They stated that guilt and resentment are what result when forgiveness does not happen. DiBlasio and Proctor (1993) clarified the difference between "hurt" and "resentment." They described hurt as the pain a person suffers from another's mistake, and resentment as the negative feeling one develops toward the offender for the hurt experienced.

A study by DiBlasio (1992) showed that therapists over age 46 had more favorable attitudes about forgiveness. The explanation might be that forgiveness is a developmental issue increasing in perceived value as a person matures. Erickson (in DiBlasio, 1992; and in DiBlasio & Proctor, 1993) explained integrity versus despair means finding one's contribution in life,

forgiving past mistakes made by oneself and by others, and accepting that life is a mixture of pleasant and adverse realities. All three studies by DiBlasio (1991, 1992, 1993) revealed that the majority of therapists have a favorable impression toward forgiveness, but as a group they reported a deficiency in the theoretical application of techniques and guidelines for implementing the concept in their practices.

Meditation/Prayer (Contemplation)

Benson, president of the Harvard Medical School's Mind/Body Medical Institute, stated (in Hilts, 1995) that his office at Harvard was getting five to six calls a week from Health Maintenance Organizations that were interested in the medical uses of relaxation and other nontraditional treatment methods. Studies showed that meditation and prayer are effective for illnesses such as depression, anxiety, high blood pressure, cardiac pain, insomnia, diabetes, ulcers, cold, fever, asthma, arthritis, and alcoholism. Blood pressure patients were able to reduce or eliminate drugs through relaxation techniques. The cost effectiveness attracts some medical practitioners.

When Benson offered (in Hilts, 1995) a menu of practices to patients, he said that he found about 80%

of the patients chose prayer (see also Elkins, Anchor, & Sandler, 1979; Gross, 1980; Levin & Coreil, 1986; Novak, 1984; Simonton et al., 1978; Walker, 1987; Welford, 1947; Woodward, 1997). Patients from these studies indicated that prayer for them helped modify their attitude in situations, brought peace of mind, clarified their desires, brought healing, dispelled their fears, relieved tension, and brought emotional stability.

Novak (1984) stated that psychologists distinguish between concentrative meditation and receptive meditation. The former implies concentration of consciousness upon a single object until a psychic breakthrough is achieved. Receptive meditation is a sustained, open and non-reactive attention to one's stream of consciousness, not limited to a single object. Walker (1987) explained that in the Buddhist tradition meditation practice is seen as a basic discipline of non-aggression which encourages friendliness towards self. It also serves as the ground for compassionate action (see also Epstein, 1988; Mansfield, 1991).

Gross (1980) noted that meditation is an experiential exercise that involves the person's mastery over his/her own attention. Through focusing one's attention, the individual learns an alternative

to the mind's stressful habit of flitting from one thing to another (Pelletier in Gross, 1980). According to McCamy and Presley (in Gross), one's usual habits of thinking literally wear people out, whereas, the non-thinking produced by meditation blanks out stress and permits the body to restore itself. Meditation is a restorative process-a healing silence.

Finney and Malony (1985c) argued that prayer is a core religious practice that should not be neglected as a subject for research by those interested in integration of spirituality and counseling. Byrd (1993) observed that a Newsweek Poll found 91% of American women pray and 85% of American men do. In a new Newsweek Poll, Woodward (1997) noted that 54% of American adults pray on a daily basis with 29% reporting that they pray more than once a day.

In the literature prayer, was described as an intentional communication with a Supreme Being manifesting a basic human capacity for relationship (Elkins et al., 1979; Finney & Maloney, 1985b), an essential ingredient of positive mental health (Finney and Maloney, 1985b). Quoting the New Testament, Armstrong (1989) stated that prayer has the power to move mountains. Christian prayer is characterized by confidence in God's responsiveness to human need. The phrase "contemplative prayer" was found in Aristotle

and was contrasted with political life and a life of pleasure (Bellah, 1976).

Barry (1977) observed that prayer out of a sense of obligation or duty is not the best "bedrock upon which to build a love relationship" (p. 92). Prayer used exclusively for making petitions, or for making resolutions does not engender the enthusiasm associated with any close relationship of love. When a person notices how God is responding to them, he/she tends to enjoy contemplative prayer.

Contemplative prayer connotes an attitude of wonder and openness. The Center for Religious Development (in Barry, 1977) noted that prayer can be as simple as looking at the stars, watching a sunset, or seeing the smile on another's face, and responding to what one sees. Barry observed that concentrating on one's self and on one's problems hinders contemplation. St. John of the Cross (16th century/1964) and St. Teresa of Avila (16th century/1976) described contemplative prayer as a peaceful loving attention on God. God is known without images or words.

Centering prayer has lately become popular. In this prayer one focuses one's attention by following the breath as it flows in and out of the body. This process facilitates the quieting of one's mind while acknowledging the presence of the Transcendent Being.

A mantram-like technique focused on a faith word can also be used. Centering prayer was taken from the Jesus prayer in the Eastern Orthodox tradition. It is simply the prayer of the tax collector, and was taken from Jesus Christ's parable of the Pharisees and the tax collector in the New Testament Bible (Luke 18:9-14 in Finney and Maloney, 1985b; Novak, 1984; see also de Mello, 1978; Keating, 1986).

Finney and Maloney (1985b) noted that contemplative prayer is essentially a technique for spiritual development. However, the research on meditation suggests that when contemplative prayer is used as an adjunct to psychotherapy, therapeutic benefits such as desensitization, reduction of anxiety, and increased emotional and psychological stability will likely result. Patient comments following a study by Finney and Maloney (1985a) supported contemplative prayer with therapy: (a) "I felt that the therapy process speeded up when I started contemplative prayer." (b) "With contemplative prayer it was like I continued the work of therapy all the time. It made me much more open and vulnerable in therapy and much more aware." (c) "Quite often I would go into contemplative prayer tense from the day, and following it would be refreshed and re-energized. Following contemplative prayer I was able to focus and concentrate on what I

needed to do." (d) "My search for who I am and my identity found its roots in communion with the Lord during contemplative prayer." (p. 288) Novak (1984) perceived that contemplative prayer has the potential for deep psychological transformation.

Mystical experience can be defined as:

> An experience in a religious context that is immediately or subsequently interpreted by the experiencer as an encounter with ultimate divine reality in a direct non-rational way that engenders a deep sense of unity and of living during the experience on a level of being other than the ordinary (Ellwood in Finney & Maloney, 1985b, p. 174).

They noted that mystical experience leaves one with a sense of having perceived reality from a wholly different frame of reference. Such an experience is profound, and as St. Augustine perceived when he said, Our hearts are restless until they rest in You, O Lord. Nothing, except that unity with the Beloved, will ever again completely satisfy the soul.

Goal: Integration for Society

The fruit of contemplative prayer can be seen by the gifts of the spirit operating in one's life. The mission of Jesus Christ in which Christians are called

to participate is to experience the kingdom of God on earth. Armstrong (1989) stated that the goal of being an integrated inner person through holistic health is to be a productive outer person. Harman perceived (in Levin and Coreil, 1986) that the core beliefs of holistic health could become the basis of a new global order that provide the health and healing sadly absent from present-day society. The goal of holistic health is "to build the earth" (Teilhard in Erickson (1987). LeFevre stated (in Maloney, 1972):

> Should we feel that we could no longer be Christians within our particular profession or that we could better exercise our responsibility as Christians within another calling, other things being equal, we would feel a strong inward pressure to relinquish our present work and to seek some other. (p. 137)

The overarching goal of persons desiring holistic health by developing their full potential is to seek social change through personal transformation in union with others in tune with Divine guidance.

Chapter III

Method

Participants

The sample for this study consisted of 80 participants. The survey was conducted between January and April, 1996. The 10 male and 30 female therapists participating in the study were volunteers from Missouri and Illinois who attended Joseph Zinker's Gestalt therapy annual workshop in St. Louis, Missouri; Edward Harris' Gestalt group therapists' training in St. Louis; John Thekkedam's seminar at the St. Louis Behavioral Medicine on the integration of spirituality and psychology from an East-West perspective; and from Biobehavioral Health Institute in Fairview Heights, Illinois.

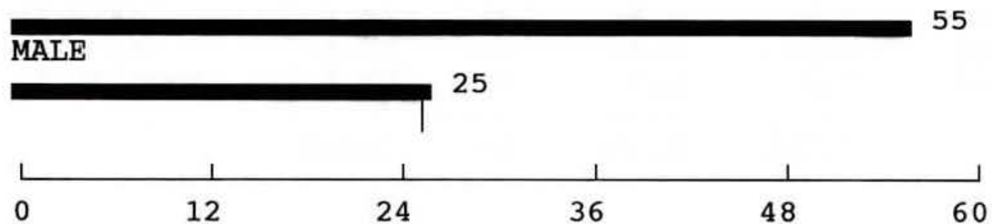
The 15 male and 25 female participating clients were recruited either by the therapists from their place of business, or by the researcher. The clients were from Biobehavioral Health Institute, St. Louis Behavioral Medicine, or from Life Crisis in St. Louis. The majority of the participants were Caucasian from various economic and educational backgrounds.

As shown in Figure 1, from the 80 participants, fifty-five (68.8%) were female, and 25 (31.3%) were male.

Figure 1. Sample Distribution by Gender

GENDER

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
FEMALE	1.00	55	68.8	68.8	68.8
MALE	2.00	25	31.3	31.3	100.0
	Total	80	100.0	100.0	



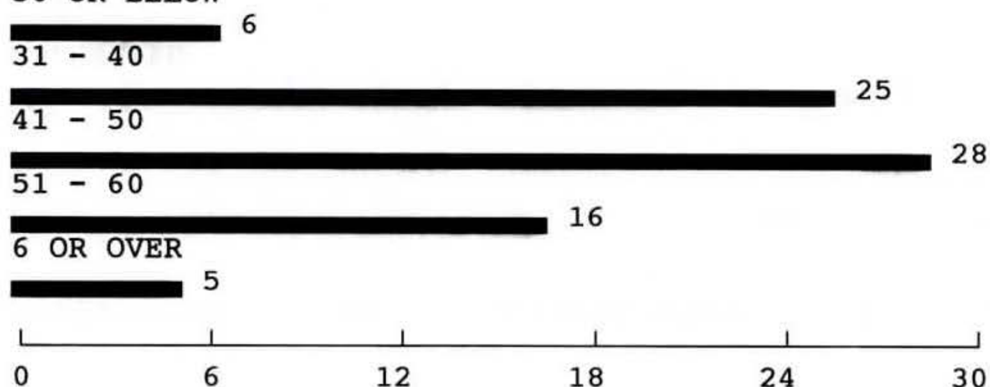
Valid cases 80 Missing cases 0

The age of the participants approximated a normal (bell-shaped) distribution (see Figure 2) where 28 of the 80 participants (35%) were between the ages of 41-50, with 31 (38.8%) of the participants below the age of 41, and 21 (26.3%) participants over 50 years of age.

Figure 2. Sample Distribution by Age

AGE

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
30 OR BELOW	1.00	6	7.5	7.5	7.5
31 - 40	2.00	25	31.3	31.3	38.8
41 - 50	3.00	28	35.0	35.0	73.8
51 - 60	4.00	16	20.0	20.0	93.8
61 OR OVER	5.00	5	6.3	6.3	100.0
	Total	80	100.0	100.0	



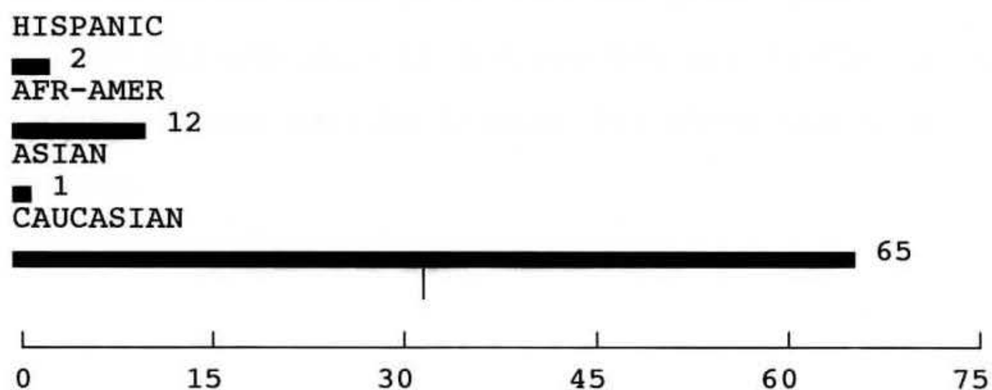
Valid cases 80 Missing cases 0

As shown in Figure 3, the racial distribution of the therapists and clients were predominantly Caucasian (81.3%) with 15% African-American, 2.5% Hispanic and 1.3% Asian.

Figure 3. Sample Distribution by Race

RAC RACE

Value Label	Value	Frequency	Per cent	Valid Percent	Cum Percent
HISPANIC	1.00	2	2.5	2.5	2.5
AFR-AMER	2.00	12	15.0	15.0	17.5
ASIAN	3.00	1	1.3	1.3	18.8
CAUCASIAN	4.00	65	81.3	81.3	100.0
Total		80	100.0	100.0	



Valid cases 80 Missing cases 0

The educational level of the therapists' sample showed 65% with a M.A. degree and 30% with a Ph.D. or more, as contrasted with the clients' sample where 40% had only a high school education or less and 32.5% held an M.A. with only 5% receiving a Ph.D. Of the total sampling 48.8% held a M.A. degree.

Of the therapists' sample 52.5% reported an income of 20,000 to 45,000 with 37.5% receiving 45,000 to 70,000, and only 5 female therapists receiving less than 20,000. 65% of the clients' sample reported an income of 10,000 or less, and 35% reported receiving an income between 10,000 to 60,000.

47.5% of the therapists practiced for five years or less while 32.5% practiced for 16-30 years. 12.5% of the clients were in therapy for six months or less while 40% had been in therapy for three years or longer.

Procedure

The researcher attended Joseph Zinker's 1996 annual workshop in St. Louis, Missouri; Edward Harris' 1996 Gestalt group training for therapists in St. Louis; and John Thekkedam's seminar on the integration of spirituality and psychology at St. Louis Behavioral Medicine. At an appropriate point during each session, the researcher explained the one-page attitudinal self-report survey to the participants, and requested volunteers to complete the survey at the site or to return them by mail. Some therapists took copies of the survey and recruited client and/or therapist volunteers from their place of work and returned the survey by mail. The researcher indicated a deadline for surveys to be returned; however, that time period was later extended.

From her place of work as administrative assistant at Biobehavioral Health Institute in Fairview Heights, Illinois, the researcher also obtained volunteer therapists and clientele. The researcher read the survey on an individual basis to a few clients who were illiterate. Clients came to the researcher's office and completed the surveys. As needed, the researcher answered clarifying questions. Clients were obtained from some of the participating therapists who gave the survey to their own clients.

Instrument

Shafranske and Gorsuch's survey (1984) sparked ideas for the researcher's study. The researcher composed an attitudinal survey (see Appendix B and C) which was approved by her advisor and by her research professor. The survey included six demographic items with the independent nominal (categorical) variables: age, gender, race, education, income, the number of years of practice for therapists, and the number of years in therapy for clients. Both therapists and clients responded to the first five questions by choosing one of the five options. Options were ranked on a Likert-type comparison scale using the ordinal dependent variables: 1 = always, 2 = frequently, 3 = occasionally, 4 = rarely, and 5 = never.

The question number six listed 12 specific issues using the independent nominal (categorical) variables: forgiveness, anger toward God, guilt, grief, sexuality, image of higher power, healing life's hurts (memories), prayer, self-esteem, God's love, dream work, death, after life, or none of the above. Therapists were asked to choose which issues they currently incorporated integrating spirituality and counseling. Of the issues chosen they were asked to rank them first to least in importance; the number one indicated the issue most frequently discussed, and the number twelve

indicated the issue least frequently discussed by their clients in therapy. In a similar manner, the clients responded to the same list of issues indicating and ranking only those items they discuss in their therapy sessions in relationship to their spirituality.

Statistical Procedures

The statistical procedures used on participants' survey responses for items one through five were: (a) chi-square statistic as a method of counting and analyzing the data, and (b) correlation to compare the relationship between the variables. The chi-square analysis was used essentially to bring out the relationship among the variables. Participant responses to item number six were described, but not analyzed.

Chi-square analysis. To evaluate the discrepancy between a set of observed frequencies and a set of expected frequencies, the chi-square statistic was used. For each cell of a table the difference between the observed frequency and the expected frequency was computed. The difference was squared and then divided by the expected frequency. The computation for each cell was added. The sum was the Pearson chi-square statistic for the table (Howell, 1992; Norusis, 1991).

To find out the independence of two variables, a

contingency table (a two dimensional table) was used. Norusis (1991) stated: "Two values are independent whenever knowing the value of one variable tells you nothing about the value of the other variable" (p. 263). Variables are related when they have something in common. They are in some way connected to each other. However, the existence of a relationship between two variables did not mean that one variable caused the other. The expected values used in calculating the chi-square were the values that would be expected if the two variables were independent. If the variables were independent, the same percentages would be expected in each category; the observed and the expected frequencies would be close to each other; and the value of the chi-square statistic would be small (Norusis, 1991). As the cell values in the table increased, the chi-square value increased. To calculate the observed significance level, the number of degrees of freedom was used. The number of degrees of freedom in a table is a way of accounting for how many different cells can contribute independent pieces of information to the chi- square. Row minus one (R-1) multiplied by column minus one (C-1) was used to calculate the degrees of freedom. The degrees of freedom were based on the number of observed and expected frequencies being compared, and their

arrangement in the table. The observed significance depends both on the degrees of freedom and on the value of the chi-square statistic (Norusis, 1991).

Correlation. Correlation responded to the question: Was there a relationship between the two variables? How did they behave together? The existence of a relationship did not mean that one value caused another. The Pearson Product Moment Correlation where "r" was the statistic, was named after Karl Pearson, an eminent statistician of the early twentieth century (Norusis, 1991). When r was less than or equal to one and greater than or equal to zero, r was positive. Correlation's meaning was determined by squaring r. "R" squared showed the amount, in percent, of variation in "y" that was accounted for by the variation in "x".

Norusis (1991) stated: "If there's a perfect relationship between two variables, you should be able to see a distinct pattern" (p. 336). When the first variable increased while the second variable also increased, the relationship was positive. When one variable increased while the second variable decreased, e.g., as age increased, father's education decreased, a negative relationship was indicated. If there was a perfect negative linear relationship, the value was negative one. The values of the coefficients ranged

from negative one to positive one. If there was no linear relationship between the two variables, the value of the coefficient was zero (Norusis, 1991).

Description of survey item number six. Results of the participants' responses to item number six were described. Participants were asked to first choose items and then to rank those items. Because the subjects each ranked a different number of items (e. g., some participants ranked 12 items while others only ranked three items), results did not lend analysis such as Kendall's coefficient of concordance (W). Consequently, data to survey item number six was described, but not analyzed.

Chapter IV

Results

The description of the results was divided into three parts: (a) analysis of the chi-square statistics, (b) analysis of the correlation statistics, and (c) a description of the results of item number six.

Chi-Square Analysis

The chi-square analysis did not directly relate to the stated thesis hypothesis, but reflected relevant information; therefore was included. Cross tabulation of the subjects, therapists and clients, by their responses (i. e., always, frequently, occasionally, rarely, and never) to questions (number one through five) on the survey were run (see Tables 1 through 5), and explained.

In Table 1, subjects were a nominal level of measurement used to divide the variables into two categories: therapists and clients. They were the independent variables chosen by the researcher. On the survey both therapists and clients responded to the statement, "I am personally involved with an organized religion." Personal involvement in an organized religion is the dependent variable, the outcome of the experiment.

Table 1: Cross tabulation of therapists and clients with the survey item: I am personally involved with an organized religion.

SUB BY ORG

Exp V Row P Col Count Tot P	Always 1.00	Fre- quent- ly 2.00	Occa- sion- ally 3.00	Rarely 4.00	Never 5.00	Row Total
Thera- pist 1.00	9 9.5 22.5% 47.4% 11.3%	9 7.0 22.5% 64.3% 11.3%	12 10.0 30.0% 60.0% 15.0%	6 9.0 15.0% 33.3% 7.5%	4 4.5 10.0% 44.4% 5.0%	40 50.0%
Client 2.00	10 9.5 25.0% 52.6% 12.5%	5 7.0 12.5% 35.7% 6.3%	8 10.0 20.0% 40.0% 10.0%	12 9.0 30.0% 66.7% 15.0%	5 4.5 12.5% 55.6% 6.3%	40 50.0%
Column Total	19 23.8%	14 17.5%	20 25.0%	18 22.5%	9 11.3%	80 100.0%

Chi-Square	Value	DF	Significance
Pearson	4.10660	4	.39177
Likelihood Ratio	4.16715	4	.38386
Mantel-Haenszel test for linear association	.70135	1	.40233

Minimum Expected Frequency - 4.500
Cells with Expected Frequency < 5 -- 2 of 10 (20.0%)

Number of Missing Observations: 0

Table 2: Cross tabulation of therapists and clients with the survey item: Spirituality is personally relevant to me.

SUB BY RET

Count Exp Val Row Pct Col Pct Tot Pct	Always 1.00	Fre- quently 2.00	Occa- sion- ally 3.00	Rarely or Never 4.00	Row Total
1.00 Ther- apist	27 25.0 67.5% 54.0% 33.8%	7 5.5 17.5% 63.6% 8.8%	4 5.5 10.0% 36.4% 5.0%	2 4.0 5.0% 25.0% 2.5%	40 50.0%
2.00 Client	23 25.0 57.5% 46.0% 28.8%	4 5.5 10.0% 36.4% 5.0%	7 5.5 17.5% 63.6% 8.8%	6 4.0 15.0% 75.0% 7.5%	40 50.0%
Column Total	50 62.5%	11 13.8%	11 13.8%	8 10.0%	80 100.0%

Chi-Square	Value	DF	Significance
Pearson	3.95636	3	.26622
Likelihood Ratio	4.07062	3	.25394
Mantel-Haenszel test for linear association	2.57199	1	.10877

Minimum Expected Frequency 4.000
Cells with Expected Frequency < 5: 2 OF 8 (25.0%)

Number of Missing Observations: 0

Table 3: Cross tabulation of therapists and clients with the survey item: To what degree do your religious beliefs impact your therapeutic intervention?

SUB BY IMT

Count Exp V Row P Col P Tot P	Always 1.00	Fre- quent- ly 2.00	Occa- sion- ally 3.00	Rarely 4.00	Never 5.00	 Row Total
Thera- pist 1.00	5 5.5 12.5% 45.5% 6.3%	12 11.0 30.0% 54.5% 15.0%	16 13.5 40.0% 59.3% 20.0%	6 7.0 15.0% 42.9% 7.5%	1 3.0 2.5% 16.7% 1.3%	40 50.0%
Client 2.00	6 5.5 15.0% 54.5% 7.5%	10 11.0 25.0% 45.5% 12.5%	11 13.5 27.5% 40.7% 13.8%	8 7.0 20.0% 57.1% 10.0%	5 3.0 12.5% 83.3% 6.3%	40 50.0%
Column Total	11 13.8%	22 27.5%	27 33.8%	14 17.5%	6 7.5%	80 100.0%

Chi-Square	Value	DF	Significance
Pearson	4.15103	4	.38595
Likelihood Ratio	4.40212	4	.35431
Mantel-Haenszel test for linear association	.98799	1	.32023

Minimum Expected Frequency - 3.000
Cells with Expected Frequency < 5 -- 2 of 10 (20.0%)

Number of Missing Observations: 0

Table 4: Cross tabulation of therapists and clients with the survey item: To what degree is spirituality an important part of your therapeutic sessions?

SUB BY IMP

Count Exp Val Row Pct Col Pct Tot Pct	Always 1.00	Fre- quent- ly 2.00	Occa- sion- ally 3.00	Rarely or Never 4.00	Row Total
Thera- pist 1.00	4 5.5 10.0% 36.4% 5.0%	13 11.5 32.5% 56.5% 16.3%	19 14.5 47.5% 65.5% 23.8%	4 8.5 10.0% 23.5% 5.0%	40 50.0%
Client 2.00	7 5.5 17.5% 63.6% 8.8%	10 11.5 25.0% 43.5% 12.5%	10 14.5 25.0% 34.5% 12.5%	13 8.5 32.5% 76.5% 16.3%	40 50.0%
Column Total	11 13.8%	23 28.8%	29 36.3%	17 21.3%	80 100.0%

Chi-Square	Value	DF	Significance
Pearson	8.76730	3	.03255
Likelihood Ratio	9.07761	3	.02828
Mantel-Haenszel test for linear association	.47911	1	.48883

Minimum Expected Frequency - 5.500

Number of Missing Observations: 0

Table 5: Cross tabulation of therapists and clients with the survey item: Do you freely allow clients to discuss issues concerning their spirituality?

SUB BY DIS

Count Exp V Row P Col P Tot P	Always 1.00	Fre-quent-ly 2.00	Occa-sion-ally 3.00	Rarely 4.00	Never 5.00	Row Total
Thera-pist 1.00	27 15.5 67.5% 87.1% 33.8%	10 9.5 25.0% 52.6% 12.5%	2 5.5 5.0% 18.2% 2.5%	1 3.5 2.5% 14.3% 1.3%	0 6.0 0% 0% 0%	40 50.0%
Client 2.00	4 15.5 10.0% 12.9% 5.0%	9 9.5 22.5% 47.4% 11.3%	9 5.5 22.5% 81.8% 11.3%	6 3.5 15.0% 85.7% 7.5%	12 6.0 30.0% 100.0% 15.0%	40 50.0%
Column Total	31 38.8%	19 23.8%	11 13.8%	7 8.8%	12 15.0%	80 100.0%

Chi-Square	Value	DF	Significance
Pearson	37.14312	4	.00000
Likelihood Ratio	44.60226	4	.00000
Mantel-Haenszel test for linear association	34.20570	1	.00000

Minimum Expected Frequency -- 3.500
Cells with Expected Frequency < 5 -- 2 of 10 (20.0%)

Number of Missing Observations: 0

Each table had five figures for each cell: the observed frequency, the expected value, the row percentage, the column percentage, and the total percentage. The directory in the upper left-hand corner explained the numbers used in each table.

As shown in Table 1, the probability that therapists and clients were frequently or always personally involved in an organized religion, given random sampling, was 19 + 14 = 33 out of 80 or 23.8% + 17.5% = 41.3%. The probability that therapists and clients were occasionally personally involved in an organized religion, given random sampling, was 20/80 or 25%. The probability that therapists and clients were rarely or never involved in an organized religion was 18 + 9 = 27 out of 80 or 22.5% + 11.3% = 33.8%.

From the therapist sample 18/40 or 45% were always or frequently involved in an organized religion in contrast to the clients sample of 15/40 or 37.5%. The therapists sample showed 12/40 or 30% occasionally involved in an organized religion compared with 8/40 or 20% of the clients. The therapists sample indicated that 10/40 or 25% rarely or never involved in an organized religion whereas 17/40 or 42.5% of the client sample were.

In a chi-square test, when the expected value was less than five, the observed significance level might

not be correct. When more than 20% of the cells had expected values less than five (see Table 2 and 4), the cells were collapsed, and the chi-square was run again. In Tables 2 and 4, cells four and five were collapsed, thereby combining the responses: rarely and never.

As shown in Table 2, 27 out of 40 or 67.5% of the therapists' sample and 23 out of 40 or 57.5% of the client sample reported that spirituality was personally relevant to them. Of the total participants, 50 out of 80 or 62.5% reported spirituality as always personally relevant. In the total sampling, 61 out of 80 or 76.3% reported spirituality as frequently or always personally relevant for them whereas only 8 out of 80 or 10% rarely or never reported spirituality as personally relevant for them.

As shown in Table 3, the probability that therapists' religious beliefs frequently or always impact their therapeutic interventions, given random sampling, was 17/40 or 42.5% relative to the clients sample of 16/40 or 40% that their religious beliefs frequently or always impact their therapeutic sessions. The probability that therapists' religious beliefs rarely or never impacted their therapeutic interventions was 7/40 or 17.5% contrasted with the clients sample that their religious beliefs impact their therapy sessions, given random sampling, 13/40 or

32.5%.

From the total sample, 34 out of 80 or 42.6% reported spirituality was frequently or always an important part of therapy contrasted with 21.3% who reported spirituality was rarely or never an important part of therapy (see Table 4).

As shown in Table 5, the therapists' sample reported that 37/40 or 92.5% frequently or always allow clients to freely discuss issues concerning their spirituality, juxtaposed with the clients sample that reported 13/40 or 32.5% frequently or always freely discuss issues concerning their spirituality with their therapists. The therapists' sample reported 1/40 or 2.5% rarely or never allow clients to freely discuss issues concerning their spirituality, whereas, the clients' sample reported that 18/40 or 45% rarely or never freely discuss issues concerning their spirituality.

In Table 1 the null hypothesis stated: There was no relationship between personal involvement in an organized religion and the subjects, therapists and clients. The alternative hypothesis stated: There was a relationship between personal involvement in an organized religion and the subjects, therapists and clients. As shown in Table 1, the calculated value of the Pearson chi-square statistic was 4.1066 with four

degrees of freedom, and an observed significance level of .39177. With an alpha risk value (significance level) of .05, if the result is less than .05, that result is statistically significant and the null hypothesis would be rejected. In Table 1 since .39177 was greater than .05, the null hypothesis was not rejected. There was no relationship between personal involvement in an organized religion and the participants (therapists and clients).

In Tables 1, 2 and 3 the researcher failed to reject the null hypothesis. In Table 2 after collapsing the cells, 25% of the cells still have expected values less than five. Therefore this chi-square was suspect. However, in Tables 4 and 5 the null hypothesis was rejected, and with a 95% confidence the alternative hypotheses for the tables were accepted. Therefore, there is a relationship between the variables. The variables were: "To what degree is spirituality an important part of your therapeutic sessions" and the "subjects, therapists and clients." There is also a relationship between the variables: "Do you freely allow clients to discuss issues concerning their spirituality," and the "subjects, therapists and clients."

Correlation Analysis

Participants as a total sample were correlated with their responses to the five questions (see Table 6). The five survey items were correlated with each other (see Table 7). The unit of measurement was comparative, or ordinal. As shown in Table 6, (SUB correlated with ORG), the variables compared were therapists and clients with survey item number one: "I am personally involved with an organized religion?" In each cell of the table there were three numbers. The first number was the value of the coefficient, the "r" value. The second value was the number of the cases used to calculate it (80 cases in this study). The third number was the observed significance level.

The value of the correlation coefficient for subjects with survey item number one was .0942. This figure was based on 80 cases. The probability was less than .406 that one would observe, in such a sample, a correlation coefficient larger than positive .0942 or smaller than negative .0942 when the value in the population was zero. The null hypothesis stated that the variables were independent. The variables were: "I am personally involved with an organized religion," and the "total sample." There was no relationship between the variables. The alternative hypothesis stated that the variables were not independent. They were related.

Table 6: SUB (subjects, therapists and clients) correlated with their responses to the five survey items

CORRELATIONS: SUB

ORG	.0942 (80) P = .406
RET	.1763 (80) P = .118
IMT	.1118 (80) P = .323
IMP	.1322 (80) P = .242
DIS	.6580 (80) P = .000

(Coefficient / (Cases) /Two-tailed Significance)

Table 6 and Table 7 label variables:

ORG = I am personally involved in an organized religion.
RET = Spirituality is personally relevant to me.
IMT = To what degree do your religious beliefs impact your therapeutic sessions? (for clients)? your therapeutic interventions? (for therapists)
IMP = To what degree is spirituality an important part of your therapeutic sessions?
DIS = Do you freely discuss issues concerning your spirituality with your therapist? (for clients)
DIS = Do you freely allow clients to discuss issues concerning their spirituality? (for therapists)

TABLE 7: ORG, RET, IMT, IMP, and DIS (the five survey items) correlated with each other

CORRELATIONS:

	ORG	RET	IMT	IMP	DIS
ORG	1.0000 (80) P= .	.4899 (80) P= .000	.4417 (80) P= .000	.4733 (80) P= .000	.3198 (80) P=.004
RET	.4899 (80) P= .000	1.0000 (80) P= .	.4583 (80) P= .000	.5728 (80) P= .000	.4845 (80) P=.000
IMT	.4417 (80) P= .000	.4583 (80) P= .000	1.0000 (80) P= .	.5963 (80) P= 000	.3776 (80) P=.001
IMP	.4733 (80) P= .000	.5728 (80) P= .000	.5963 (80) P= .000	1.0000 (80) P= .	.4693 (80) P=.000
DIS	.3198 (80) P= .004	.4845 (80) P= .000	.3776 (80) P=.001	.4693 (80) P=.000	1.0000 (80) P= .

(Coefficient / (Cases) / two-tailed significance)
"." is printed if a coefficient cannot be computed

The calculated values were positive .0942 showing a positive correlation. As SUB increased, ORG increased. If r equaled .0942, r squared equaled .0089. The observed significance level, p equaling .406 was greater than alpha, .05, thereby accepting the null hypothesis. The correlation coefficient of zero did not mean that there was no relationship between the two variables. The Pearson correlation coefficient only measures the strength of a linear relationship (Norusis, 1991). A strong nonlinear relationship could exist.

As shown in Table 7, each row and column represented one of the variables with ordinal unit of measurement. When ORG was correlated with RET, the value of the correlation coefficient was .4899. This figure was based on 80 cases. The probability was less than .005 that one would observe, in such a sample, a correlation coefficient larger than positive .4899 or smaller than negative .4899 when the value in the population was zero. The null hypothesis was: The variables ORG and RET were independent. There was no relationship between them. The alternative hypothesis was: (ORG) I am personally involved in an organized religion and (RET) spirituality is personally relevant to me were not independent. They were related.

The calculated values were .4899, showing a positive correlation. As (ORG) increased, (RET) also increased. If r equaled .4899, r squared equaled .24. The observed significance level, p equaling .000 was less than alpha, .025 (two tailed) significance, thereby rejecting the null hypothesis. Therefore, there was a relationship between the two variables, (ORG) and (RET). Since the statistic r equaled .4899 and r squared equaled .24, only 24% of variation in y was accounted for by the variation in x.

When ORG was correlated with IMT (see Table 7), the calculated value, the statistic r, was .4417. This correlation indicated a positive relationship. As ORG increased, IMT also increased. The null hypothesis was: The variables ORG and IMT were independent. There was no relationship between them. The alternative hypothesis was: ORG and IMT were not independent. They were related. The "p" value of .000 was the significance level. When compared with an alpha of .025 (two-tailed), the significance level was less than alpha, therefore, the null hypothesis was rejected. With 95% confidence level, the variables ORG and IMT were not independent but were dependent. There was a relationship between them. Since the statistic r equaled .4417 and r squared equaled .195, only 19.5% of variation in Y was accounted for by the variation in X. Since the significance level on each of the variables in Table 7 were less than an alpha of .025, when correlated with one another, each of the variables showed a positive relationship.

Description of Survey Item Number Six

Forgiveness ranked number one by 21.3 % and number two by 13.8% as the issue therapists and clients currently incorporate or discuss integrating spirituality and counseling. Self-esteem/God's love ranked number one by 15% of the total sample. Image of a Higher Power ranked number one by 11.3% of the participant sample. 8.8% of the total sample chose "none of the above" and therefore did not choose any other item. Of the therapists and clients, 17.5% ranked healing of life's hurts (memories) as second. 13.8% of the therapists and clients ranked guilt as the number two issue for them, while 13.8% ranked guilt as the number four item in their therapy. Of the total sample, 15% ranked grief third, while 10% ranked death third; 8.8% of the participants ranked sexuality as fourth for them. Thereafter, first to least in importance were anger, prayer, dream work, and after-life.

Chapter V

Discussion

The discussion is divided into three sections: (a) implications, (b) limitations, (c) recommendations for future study.

Implications

The null hypothesis for this research study states: Spirituality issues are independent of counseling. The alternative hypothesis states: Spirituality issues are not independent of counseling/ Spirituality is a part of a whole person approach integrating mind, body, and psyche (soul), therefore, spirituality issues are integrated in counseling/psychotherapy. The findings of this study do not disprove the null hypothesis. However, the study suggests that there is a relationship between spirituality and counseling.

The chi-square analysis for survey items four, and five, show that a relationship exists between the variables. These two items are directly related to the integration of spirituality and counseling. Correlation of subjects by survey item five (freedom to discuss spirituality issues in counseling), also shows that a relationship exists between the variables. Correlation of the five survey items with each other, show a relationship exists between all five of the

survey items.

Chi-square results for this survey show that therapists are more highly involved in organized religion than clients are. In the literature review from a 1985 Gallup survey, Kroll and Sheehan had concluded (in Pete and Bondi, 1992) that 90% of the general public profess a belief in God compared with 43% of psychologists. The results of this survey show the reverse; therapists are more involved in organized religion than clients are. However, this survey indicates more clients than therapists find that their religious beliefs impact their therapeutic sessions.

This survey points to a strong discrepancy in the way therapists see themselves freely allowing their clients to discuss issues concerning their spirituality and the clients' freedom to discuss issues concerning their spirituality. In the total sampling, 76.3% indicate their spirituality is frequently or always relevant, and yet 23.8% of participants report they rarely or never freely discuss spiritual issues in counseling. The 76.3% of the total sampling supports the alternative hypothesis and the literature review that spirituality is an integral part of holistic health. A question raised by this survey is: What makes some therapists integrate spirituality in counseling where others do not? If spirituality has

such a high degree of relevance for both therapists and clients, what keeps spirituality issues from being discussed in therapy? Therapists are trained not to impose their own values and beliefs upon their clients; are they instead possibly unconsciously impeding clients from integrating the client's spiritual issues?

For survey item number six in which therapists and clients ranked issues, 35% of the therapists and clients sample rank forgiveness as their first or second priority currently discussed in therapy. Studies noted in the literature review (DiBlasio, 1992; Enright et al., 1992; Hebl & Enright, 1993; Levin & Coreil, 1986) suggest the value of integrating forgiveness for client healing toward holistic health. Other issues receiving high priority by therapists and clients are self-esteem, God's love, image of a "Higher Power," healing life's hurts, guilt, grief, and death. These results support the alternative hypothesis that spirituality is not independent of counseling, but part of an approach to the whole person.

This survey indicates the importance of a transcendent relationship for both clients and therapists. From the literature review, the findings of Noble, who had studied transcendent experiences among a variety of populations, documented higher levels of psychological well-being among those who have

had transcendent experiences than among those who have not (Westgate, 1996). Facilitating clients in owning and integrating their transcendent experiences could lead to deeper client self-actualization.

The twelve steps Alcoholics Anonymous program is based on belief in a Higher Power. As noted in the literature review, Warfield and Goldstein (1996) saw spirituality as the key to recovery from alcoholism. And yet they found, unfortunately for the alcoholic, the spiritual aspect was most often de-emphasized in treatment programs. From the literature review, Richards, Owens, and Stein (cited in Westgate, 1996) found improvement in depression levels following cognitive therapy with a religious/spiritual component.

In this study, item number six shows that prayer ranks low as a value for therapists and clients in counseling. However, in the literature review, studies show contemplative prayer as an essential ingredient of positive mental health (Finney & Maloney, 1985a, 1985b). Benson had found (in Hilts, 1995) that when he offered patients a variety of suggestions that included prayer, 80% chose prayer. Perhaps the clients in this survey have either not been given a choice, or do not understand the difference between contemplation and verbal prayer. The review of the literature indicated both in the medical field (Reed, 1992) and in

psychology a movement toward integrating various dimensions of the person from a wholistic perspective.

Limitations

Limitations of the study might be random sampling and survey design. Some persons filling out the survey professed to be agnostic. However, since one third of the therapists' sample attended John Thekkedam's seminar on the integration of spirituality and counseling, those therapists would likely have been biased in favor of the integration. Random sampling could be suspect.

In regard to the design of survey, in the section on demographics, the client and therapist surveys use two separate increment amounts for yearly income, making analysis difficult. With item number six subjects choose and then rank a different number of items, also making analysis difficult. The items chosen and ranked lend support to the study, and warrant greater research and analysis.

On the survey, because religion and spirituality are not defined, clarity suffers. Participants use their own subjective interpretation. The meaning for different people may not have been consistent. Some persons do not attend a weekly traditional church but participate in an organized church renewal. The researcher intended to be open to all spiritualities,

but one participant did not answer item number six, commenting, "I am a Buddhist. I don't believe in God." The researcher discovered the underlying spirituality in the survey implied a Judeo-Christian approach. That survey was not used. The survey items might be set up in such a way to more directly relate to the stated hypothesis. Therapists might be asked to designate to what degree their therapeutic practice is Holistic (with Holistic Health defined).

Recommendations for Future Studies

Suyemoto and MacDonald (1996) suggest that further research into religious beliefs may help psychologists in a quest to understand the motivations and needs of human beings. They stated that religious beliefs could serve as a resource in helping clients realize their full potential. The most important aspect of holistic health is preventive interventions. They suggested hypothesis such as, (a) because beliefs in a Transcendent Other help individuals feel less helpless, they combat feelings of depression and despair; (b) because spirituality helps individuals feel connected to others and less isolated, they combat psychopathology; (c) because a belief in the soul and the afterlife significantly affects the grieving process, spirituality helps people cope with loss of a significant other.

Studies on forgiveness suggest a deficit in the theoretical application of forgiveness techniques to therapeutic practice (DiBlasio, 1992; DiBlasio & Benda, 1991; DiBlasio & Proctor, 1993). The study by DiBlasio and Proctor (1993) noted that of over 2,000 articles in four psychiatric journals between 1978 and 1982; only 59 included a quantified religious variable. They concluded that a serious deficiency exists in the knowledge of the dynamics of religious beliefs and psychiatric treatment. Clinicians reported the usefulness of forgiveness for healing, but empirical evidence is scarce (DiBlasio & Benda, 1991). Pettitt (1987) suggested the amount of drug usage warrants more research in the area of forgiveness. Unresolved grief issues at times suggest a need for forgiveness. Since forgiveness ranked as first and second priority among therapists and clients, more research in this area is warranted.

The researcher recommends more research studies be done on the value of solitude and contemplative prayer for holistic health. The literature review indicated longer life with a simpler life style and contemplative approach. From the researcher's experience, solitude in the presence of an all loving transcendent being heals, renews, deepens the quality of life, and enhances creativity in response to life's problems.

Due to the dichotomy that has existed between spirituality and psychology, the researcher with background and training in spirituality, suggests an attitude of openness for experimentation and learning that spirituality might be integrated for holistic health in assisting clients on their journey in developing their full potential.

Appendix A

Westgate (1996) used four dimensions of spiritual wellness for client exploration and assessment:

1. Meaning in life: What provides the client with a sense of direction and meaning in life? To what extent has the client explored her or his spirituality? How has the client's spirituality affected her or his sense of well-being?
2. Intrinsic values: What role does spirituality play in the client's values? Is the client's value system based on external, visceral considerations or on internal, stable factors? Are the client's spiritual beliefs functional or dysfunctional?
3. Transcendence: Does the client believe in a "higher power" or in some force or plan greater than herself or himself? Does the client view this relationship as a source of support and guidance or of punishment and retribution?
4. Spiritual community: Is a spiritual community a part of the client's support system? Does the client's spiritual community provide support for the client as well as opportunities for the client to be

supportive of others?

Dombeck and Karl (1987) gave these guidelines for taking a religious history:

1. Placement within a religious community. Religious affiliation? Changes in religious affiliation? When did changes take place? What is the level of present involvement? What is the relationship with pastor and community?
2. Personal meanings attached to symbols, rituals, beliefs, and divine figures. What religious practices are most meaningful? When and in what ways does one feel close to the divine? What does one pray about? When? Where? What gives special strength and meaning?
3. Relationship to religious resources. What is your image of God? [added by researcher] What is relationship with God? How is God involved in your problems? Has there ever been a feeling of forgiveness?

ATTITUDINAL SURVEY: FOR THERAPISTS **Appendix B**

AGE: (1) (2) (3) (4) (5)
____30 or below ____31-40 ___41-50 ____51-60 ____61 or over

SEX: ____female (1) _____male (2)

RACE: ___Hispanic (1) ____Afro-American (2) ____Asian (3)
___Caucasian (4) ___Other (5)

ECONOMIC STATUS (Income per year):
___20,000 or less (1) ___20.001-45,000 (2) ___45,001-70,000 (3)
___70,001-95,000 (4) ___95,001-120,000 (5) ___120,001+ (6)

EDUCATION:
___ Elem(1) ___ (HS)(2) ___BA(3) ____MA(4) ____PhD(5) ____PhD+(6)

YEARS PRACTICING:
___5 yrs and under(1) ___6-15 years(2) ___16-30 yrs(3) ___30+(4)

1. I am personally involved with an organized religion?
____always ____frequently ____occasionally ____rarely
____never

2. Spirituality is personally relevant to me?
____always ____frequently ____occasionally ____rarely
____never

3. To what degree do your religious beliefs impact your therapeutic intervention?
____always ____frequently ____occasionally ____rarely
____never

4. To what degree is spirituality an important part of your therapeutic sessions?
____always ____frequently ____occasionally ____rarely
____never

5. Do you freely allow clients to discuss issues concerning their spirituality?
____always ____frequently ____occasionally ____rarely
____never

6. What specific issues do you currently incorporate integrating spirituality and counseling (therapy)? Rank items first to least in importance 1, 2, 3, etc.

____forgiveness (God, self, others)
____anger toward God
____guilt
____grief
____sexuality
____image of higher power
____healing life's hurts (memories)
___prayer
___self-esteem/God's love
___dream work
___death
___after life
___none of the above

ATTITUDINAL SURVEY: FOR CLIENTS **Appendix C**

AGE: (1) ____30 or below (2) ____31-40 (3) ____41-50 (4) ____51-60 (5) ____61 or over

SEX: ____female (1) _____male (2)

RACE: ___Hispanic (1) ____Afro-American (2) ____Asian (3)
___Caucasian (4) ____Other (5)

EDUCATION:
___Elem(1) ___HS(2) ____BA(3) ____MA(4) ____PhD(5) ___PhD+(6)

ECONOMIC STATUS: (Income per year)
___10,000 or less (1) ___10,001-35,000 (2) ___35,001-60,000 (3)
___60,001-85,000 (4) ___85,001-110,000 (5) ___110,001+ (6)

YEARS AS A CLIENT:
___less than 6 months (1) ___6 months to less than 1 year (2)
___1 year to less than 3 years (3) ___3 years + (4)

1. I am personally involved with an organized religion?
____always ____frequently ____occasionally ____rarely
____never

2. Spirituality is personally relevant to me?
____always ____frequently ____occasionally ____rarely
____never

3. To what degree do your religious beliefs impact your therapeutic sessions?
____always ____frequently ____occasionally ____rarely
____never

4. To what degree is spirituality an important part of your therapeutic sessions?
____always ____frequently ____occasionally ____rarely
____never

5. Do you freely discuss issues concerning your spirituality with your therapist?
____always ____frequently ____occasionally ____rarely
____never

6. What specific issues do you discuss in your therapy sessions in relationship to your spirituality? Rank items first to least in importance 1, 2, 3, etc.

____forgiveness (God, self, others)
____anger toward God
____guilt
____grief
____sexuality
____image of higher power
____healing life's hurts (memories)
___prayer
___self-esteem/God's love
___dream work
___death
___after life
___none of the above

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Vita Auctoris

My name is Mary Ann Theresa Bernadette Kniess. I was born on October 8, 1948 in Galveston, Texas as the tenth child of Evelyn Frane and Myron Kniess. At the age of four I moved with my nine sisters and two brothers to a farm near Bowling Green, Missouri. My schooling began at St. Clement Parish (1954-1962) in Bowling Green, Missouri. My education continued at the Bowling Green Public High School (1962-1964). I wanted to give my life to God. I entered the Precious Blood religious congregation of O'Fallon, Missouri, and made first vows in August, 1972 with final vows in August, 1974. Through a life of prayer, community, and service I received and nurtured life and love. My education continued at St. Mary Junior College in O'Fallon, Missouri, with a Liberal Arts program (1966-1968). At Fontbonne College (1968-1971) in St. Louis, Missouri, I majored in mathematics with a minor in theology.

I taught elementary students at St. Stephen Parish (1971) in St. Louis, Missouri; Assumption Parish (1972-1975) in O'Fallon, Missouri; St. Pius X Parish (1975-1978) in San Antonio, Texas; and St. Brendan Parish (1979-1980) in Mexico, Missouri. I taught high school theology at St. Elizabeth High School (1978-1979) in St. Louis. At St. Sabina Parish (1980-1984) in Florissant, Missouri, I did home visitation and was

adult education coordinator.

In 1982 I received a Master's Degree in Christian Spirituality at Creighton University in Omaha, Nebraska. I served as secretary with Inter-Community Consultants (1984-1986) in St. Louis. After three months of Spanish language study in Antigua, Guatamala, I served as adult education coordinator, and worked in evangelization with people of Hispanic origin at Assumption Parish (1986-1988) in Harlingen, Texas. I continued leadership training for Bible Studies, neighborhood base communities, and the city-wide baptismal program for parents who wanted their children baptized.

I served as religious education area coordinator (1988-1990) with the Corpus Christi Diocese in Texas. In this position I was an adjunct faculty member in adult formation for Incarnate Word College, San Antonio, Texas, and continued leadership training programs for Bible Study faith sharing groups, and neighborhood base communities.

After 24 years of religious life, I experienced the Lord calling me through religious life to something else. That something else is still unfolding. I spent eight months in prayer and discernment, then served as radio dispatcher (1990-1994) for Ralls County Sheriff's Office in New London, Missouri. During my discernment

a vision for holistic ministry (I prefer the spelling, wholistic), integrating spirituality and counseling with alternatives to the medical model, unfolded. In January, 1994, I began this Professional Counseling degree to prepare for such a ministry. Presently I am administrative assistant to Biobehavioral Health Institute (1996-present) in Fairview Heights, Illinois.

John K. Thekkedam, Ph.D. and I plan to minister together here and in India, networking with others, focusing on what unites rather than on what divides, to build global faith community. Upon reading this document, if you have an interest in networking with us for ministry, write or call, Mary Ann Kniess, at P. O. Box 74, Saverton, Missouri, 63467; 800-618-3067.

"Vita" in Latin means life. It is by continually centering in God's life and love that I receive life. The theme for my religious profession 23 years ago was taken from a song: God has touched me with love, and I want to pass it on. It only takes a spark to get a fire going, and soon all those around, are warmed within its glowing. That's how it is with God's love, once you've experienced it, it's fresh like spring, you want to pass it on (The song, Pass It On, author unknown). I trust God to use my talents and gifts for the betterment of society while at the same time taking care of my needs.