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The Integration of Spiritual and Religious Issues in Racial-Cultural Psychology and Counseling

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The Society for the Study of Ethnic Minorities convened a special program on spirituality at the year 2000 National Convention of the American Psychological Association, with Joseph Trimble delivering a presidential address entitled "Spiritual Affinity and Its Influence on Acculturation and Ethnic Identification." In that message, Trimble emphatically stated, "We can no longer ignore what is so basic and fundamental to three-fourths of the world's population … The academy has ignored spirituality. As of today, that ends!" His address received a prolonged standing ovation.

A new movement has begun. Spirituality and religion are being integrated into racial-cultural psychology and counseling. This chapter will review the literature that is the basis of that movement. We first describe the historical forces alluded to by Trimble (2000) that until only recently have minimized the relevance of religion and spirituality to psychological research and practice. We then summarize the potential benefits and concerns about incorporating spiritual and religious perspectives into research and practice that have been suggested in publications of the past 30 years. To demonstrate that religion and spirituality are central to racial-cultural psychology and counseling, literature describing the complex relationship between mental health, race and culture, and religiosity/spirituality is reviewed, as well as the literature investigating the relationship between religion and racism. Recommendations for future scholarship are provided in the concluding section of the chapter.

Some authors define religiousness as an individual’s degree of involvement in an organized religion and its accompanying system of worship, rituals, and doctrines and spirituality in terms of private/personal transcendent beliefs and actions (e.g., Kelly, 1995;
Richards & Bergin, 1997). In this chapter we assume that religiousness and spirituality are highly interrelated and that both are salient to racial-cultural issues and to mental health. Given that the term *faith* can describe “the spiritual apprehension of … realities beyond the reach of sensible experience or logical proof,” (Oxford University Press, 2002) the generic term *faith* will sometimes be used to describe the combination of the religious and spiritual (see also Fowler, 1981).

As we present this review of the literature relevant to issues of faith, we acknowledge that many consider spiritual and religious experiences sacred, beyond description, or intensely personal. In our desire to appreciate all perspectives, we acknowledge the limitations in our coverage of the topic. Nevertheless, we hope that this chapter will facilitate future scholarship needed for faith to become a defining force in the field.

Review of the Professional Literature

*Historical Trends of the Literature Addressing Religion and Spirituality*

As publications in racial-cultural psychology and counseling have so clearly demonstrated, the assumptions and values of European and European American cultures have constrained the validity of mental health practices and research since their foundation (Carter, 1995; Helms & Cook, 1999). One of those foundational assumptions is that human behavior can be completely explained by observable natural phenomena. All alternative explanations have been considered untenable, including the existence of spiritual forces or beings. The formation of psychology as an academic discipline in the late 1800s in Europe and North America was partly a reaction *against* religious approaches to the study of human behavior (Haque, 2001; Richards & Bergin, 1997).
Given that historical context, for many decades spirituality and religion were largely considered irrelevant to mental health, dismissed from serious discussion, and even scorned by professionals in the field (Bergin, 1980). Some scholars went so far as to portray religion as harmful to mental health. Most notably, Freud (1927), Watson (1924), Skinner (1971), and Ellis (1971) sought to liberate individuals professing faith in spiritual or religious beliefs with strong doses of rationalism, skepticism, and determinism. Throughout most of the previous century, during which time psychology and counseling developed and flourished, religion and spirituality were either ignored or repudiated by the profession.

In such a critical climate, few defended the relevance of religion and spirituality to mental health. Notable exceptions, however, are found in the work of William James (1936), Carl Jung (1933), Gordon Allport (1950), Erik Erikson (1985), Abraham Maslow (1964), and Rollo May (1982), all of whom recognized that spirituality is a fundamental component of human experience. James (1936) undertook a philosophical approach to the study of religion, delineating the benefits and limitations of religiosity and emphasizing the spiritual aspects of human experience. Jung (1933) took an analytic approach to faith, acknowledging spirituality as a source of meaning and psychic wholeness. Allport (1950) took a social psychological approach, emphasizing differences between religiosity for intrinsic means and religiosity for extrinsic means. Erikson (1985) asserted that religion helps children internalize the faith, trust, and ego for healthy development and provides meaning, certainty, and hope throughout the lifespan. Maslow (1964) encouraged scientific study of religion so as to better understand the process of self-actualization and spiritual “peak experiences.” May (1982) also emphasized the need for spiritual meaning and self-transcendence. A review of current publications relevant to
religion and spirituality emphasizes the importance of these scholars, with current writings on the topic still reflecting many of the ideas and concepts they advanced.

Although these notable scholars and their followers referred to the importance of religion and spirituality to mental health in theoretical terms, there was little empirical research on the topic until the second half of the 20th century. This research was inconsistent and limited in scope and quality. In the 1970s several reviews appeared (Argyle & Beit-Hallahmi, 1975; Malony, 1977; Strommen, 1971) that set the stage for an increase in the quality of scholarship, catalyzed further by Allen Bergin’s call to the profession in 1980, theoretical work by James Fowler (1981), and reviews by Batson and Ventis (1982) and Bergin (1983), among others. The figurative floodgate to publication opened during the 1980s and was swept away in the 1990s, with literally hundreds of subsequent empirical studies (re)affirming the salience of religiosity and spirituality to mental health research and treatment (Batson, Schoenrade, & Ventis, 1993; George, Larson, Koenig, & McCullough, 2000; Koenig, McCullough, & Larson, 2001; McCullough, 1999; Payne, Bergin, Bielema, & Jenkins, 1991; Smith, McCullough, & Poll, in press; Worthington, Kurusu, McCullough, & Sandage, 1996). A deluge of empirical research challenged decades of criticism that the study of religious and spiritual influences upon mental health was neither scientific nor productive.

Although recent research findings are complex and sometimes inconsistent, the clear majority of empirical studies during the past two decades have observed positive associations between faith and wellness (e.g., Koenig et al., 2001). For example, numerous studies exploring the relationship of religious commitment to psychological adjustment and life satisfaction have found that people who are religiously devout but not extremists tend to report greater subjective well-being and life satisfaction, greater marital satisfaction and family cohesion, more ability to
cope with stress and crises, less depression, and less worry and guilt than others (Batson et al., 1993; Gartner, 1996; George et al., 2000; Payne et al., 1991). Similarly, a large number of studies have explored the relationship of religious affiliation and commitment to various indicators of social conduct. In general, the findings indicate that religiosity is inversely related to alcohol and drug abuse, delinquency and criminal behavior, suicide, teen pregnancy, and divorce (Gartner, 1996; Koenig et al., 2001; Payne et al., 1991).

Not all of the research findings on religion and mental health have found a positive relationship. There is some evidence that religiosity may be positively associated with authoritarianism, dogmatism, rigidity, suggestibility, and dependence (Batson et al., 1993; Gartner, 1996). Due to inconsistent findings, the relationships of religiosity to self-esteem and anxiety are unclear (Batson et al., 1993; Gartner, 1996). There is also a marked absence of research examining the relationship of religious devotion and serious mental illness or impairment (Payne et al., 1991).

Some researchers have challenged the negative and ambiguous associations between religiosity and psychological adjustment. They cite that these findings are largely based upon paper and pencil personality tests that are subject to a variety of possible psychometric and researcher biases (Bergin, 1983; Gartner, 1996). In contrast, many of the positive associations have been observed on “‘real life’ behavior events that can be directly observed and reliably measured” (Gartner, 1996, p. 201). The preponderance of current evidence points to a beneficial influence of religion on psychological and social functioning.

However, few scholars would assert that all forms of religion are healthy or beneficial. Some religious beliefs, practices, or manifestations are clearly dysfunctional and even pathological, such as purported demonic possession, scrupulosity (obsessive over-concern for
one’s sinfulness), religious delusions and compulsions, and mass suicides of religious cult members (Galanter, 1996; Meadow & Kahoe, 1984; Meissner, 1996). Furthermore, abuses of religious leadership and principles can occur, leaving adherents disillusioned or injured (Benyie, 1998).

Unfortunately, most research on mental health and faith has been correlational. Therefore although we know that the two constructs are usually positively related, we know little about what factors moderate or mediate their relationship. Future research in the area needs to address several sets of potential moderators and mediators to better explain how mental health and faith are related. First, the impact of social involvement warrants scrutiny. It may well be that participation in an organized religion enhances social support, which is a known buffer of stress and pathology (Joiner & Coyne, 1999). Less common than the pervasive but indirect benefit of socializing are direct services or charities provided by some churches to members experiencing economic or emotional distress. Informal pastoral counseling may also alleviate psychological or emotional distress. Second, variables related to self-disclosure should be examined. It may be that the norms of certain faith communities sanction (or oppositely, stigmatize) the admission of personal limitations, thus creating a forum for self-disclosure that has been strongly associated with positive outcomes (Pennebaker, 1997). Testimonials, public speaking opportunities, and other group processes may encourage individuals to process emotional content in supportive settings, similar to group therapy (McRae, Carey, & Anderson-Scott, 1998). Third, cognitive strategies may play a role. Spiritual perspectives may have the effect of increasing hopefulness and optimistic beliefs, which are widely known to enhance psychological functioning (e.g., Seligman, 1990). It may be that individuals who express a faith in principles or in powers that cannot be proven are simply more ready to suspend
disbelief/doubt than are others. Similarly, religious practices may sometimes create a positive distraction from ruminative or self-critical thinking (Nolen-Hoeksema, 1991). It may also be that spirituality supports a perspective on the value of life and on passage of time that is conducive to mental health (e.g., Carstensen, Isaacowitz, & Charles, 1999). Finally, issues of behavioral congruence should be examined. It may be that individuals who report high levels of faith are also more likely to report personal behavior that matches their expectancies/values. Such congruence between one’s beliefs and actions is predictive of mental health (Maddux, 1995). In sum, investigation of these and other potential moderating and mediating variables will be necessary for future scholarship to effectively integrate issues of faith with racial-cultural psychology and counseling.

Integration of Religion and Spirituality with Racial-Cultural Psychology and Counseling

From a historical perspective, scholars working in the 1950s and 1960s to advance a multicultural agenda and those interested in integrating religious and spiritual issues into psychology and counseling had the same goal: to gain wider recognition and respect in the field and, eventually, to change the profession itself. During the 1970s and early 1980s when mainstream psychology began to openly acknowledge some of its major errors and omissions (racial inequities and injustices, etc.), arguments supporting spirituality and religion also gained some audience (Richards & Bergin, 1997). Despite these similar aims and despite the similar historical struggle to overcome biases in the larger field, the development of literature specific to religious and spiritual issues was for many years separate from and parallel to the literature advocating multicultural and racial-cultural perspectives. The two literatures were characterized by separate scholarly networks, professional associations, journals, and to some degree worldviews. Nevertheless, there were notable exceptions to this general trend.
Beginning primarily in the 1960s, articles began to appear on the unique mental health contexts of individuals from specific cultural-religious groups (e.g., North African Muslims, Jamaican Rastafarians). These types of articles provided information useful to psychological practice, but they were mostly opinion papers and rarely contained empirical data. The number of articles and book chapters of this kind steadily increased in number during the 1970s and 1980s, and they remain common in the current literature (e.g., Garrett, 1999; Baez & Hernandez, 2001).

However, some articles appearing in the 1980s and early 1990s went beyond describing spiritual and religious issues of specific racial and cultural groups to advocate changes within the field itself, coupled with an open acknowledgement of issues of faith generally (e.g., Bishop, 1992). This type of advocacy increased substantially through the late 1980s to mid 1990s, when empirical reports and papers by scholars already recognized for their work in the multicultural literature began to take up the issue. For example, Courtland Lee (Lee, Oh, & Mountcastle, 1992) wrote on indigenous healing methods and on the spiritual and religious influences that need to be considered by counselors in their work. Similarly, Clemmont Vontress (1996) reported on the relevance of traditional spiritual forms of healing in Africa and on existential approaches to treatment. Nancy Boyd-Franklin (1989) addressed the salience of religious issues in African American families. These and other authors strengthened the sense of credibility behind such scholarship efforts.

Among the major contributions of the late 1980s and early 1990s was the work of Linda James Myers (1988). Grounded in an African worldview, Myers’ Optimal Theory takes an explicitly spiritual perspective of psychology: “Human beings are the expression of what can be defined as energy, spirit, consciousness, or god/goddess” (Myers & Speight, 1994, p. 103).
Optimal Theory asserts that each individual is part of a much larger whole, a unified consciousness that includes past and future generations. Optimal Theory therefore emphasizes interrelatedness and interdependence as the foundation for mental health. From this perspective, dysfunction and distress occur when individuals fail to recognize their connections with others, becoming fragmented as they base their identity and worth on external criteria such as material possessions. In sum, Optimal Theory translates traditional African perspectives on life and healing into contemporary psychological terms, infusing psychotherapy and counseling with insight rich with wisdom collected over centuries. Optimal Theory has been used to develop a model of identity development (Myers et al., 1991) and used to advocate for a shift of emphasis in multicultural approaches to treatment, training, and research (Speight, Myers, Cox, & Highlen, 1991). Clearly, Optimal Theory and the similar African-centered models of Akbar (1995) and Philips (1990) represent the potential for scholars to effectively combine cultural and spiritual perspectives that inform psychology and counseling.

During the late 1990s more and more authors joined the chorus of publications advocating the integration of issues of faith into racial-cultural psychology and counseling. Special issues of Multicultural Counseling and Development and Counseling and Values addressed the overlap of racial-cultural and spiritual themes, and the journal Mental Health, Religion, and Culture was created to service increased scholarship in the area. At the same time, the number of presentations on the topic at national professional conventions increased exponentially. For example, Sue, Bingham, Porche-Burke, and Vasquez (1999) identified spirituality as a basic dimension of humanity, one of the five major themes of the first National Multicultural Conference and Summit. They affirmed that "understanding that people are
cultural and spiritual beings is a necessary condition for a psychology of human existence" (p. 1065), thus confirming the place of spirituality in the multicultural revolution.

Scholarly books on the topic began to appear in the late 1990s, among them Mary Fukuyama and Todd Sevig’s Integrating Spirituality into Multicultural Counseling (1999) and P. Scott Richards and Allen Bergin’s edited Handbook of Psychotherapy and Religious Diversity (2000). Fukuyama and Sevig present a comprehensive overview of the topic, using the multicultural literature as a foundation. They cover differences in religious and spiritual worldviews across racial groups, and they parallel competencies for working with racial issues to competencies for working with issues of faith. The process of spiritual development and specific spiritual techniques for working with clients are detailed. Most important, they provide models of training and practice that made religious and spiritual issues explicit. Richards and Bergin’s Handbook provides descriptions of 12 religious groups found in North America, along with chapters specific to the faith issues of 4 racial-cultural groups. Each chapter provides concrete, specific information on a denomination, including unique mental health issues, attitudes toward psychotherapy, and attitudes toward potentially problematic issues of perfectionism, sexuality, abortion, substance use, etc. Specific racial-cultural influences on spirituality are detailed, as are relevant historical, political, and social factors that contribute to the heterogeneity of beliefs within each group.

In addition to these major contributions, textbooks on multicultural and racial-cultural psychology and counseling have begun to devote chapters to religious and spiritual issues (e.g., Pedersen, Draguns, Lonner, & Trimble, 2002; Smith, 2004; Trusty, Sandhu, & Looby, 2002). The number of journal articles on the topic is also increasing exponentially. Nevertheless, despite the increase in professional interest, very few empirical studies have examined the
interactions among race, culture, faith, and mental health (Richards & Bergin, 2000). This is a glaring deficiency in the field.

Moreover, most of the extant research on religion and mental health has been done with European and European American Protestants and Roman Catholics. Thus the research findings of a positive relationship between religiosity/spirituality and mental health have been based largely on samples of Whites and Christians. Clearly, major problems of external validity need to be overcome (Sue, 1999). And despite ample anecdotal evidence that faith beliefs and faith communities are a benevolent influence in many other racial groups (e.g., Garrett, 1999; Mbiti, 1990; Richards & Bergin, 2000), additional research studies are needed to confirm or refute the rationale for integrating spiritual and religious issues with racial-cultural psychology and counseling.

Rationale for Integrating Spiritual and Religious Issues with Racial-Cultural Psychology and Counseling

As emphasized in many recent publications, there are several compelling reasons for integrating spiritual and religious issues in racial-cultural psychology and counseling (e.g., Fukuyama & Sevig, 1999). First, such an approach represents global demographics. In North America, the vast majority of people hold spiritual convictions, with most affirming the importance of those beliefs to their lives and well-being (Gallup, 1995). The same trend typifies most world populations (Keller, 2000; O'Connor, 1998). Spirituality appears to be central to the experiences of most humans. However, even if spirituality and religion were valued by a small minority of the population, other compelling reasons would remain.

Second, an approach that incorporates spiritual and religious variables better reflects client self-understanding and client cultural/historical/social contexts (Fallot, 2001) than one that
does not. Accurate understanding of context is invaluable for psychological research and practice (Slife, Hope, & Nebeker, 1999). Nevertheless, present practices often overlook important contextual issues, often to the detriment of groups not adequately represented in the literature (Smith, 2004; Sue, 1999). There are thousands of religious and spiritual perspectives represented across the globe, yet we have only begun to address this fundamental element of human experience. We need research representative of spiritual contexts and religious diversity (Fukuyama & Sevig, 1999; Richards & Bergin, 2000). As such research increases, the external validity of extant theories and research results will become clearer, with perhaps more accurate models developing over time. Improving understanding of people’s experiences and perspectives would also allow the field to reach many who are not adequately represented by current mental health practices. Additionally, it could improve efforts to increase empowerment, social justice, and community building (Kloos & Moore, 2000)—all aims of racial-cultural psychology and counseling.

Third, an approach that values spiritual and religious experience is rooted in meaning and making meaning—processes of interpreting reality that are fundamental to mental health (Rhi, 2001; Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000). Some theorists go so far as to call the process of making meaning the foundation for all psychological inquiry (e.g., Richardson, Fowers, & Guignon, 1999). Spiritual and religious teachings emphasize this process of deriving meaning from life’s experiences, from the global existential questions of “Where did I come from?” “Why am I here?” and “Where am I going?” to the specific lessons or principles derived from pain and suffering during any given moment. As has been noted, “Religious cultures are the most powerful factors that modify the individual’s attitudes toward life, death, happiness and suffering” (Rhi, 2001, p. 573). Spirituality and religion are primary mechanisms for meaning
making that are inseparable from perceptions of wellness for many individuals (Cook & Kelly, 1998; Young, Cashwell, & Woolington, 1998). Individuals whose spiritual or religious beliefs are not acknowledged or respected may therefore experience counseling as confusing or even harmful.

Fourth, an approach that incorporates spiritual and religious contexts is not only grounded in the lived experience of the individual, but it also makes possible a shared foundation upon which universal experiences may be comprehended. Thus it speaks to both sides of the emic/etic conundrum (e.g., Myers & Speight, 1994; Speight et al., 1991). Spiritual beliefs tend to be quite personal and intimate; they often comprise the essence of a person's uniqueness or the perceived core of one’s being. Yet most spiritual beliefs emphasize the spiritual nature of all of existence, and it is often assumed that spirituality is a reality that impacts all people, whether or not they acknowledge it (Cook & Kelly, 1998). Spiritual beliefs attempt to cultivate a profound respect for the individual by emphasizing that each person shares the same ultimate reality as all other individuals (e.g., we are all a part of the fabric of nature, all children of God, etc.), providing a both/and perspective rather than an either/or categorization. In sum, a spiritual approach provides a perspective that may be portrayed as a relational web that transcends the emic/etic dichotomy: An individual is of great worth because of connections to others and to a power greater than self (Smith & Draper, 2004).

Implied in the previous point is a fifth benefit of taking a spiritual perspective. Most spiritual or religious tenets tend to shift the focus of inquiry or intervention away from the “self” and away from individualistic values that do not facilitate emotional growth and happiness, offering instead a more collectivist perspective that does (e.g., Myers, 2000). As research has shown, self-focused attention predicts decreased well being and negative affect (Flory,
Raikkonen, Matthews, & Owens, 2000), and excessive self-focus is a common symptom for nearly all mental illnesses (Ingram, 1990). In opposition to self-focus, many religious and spiritual tenets emphasize the importance of service, giving, and responsibility to others and the environment, along with the need to transcend self-focused desires and actions. Thus, spiritual and religious perspectives can serve as a buffer against the harmful effects of self-preoccupation.

Sixth, race and culture moderate how spirituality and religion are interpreted and expressed (e.g., Höllinger & Smith, 2002; Miller, Fleming, & Brown-Anderson, 1998). Racial and cultural groups have unique ways of viewing and practicing even similar religious doctrines or spiritual teachings. Therefore, “the counseling process requires continued research regarding how people experience spirituality across cultures” (Ingersoll, 1998, p. 156). In particular, people in situations of pervasive hardship or distress and people who have relatively less access to other coping resources gravitate to spiritual and religious methods of coping (Pargament, 1997). For example, in North America spirituality and religious beliefs and practices are endorsed more by Blacks than by Whites (Taylor, Mattis, & Chatters, 1999). Effective mental health treatment therefore recognizes that "spiritual or religious issues are often embedded within the issues that bring many racial and ethnic minority clients to counseling" (Constantine, 1999, p. 179). Yet people of color often fear that their spiritual and religious beliefs will be misunderstood by mental health professionals (Cinnirella & Loewenthal, 1999). Because racial-cultural psychology and counseling advocates the cause of oppressed peoples, it can play an important role in training professionals to understand and respect spiritual and religious issues, particularly as they relate to clients who are coping with adversity.

Seventh, religion and spirituality are fundamental aspects of human diversity, representing sources of both inter-group conflict and inter-group collaboration. In North
America alone, there are hundreds of religious and spiritual groups, and this represents only a small portion of the remarkable diversity across the globe (Keller, 2000). Nevertheless, diversity is frequently a source of conflict. Intolerance of religious or spiritual differences characterizes North American history (Carnes, 1995) and inter-group conflicts throughout the world. Conflict has repeatedly been instigated and perpetuated by religious differences (e.g., Christian colonizers vs. indigenous peoples). Addressing spiritual and religious contexts is therefore necessary to increase inter-group respect and to combat oppression based on religious differences. Moreover, differences in religious and spiritual beliefs often parallel differences of race or culture. Racial-cultural counseling and psychology can provide a forum for increasing mutual respect among all people, particularly those whose spiritual or religious differences fall along racial lines.

Eighth, integrating spirituality into treatment has potential to augment the effectiveness of that treatment by (a) strengthening the therapeutic alliance and (b) drawing upon existing client resources (Richards & Bergin, 1997). Some clients may not feel comfortable speaking openly about their spiritual beliefs or experiences with acquaintances or friends. Thus a therapist who enables clients to express their personal ways of finding meaning can potentially facilitate additional interpersonal growth and trust. Furthermore, increased understanding of a client's spiritual perspective may help the therapist access resources with the potential to heal. Particularly for a client already grounded in a specific religious or spiritual orientation, the practices, principles, and people associated with that orientation can be used to inform and augment treatment. It has been observed that "organized religious communities are the largest untapped resources for aiding the therapeutic process with religious clients" (Bishop, 1992, p. 181).
Finally, study of spiritual or religious methods of healing can inform psychological theory and practice (Kloos & Moore, 2000; Lee et al., 1992; Myers, 1988; Richards & Bergin, 1997). Although psychology has discovered many useful principles that can facilitate wellness and healing, psychology has a short history compared with religious and spiritual forms of healing. The wisdom of ages has shaped the practices and traditions of faith in many cultures across the world to enhance coping, resilience, and healing (e.g., Garrett, 1999; Lee et al., 1992). Psychology has only begun to consider the potential healing power of faith. Yet such efforts must first address several potential obstacles to the integration of spiritual and religious perspectives in psychology.

Potential Obstacles in Integrating Faith Perspectives into Racial-Cultural Psychology and Counseling

Despite the compelling rationale presented in the recent literature to integrate religious and spiritual perspectives into psychology and counseling, recent authors have also raised several concerns and pointed to obstacles with the potential to retard the growth of the field if they are not openly acknowledged and addressed (e.g., Fukuyama & Sevig, 1999; Funderbunk & Fukuyama, 2001; Richards & Bergin, 1997, 2000). These obstacles include the historical factors reviewed earlier, perceived conflicts between religious and spiritual issues and the values and practices of the mental health profession, and pragmatic concerns related to conducting research on a topic that is complex and abstract. These obstacles and related concerns that have been raised in the professional literature are briefly summarized in this section.

Obstacles Described in the Literature that are Grounded in Historical Factors

As noted previously, several historical factors have contributed substantially to restricting discussion of spiritual and religious issues in psychology and counseling. Therefore, removing
contemporary obstacles to integrating issues of faith in psychology and counseling requires that these factors be acknowledged. The most pernicious of these factors include (a) a focus that either magnifies or minimizes the negative aspects of spirituality and religiosity, (b) interpretations of science that conflict with the essence of faith, and (c) lack of professional training on the topic.

**Magnification or minimization of negative coping styles and harmful religiosity.** Not all religious and spiritual practices are healthy (Richards & Bergin, 1997). In some cases, zealous devotion can cause excessive and unproductive shame, entrench mechanical rituals to the point of compulsion, restrict intellectual exploration, or reinforce fatalistic perceptions that undermine a need to improve social conditions (Gotterer, 2001). Witch hunts, the transitory euphoria of religious revival meetings, possession syndromes among folk religionists, and a host of questionable to clearly negative mental health outcomes can be associated with spiritual practices or religious dogmas (Rhi, 2001). People can unproductively blame God for their problems, demonstrate excessive dependence upon rituals or leaders, or engage in various other forms of negative coping detailed elsewhere (Pargament, 1997). Clinicians and researchers may therefore raise legitimate concerns about how certain spiritual or religious practices and doctrines are interpreted and acted out. For example, because religious language and imagery tend to be abstract and symbolic, clinicians should appropriately monitor their emphasis on religious themes with clients who have a history of delusional or magical thinking (Fallot, 2001). In such cases, “the area between providing validation and a reality check can be blurry” (Gotterer, 2001, p. 191).

Rather than deal with this complexity, some scholars and clinicians have artificially reduced the blurriness of the topic by either critically magnifying the negative aspects of religion
to the point of obscuring the positive aspects (Freud, 1927) or else naively focusing on the positive aspects and minimizing potential negative aspects (see Smith et al., in press). Optimal practice and research will expend effort to determine when clients warrant validation or a reality check, through careful assessment of the degree to which the style of religious coping is both helpful and potentially harmful for the client. Furthermore, because negative religious coping styles often represent dysfunction in other areas of the client’s life, this information can augment effective treatment and referrals. Therapists can help clients identify both helpful and harmful consequences of their beliefs and actions without inappropriately magnifying or minimizing those consequences (Richards & Bergin, 1997).

Narrow interpretations of empiricism. The scientist-practitioner model of training and the philosophy of empiricism from whence this model is derived are meant to help mental health professionals remain as objective as possible, replacing personal beliefs and values with empirical data. This emphasis on observable data has led some to conclude that science and religion are strictly incompatible (e.g., NAS, 1984). Therefore, suspicion of any claim to knowledge not based on the five senses may still impede serious scholarship in the area (Slife et al., 1999). However, as so many theorists have shown in recent years, religion and science can be quite compatible, particularly once researchers and scholars recognize that empiricism is not immune from human values, nor can it provide truly objective data (Bergin, 1980; Haque, 2001; Richards & Bergin, 1997). Religion and spirituality can be objectified to a certain extent, but can also be considered within narrative and dialectic frameworks (Slife et al., 1999).

Need for professional training. Unless current research and theory regarding religion and spirituality becomes infused in graduate school curricula, the future will be much like the past. Practitioners can only be expected to practice within the bounds of their competence, and
without additional training practitioners may not be competent to address the spiritual or religious issues presented by their clients (Fukuyama & Sevig, 1999; Souza, 2002). At present even “multicultural” education does not sufficiently inform students about religious or spiritual issues (Ribak-Rosenthal & Kane, 1999). A survey of APA accredited clinical psychology programs found that only 57% of multicultural courses explicitly include issues of faith (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnson, 2002). This same survey found that only 17% of training programs make a systematic effort to address the topic, and most address it only superficially or on a strictly intellectual level. Nevertheless, because an understanding of a client's experience of faith, similar to experience with race, entails emotive and experiential awareness, care must be taken in the development of training models and texts to provide more than superficial coverage of the topic.

Even though professional standards are being revised to specifically include competence in spiritual and religious diversity (Miller, 1999), very few training models have been developed (Souza, 2002; Speight et al., 1991), a deficit that limits the likelihood of systematic implementation. Treatment models that explicitly integrate spirituality and mental health (e.g., L. Myers et al., 1991; J. Myers, Sweeney, & Witmer, 2000; Richards & Bergin, 1997) have not yet become widely acknowledged and adopted. Thus even though some psychologists are already using spiritual interventions in psychotherapy (Richards & Potts, 1995), many lack even a basic knowledge of minority religious groups (Ribak-Rosenthal & Kane, 1999). In sum, making spirituality one of the major themes of a racial-cultural psychology (Sue et al., 1999) entails a substantial increase in training initiatives.
Obstacles Discussed in the Literature that Relate to Value Conflicts

At another level, certain values and beliefs prevalent in the field present obstacles to the integration of issues of faith into racial-cultural psychology and counseling. These potential conflicts are partly due to historical influences in psychology, but they are also partly due to the influences of contemporary Western culture. They include several sources of bias against organized religion that often remain implicit in discussions of the topic. In order for the movement to advance, these biases must be addressed.

Materialistic values. Values of materialism embedded throughout all aspects of contemporary society conflict with many spiritual principles and religious teachings. Devotion to technology, wealth, and personal recognition characterize both North American society and the mental health professions. In such a climate, spiritual and religious tenets that contradict materialism and material explanations of human behavior may be suspect because they go against the grain of popular thinking (Rhi, 2001). “The notion of spirituality is [seen as] irrelevant to everyday life or has a specious image projected onto it by our materialistic culture” (Gotterer, 2001, p. 191).

The “religiosity gap.” Several surveys have shown that mental health professionals, psychologists in particular, are notably less likely to endorse religious tenets than are members of the general public (e.g., Shafranske, 2000). This so-called “religiosity-gap” (Fallot, 2001, p. 83) may account for the reluctance of some clinicians to address clients’ religious experiences in their practice. Gotterer (2001) has noted that clinicians’ reactions to the topic of religion can roughly be broken down into three types: “(a) those who are spiritual and/or religious but able to acknowledge others’ beliefs; (b) those uncertain about religious and spiritual beliefs and wary of entering into this territory; and (c) those turned off altogether by either religion and spirituality,
or religion in particular” (p. 191). To overcome the effects of the “religiosity gap” as a potential barrier to integrating issues of faith in psychology and counseling, professionals should explicitly recognize their own personal values regarding spirituality and religion. For example, therapists who have had negative personal experiences with religious institutions or their leaders can work through their own negative feelings so as to effectively assist others in working through their issues.

Dichotomizing religion vs. spirituality. Although only 48% of psychologists report that religion is important to them, 73% strongly endorse the importance of spirituality (Shafranske, 2000). Not surprisingly, this emphasis on spirituality over religion is also prevalent in the mental health literature, which tends to draw a clear distinction between religiosity and spirituality. Many authors seem to prefer speaking about spirituality, ostensibly because it is a broader concept and lacks the baggage associated with specific institutions (Fallot, 2001). Metaphorically, it is as if spirituality is the substance worthy of attention, while religion is but one of many ways one can attempt to capture that substance in a container of a particular shape and size. The container (religion) is assumed irrelevant, as long as the substance (spirituality) is addressed. Spirituality, as commonly understood in Western culture, is essentially an intra-personal and highly subjective (i.e., psychological) experience.

However, perspectives emphasizing the differences between spirituality and religion are less common in cultures in which the distinctions between the social aspects of religion and the psychological aspects of spirituality are not always clear (Carr, 2000; Mbiti, 1990; O'Connor, 1998). Even in Western cultures, where many individuals reject religion but embrace spirituality, the two constructs overlap substantially (Hill et al., 2000). Religious devotion often involves intensely personal and private experiences or practices, and more to the point, among
some individuals and groups their religion can be practiced as a *way of life* that is internalized and assumed to address a universal essence, not merely as a set of external social prescriptions. Unfortunately, by drawing a clear distinction between spirituality and religiosity, psychologists may unintentionally minimize the values and experiences of certain clients, particularly those who view life in more holistic and less dichotomous terms. As has been noted:

> [A] sharp and judgmental separation between [religion and spirituality], especially for counselors, is neither sound nor constructive…To omit either, to artificially separate them, or to confuse their special meanings would be to distort or trivialize the deep and diverse religious/spiritual attitudes that so many people hold and bring to counseling (Kelly, 1995, p. 7-8).

**Concerns about intrusiveness.** Some clinicians may feel that addressing spiritual issues with clients feels too intrusive or that it violates social norms that tend to avoid discussion of religious topics (Fallot, 2001; Gotterer, 2001). Indeed, clients’ spiritual and religious experiences may be difficult topics to discuss openly. However, therapy commonly addresses other difficult topics such as racial dynamics, sexuality, abuse, and a host of undesirable behaviors embarrassing to the client. Thus it is questionable why issues of faith receive special exclusion from therapy. To remove this potential barrier, the possibility that therapists’ personal discomfort with spirituality and/or religion can be projected onto clients should be explored (Souza, 2002).

**Concerns about imposition of values.** Throughout recorded history, people in positions of power have foisted their religious and spiritual beliefs and practices upon others. With that context in mind, it has been argued that professionals who discuss issues of faith with clients or who use spiritual interventions are in danger of imposing their own values on clients (e.g.,
Richards & Potts, 1995; Seligman, 1988). For example, when a client adheres to atheism, it is possible that a therapist who holds strong religious convictions may directly or indirectly attempt to change the client's atheistic values. This is a serious concern that may lead some professionals to avoid addressing spiritual issues in therapy altogether.

Without question, incorporation of spiritual perspectives into psychotherapy brings value issues to the foreground (Richards & Bergin, 1997). However, there is currently no evidence that therapists who integrate faith issues into treatment are more likely to impose their values on clients than are other therapists. In fact, some have argued that therapists who make their values explicit in therapy (rather than leaving them implicit) are less likely to impose their values on clients (Bergin, 1980, 1991; Bergin, Payne, & Richards, 1996; Richards & Bergin, 1997). Nevertheless, it is important to emphasize that all therapists have a responsibility to monitor their own values and to avoid imposing their own values on clients (ACA, 1995). In light of the reality that many people approach life from a spiritual perspective (Keller, 2000), this injunction could include monitoring the promotion of secular values among therapists who insist on excluding spiritual issues from treatment (Bergin, 1980).

Conflicting political agendas. Religious groups sometimes identify themselves closely with a political party or with a clear political agenda (e.g., the Christian Right in the United States, Protestants vs. Catholics in Northern Ireland). When those political agendas conflict with psychological research or with the personal values of a psychologist, organized religion can becomes a source of tension in therapy. Unfortunately, there is a tendency to dismiss religion in general because of the political motives of a few groups (e.g., defamation of Islam based solely on the actions of a few extremists) – and a similar tendency to treat all religious groups as if they share the same characteristics (Queener & Martin, 2001). Generalized bias against certain
religious traditions may influence some professionals to perceive all organized religion as oppressive or to continue to denounce specific sects long after they have changed their official policies and practices.

Patriarchy and sexism. As has been noted by Funderburk and Fukuyama, “spirituality and religion are imbedded in patriarchal structures” (2001, p. 7). Men have traditionally been the leaders of spiritual and religious movements, with women frequently excluded from public recognition and organizational authority. Women may therefore feel invisible or disrespected in patriarchal organizational structures. They may feel encouraged to keep silent, sacrifice themselves for the benefit of men, and inhibit their natural inclinations and desires, all emphases that conflict with the tenets of feminism. Nevertheless, feminist approaches to therapy have acknowledged the integral nature of spirituality and the intrinsic benefits of faith, particularly a faith rooted in relational and egalitarian structures that minimize the harmful effects of sexism (Funderburk & Fukuyama).

Oppression and racism. Throughout recorded history, religion has been used to justify subjugation and tyranny but has also inspired liberation and equality. It has contributed to widespread oppression but also to worldwide charitable relief efforts and mutually beneficial inter-group exchange. It has aided in the fight against racial segregation in public institutions, yet religious institutions themselves have been and continue to be highly racially segregated. In addressing the complex and contradictory associations between religion and racial prejudice, Gordon Allport's observation of nearly 50 years ago is still true: "Some people say the only cure for prejudice is more religion; some say the only cure is to abolish religion" (1954, p. 444). This contradiction and the lingering impact of racial injustices present an obstacle to the integration of
spiritual and religious issues into racial-cultural counseling that warrants an examination of the relevant research literature.

Following the horrors of the Holocaust, researchers investigating the complex association of religion and racism came to the perhaps ironic conclusion that individuals who accepted an organized religion were more prejudiced in their racial attitudes than were non-religious individuals (e.g., Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1950). This finding was replicated across several studies (Gorsuch & Aleshire, 1974), although many of them were limited in external validity and in methodological rigor (Scheepers, Gijsberts, & Hello, 2002).

In explaining why religion may actually increase racial prejudice, Allport asserted that "the chief reason why religion becomes the focus of prejudice is that it usually stands for more than faith--it is the pivot of the cultural tradition of the group" (1954, p. 446). Original religious teachings are misinterpreted and modified over time to match cultural contexts (Rhi, 2001). Allport (1954) pointed out that this blending of cultural and religious/spiritual beliefs often leads to the presumption that social values hold the same sacrosanct status as faith values. When this occurs, it becomes fairly easy to distort and abuse religious/spiritual principles (Davies, 1988), a distortion which may then serve as a front for those seeking power at the expense of others. Religious values mixed with cultural values represent fundamental sources of power and privilege frequently associated with political agendas (e.g., Servin & Torres-Reyna, 1999), as noted above. Religious teachings that in their original form advocated mutual respect and good will therefore can become corrupted into tools for manipulation or exploitation.

In addressing this important topic, Allport (1954) also proposed that religion influences people (and their racial biases) in two seemingly incompatible ways because there are two distinct types of motivations for religious practice. First, there are extrinsics, who use religion
for their own ends, ranging in magnitude from desires to simply expand social circles to desires for power or wealth. Second, *intrinsic* devoutly seek individual and, ultimately, world peace through internalizing positive, pro-social values.

This intrinsic-extrinsic paradigm of religious orientation is perhaps the most widely examined theoretical framework in the literature (Donahue, 1985). However, much of the research based on it has been contradictory or inconclusive, suggesting a possible curvilinear relationship. For example, several researchers have found no linear relationship between degree of religious/spiritual commitment and racial attitudes (e.g., Boivin, Darling, & Darling, 1987; Boivin, Donkin, & Darling, 1990). However, others have found that strong, but not nominal, intrinsic religious commitment is associated with lower levels of prejudice (e.g., Fulton, 1997; Ponton & Gorsuch, 1988). Thus although moderate support for Allport's (1954) theory has been provided, it is now clear that the relationship between religious/spiritual variables and racist attitudes depends upon the context (Cygnar, Jacobson, & Noel, 1977; Griffin, Gorsuch, & Davis, 1987; Jackson & Hunsberger, 1999). Important moderators include age, educational level, degree of geographical religious homogeneity, and the type of religiousness being assessed (e.g., Scheepers et al., 2002). Specifically, older and less educated populations tend to endorse more religious beliefs than do younger and more educated populations, but they also endorse more racist beliefs than do younger and more educated populations (for reasons unrelated to religion). Similarly, geographic areas with high religious homogeneity tend to have more racial bias than regions with religious heterogeneity. The type of religious activity being measured also influences the association: Behavioral adherence to religious doctrines is associated with racial tolerance, whereas religious particularism is associated with racial prejudice. In sum, the association between religiousness and racism is complex because there are many factors that
moderate and mediate the relationship. Depending on the context, religion can increase
tolerance or intolerance. This complexity will need to be considered carefully in efforts to
integrate spirituality and religion into racial-cultural psychology and counseling, such that
moderating factors and the politicization of religion are openly acknowledged and considered in
connection with the faith professed by individuals.

Pragmatic Obstacles for Future Scholarship

At another level, an obstacle to integrating issues of faith into racial-cultural psychology
and counseling is the current dearth of quality research and theory specific to the topic. Unless
quality work becomes more prevalent, the movement will disappear in a few short years. Three
obstacles that could prevent the movement from flourishing are lack of interdisciplinary
collaboration, failure to address the native complexity of the topic, and failure to develop a
consistent and precise lexicon to describe spiritual and religious experiences and conditions.

Interdisciplinary collaboration. As described in the foregoing review of the literature,
until only recently much of the research and theory concerning spirituality and religiosity have
developed separately from efforts to promote racial-cultural psychology. Researchers across
disciplines have rarely interacted, largely keeping to their own journals and professional
associations. Thus many of the efforts by scholars to integrate issues of spirituality and religion
into racial-cultural psychology and counseling have tended to lack rigor or depth. Most
publications on the topic are opinion papers; empirical research is scarce. We have yet to see
widely recognized theoretical models of human development, personality, pathology, etc. that
explicitly address issues of faith. Therefore, some scholars have simply taken existing models
from the racial-cultural literature and applied them to spiritual and religious issues (e.g., the
construct of “White privilege” altered to “Christian privilege,” models of racial identity
development modified into models of spiritual identity development, etc.). The field might advance more quickly if rather than alter racial-cultural theories to fit religious and spiritual issues, efforts focused on increased collaboration with anthropologists, family scientists, political scientists, psychologists, sociologists, and religious scholars already grounded in theory and research specific to spiritual and religious issues.

**Complexity.** Like mental health and culture, religiosity and spirituality are exceedingly complex. Underlying this complexity is the fact that religious and spiritual behaviors, like culture and mental health, are multiply determined. For example, even observable behaviors such as church attendance are moderated and mediated by many factors (age, education, physical ability, upbringing and previous experiences, perceptions of religious leaders, social skills, personal motivations, etc.), most of which are frequently ignored by researchers to the extent that church attendance alone may be falsely assumed to equate with level of religiosity. Further compounding the complexity is that there are multiple aspects of religiosity including attitudinal (e.g., doctrinal beliefs), behavioral (e.g., orthodoxy), relational (e.g., prayer and worship), and perceptual (e.g., God image). Examination of religiosity, therefore, requires that moderators and mediators be specified, with a clear description of the type of religiosity to be assessed. As research efforts improve in specificity, the results will be more valid and more useful in informing theory and practice. Nevertheless, amidst the resulting reductionism aimed at improving specificity for purposes of measurement and analysis, care must be taken to maintain open dialectics that provide the essential context for empirical inquiry (Slife et al., 1999).

**Linguistic difficulties.** As has been noted, “A challenging aspect of research in the realm of spirituality is the ineffable quality spiritual experiences have that render their symbolization with language very difficult” (Ingersoll, 1998, p. 161-162). Simply put, language is sometimes
inadequate to convey spiritual content. In clinical settings, a client may therefore have difficulty describing spiritual experiences (Souza, 2002) much in the same way he or she might have difficulty describing the taste of a flavorful ethnic food to a friend who is unfamiliar with that particular cuisine. Adjectives such as spicy, sweet, or sour may give a general impression of the flavor and may even allow the listener to categorize it as being similar to or different from familiar foods. However, any description of personal experience will be both subjective and imprecise, leaving the hearer with a fuzzy impression and the speaker with a sense of mild frustration. This is particularly true when attempting to describe a religious or spiritual experience, where terms such as peaceful, loving, or joy represent emotive states that are very general and do not convey distinctions between an experience specifically perceived as spiritual versus any other positive event. Thus research in the area faces some difficulty in using terms that have sometimes been inconsistent and/or imprecise. For example, the terms faith development, faith maturity, and spiritual maturity have all been used to describe similar processes, with different authors attributing their own unique variations to the definition and assessment of each (e.g., Hill & Hood, 1999). Similarly, despite their widespread use, concepts such as spiritual well-being, fundamentalism, and extrinsic religiosity have been disputed and subdivided by various authors (e.g., Batson & Ventis, 1982; Malony, 1977; Richards & Bergin, 1997).

A related potential difficulty comes from construct overlap. Many descriptions of core spiritual values, embodied in terms such as hope, connectedness, etc. (Cook & Kelly, 1998; Ingersoll, 1998), are hard to distinguish from definitions of wellness. Few scholars would argue that spiritual health and mental health are the same construct. Most of the research literature assumes that faith positively influences wellness. Nevertheless, overlap in definitions could
account for research affirming a positive association between mental health and spirituality, rather than any causal processes. This issue clearly warrants clarification because interpretation of research findings will depend completely upon how faith is operationally defined.

However, just because a topic is difficult to define does not mean that it cannot be defined. It is possible to examine spirituality with scientific rigor (Bergin, 1980). Despite imprecise language, dozens of measures of spirituality or religious involvement have been shown to be psychometrically robust (Hill & Hood, 1999). And although there is certainly need for greater specificity, people do seem to understand what is meant by the global terms spiritual and religious. We therefore take the perspective that faith can be described with some consistency, just as food taste can be described, so long as the terms have similar meanings across people and are sufficiently specific. Future research needs to develop a consistent and specific expanded lexicon to better address how faith, mental health, and culture intersect and influence one another. Of course, simultaneous with the development of such terms is the development of quality theories that articulate the intersections between race and culture. To that end, the following section will provide an overview of some basic interactions between faith and culture, with accompanying recommendations for future theory development and empirical research.

The Intersections of Faith and Culture:

Fruitful Areas of Theory Development and Empirical Research

Implications for Theory Development: Similar Psychological Functions of Faith and Culture

Although psychological theories specific to race and culture and specific to religion and spirituality have been developed over the past several decades, only a few scholars have considered the overlap and interactions between these related sets of variables (e.g., Fukuyama & Sevig, 1999; Myers, 1988). A central assertion of these scholars is that cultural mores and
Spiritual or religious expressions of faith are intricately intertwined, each influencing the other in a myriad of ways. In some societies, such as contemporary European nations, this mutual influence is minimal or predominantly in the direction of culture influencing religion (Höllinger & Smith, 2002). For example, many Protestant Christian denominations have altered their official policies and practices to conform with social norms, such as in the ordination of women to church offices. In other societies, such as contemporary North African nations, the influence can be quite notable in the opposite direction: religion strongly influences culture. For example, public laws on alcohol consumption reflect the teachings of Islam. In societies with high religious homogeneity, this mutual influence of culture and religion is generally accepted (e.g., Thailand), while in societies with religious heterogeneity it can be a source of conflict (e.g., Sri Lanka). Paralleling these social processes are equivalent psychological processes, such that within any given group an individual may or may not experience a significant influence or internal conflict due to factors of this sort. Acknowledging these potential influences and interactions at both the societal and individual level can facilitate improved understanding of societies’ and individuals’ identities, motivations, values, etc. In short, improved understanding of others’ worldview and well-being will come as scholars develop and refine theoretical models inclusive of both faith and culture.

Fundamental to the development of integrated models is an understanding of the ways in which culture and religion/spirituality can serve similar psychological functions. Both culture and faith provide individuals with a template to contextualize most aspects of life, allowing for comprehension amid chaos (Cook & Kelley, 1998; Hong, Morris, Chiu, & Benet-Martinez, 2000). Both religion and culture provide meaning and a predictable social structure, making them relevant to and indeed inseparable from psychological inquiry. Both influence not only the
way in which mental health is perceived and treated but also the way in which people act and see themselves generally. An optimal approach to theory development therefore considers not only the relevance of an individual’s internalized spiritual and cultural meanings to mental health symptoms (e.g., Bishop, 1992), but also the impact of such meanings upon an individual’s identity, motivations, and values.

Identity. Both religion/spirituality and culture provide a context from which an individual can compare and contrast their own attributes and experiences with those of others who are similar and dissimilar. Through such comparisons and contrasts, children and adolescents develop their basic identity (Erikson, 1985). Because identity is developed in relation to others, it can serve as an important buffer against distress. That is, individuals who see themselves in terms of cultural and religious/spiritual groups perceive themselves as belonging to larger collectives, a shared identity that can provide emotional resources and the security of knowing that one is not alone.

Motivation. One’s perspective of self and others has clear implications for one’s actions. Faith and culture shape behavior. They both hold the promise of rewards for certain behaviors and punishments for others. They both provide for proximal and distal outcomes that can be consequential and pervasive. Thus culture and faith are among the strongest motivators for group behavior.

The influence of culture and faith in motivating a group is most notably demonstrated in cases of inter-group conflict, such as those in contemporary Indonesia, Bosnia, Sri Lanka, Northern Ireland, and Tibet, where religious differences rouse millions. Multiple examples from across the globe and across history could also be cited. Similarly, at the individual level a person
who perceives a threat to her or his culture and/or faith mobilizes defenses if his or her identity seems to be under attack.

Additionally, cultures and faiths also motivate groups and individuals toward higher achievement and toward resilience in the face of opposition. For example, the history of Jewish peoples demonstrates how cultural and theistic motivations have maintained collective group identity for approximately 3,000 years. For an individual, a cause worth sacrificing for in times of peace is often worth dying for in times of oppression.

Values. Culture and faith provide identity and motivation because they inform values. They give life flavor and texture, which can then be shared and affirmed. They shape social structures that model and reify normative action and discourse, with even language becoming an act of values preservation. Culture and faith allow for judgment and, by extension, internalization, labeling what is bad or good, defining what is “me” or “not me.” In short, both faith and culture define what is health, what is illness. They define a person's or a group's psychology.

Cultural and faith values tend to be similar within a given individual or group because unresolved contradictions between culture and religion, although sometimes present, are usually minimized or dismissed. Through processes that reduce cognitive dissonance (Festinger, 1957), when one's faith and culture are at odds, an individual will tend to modify one or the other. For example, an individual may have to choose between a cultural expectation/ceremony that involves alcohol consumption and a religious prohibition of alcohol. A person can value only so many things, and the most salient values are preserved. Once internalized, values become a schema through which life is seen. They provide the individual with a perspective of a world
created in her or his own image. Cultural and faith values impress themselves upon the external world, but such is usually useful and even necessary (Hong et al., 2000; Richardson et al., 1999). It is hoped that an increase in scholarly attention to the kinds of relationships described here will spur the much needed development and refinement of psychological theories integrating race, culture, and faith to enhance our understanding individuals’ and groups’ worldviews, well-being, etc. And although some existing models have begun to address these issues (e.g., Myers, 1988), future research can clearly facilitate exploration and then confirmation of ways in which faith and culture combine to influence mental health and wellness.

**Recommendations for Future Research**

Repeated assertions of the need to conduct research investigating possible relationships between cultural and spiritual/religious contexts appear in the current literature (e.g., Bishop, 1992; Constantine, 1999; Fukuyama & Sevig, 1999; Richards & Bergin, 2000). Yet even across a variety of sources, several consistent themes can be distilled. First, research is needed into ways in which counseling and psychotherapy can be made more compatible with faith perspectives (Braun-Williams, Wiggins-Frame, & Green, 1999). Because faith beliefs and faith practices have such a strong influence among many people and because faith values may sometimes conflict with values advocated in the mental health professions, a tendency to openly mistrust psychological treatment may be noted among religious individuals (e.g., Cinnirella & Loewenthal, 1999). Moreover, some religious traditions view mental illness as a deserved punishment from supernatural sources, so treatment that responds to issues of stigmatization should be investigated. Similarly, because some cultures make little distinction between spiritual and mental health, the effectiveness of interventions that incorporate full physical/emotional
involvement or specific spiritual methods can be investigated relative to traditional “talk therapies” (e.g., Wiggins-Frame, Braun-Williams, & Green, 1999). Case studies that inform the integration of spiritual perspectives into treatment (e.g., Shimabukuro, Daniels, & D’Andrea, 1999) can help to refine such practices, which can then be assessed via traditional outcome research methodologies.

Related to this compatibility issue is a second area for future research: the need to identify unique mental health issues of specific religious/spiritual groups and subgroups. Animists, Ethnic Religionists, and Spiritists of African, Asian, and Latin American origin, along with Jains, Sikhs, and Zoroastrians, are among those whose beliefs and practices are likely to be misunderstood by North American mental health practitioners. But misunderstanding is also likely with religious groups that are more prevalent, such as Hindus and Muslims. Research and other publications that help clarify unique symptom patterns, common differential diagnoses, and typical expectations relevant to mental health and therapy are needed (Richards & Bergin, 2000).

Third, study should be undertaken of the benefits of collaboration with local spiritual organizations and leaders (e.g., Kloos & Moore, 2000). Such collaboration can involve simultaneous treatment by a spiritual leader and a therapist or the establishment of effective referral networks. (For an example service delivery model see Queener & Martin, 2001). Because clergy are typically viewed with reverence and may exert great community influence, research specific to improving pastoral counseling efficacy may also be of benefit.

Fourth, the potential of faith traditions to buffer against negative influences such as racism should be studied. It may well be that an active faith shared in public settings with members of the same racial group facilitates a sense of protection or refuge from a larger society that does not share similar values and that oppresses racial differences. Similarly, because
opportunities to gain social status are often limited for oppressed groups, the degree to which religious involvement serves to create an internal system of recognition and value could be explored (Boyd-Franklin, 1989).

Fifth, the process of spiritual and religious identity development needs to be articulated, particularly in relation to racial identity development, acculturation, and other racial/cultural factors known to influence therapy process and outcome (Carter, 1995). Although tentative models of spiritual identity have been proposed (e.g., Poll & Smith, in press), research is clearly needed to refine these models and to specify their utility in clinical settings.

A sixth topic for future research concerns the efficacy of collectivistic vs. individualistic approaches to mental health treatment. Because spiritual beliefs frequently emphasize the importance of connectedness and responsibility to others, treatment approaches that emphasize interpersonal interdependence can be developed and tested with populations who typically express these values. Treatments that emphasize a relational perspective (Smith & Draper, 2004) and that explicitly involve clients’ support systems, including extended family, can be compared with traditional individual counseling.

Seventh, an alternative to professionally-driven research agendas may be found in collaborative action research partnerships (e.g., Kloos & Moore, 2000), possibly an optimal way to meet local needs and at the same time reveal reforms that should be considered in our professional practices. Such research grounded in the experience of individuals and groups has a unique potential to inform psychological theory and practice.

Finally, and perhaps most importantly, the rationale and obstacles presented earlier in this paper for integrating faith perspectives into racial-cultural psychology and counseling should be addressed through ongoing, systematic empirical efforts. Researchers need to specify the types
of religiosity and spirituality that promote mental health while also addressing the types that yield negative consequences (e.g., Smith et al., in press). Researchers need to assess the effectiveness of integrating faith perspectives into professional training programs (Souza, 2002). They should also address the conflicts that may hamper future work in the area, including issues of racial segregation and racism in religious institutions, disagreement over the politicization of religious tenets, differences in materialistic vs. spiritual perceptions of well-being, etc. They should use research designs that can address the innate complexity spirituality and religion, including assessment of variables that potentially moderate or mediate the association with mental health, such as time perspective, perceptions of stressful events and emotional pain, opportunities for and beliefs about emotional disclosure, social support, and behavior/belief congruency, each of which is also influenced by cultural factors. To address this complexity effectively, scholars will need to collaborate with colleagues in other disciplines and work towards the development of a systematic lexicon for describing and assessing spiritual experiences. Finally, although several studies using predominantly European American samples have documented that therapy inclusive of spiritual and religious content is just as effective as secular therapy and is particularly effective with religious clients (McCullough, 1999), additional work is necessary to confirm these findings across other cultural and racial groups.

Future scholarship on these and similar topics can improve our understanding of how race, culture, faith, and mental health interact. Racial-cultural psychology and counseling have the potential to affirm faith as a fundamental aspect of human nature (Sue et al., 1999). But there is much work to be done. Although we know a great deal about reducing distress and promoting wellness, there are many potentially helpful and harmful influences of spirituality and religion on mental health that we are only just beginning to document and understand.
References


