COMMENTARY

Integrating Spirituality and Psychotherapy: Ethical Issues and Principles to Consider

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Professional and scientific psychology appears to have rediscovered spirituality and religion during recent years, with a large number of conferences, seminars, workshops, books, and special issues in major professional journals on spirituality and psychology integration. The purpose of this commentary is to highlight some of the more compelling ethical principles and issues to consider in spirituality and psychology integration with a focus on psychotherapy. This commentary will use the American Psychological Association's (2002) Ethics Code and more specifically, the RRICC model of ethics that readily applies to various mental health ethics codes across the world. The RRICC model highlights the ethical values of respect, responsibility, integrity, competence, and concern. Being thoughtful about ethical principles and possible dilemmas as well as getting appropriate training and ongoing consultation can greatly help the professional better navigate these challenging waters. © 2007 Wiley Periodicals, Inc. J Clin Psychol 63: 891–902, 2007.

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Professional and scientific psychology appears to have rediscovered spirituality and religion during recent years (e.g., Hartz, 2005; McMinn & Dominquez, 2005; Plante & Sherman, 2001; Richards & Bergin, 1997; Sperry & Shafranske, 2005). There have been a large number of conferences, seminars, workshops, books, and special issues in major professional journals on spirituality and psychology integration of late. Journals such as the *American Psychologist*, *Annals of Behavioral Medicine*, and *Journal of Health Psychology*, among others, have recently dedicated special issues to this important topic.

Psychology and Religion: A Tumultuous Relationship

Curiously, while a number of our prominent psychology forefathers such as William James, Carl Jung, and Gordon Allport were keenly interested in the relationship between

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psychology and religion (e.g., Allport, 1950; James, 1890, 1902; Jung, 1938), most of professional and scientific psychology during the past century has avoided the connection between these two areas of inquiry. For example, Collins (1977) stated: " . . . psychology has never shown much interest in religion . . . apart from a few classic studies . . . the topic of religious behavior has been largely ignored by psychological writers" (p. 95). Perhaps psychologists have been overly influenced by the words and perspectives of leaders in the field such as Sigmund Freud, B. F. Skinner, John Watson, and Albert Ellis who found little, if any, value in the study or practice of religion (e.g., Ellis, 1971; Freud, 1927/1961; Watson, 1924/1983). For example, in *Future of an Illusion*, Freud (1927/1961) stated that religious views "are illusions, fulfillments of the oldest, strongest and most urgent wishes of mankind" (p. 30) and referred to religion as an "obsessional neurosis" (p. 43). Psychology has had a long history of being neglectful, if not outright antagonistic, to issues related to spirituality and religion, often finding those who are spiritual or religious as being deluded or at least not as psychologically healthy and advanced as they could be (e.g., Ellis, 1971; Freud, 1927/1961). While Freud called religious interests "neurotic" (p. 43), Watson (1924/1983) referred to religion as a "bulwark of medievalism" (p. 1).

Furthermore, psychology in the 20th century prided itself on being a serious science and perhaps tended to shy away from all things religious or spiritual in an effort to maximize and emphasize the rigorous scientific approach to both research and clinical practice. Since much of religion and spirituality concerns matters that were not readily observable or measurable, the field tended to stay as far away as possible from religious and spiritual constructs in an effort to prove that psychology should be taken seriously as a rigorous, empirical, and respected discipline (Ellis, 1971; Richards & Bergin, 1997; Watson, 1924/1983). Those psychologists who were religious or spiritual and wanted to integrate their faith traditions into their professional work generally needed to keep their interests fairly quiet and certainly would not profess their beliefs during the more vulnerable years of graduate and postgraduate training. Yet, several training programs often associated with evangelical Protestant churches did emerge that freely embraced and nurtured religion and psychology integration (American Psychological Association, 2006).

The Times They Are a' Changing for Psychology and Religion

Toward the very end of the 20th century, psychology (as well as science in general) has embraced spirituality and religion more and has used rigorous scientific methods such as double-blind randomized clinical trials to examine important questions related to psychology and religion integration (Miller, 1999; Miller & Thoresen, 2003; Plante & Sherman, 2001). These include the influence of religious and spiritual behaviors and beliefs on both mental and physical health outcomes (Koenig, McCullough, & Larson, 2001; Pargament, 1997; Plante & Sharma, 2001). In recent years, spirituality, religion, psychology, and science integration has been legitimized and has received significant grant and both professional and public support (Hartz, 2005; Koenig, 1997; Koening et al., 2001). Perhaps this is due to the increasing interest among the general population and psychotherapy clients in spirituality and health integration as well as the increasing media attention to this topic. Many professional organizations such as the Society of Behavioral Medicine have now developed new special-interest groups that focus on religion and health integration. Large foundations such as the John Templeton, Lilly, and Fetzer Foundations as well as major government granting agencies such as the National Institute of Health have funded large-scale projects in this area (Miller & Thoresen, 2003). Much professional as well as popular attention has focused on the physical and mental health

benefits of religion and spirituality. In fact, national and international news weeklies such as *Time*, *Newsweek*, and *U.S. News and World Report* have all devoted cover stories on multiple occasions to this very topic.

Taken together, most of the quality research in this area supports the connection between faith and health (Koening et al., 2001; Pargament, 1997; Plante & Sherman, 2001; Richards & Bergin, 1997). Furthermore, since the vast majority of Americans (and others around the world) consider themselves to be spiritual and/or religious (Gallup, 2006; Myers, 2000), many have been demanding that health professionals (including mental health professionals) respect, acknowledge, and integrate spirituality and religious principles into their professional work (Miller, 1999). Psychology's new focus on "positive psychology" also underscores the desire for a more friendly relationship between religion and psychology (Lopez & Snyder, 2003). While both research and practice now support benefit to the integration of psychology and religion, some critics have cautioned that the integration of religion and spirituality into psychology and science is ethically, professionally, and scientifically dangerous (Sloan, 1999, 2001). Sloan, Bagiella, and Powell (2001) argued that the research support is weak, problematic ethical issues abound, and clergy are best suited to manage spiritual and religious concerns rather than are health care professionals.

Curiously, during recent years many mental health professionals, including psychologists, have become interested in spirituality and religion as part of their professional work and are seeking ways to better integrate spirituality into their psychotherapy activities (Miller, 1999; O'Hanlon, 2006). Yet, almost all graduate and postgraduate training programs still offer no training in this integration (American Psychological Association, 2006; Russell & Yarhouse, 2006; Shafranske, 2001).

American Psychological Association Ethics Code Supports Religion as Diversity

The current (2002) version of the Ethics Code of the American Psychological Association (APA) clearly states that psychologists should consider religion and religious issues as they do any other kind of diversity based on, for example, race, ethnicity, gender, sexual orientation, and so on. Specifically, the APA Ethics Code states

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. (p. 1063)

The Code thus demands some degree of sensitivity and training on religious-diversity-related issues. Furthermore, the multicultural guidelines of the APA (2003) further discuss the need to respect and be competent in diversity issues including those reflecting religious and spiritual diversity. Yet, still little if any training exists, with the exception of optional continuing-education conferences, workshops, and seminars offered to professionals after they are licensed (Miller, 1999; O'Hanlon, 2006).

Using the RRICC Approach to Ethical Decision Making

If psychology and related fields continue to integrate religious and spiritual matters into their professional work, a variety of important ethical issues must be considered to proceed with integration in a thoughtful and ethically sound manner. The purpose of this commentary is to highlight some of the most compelling ethical issues to consider in spirituality and psychology integration with a focus on psychotherapy. While the

commentary will use the 2002 APA Ethics Code, it more specifically will use the closely related RRICC model of ethics that readily applies to various mental health ethics codes across the world (Plante, 2004). The RRICC model was developed to highlight the primary values supported in all ethics codes associated with various mental health professions both in the United States and abroad (Plante, 2004). RRICC stands for the values of respect, responsibility, integrity, competence, and concern. The RRICC model is an easy-to-use way to highlight the values outlined in both the current and previous versions of the APA's Ethics Code as well (American Psychological Association, 1992). These values are highlighted in the ethics codes of not only psychologists but also social workers, marriage and family counselors, and alcohol and drug counselors as well as from mental health professionals from other countries. Therefore, these ethical principles or values are likely relevant for most all mental health professionals in the United States and abroad. The other professional codes are more similar than different regarding these principles (Plante, 2004).

In this commentary, a focus on the psychologist code from the APA will be used for quotes and as a reference for efficiency.

Using the RRICC Model to Highlight Ethical Issues in Spirituality and Psychotherapy Integration

Respect

The 2002 APA Ethics Code quote mentioned earlier was taken from the section of the code that focuses on "respect for people's rights and dignity" (Principle E, p. 1063). Too often in the past, highly religious or spiritually minded persons usually were pathologized by professional psychology and individual clinicians. They were often considered defended, insecure, deluded, and thought to be suffering from some important psychological dysfunction needing treatment (e.g., Ellis, 1971; Freud, 1927/1961). Their views and beliefs were certainly not respected. The 2002 APA Ethics Code and other professional ethics codes now articulate the need to respect the beliefs and values associated with religion and spirituality and to avoid pathologizing those who seek religious and spiritual growth, development, and involvement. While we are not required to agree with all faith beliefs and faith-based behaviors and even might find some religious points of view distasteful and destructive to health and well-being, we are asked to be respectful of the religious and spiritual beliefs, behaviors, and traditions of others. We also must be respectful of the role of religious clergy and spiritual models (both alive and deceased) have in the lives of our religious and spiritual clients. The 2002 Ethics Code calls for us to avoid bias in this regard, stating: "Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices" (p. 1063). Section 3.01 under the Human Relations section of the 2002 APA Ethics Code further calls for us to avoid any kind of discrimination based on, among other qualities, "religion" (p. 1064). Therefore, we must be sure that we are respectful to those from all religious and spiritual traditions and beliefs without discrimination or bias.

Responsibility

Quality research and polling from multiple sources over multiple years clearly indicate that the vast majority of Americans (and those from around the world) believe in God, are affiliated with a religious tradition and some type of church, mosque, or temple, wish to

be more spiritually developed, and want their health care providers (including mental health professionals) to be aware and respectful of their religious and spiritual traditions, beliefs, and practices (Hartz, 2005; Koenig, 1997; Koenig et al., 2001; Myers, 2000). Since religion and spirituality play such an important role in the lives of most people, it is irresponsible to ignore this critical aspect of peoples' lives as we work with them in psychotherapy or in other professional psychological services. We have a responsibility to be aware and thoughtful of how religion and spiritual matters impact those with whom we work. Furthermore, when desired by our clients, psychologists and other mental health professionals should work collaboratively with clergy and other religious leaders involved with their pastoral care (McMinn & Dominquez, 2005; Plante, 1999). The 2002 APA Ethics Code states: "Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interest of those with whom they work" (p. 1062). While we usually have no trouble working collaboratively with physicians, school teachers and counselors, or attorneys as needed for our clients, we also must now add clergy and religious leaders to this list of typical collaborating professionals. Just as we have some responsibility to be aware of the importance and influence of biological, psychological, and social influences on behavior and functioning, we also must manage the responsibility of being aware and thoughtful about religious issues and influences. Furthermore, we have a responsibility to seek appropriate consultation and referrals to religious and spiritual professionals such as clergy as needed just as we do with physicians when our clients experience medical or biologically based concerns.

Integrity

We are required to act with integrity in being honest, just, and fair with all those with whom we work. Integrity calls for us to be sure that we are honest and open about our skills and limitations as professionals and to avoid deception. We cannot fake interest or agreement with our clientele. We should not be dishonest in any way. Integrity calls for us to be sure we carefully monitor professional and personal boundaries which can be blurred easily with psychology and religion integration. For example, we must remember that we are professional and licensed mental health professionals and not members of the clergy (assuming this is true for most readers). Even if we are members of a particular religious faith tradition, it does not make us experts in religious areas that were not part of our professional psychological training and licensure process.

Competence

Since the vast majority of graduate and postgraduate training programs currently ignore spirituality and religious integration in professional training, how can mental health professional competently provide the much-needed services of integration? Clearly, professionals are on their own to get adequate training and supervision to ensure that they provide state-of-the-art and competent professional services if they plan to integrate spirituality and religion into their professional psychological work. Richards and Bergin (1997) offered several specific recommendations about training to better ensure competence in spirituality and psychotherapy integration among professionals. They suggested that professionals read the quality books and other publications now available on this topic, attend appropriate workshops and seminars, seek out supervision and consultation from appropriate colleagues, and learn more about the religious and spiritual traditions of the clients they typically encounter in their professional activities. Luckily, today there

are many quality workshops, conferences, seminars, books, articles, and even special series of professional journals dedicated to religion and spirituality integration in psychology. Furthermore, securing ongoing professional consultation with experts in integration is now likely possible in many locations due to the popularity of the topic. Psychologists and other mental health professionals need to be keenly aware of their areas of competence and not overstep their limits and skills.

Concern

At the heart of our profession is concern for the well-being and welfare of others. This concern must be nurtured and expressed among those working in the area of integration of psychology and religion. Unfortunately, many people have suffered a great deal due to religious conflicts and beliefs over the centuries, and even still do so today. There are too many examples of people being abused, neglected, victimized, and even killed for religious beliefs and behaviors. Sadly, religion and spiritual issues can be harmful to others. Our concern for the welfare of people must be paramount in our work in professional psychology, especially with those whose religious beliefs create harm to self or to others. Thus, while we are asked to be respectful to those from various religious traditions, this respectfulness has limitations when religious beliefs and behaviors turn violent and destructive. Concern for the welfare of others always trumps other ethical values (Plante, 2004). Thus, when someone seeks to "kill infidels," commit terrorism, or oppress and abuse others in the name of their religious tradition, our concern for others must force us to act to prevent harm. This concern might propel us to report child abuse, involuntary commit someone to a psychiatric facility, or perhaps engage other legal means to avoid any serious harm to self and others.

By carefully reflecting upon ethical principles that best guide our professional behavior, we are better able to integrate psychology and religion in ways that can enhance our professional work and perhaps also our personal lives. Next, we turn to several common ethical pitfalls in the area of religion and psychotherapy integration.

Four Ethical Pitfalls

Several important ethical pitfalls can emerge among professionals seeking to integrate psychology and religion. While this list of four pitfalls does not claim to be exhaustive, it does provide some guidance for likely ethical dilemmas. Case examples will be presented for each pitfall as well.

1. Integrity Issues: Blurred Boundaries and Dual Relationships

Many members of the clergy also are licensed mental health professionals. In addition to their pastoral work, they also provide professional psychological services. While it may prove highly useful for members of the clergy to have extensive psychological training, it provides an easy opportunity to blur professional boundaries and develop potentially problematic and confusing dual relationships. For example, when is someone acting in their role as clergy person versus a psychologist? Legal and ethical issues such as limits to confidentiality may be very different for clergy than for mental health professionals and might confuse clients. For example, serious and immediate danger to self and others as well as information about possible child, elder, or dependent-adult abuse is reportable for mental health professionals in almost all jurisdictions; however, this mandated report-

ing responsibility may very well not be mandated for clergy members acting in their pastoral role. If the clergy person who happens to be a mental health professional hears a confession while in one role, he or she may act very differently about the confession if they heard the information via the other professional role. A case example well illustrates this dilemma.

Case Example: Fr. M.

Fr. M. is a Catholic priest and licensed clinical psychologist. He conducts both pastoral counseling as well as professional psychological therapy. He works out of his parish office. A client discloses to him that she has harmed her child by severely hitting the youngster. Fr. M. informs the client that he is a mandated child-abuse reporter as a licensed psychologist and thus must break confidentiality and call child protective services; however, the client angrily retorts that everything she says should be kept in confidence since she is confessing her sin of abuse to a priest under the sacrament of reconciliation.

Fr. M. could have avoided this ethical dilemma by being sure that his clients fully understood his roles as priest and therapist, and which role he maintains during each encounter with her. Fr. M. may wish to separate his two roles, perhaps even maintaining two separate offices (i.e., one within the church facilities as a priest and one in a more secular medical-office environment as a psychologist). Furthermore, he may wish to maintain a separation of roles by not treating his own parishioners as psychotherapy clients.

In another common ethical dilemma, many mental health professionals who are active members of a religious or spiritual tradition may secure ongoing referrals from their clergy person or church group. This creates boundary conflicts when the professional now treats or evaluates many members of his or her own faith or church community. Many religious and spiritual people desire to work with professionals who share their faith tradition and interests. Therefore, it would be very common for church members to refer to a member of their own group. There are rarely hard and fast rules about these potential boundary conflicts other than avoiding possible exploitation of others and confused roles. Taking into consideration the nature of the professional work, the size of the religious congregation, the type of possible dual relationships that might emerge, and the need for clarity of roles and responsibilities all need to be carefully considered.

Finally, professionals who integrate spirituality and psychology usually are active in some faith tradition. Being an active and involved member of a church or religious group does not make someone an expert in that area of theology and pastoral care. Thus, if clients are well aware of the professional's religious or spiritual affiliation, they may seek spiritual, theological, or pastoral guidance which may not be in the area of professional competence of the provider. Mental health professionals may inappropriately and unethically usurp the role of the clergy in these situations. Thus, keeping these boundaries clear and knowing when to consult with and refer to others is vitally important.

Case Example: Dr. G.

Dr. G. is very active in her reform Jewish temple serving on various committees and attending both regular religious services and various ongoing study groups. Since she is well known to her faith community, she regularly gets referrals from the rabbi, cantor, and fellow congregants to provide psychotherapy to members of the Jewish community in the area. Dr. G. welcomes these referrals since she needs the business as she tries to maintain a full-time private practice in a competitive urban environment and very much enjoys working with others who share her faith and cultural tradition. However, several challenging ethical dilem-

mas emerge fairly quickly where dual relationships unfold. Furthermore, Dr. G.'s son befriended the children of some of Dr. G.'s patients at the temple during Hebrew school and now wants to have sleepover parties and various play dates with these new friends. Dr. G.'s role on the temple's Membership Committee has ultimately discovered that one of her patients who benefits from a reduced psychotherapy rate due to self-reported low income actually makes a huge salary and has made a very large and appreciated donation to the temple.

Dr. G. could have avoided these ethical dilemmas by being more thoughtful about whom to accept as patients and whom to refer to other professionals. Dr. G. may have developed a plan that would have minimized these ethical binds by being very selective in the cases she takes on (if any) from her own temple. Perhaps she could accept referrals from congregants from a cross-town temple while referring members of her own temple to another appropriate professional located close by.

It is reasonable and understandable that Dr. G. would get referrals from her religious community who get to know and trust her over time as a member of a shared faith tradition and temple. She must thoughtfully consider potential dual relationships and the many potential unforeseen consequences of blending her spiritual and professional life. While she may chose not to rigidly refuse to professionally treat or collaborate with any member of her temple, she at least must carefully consider how to interact with members of her particular faith community during any possible professional interaction and carefully weigh the pros and cons of these collaborations.

2. Respect Issues: Spiritual and Religious Bias

As mentioned, most professionals interested in spiritual and religious integration with psychology likely come from an active and involved religious tradition. They may feel very comfortable and knowledgeable about their own tradition yet feel rather uninformed about issues related to other faith traditions. For example, a Christian psychologist may know a great deal about the Christian tradition from his or her denominational perspective (e.g., Catholic, Methodist, Seventh-Day Adventist), but know very little about the non-Christian traditions or even other Christian denominations different from their own. Thus, it becomes important for professionals to keep their own potential biases in check, most especially when they know little or perhaps are even antagonistic toward particular religious traditions and denominations.

Case Example: Dr. A.

Dr. A. is an evangelical Protestant psychologist who is highly active in his church and faith community. He also serves as a deacon in his church and participates in missionary activities overseas each summer. He enjoys working with patients and bringing spiritual and religious issues into his sessions; however, he believes that unless you accept Jesus as you personal savior, you are doomed to hell. Patients who are either from a different religious group or not interested in religion at all get referred to him since he is well known for his skills using biofeedback for headache and general pain control. In a conversation with an agnostic patient who suffers from chronic headaches, Dr. A. suggests that the patient accept Jesus as his personal savior and further implies that by doing so the headaches would greatly improve or stop.

Dr. A. has clearly overstepped his professional bounds and has allowed his bias to infringe on his professional work. Regardless of Dr. A.'s religious beliefs, he must keep his bias in check to provide professional, ethical, and state-of-the-art services to his clients. Furthermore, his professional license to practice psychology demands that he provide competent professional services in a respectful manner and does not give him license to preach

about his religious views. Ongoing consultation or supervision may help him better manage these potential conflicts.

3. Competence Issues: A Member of a Faith Tradition Does Not Make One an Expert

Just because a mental health professional is a member of a particular faith tradition does not mean that he or she is an expert in that tradition or can integrate spirituality and religion into his or her professional psychological work. Members of faith traditions vary greatly in their knowledge and comfort level, and thus professionals must be cautious in using their spiritual and religious knowledge with their clients in a manner that appears that they are experts in their faith tradition. Furthermore, professionals must be sure that they do not usurp the role of clergy in their psychotherapeutic work. They must avoid falling into pastoral care, spiritual direction, or theological consultation if they are not competent to do so or if their professional role does not include these areas of competence or expertise.

Case Example: Dr. P.

Dr. P. is a Catholic psychologist who is well known for his work with the Catholic Church. His patient experiences a great deal of guilt that she attributes to her strict Irish Catholic background. She has panic disorder and worried about how her thoughts, behaviors, and impulses might be sinful. She knows that Dr. P. is a Catholic and asks if some of her most embarrassing thoughts and feelings which she is too uncomfortable discussing with her priest might be sins. She asks questions about life after death and about Church teaching on a variety of topics. While Dr. P. has thoughts on these matters as a Catholic, he informs her that these types of questions are best addressed in spiritual direction with a clergy person or church professional, but that psychotherapy can help with the feelings and coping strategies associated with her beliefs.

Dr. P. has carefully articulated his area of competence and tries to provide his client with appropriate referrals to help address her religious questions. Dr. P. certainly may be tempted to express his views on religious matters, but must be mindful of his professional obligations to practice his professional psychological services within the boundaries of his training and licensure. He also must be careful to refer to other professionals (including members of the clergy) to help his client better understand religious teachings and theological understandings of sin and other religious concepts within her faith tradition.

4. Concern Issues: Destructive Religious Beliefs and Behaviors

Tragically, religious beliefs can lead people to engage in highly destructive and lethal behaviors. While terrorism and suicide bombing in the name of religion are extreme examples, less fatal yet still destructive behaviors occur in the name of religion. For example, parents of particular religious traditions refuse medical treatment for sick children or believe that physical punishment of children and spouses is acceptable. Some believe that circumcision should be conducted on adolescent girls. Others believe that denying females medical, educational, and other services is the right thing to do. While the ethics codes require professionals to be respectful of faith and religious traditions and beliefs, the codes certainly do not require us to be complacent or condone destructive thoughts, feelings, and behaviors, most especially when they result in significant physical or mental harm, abuse, or neglect as defined by both legal and ethical definitions. Our concern for the welfare of others as well as both the legal and ethical mandates to protect

others from harm force us to act when religious and spiritual beliefs put our clients or others at risk.

Case Example: Dr. T.

Dr. T. treats a family who maintains very conservative religious beliefs in the Scientology Church. The parents refuse to engage medical professionals to treat their child suffering from Type I diabetes. Doctors believe that the child can easily live a normal life span with medical intervention, but will likely die rather soon without it. The psychologist became involved after the school referred the child for an attention deficit hyperactivity disorder evaluation due to classroom-management issues.

While Dr. T. may be respectful of the parents' religious tradition and beliefs, he cannot condone the disregard for the medical well-being of the child. Dr. T. likely would need to make a child protective services report to increase the chances of medical attention for the child. In most jurisdictions, Dr. T. would be a mandated reporter of child abuse and neglect, and is legally required to report any reasonable suspicion of abuse or neglect to civil authorities for further investigation. Even if abuse and neglect are justified by the client based on religious reasons, the psychologist is still mandated to break the confidentiality arrangement and report the potential abuse or neglect.

Conclusion

Psychology and spiritual integration in psychotherapy is likely to continue to evolve and develop in ways that will hopefully benefit psychotherapy clients (McMinn & Dominquez, 2005; Miller & Thoresen, 2003; Sperry & Shafranske, 2005). Americans as well as most of the world's population tend to be religious and spiritual (Gallup, 2006), and thus those highly engaged and involved with spiritual and religious issues are likely to find their way to psychologists and other mental health professionals. Ongoing quality research has begun and will likely continue to apply state-of-the-art research methodologies to spiritual and psychotherapy integration topics that will provide a more solid scientific foundation for this integration (Hill & Pargament, 2003; Koenig et al., 2001; Plante & Sherman, 2001). The APA's (2002, 2003) directive to be respectful and knowledgeable about religious diversity hopefully will result in more educational opportunities for both psychology professionals and students in training. Spiritual and psychotherapy integration is unlikely to be a trendy fad (Miller, 1999). People have been interested in spiritual and religious matters for thousands of years. It is only more recently that psychology as a profession and as a discipline has evolved to better accommodate and accept these interests and perspectives into their professional work (Lopez & Snyder, 2003; Miller, 1999; Miller & Thoresen, 2003).

Thus, it appears clear that psychology and spiritual integration is here to stay and likely has many benefits for both professionals and the public (Hartz, 2005; Miller, 1999). Closely monitoring ethical issues that emerge or are likely to emerge during the course of our professional work is critical. Being thoughtful of ethical principles such as respect, responsibility, integrity, competence, and concern for others as well as possible ethical dilemmas and getting appropriate training and ongoing consultation can greatly help the professional navigating these often very challenging waters.

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