Association of Christians in Counselling and Linked Professions

Faith, Religious and Spiritual Interventions in Clinical Practice

THE CHURCHILL FRAMEWORK

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Since its publication, the Churchill Framework, (a core competence framework for counselling and psychotherapy) has been positively received by professionals working in the field of counselling and psychotherapy. It has been adopted by the Association of Christians in Counselling and Linked Professions (ACC) as a core part of their professional ethics, and by the Counselling and Psychotherapy Central Awarding Body (CPCAB) as a reference document. It has become a reliable guide for ethical thinking when integrating faith/religion/spiritual issues in counselling and psychotherapy for practitioners. However, as the framework has been gradually embedded in training and practice, one question that has emerged is: what are faith/religious/spiritual interventions (FRSIs)? My aim in this paper, therefore, is to briefly set out some examples of FRSIs and give examples.

Firstly, however, it will be of value to explain the difference between implicit and explicit FRSIs.

Implicit interventions

In certain situations, for example when a client does not hold a Christian faith, and/or if a Christian client does not wish to explore FRSI issues, it is possible for a Christian therapist to engage in what Tan describes as '*implicit*' integration (2011: 340) or, what Gubi describes as a '*covert*' approach (2011: 65). An example of this would be when a Christian practitioner decides to silently pray for their client. Therefore, to an observer of the counselling session and indeed even to the client concerned, it would not be obvious that any FRSIs had been utilised.

It must be acknowledged that some have made the argument that it is potentially unethical to silently pray for a client on the basis that it causes the counselling dyad to become a triad (counsellor, client and God) without the client's informed consent. Whilst this view must be respected, there are two main problems with this argument. Firstly, Christians frequently view their faith as a vital part of who they are (Jenkins, 2011). To suggest therefore that a therapist's Christian faith, including their ability to silently pray, can or should somehow be left outside the

counselling room is both unthinkable and incongruent. Secondly, with regard to silently praying for a client, Gubi convincingly argues from a Christian perspective, that silent prayer is '*an attitude that is inherent in the counsellor's way of being'* and gives the counsellor '*the sense of being a part of something bigger to which the counselling work can be entrusted'* (2011: 65. See also Post et al., 2000). In addition, silent prayer by a therapist can 'sustain' a therapist during difficult sessions (McMinn, 1996: 69).

Explicit interventions

In addition to implicit interventions, there is also what Tan describes as an *'explicit'* approach to integration (2011: 66), or what Gubi describes as an '*overt*' stance (2011: 65), that is an approach which includes the explicit and obvious use of a range of Christian FRSIs in clinical practice. The use of these interventions has the potential to help a client address their presenting problem and in addition consider any faith, religious or spiritual difficulties, for example, difficulties in their relationship with God (see Chappelle, 2000 and Captari, 2018).

There are a broad range of explicit interventions, and it is beyond the scope of this paper to mention them all. Therefore, five interventions have been highlighted, mainly because these are the ones that research and literature have identified as being commonly used by Christian therapists when they integrate FRSIs into their clinical practice.

1. **The appropriate use of scripture**

   There is considerable evidence that the use of scripture with Christian clients can sometimes be beneficial (for example, see Propst, 1992; Koenig, et al, 2016; de Abreu Costa & Moreira-Almeida (2021). Nevertheless, this is perhaps one of the most controversial FRSIs, not least because, as Johnson highlights, the '*task of relating the Bible to the human science is fraught with difficulty*' (1992: 346). In addition, there is considerable evidence that scripture has been misused in the counselling room, for example, when it is

used as a corrective tool; a means of '*speaking truth in love'* (see Powlison, 2010: 258 who has advocated this approach).

The danger of the misuse of scripture (as well as the misuse of other FRSIs) has, as Gubi points out, often been linked to the potential to create a '*power imbalance*' (2009: 119). In addition, as Tan has pointed out, *'the thoughtless and superficial use of scripture in therapy can lead to harmful consequences'* (2011: 353).

The damage caused by the misuse of scripture has been well documented and highlighted by a number of studies. For example, research conducted by Fouque and Glachan demonstrated that clients who perceived that their counsellor placed an '*emphasis*' '*on the use of prayer and scripture*' reported a '*greater negative experience of the counselling process'* (2000: 214). (See also research conducted by Martinez et al., 2007 and Scott, 2013).

To minimise, as far as is possible, the misuse of scripture, it is recommended that if a client raises the use of scripture during their counselling session (and it would normally be expected that it would be the client and not the therapist who would initiate the use of scripture), it is important for the therapist to take a neutral and curious explorative approach, providing the client with sufficient space to explore their own (and not the therapist's) interpretation of scripture (see McMinn, 1996; Young et al., 2009; West 2011, b). This nondirective and curious approach is ethical and allows a client's perceptions to be explored. It also prevents, as far as is possible, a therapist's own agenda from being imposed. Finally, it is also worth mentioning that if a client requests the use of scripture in counselling, it can be valuable to discover from the client what biblical texts the client has personally found bring them comfort and/or what they have found helpful (Johnson, 1992. See also de Abreu Costa & Moreira-Almeida, 2022).

2. Use of prayer (by the client or therapist, dependant on the client's choice)

Alongside the use of scripture, prayer is one of the most commonly used FRSIs (McMinn & Campbell, 2007; Aten & Leach, 2009; Tan, 2011; Thurston Dyer & Hagedorn, 2013). As an explicit intervention, prayer may be used, with caution, usually when a client specifically requests this. Gubi (2011) sets out several valuable recommendations on the use of prayer in clinical practice, including:

i. The importance of therapists being aware that the use of prayer can be '*contentious*' (2011: 67) and that it is thus essential that therapists reflect on the ethical issues over the use of prayer and especially the importance of clients giving specific informed consent for the use of prayer;
ii. That the prayer offered should not be directive, but rather be both sensitive and '*relevant to the context and the moment of what is being shared*' (2011: 71);
iii. That prayer should usually be offered at the end of the session so that it is '*less intrusive to the therapeutic process of the session*' (2011:73)
iv. That prayer '*should not be used to impose or communicate the counsellor's values to the client*' (2011: 74).

Research confirms that clients can experience prayer at the end of the session as a source of great comfort and support (see Fallot, 2001 and Thurston Dyer & Hagedorn, 2013). It is worth noting West's caution, however, that therapists must be aware *'about any use of prayer and its impact on the client and the therapeutic alliance and its potential contribution to a successful outcome'* (West 2011, a: 215. See also McMinn, 1996; Post et al., 2000).

3. **Exploring religious/spiritual concerns and taking a religious/spiritual history**

   A client's faith, religious and/or spiritual concerns can be many and varied. If a client desires to explore their faith, religious, spiritual issues, taking a narrative approach to help a client explore these is useful. By listening carefully to a client's story, including their faith issues, this approach helps the therapist to discover a client's faith background, experience, perception, relationships and potential faith issues (Fallot, 2001. See also Captari, 2018). A further way of exploring a client's faith/religious/spiritual difficulties is to use, what Wiggins suggests, a spiritual autobiography and/or a '*spiritual genogram*,' where a client shares their faith/religious/spiritual experiences and difficulties alongside their difficult life events (Wiggins, 2009:59). Wiggins believes this can shed light on and clarify a client's faith issues.

   It is also worth noting that research identifies one particular faith religious/spiritual difficulty that often arises. This issue relates to the potential link between a client's difficult experience of their early care givers and their subsequent internal working model of themselves, how they perceive and relate to others (see Bowlby, 1973) and how this can result in their experience of and relationship with God (see Rizzuto,1979; Brockaw & Edwards, 1994).To explain this further, whilst Christians would generally disagree with Freud's assumption that faith in God is a mere 'wish fulfilment' and something to overcome (1927/1973) nevertheless, research has shown Freud was right in determining that faith can, at times, be a projective system (see TenElshof & Furrow, 2000; Njus & Scharmer, 2020). In other words, a person's relationship with God can sometimes correspond with, and mirror, the nature and quality of the attachment relationship they experienced with their early care-givers in childhood (see Rizzuto, 1979; Brockaw & Edwards, 1994; Kirkpatrick, 1999; Aten & Leach, 2009). Assisting a client to become aware and conscious of these potential links between

their early life experiences and relationships and their subsequent faith in God can be profoundly helpful, even transformational (see Captari et al., 2018; Viftrup et al., 2021).

4. **Exploring forgiveness**

Several writers encourage the therapeutic use of forgiveness in counselling (see Post et al, 2000; Kersting, 2003; Baskin & Enright, 2004; Frise & McMinn, 2010; Wade et al., 2014) and it is worth noting that in a study by Martinez et al., clients perceived exploring forgiveness as one of the most valuable FRSIs (2007: 949).

Enwright (2023) proposes eight steps towards forgiveness, highlighting that forgiveness can facilitate healing for deep pain and wounds, enabling clients to gain a greater sense of freedom and security (see also Kersting, 2003 and Baskin & Enright, 2004). In addition, Wade et al., (2014) found that the use of forgiveness interventions assisted clients to find a level of resolution over the trauma or offence they had suffered. Nevertheless, when a therapist discusses forgiveness in a therapeutic context, they need to be aware of a number of considerations.

Firstly, there can be misconceptions about the concept of forgiveness and for this reason a therapist may need to make use of psychoeducation in order to correct any misunderstandings; for example, forgiveness does not mean the offence doesn't matter, or that forgiveness somehow justifies or condones the abuse or offence, or that forgiveness means forgetting the pain and damage that it has caused (see Wake, 2025). Secondly, as Sutton (2020) points out, great damage can be done if clients feel in any way rushed to forgive. Thirdly, forgiveness should be seen as a process and that clients must not feel pressured to forgive too early in the process, nor should they feel judged, but rather supported when they choose to explore the concept of forgiveness (see Baskin & Enright, 2004 and Martinez et al.,

2007). Finally, McMinn cautions therapists to explore the topic of forgiveness with great empathy and humility (1996: 235).

For all of these reasons, it is therefore strongly recommended that generally it should be the client and not the therapist who introduces the concept of forgiveness. This ensures that exploring forgiveness is the client's choice and agenda and thus not the therapist's agenda or desire.

5. Use of spiritual meditation and/or mindfulness

The benefits of meditation and mindfulness have been well documented (Seeman et al., 2003; Shapiro, et al., 2005). West points out that '*one of the most curious and interesting developments*' in recent times has been the increasing interest in mindfulness and meditation (West, 2011, b: 26).

Literature highlights how therapists can choose to incorporate a wide variety of techniques based on spiritual meditation and mindfulness, depending upon what a client finds helpful (see Post & Wade, 2009). It is beyond the scope of this paper to distinguish between meditation and mindfulness, suffice it to say that research has demonstrated that the use of Christian meditation/mindfulness in clinical practice has been found to be helpful to not only reduce a client's levels of stress, anxiety and mental health difficulties, but also facilitate clients to improve their relationship with God (Wachholtz & Pargament, 2005; Frederick & White, 2015, Knabb, et al., 2020).

Nevertheless, meditation or mindfulness is not for all clients and some may find it unhelpful (see Johnston, 2021). Therefore, as with all FRSIs, therapists must discover from their client what their client believes might be valuable. In addition, some Christians may be reluctant to engage in mindfulness on the basis that it contradicts their Christian faith. Without getting into doctrinal debates with clients, it might be valuable for a therapist to explore

a client's concerns and/or reluctance to engage in mindfulness/meditation practice and, if helpful, refer them to books and articles that Christians have specifically written on the topic (for example see Collicutt, Bretherton & Brickman, 2016).

Conclusion and a final word from the author

There is overwhelming evidence that for some Christian clients, the inclusion of FRSIs leads to better clinical outcomes (see Propst, 1992, Post & Wade, 2009; Captari et al., 2018; de Abreu Costa & Moreira-Almeida, 2022; Rathore & Kriplani, 2023). Nevertheless, the inclusion of FRSIs in therapy creates the potential for complex ethical difficulties to arise. Therefore, in closing, it would be remiss of me not to reiterate and emphasise the importance that when a therapist utilises FRSIs, they openly explore and specifically contract with each client what their unique wishes and desires are regarding exploring any faith, religious or spiritual concerns and difficulties, and/or if they are pleased for FRSIs to be used in therapy. This ensures therapists gain explicit informed consent from clients to work in this area and in addition ensures the client's right to autonomy. It also confirms that a shared understanding must be reached between both the therapist and their client regarding the client's wishes (see Chappelle, 2000; Hathaway & Ripley, 2009; Leach et al., 2009; Jenkins, 2011; Tan, 2011; Captari, et al., 2018). It is also worth stressing that it is essential clients do not feel coerced or pressurised in any way to engage with religious and/or spiritual material unless they explicitly wish to do so (see Knox et al., 2005; Barnett & Johnson, 2011).

Finally, it is important to say that this paper should be read alongside, and in conjunction with, The Churchill Framework for Counselling and Psychotherapy (2025) to ensure FRSIs are used ethically, compassionately and competently by therapists in their work with clients.

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