Issues and Insights

The Ethics of Prayer in Counseling

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Spirituality has become increasingly important in counseling, with prayer being the spiritual intervention of choice for Christian counselors. The controversial nature of including prayer in counseling requires careful consideration of ethical issues. This article addresses the intersection of spiritual interventions, particularly prayer, with client welfare, multicultural sensitivity, values, and countertransference. The authors consider the ethical mandates, articulate concerns, and make recommendations.

Spirituality has been increasingly recognized as important in counseling (Miranti & Burke, 1995; Wade & Worthington, 2003). The majority of mental health professionals claim some type of religious affiliation, believe that spirituality is personally relevant, and value personal prayer (Bergin & Jensen, 1990; Carlson, Kirkpatrick, Hecker, & Killmer, 2002; Shafranske & Malony, 1990). Many mental health professionals also speak of the importance of spirituality to people's well-being (Genia, 2000; Miranti & Burke, 1995; Wade & Worthington, 2003). Prayer is the spiritual intervention most frequently used by Christian counselors (Sorenson & Hales, 2002; Wade & Worthington, 2003). Even secular practitioners regularly incorporate religion into their practices (Ball & Goodyear, 1991), with many believing that praying for a client is appropriate. Some secular practitioners do pray with clients, although most believe that it is inappropriate to do so (Carlson et al., 2002; Shafranske & Malony, 1990).

Perhaps as a result of the majority of the U.S. population's belief in God (Gallup Organization, 2006) and the power of prayer (Princeton Survey Research Associates, 2003), many clients want to discuss religious or spiritual issues within the context of counseling (Rose, Westefeld, & Ansley, 2001). Christian clients in particular expect prayer to be included in Christian counseling (e.g., Belaire & Young, 2002). Because sensitivity to clients' expectations helps build the therapeutic alliance, which in turn contributes to positive outcomes (Horvath & Symonds, 1991; Kim, Ng, & Ahn, 2005; Strauser, Lustig, & Donnell, 2004), methods for including prayer in counseling with some clients need to be examined.

However, ethical concerns are often raised when considering the use of prayer as an intervention in counseling, particularly when considering audible in-session prayer (Richards & Potts, 1995). Conversely, ethical concerns exist about secular counselors' inability to respond helpfully to clients' spiritual

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needs and expectations because of lack of awareness or countertransference related to religious issues (Richards & Potts, 1995). Therefore, in this article, the authors consider the ethical mandates that intersect with the use of prayer in counseling, articulate concerns, and make recommendations. Ethical areas to be discussed include client welfare, multicultural sensitivity, values, and countertransference. Types of prayer assumed in this discussion include clients praying without being in the presence of the therapist, sometimes at their own instigation and sometimes as "homework" given to them by the counselor; counselors praying silently in session or outside of the session for the client; and either the practitioner or the client praying audibly during the session (Decker, 2001; Magaletta & Brawer, 1998; McCullough & Larson, 1999).

Prevalence and Beliefs About Prayer in Counseling

Surveys of both secular and Christian mental health professionals have begun to establish the degree of acceptance and frequency of use of prayer as an intervention (Ball & Goodyear, 1991; Carlson et al., 2002; Shafranske & Malony, 1990; Sorenson & Hales, 2002; Wade & Worthington, 2003; Worthington, Dupont, Berry, & Duncan, 1988). Research indicates that 78% of counselors in Christian agencies and 100% in Christian private practices believe it is appropriate to pray with or for a client (Wade & Worthington, 2003). Sorenson and Hales reported that approximately 30% of Christian therapists actually prayed with clients during sessions (see also Ball & Goodyear, 1991). Richards and Potts (1995) determined that silent therapist prayer was the spiritual technique most often used by therapists who were of the Mormon faith; some of these therapists also engaged in vocal in-session prayer and assigned client out-of-session prayer. Only 11% of the therapists in secular agencies thought that praying with or for a client was appropriate (Wade & Worthington, 2003). Yet, interestingly, Shafranske and Malony determined that 24% of the secular clinical psychologists said that they prayed privately for a client, and 7% reported having prayed with a client. It should be noted that the majority of secular mental health providers do not consider spirituality particularly important to treatment efforts (Bergin & Jensen, 1990; Carlson et al., 2002; Shafranske & Malony, 1990).

However, marriage and family counselors differ from other providers. Carlson et al. (2002) summarized the results of their study of 153 marriage and family therapists as follows: "While 95% of the respondents believed there is a relationship between spiritual and mental health, only 62% believed that a spiritual dimension should be considered in clinical practice, and . . . 47% agreed it was necessary to address a client's spirituality in order to help them" (p. 166). Additionally, "only 68% believed that it was appropriate for therapists to ask clients about their spirituality, and only 42% agreed it to be appropriate to help clients develop their spirituality" (p. 166). These researchers attributed the seeming disparity between therapists' beliefs and practice to two causes: lack of education in how to integrate spirituality and therapy and "the newness of spirituality as a viable topic for therapy" (p. 167). The authors concluded that if nearly half of marriage and family therapists surveyed believe in

integrating a client's spirituality into clinical work, spirituality has clearly become an important issue in marriage and family therapy.

In spite of some therapists' reluctance to incorporate spirituality into therapy, religious or spiritual issues are increasingly included in scholarly discussions, even by secular providers. "Religious or Spiritual Problem" was added to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., *DSM-IV;* American Psychiatric Association [APA], 1994) and continued in the text revision of *DSM-IV* (APA, 2000). Moreover, the number of studies being conducted to evaluate the link between people's spirituality and mental health and between clients' spirituality and effective psychotherapy (e.g., Gordon, Feldman, Crose, Schoen, Griffing, & Shankar, 2002; Wade & Worthington, 2003) indicates that there is presently a more amiable posture between secular psychology and religion than was historically evidenced.

Client Welfare

The *ACA Code of Ethics* (American Counseling Association [ACA], 2005) requires that counselors "promote the welfare of clients" (Section A.1.a.) and "avoid harming their clients" (Section A.4.a.). To meet these requirements with respect to prayer, counselors need to fully assess clients' spirituality and prayer life and their expectations about the inclusion of prayer and other spiritual interventions in counseling. Counselors also need to be aware of the benefits and harm related to spirituality and spiritual interventions, including prayer. Further, counselors need to exercise multicultural sensitivity (ACA, 2005) and need to avoid imposing their own values on clients (Section A.4.) or acting out their countertransference (Sections C.2.g. & F.5.b, c.).

Initial Assessment

Without assessing a client's spirituality, counselors may engage in inappropriate or ineffective use of spiritual interventions or treatment of highly religious clients (Richards & Potts, 1995). Therefore, before using spiritual interventions such as prayer, Richard and Potts advised counselors to respect individual differences and learn about "each client's unique religious understandings" (p. 169). "Even when the client belongs to the same religion as the therapist," they indicated, "major differences in belief can exist, and so therapists should not make assumptions about the religious beliefs and values of the client" (p. 169). Pargament (2002) suggested that after joining with the client, the counselor could ask the following five questions: (a) "How does your faith give your life meaning?" (b) "What are the advantages and disadvantages of your faith?" (c) "Does your faith help you with some situations more than with others?" (d) "Who can support you so that you can grow in your faith in helpful ways?" and (e) "Might there be a solution to your problems that includes other personal strengths besides your faith?" Griffith and Griggs (2001, p. 22) suggested additional questions: "Do you

have a religious preference?" "Do you currently attend religious services?" "What are your reasons for attending services?" and "How important are your religious beliefs to you?" Therapists might also ask, "In what ways do you want to include spirituality in our counseling sessions?" Hartz (2005) suggested a client-centered approach that asks clients to indicate how their spirituality might contribute to their understanding of the problem or solutions; such an approach would allow clients to feel free to share. McCullough and Larson (1999) suggested assessing prayer specifically by asking clients about the types of prayer they use and how they find it helpful in coping with difficult life situations. The previously mentioned questions may also be recrafted to ask clients more specifically about their prayer experiences and expectations.

Normative Versus Harmful Beliefs

Genia (2000) listed four reasons that explicit spiritual interventions might run counter to client welfare: lack of therapist training in working with spiritual techniques, possible violation of laws related to the separation of church and state, iatrogenic consequences for more seriously disturbed individuals, and use by therapists who do not nurture their own spiritual lives. Sperry (2001) added that prayer may be contraindicated for fragile clients with poor ego boundaries, when it might threaten the therapeutic alliance, or if it disrupts therapist neutrality or objectivity. We agree with these notions and urge counselors to be cognizant of when they may apply. However, more subtle dangers exist in colluding with clients whose faith is practiced in harmful ways (Arterburn & Felton, 1992; Lovinger, 1996; Taylor, 2002) or in intervening in ways that do not match clients' developmental readiness (Fowler, 1986; Griffith & Griggs, 2001; Worthington, 1989). Therefore, as Lovinger stated, "Clinical assessment must be informed by an understanding of what constitutes normative beliefs and behaviors within particular denominations" (p. 346). Further, during assessment, counselors must determine a client's developmental abilities to understand how these relate to particular faith practices (Griffith & Griggs, 2001; Worthington, 1989).

Harmful faith. In some cases, clients with mental health problems may act out their problems religiously. For instance, religious addiction is often accompanied by compulsive prayer. Therefore, an uninformed clinician may exacerbate pathology by praying with such a client (Taylor, 2002). Additionally, a religiously addicted spouse may force "sessions of prayer" and "scripture quoting" and engage in physical abuse when the other partner violates a dogmatic rule (Taylor, 2002, p. 304). Therefore, inclusion of prayer within sessions or as homework may reinforce the controlling behavior of the religiously addicted spouse and may foster unhealthy dependency between the partners (Taylor, 2002). Finally, Arterburn and Felton (1992) indicated that the religiously addicted "adhere to a hurtful religion to dodge the emotional turmoil that comes with facing the reality of their circumstances" (p. 114). Consequently, any intervention is contraindicated that encourages clients to adhere to a harmful faith in ways that interfere with attention to their central problems.

Lovinger (1996) offered the following 10 indications of "probable religious pathology" (p. 347): self-oriented or narcissistic displays, religion used to gain rewards from God, scrupulosity in avoiding sin or error, relinquishing responsibility for problematic behavior to "the devil" (p. 348), ecstatic frenzy or intense emotionality, persistent church shopping, inappropriate sharing of one's religious experiences, religiously inspired "love" that causes pain or confusion, using the Bible to answer "ordinary questions about daily living" (p. 349), and reports of possession by the devil.

Lovinger (1996) contextualized the preceding list by offering the following indices of mature religious adjustment: awareness of complexity and ambiguity in the Bible and faiths more generally, religious affiliation based on a thoughtful decision-making process, value–behavior congruence, recognition of one's shortcomings, and respect for boundaries. Sperry (2001) also indicated the following benefits of including prayer in counseling: It may offer comfort and hope, convey a clinician's caring for and commitment to the client, may combat client isolation and loneliness, and enhance trust. Pargament (2002) offered similar thoughts, indicating that faith that is internalized and provides meaning in life fosters well-being. He indicated that even the most controversial religions seem to have advantages. For instance, research has indicated that fundamentalism correlated both with greater prejudice toward those different from oneself and with increases in well-being. It also seems that socially marginalized groups, more religiously committed people, and those experiencing very stressful situations (i.e., death) found more benefit in religion than did others. Finally, Pargament noted,

> The efficacy of religion depends on the degree to which it's integrated into peoples' lives. Those who benefit most from their religion are more likely to (a) be part of a larger social context that supports their faith; (b) apply means that are appropriate to their religious ends; (c) select religious appraisals and solutions that are tailored to the problem at hand; and (d) blend their religious beliefs, practices, and motivations harmoniously with each other. (p. 178)

Knowledge about the harm and benefits that may accrue from faith, and specifically from prayer, informs a clinician's assessments of the role of faith in a client's life, the ways in which the client expresses his or her faith, the client's expectations about the role of spirituality in the counseling sessions, and the most helpful ways to intervene with religious clients (Magaletta & Brawer, 1998). Assessment allows counselors to address religious concepts that may be related to the client's presenting problem (Spero, 1982; Yarhouse, 1999) and to demonstrate caution in using spiritual interventions if religion seems to be part of the client's problem (Richards & Potts, 1995; Spero, 1982). Clinicians, thus, need to develop an understanding of neurotic and normal needs for prayer (Spero, 1982) and to understand their own prayer beliefs before using prayer as part of the counseling process (Magaletta & Brawer, 1998).

Developmental Readiness

Promoting client welfare and avoiding harm also requires ensuring the developmental appropriateness of spiritual interventions. Worthington (1989)

and other developmental theorists (Kegan, 1982, 1994; Kohlberg, 1981, 1984; Loevinger, 1976; Perry, 1970) indicated that as individuals become more open to diverse ways of life, religious beliefs become less rigidly held, as do client expectations about spirituality in counseling. This progression toward religious flexibility is illustrated by Marcia's (1966) developmental model, as adapted by Griffith and Griggs (2001). Marcia conceptualized Erikson's (1963) stage of identity versus identity diffusion as four stages of identity: diffusion, foreclosure, moratorium, and achievement. Griffith and Griggs (2001) used Marcia's four stages as a paradigm "to describe the various ways people adopt and experience their faith" (p. 15). In the diffusion stage, the individual either lacks interest in religion or has adopted extrinsic religious beliefs that are self-serving. In the foreclosure stage, faith remains external and self-serving, but the individual adds compartmentalized religious beliefs that are motivated by the need to gain acceptance. During the moratorium stage, the person may experience a period of openness and exploration that enables faith "to become internalized and integrated into" their identity (Griffith & Griggs, 2001, p. 18). In the achievement stage, religious faith becomes internally motivated and contributes to "the sacredness of life and relationships" (p. 19). Fowler's (1981, 1986) six stages of faith, stretching from undifferentiated to universal faith, offer a similar theory of faith development. Counselors need to learn to discriminate mature and immature religious beliefs according to the degree to which such beliefs enable autonomy and foster successful conflict resolution (Spero, 1982).

Incorporating Griffith and Griggs's (2001) or Fowler's (1981, 1986) theories into assessment and intervention strategies makes it clearer when prayer might be helpful or harmful. For example, prayer with clients who are at earlier stages of spiritual development could encourage rigidity in religious beliefs that may already be rigidly held. Prayer with such clients might also reinforce superficial faith through prayers that are either insincere, perhaps engendering client incongruency, or prayers that are not informed by basic tenets of mature faith (e.g., God is sovereign), perhaps engendering unrealistic hope. However, prayer with clients in the later stages of development could facilitate growth and self-awareness because such clients are motivated toward spiritual growth and are open-minded regarding diverse paths to spiritual growth. Thus, ethical counselors also promote client welfare and avoid harm by assessing clients' developmental levels and then intervening in developmentally appropriate ways.

Summary

Given all of the evidence of the mental health benefits of prayer and other spiritual practices (Connerley, 2003; Finney & Malony, 1985; Gordon et al., 2002; Poloma & Pendleton, 1989), therapists may be remiss in not considering prayer as a possible intervention, because prayer in the proper context may promote client welfare. However, as Kennedy and Charles (2001) stated, "sensible counselors will not quickly apply purely spiritual solutions—such as prayer and fasting—to problems that usually have deeper and more complicated origins" (p. 127). They offered the following guidelines that may be

helpful in deciding when to include prayer in the counseling process. Therapists who practice in religious settings (e.g., religious universities and church social service agencies) may find that it is expected, comfortable, and helpful to pray with clients individually or in group sessions. Therapists in private-practice settings who work with generally well-functioning, religiously devout clients also may find that praying with clients can be helpful. In some inpatient settings in which religious services are included as part of the treatment milieu, prayer may be appropriate. Koenig and Pritchett (1998) suggested including prayer in counseling when religion is an important coping strategy for the client(s); when the client asks for in-session prayer or shows no hesitation to the proposal of prayer (see also Basham & O'Connor, 2005); when the client has sufficient ego strength, stability, and boundaries; and when prayer will advance treatment goals. They further suggested that in-session prayers be kept brief; that clients do the actual praying; that if the clinician prays, he or she make the prayer general, supportive, affirming, and hopeful; and that the clinician explore client reactions to the prayer in subsequent sessions. Basham and O'Connor added that prayer may be appropriate when counselor and client share similar religious beliefs. They urged counselors to rule out and discourage prayer that is part of the client's pathology. Furthermore, if the counselor does not share the client's beliefs, the counselor should respectfully sit while the client prays or should refer the client to clergy. Finally, if the client chooses to pray as part of a session, counselor and client need to process the experience both before and after by considering such questions as "What is the purpose of praying?" and "How did it help the client?"

Multicultural Sensitivity

Attention to client welfare and avoiding harm also require multicultural competence on the part of counselors. Bergin and Jensen (1990) stated that "every therapeutic relationship is a cross-cultural experience" (p. 3). Concurring with this statement, the *ACA Code of Ethics* (Preamble; ACA, 2005) indicates that ACA "members recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts." In addition, "counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve" and "explore their own cultural identities and how these affect their values and beliefs about the counseling process" (Section A). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards further specify that such multicultural competency includes counselor sensitivity to "spiritual values" (Section 2, Standard K.2; CACREP, 2001).

Richards and Potts (1995) viewed as extreme and unwarranted the belief among some professionals that prayer should never be used. In fact, they stated that "those who would exclude all spiritual perspectives and interventions from psychotherapy are in danger themselves of violating [ACA's] ethical principles regarding respect for human diversity" (p. 169), particularly given that highly religious clients may expect in-session prayer and that there are circumstances

in which in-session prayer may be appropriate and helpful (Kennedy & Charles, 2001; Richards & Bergin, 1997). From Richards and Potts's perspective, the refusal to include a client's spirituality in the counseling process constitutes a lack of empathy, a refusal to contextualize other information offered by clients, a lack of competency in utilizing clients' spiritual resources, and a cultural blind spot that indicates disrespect for, or a lack of sensitivity to, the client's religious values.

Ingersoll (1995) urged clinicians to affirm the importance of clients' spirituality and prayerfulness and attempt to enter client worldviews with vocabulary and imagery that is congruent with clients' faith experiences. For instance, counselors might use religious images during guided imagery (Yarhouse, 1999), offer scripture passages that correspond with therapeutic prescriptions, use prayer as a means to shift cognitions (McCullough & Larson, 1999), or suggest in-session or out-of-session prayer. Clinicians might further consult with the clients' other "healers," such as clergy, when questions arise about how to do this (Ingersoll, 1995). They might engage and network with religious leaders; become familiar with community resources such as churches, synagogues, prayer groups, 12-step programs, and lay religious counselors; and develop a referral network that is composed of religious professionals from a variety of faiths (Yarhouse, 1999). Particularly important would be developing a straightforward language with which to communicate with clients about religious values (Bishop, 1995).

More secular counselors might educate themselves about spiritual issues in a number of ways. They might familiarize themselves with research on prayer so as to appreciate the healthy potentialities of religious involvement (Genia, 2000). They might pursue information about different religious values, beliefs, and practices, and strive to understand how these issues might be integrated with psychological theory and counseling practice (Bishop, 1995). Kelly (1995) advocated, at a minimum, developing sensitivity to the world's mainstream religions (Hinduism, Buddhism, Confucianism, Taoism, Islam, Judaism, and Christianity) and the role of prayer in each of these faiths.

Increased multicultural sensitivity may, therefore, be required both (a) on the part of religious counselors, who may be inclined to believe that all encounters are spiritual encounters and to impose interventions such as prayer on clients and (b) on the part of secular counselors, who may resist inclusion of any spirituality in the counseling process. Keeping in mind the sensitivity of many people about faith and about including prayer in counseling, counselors need to fully incorporate informed consent procedures. Clients have the right to participate in the decisions about how spiritual interventions, including prayer, may be incorporated into the counseling process (Section A.2; ACA, 2005).

Values and Countertransference

Practitioners generally comply with professional codes of ethics (e.g. Section A.4.b.; ACA, 2005) regarding not imposing their values on their clients and respecting the values held by their clients. However, unlike other values, faith positions may generate countertransference responses for some counselors

because of damaging past experiences. That is, some counselors may have been abused by faith communities, and others may have been "saved" by faith from very damaging life circumstances.

Respecting Client Values

Counselors might follow a number of guidelines in order to respect their clients' values regarding prayer. For example, when praying with clients or when encouraging clients to pray, "therapists need to make sure that they work within their clients' religious belief systems so that they do not impose their own beliefs about and practices of prayer on their clients" (Richards & Bergin, 1997, p. 204; see also Richards & Potts, 1995; Yarhouse, 1999). Counselors need to assure clients that their beliefs about prayer will be respected, not discounted, and even fully appreciated during their work together (Bishop, 1995; Yarhouse, 1999). In addition, Richards and Potts warned that extreme caution should be used when therapists and clients do not share the same religious worldview; spiritual interventions, including prayer, are "easier and safer" when counselors and clients share a similar faith (p. 169).

Counselors might further manage assessment, awareness, and expression of values in the counseling process by examining the values inherent in their chosen counseling theory, initiating a discussion of values with clients, or discussing the clinician's perspectives on prayer as part of the informed consent process (Yarhouse, 1999). They might be more proactive in finding ways in which the client's religious values or prayer could be used as part of the solution to the client's problem. Counselors also need to become conscious of what they may convey to clients through their resistance or cautious maneuvering around religious issues (Bishop, 1995).

Countertransference

Appropriately interacting with the client's values system requires a great deal of self-awareness. According to Spero (1982), "the therapist's ability to perceive the patient with an appropriate balance of professional enthusiasm and detachment requires ongoing self-examination" (p. 565), particularly when working with religious clients. Ongoing self-examination, he further suggested, is a "technical and ethical obligation... [for] anti- and nonreligious therapists encountering religious patients, and religious therapists encountering anti- or nonreligious patients" (p. 566).

However, this self-awareness may be hampered by unresolved issues from damaging experiences with or without religion; countertransference may, thus, emerge in both religious and secular counselors. Countertransference responses of the religious therapist can range from "rescue fantasies to disdain brought on by projection of personal insecurity, guilt, or prejudice" (Spero, 1982, p. 567). Client transference can also generate strong emotional reactions in the counselor (Spero, 1982, p. 567). For instance, transference responses of the religious client can range from "the need to replace loved objects and to obtain gratification through identification with the therapist's religious life, to

the expectation of magical cure" (p. 567). In addition, a number of authors have expressed concerns that countertransference in religious counselors can result in boundary violations as clinicians try to balance their attention to psychological and spiritual matters (Genia, 2000; Richards & Bergin, 1997; Richards & Potts, 1995). Playing two roles concurrently may confuse clients, because they may find it difficult to keep clear the differences between the roles of professional therapists and religious leaders (Richards & Bergin, 1997).

Countertransference may be particularly hard to overcome in secular counselors who have had damaging childhood experiences with religion. It may result in not seeing the importance of such spiritual interventions (Bergin & Jensen, 1990), not educating themselves about religious experience, distancing themselves emotionally from religious clients, or trying to persuade clients to give up their faith or their church because of the perception that these are in some way damaging to mental health. Secular practitioners may also have negative reactions to evangelizing clients who see themselves as morally superior (Genia, 2000). Case (1997) listed six types of countertransference phenomena that exist between counselors and religious clients:

- The therapist with a *sibling complex* engenders excessive agreement with the client or loose interpretations because of commonalities such as similar values and similar expectations of one's religious community.
- The *missionary* therapist uses the therapeutic relationship as a context to proselytize clients.
- The *spiritualizer* therapist views all client issues as requiring a spiritual intervention when many other legitimate interventions may be appropriate, a view that may be encouraged by the client's misinformed expectations about a counselor's role.
- The *reactionary* therapist experiences "aggressive feelings against the (religious) group, or unresolved rebelliousness" that can result in inappropriately avoiding religious interventions (Spero, 1981, p. 567) or acting in defiance of the client's religious traditions, behaviors, or spiritual statements.
- The *window shopper* therapist exhibits excessive curiosity about the client to gratify her or his own needs (e.g., asking clients to divulge all of their sexual secrets) due to the therapist's restrictive religious beliefs (e.g., perhaps regarding sexuality).
- *My way is Yahweh* therapists pose as the experts in spiritual matters instead of recognizing that there are many different and valid opinions and interpretations about specific spiritual issues, some of which may be held by the client.

Counselors generally pursue their own therapy or supervision in order to become aware of and appropriately manage countertransference (Agass, 2002; Astor, 2000; Wolitzky, 1995). During such a process of self-examination, they scrutinize their own religious attitudes, or lack of such attitudes, to determine whether their perspectives are normal or neurotic, mature or immature. They aim to develop a nonanxious and benevolent attitude about the anxi-

ety, anger, and frustration that emerges when encountering clients who are religiously different from themselves. They pursue tolerance of the client's normal need for an area of emotional, but not necessarily rational, commitment and belief and learn to contain their own need to impart insight into every aspect of the client's life (Spero, 1982).

Although counselors are in the process of resolving countertransferential reactions to clients, clients need protection from the potentially harmful effects of the therapist's inability to work with spiritual issues. Therefore, Genia (2000) advocated making appropriate referrals, either to other counselors who share the client's worldview or to spiritual advisors who are trained to address spiritual issues. This injunction is supported by the *ACA Code of Ethics* (ACA, 2005), which states that "Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives" (A.11.b.).

Implications for Counselors

Polls and surveys indicate the high value that the general population, clients, and many mental health practitioners place on spirituality and on prayer. Integrating spirituality into counseling procedures is widespread among Christian counselors, with prayer being their spiritual intervention of choice. Research has increasingly demonstrated the importance of sensitivity to the spirituality of clients and suggests ways to develop such sensitivity. Therefore, the ethical ramifications of incorporating spiritual interventions, particularly prayer, need to be considered.

We have addressed the intersection of prayer and other spiritual interventions with client welfare, multicultural sensitivity, values, and countertransference. In particular, we have stressed the need for counselors to carefully assess client spirituality and developmental capacities, for educating themselves about healthy and unhealthy spiritual practices, and for dealing with their own countertransference issues related to spiritual issues.

At this point, secular counselors may well ask, "But what if I don't believe in prayer or know how to pray?" Although they are wise to avoid practicing strategies that are outside their areas of competence (Section C.2.a.; ACA, 2005), such counselors certainly have the capacity to enter the client's worldview by asking the client if she or he would like to pray at the end of a session, or assigning prayer homework (e.g., praying about the problematic situation, praying for or with another person who is involved in the problem, or praying for the therapist's work or about the counselor's suggestions), or both.

In general, even professionals who regularly include prayer as a part of counseling urge counselors to use spiritual interventions only when prompted and guided by the spirit of God to do so, to establish a relationship of trust with the client before using spiritual interventions, and to obtain the client's permission before using spiritual interventions (Richards & Potts, 1995). Prayer should never be used (a) instead of referring clients to more helpful community resources, (b) if it might inadvertently strengthen a client's pathology, or (c) to

relieve the counselor of responsibility for grappling with difficult client issues. Magaletta and Brawer (1998) further urged counselors to stay aware of relevant ethical issues; to pursue self-understanding; and to participate in continual education, training, and research related to prayer in order to avoid either the denial of prayer's importance or the "utter fascination with prayer" (p. 329). In conclusion, "counselors who clearly understand their strengths and limitations in integrating religious values in therapy can enhance their effectiveness in working with clients' religious values and avoid the pitfalls associated with values conflicts in the therapeutic process" (Bishop, 1995, p. 69).

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