2

Mental health therapists consider the relevance of spirituality in their work with addiction and trauma

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Abstract

Over a 12-month period, a series of discussions were held with a group of nine mental health professionals working in a residential centre with clients who had alcohol and substance addictions. The group's initial aim was to explore the significance of spirituality for clients and to identify ways of addressing clients' spirituality in their own professional practice. In their work with their clients, they shared the perspective that addiction can develop from people's attempts to cope with the effects of trauma. They also experienced tension between institutional expectations influenced by the medical model and the need they perceived to incorporate spirituality in their work with clients. As group members explored their own spirituality in the context of their professional relationships with clients and the institution, they discovered some of the benefits of their own non-denominational counselling practices. Although addiction was conceived by the group as a false or unwelcome outcome of the struggle for meaning following trauma, it could also be seen as an adaptive process of recovery as well as a spiritual quest that might reconnect clients with their lost potential.

Keywords: addiction counselling, mental health professionals, coexisting problems, spirituality, trauma

An undeniable link has been identified between trauma and addiction (Center for Substance Abuse Treatment, 1994, 2014; Office of Applied Studies, 2010). Statistics suggest that a higher incidence of alcohol and substance addiction occurs in individuals who have experienced stressful life events, such as physical and/or sexual trauma, than by those in the general population who have not (Langman & Chung, 2013). Strong evidence also suggests that individuals with coexisting mental health problems

(CEP) use drugs and alcohol to avoid and/or to suppress the distressing effects of trauma, and that a substance-abusing lifestyle may predispose them to experiencing further traumatic events (Reynolds, Mezey, Chapman, Wheeler, & Baldacchino, 2005). Many clients seeking treatment for substance addiction therefore require trauma treatment services as well, and vice versa. Research also suggests that certain types of trauma can cause existential and spiritual crises and that addressing these can improve psychological and behavioural health (Baroody, 2010).

Spirituality may also have a significant part to play both in the prediction of recovery and in the improvement of addiction treatment outcomes. For example, in cases where individuals have recovered successfully and have maintained their changes, increases in their levels of spirituality between treatment entry and graduation have been noted (Heinz et al., 2010). A recent meta-analysis of 29 studies found evidence to support a beneficial relationship between spirituality or religion and recovery from substance use disorders (Walton-Moss, Ray, & Woodruff, 2013).

A significant aspect of recovery from addiction seems to involve overcoming struggles with existential meaning, and the construction of durable narratives that incorporate individuals' new beliefs and goals; arguably this parallels the processes of post-traumatic growth (Calhoun & Tedeschi, 2006). Interventions that utilise clients' spiritual resources could therefore provide support and strength in assisting them to resolve addiction, traumatic responses, and other coexisting difficulties (Langman & Chung, 2013). Although interventions that involve spiritual beliefs are difficult to evaluate, those that incorporate non-denominational approaches have been identified as effective at reducing trauma symptoms (Center for Substance Abuse Treatment, 2014).

Studies suggest, however, that despite the above evidence, and although individuals recovering from addictions frequently cite spirituality as a supportive influence, clinicians' perceptions of clients' spiritual needs have sometimes appeared alarmingly inaccurate (Heinz et al., 2010). In addition, numerous reasons are given to explain why counsellors and other health professionals find it difficult to consider integrating spirituality into their professional practices (see Bray, 2011). Counsellors may be constrained by their own life experiences, knowledge, and values, and/or the particular theories that underpin their work and the context and disposition of clients. Constraints may include atheistic denial of and defensiveness about the sacred; a determined rejection of all but one's own spiritual path without recognising or appreciating the diversity of the paths of others; an inability to accept that individuals

may construct their own spiritual meanings; and/or the belief that spirituality is beyond the purview of counsellors (Zinnbauer & Pargament, 2000). In addictions work, clients who bring spiritual, religious, or mystical experiences and beliefs to counselling may not always be sympathetically received or understood when also presenting with symptoms of substance misuse. A similar reception may also be experienced by their counsellors in collegial relationships when attempting to address the relevance of spirituality in their therapeutic work.

This article presents the reflections of one group of health professionals in Aotearoa New Zealand on spirituality and its relevance to their clinical practice. Here they discuss their experiences of trauma and spiritual work with clients affected by alcohol and substance addictions.

A special interest discussion group on spirituality

In 2014, I presented a paper on "spiritual emergence and emergency" (Grof & Grof, 1989) to an invited audience of mental health professionals and their clients at an addictions centre in Aotearoa New Zealand. The paper outlined specific spiritual responses to trauma that establish the appropriate conditions for post-traumatic growth to occur. Subsequently, I agreed to facilitate a series of nine or ten 90-minute conversations with some nine staff members who were interested in examining and reflecting on the role of spirituality post-trauma with clients who had been damaged by life events and had developed alcohol and substance addictions.

The group's concerns to address issues of spirituality in their work touched upon a developing trend in mental health and addictions recovery literature noted above, as well as in counselling. Since 2009, the American Counseling Association (ACA) has required its members to satisfy nine Competencies for Addressing Spiritual and Religious Issues in Counseling (Young, Wiggins-Frame, & Cashwell, 2007). These requirements assist in developing a practice framework that allows members to understand and work effectively with spiritual and religious aspects of clients' lives. They address four domains of counselling practice: knowledge of spiritual phenomena; awareness of one's own spiritual perspective; understanding clients' spiritual perspectives; and spiritually-related interventions and strategies. In Britain, too, there has been a cautious call to redress the imbalance, caused by an overemphasis on the rational, by reintegrating spirituality into counselling theory and practice (McLeod, 2010; West, 2001).

The group

The group of nine experienced psychotherapists and counsellors, psychologists, and social workers were either directly employed by the local district health board's (DHB's) mental health and addictions service or had a previous professional association with the service. They had an eclectic practice base that was largely informed and guided by the assertion that "addiction is a chronic relapsing brain disease characterized by compulsive behaviour" which causes psychological and physical harm to individuals, their families, and their communities (Walton-Moss et al., 2013, p. 224). In addition, the group also recognised that in the process of recovery, forms of spiritual rehabilitation were useful in penetrating clients' complex psychological defences (Doweiko, 1999).

Nearly half of the group acknowledged that they themselves had recovered from experiences that could be identified on the addictive continuum, including forms of trauma, and they could discriminate between psychotic and positively transformative spiritual outcomes. Their personal histories left them somewhat cautious about revealing fully their personal knowledge and values associated with the spiritual dimensions of their lives. Like their client group, they feared the judgement of their medical peers.

To set the scene for the group discussions, first the clientele then the context in which these mental health professionals worked are described.

The mental health and addictions treatment centre: The clients

The centre's staff members worked intensively with individuals from a broad range of socioeconomic backgrounds and ethnicities. Clients were comprehensively assessed by community services as meeting the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) definition for substance dependence: "a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behaviour" (American Psychiatric Association, 2000, p. 191). However, as there is a relationship between substance use and trauma-related mental health problems, it seemed important to determine whether or not a client was suffering from a trauma-related illness (Center for Substance Abuse Treatment, 1994).

In addition to moderate to severe spectrum addiction, almost all of the clients had coexisting mental health concerns, particularly PTSD and Axis II disorders (Matua Raki Workplace Innovation Awards, 2014). Clients had been diagnosed with depression; active mood, anxiety, personality, and/or eating disorders; and PTSD characterised by persistent maladaptive symptoms related to the trauma, including blunted emotional

responses, hyperarousal, and flashbacks (Logrip, Zorrilla, & Koob, 2012). Despite being drug-free, residents were vulnerable to stigmatising myths and prejudices about "addicts" that could lead them back to addictions, crime, violence, injury, and accidents; these in turn could place them in the way of further traumatising events that, even in the absence of PTSD, could precipitate relapse in these recovering addicts (Galanter, 2006; Logrip et al., 2012; Reynolds et al., 2005).[1]

The mental health and addictions treatment centre: The programme

Over an eight-week residential programme including CEP case formulation, motivational interviewing, person-centred and cognitive behavioural therapy, as well as contingency management, therapists assisted residents in developing the necessary skills to manage their addiction by the time they were discharged. Unsurprisingly, the centre's counsellors had a strong behavioural focus. As a group member explained:

> *What we are really trying to get to are the behaviours that guide clients' addictive behaviours. Looking at the cause as well as the effect…We don't often talk about drugs and alcohol but we do talk about behaviour and the things that led to substance use—these are just as much a part of the addictive behaviours as using the substances.*

In their first week at the centre, the therapeutic team would work to orient clients to residential living and to identify and manage potential risks or concerns that might affect their social interactions and health adversely, or limit their ability to participate positively in the programme. Based on eight "essential recovery components… designed to encourage the client to move towards managing his or her own recovery through increasing self-awareness, improving self-care and strengthening supports," a regular review of the Recovery Action Plan (RAP) supported clients more smoothly into their programmed recovery (Mental Health and Addictions Service, n.d.). The programme aims to support clients' self-assessed needs, strengths, and pathways to recovery, encourages self-awareness and self-reliance, and prioritises setting their own goals and developing strategies for achieving them.

In the context of recovery, this plan was guided by five areas of need: current situation; goals and hopes; actions; sharing responsibility; and progress. Consequently, counsellors would work with their clients on a number of structured activities to maintain motivation, engagement, and transformation. These included regular individual and group counselling; psycho educational training and skill development;

exploration of Aotearoa New Zealand and Māori culture and whānau; and recovery reviews that included consultation with staff and those who had referred the residents to discuss post-treatment goals, recovery maintenance plans, and emergency relapse action plans should transitioning back into the community pose risks to recovery. Clients received wrap-around care and were connected to wider services in primary care, mental health, family, and other community agencies.

The place of spirituality in the programme

A practical connection between spirituality and substance misuse and intoxication is reflected in Alcoholics Anonymous' (AA) 12 steps to sobriety and other 12-step groups that regard "the essence of spiritual experience" in recovery as an "awareness of a Power greater than ourselves" (Spencer, 2001, p. 568). Indeed, Spiegel (2005) suggested that as the 12-step programme was originally used to "heal highly traumatised alcoholics," its principles and practice might be used to restore a shattered psyche caused by a traumatic event (p. 103).

In practice, AA's 12-step model was no longer a strong influence on the centre's programme, though the inherent wisdom of using spirituality as a tool for recovery was acknowledged, even if the centre only minimally "officially" referred to it by name in documentation (also see Galanter, Dermatis, Post, & Sampson, 2013; Walker, Godlaski, & Staton-Tindall, 2013). However, 12-step elements such as "making amends," "surrendering," and being "powerless to your addiction" were frequently borrowed and successfully included in individual therapeutic approaches.[2]

In addition, one of the component areas in the eight-week programme was called "Spiritual and Cultural," and staff in the discussion group were particularly interested in how they might tackle this in a more proactive manner (Mental Health and Addictions Service, n.d.). The only aspects of the programme in which it seemed currently acceptable to deal with a client's spirituality were those that covered formal Christian values and Māori culture. As a recent Ministry of Health report remarked:

> *…non-dominant cultures frequently have broader definitions of ill health and well-being, which include such things as spiritual connectedness, access to a secure cultural identity…access to education, and whānau/family or family capacities as crucial measures of well-being.* (Todd, 2010, p. 23)

Noting that one's condition reflected one's culture, social relationships, and physical connectedness, Mason Durie (2007) observed that Māori manage to participate in the

culture of Aotearoa New Zealand while maintaining an ongoing engagement with Māori culture and society through wider whānau/family networks. As "the physical realm is immersed in the spiritual realm," so wairua/spirituality significantly influences people's relationships with the living and the dead, and in turn with their environment (Pere, 1997, p. 16).

The centre responded to the cultural beliefs and practices of Māori by explicitly incorporating bicultural approaches to practice, supported by partnerships with local and regional kaupapa Māori health services which ensured that clients had easy access to kaupapa services, kaumatua/elders, and cultural interventions identified in their RAP and clinical monthly review. Staff members were also expected to undertake regular cultural training. The centre's data suggested that this approach was effective for Māori, who were more likely to complete the programme than non-Māori.

Thus far, the programme seemed to be meeting the stringent clinical service and organisational requirements of its parent institution. However, concerned to explore and address the multiplicity of mental health disorders associated with substance use, the group was keen to develop a pragmatic and integrative service that could respond holistically to the full range of client experiences, which had to include the spiritual.

Talking about trauma and spirituality

The aim, assumptions, and process of the group

The aim of the group was to explore the ways in which spirituality was, and could be, incorporated in addictions work, the therapeutic relationship, and broader counselling practice. The group was asked to identify how spirituality influenced their work in the institution and to conceptualise how this approach to practice might be integrated into a working model.

Our discussions accommodated three important assumptions: one, that clients and counsellors bring a level of spirituality to their counselling work; two, that spirituality may be treated as a positive resource to support clients in managing the trauma of addiction; and three, that counsellors working in addiction recovery may in fact be working with both their clients' and their own spirituality (Bray, 2010; West, 2001). It was agreed that if counsellors were aware of their own spirituality, their capacity to work with the spirituality of clients would increase, which in turn must enhance their therapeutic encounters and support and nourish the clients. The group enthusiasm for examining spirituality in practice contradicted previous studies in which health professionals working in the same field, exploring the same ground, have been

"lukewarm" about incorporating spiritual interventions and regarded them as "pertaining more to the private than to the public dimension of their own approach to the treatment of addictions" (Zavan & Scuderi, 2013, p. 1159).

Although excited by the project, group members were initially anxious not to be identified for fear of being seen and judged as taking a point of view psychologically more aligned with some of their clients' positions than that of their institution's clinical expectations. Consequently, they agreed that they would observe boundaries of confidentiality around these discussions about their spirituality and its effects on their work in addictions and mental health, trauma, and recovery; their identities would not be revealed to others. Although they all agreed that spirituality worked in their counselling as a source of interventions, they recognised that it was still an uncomfortable fit with the medical model and not a demonstrable part of their practice with clients. This suggests that "medical materialism" (James, 1929), or psychology's inability to fully explain religious experiences, still has the capacity to influence therapeutic practice at a grass-roots level. Participants often hesitated to introduce spiritual ideas that might be seen as unconventional, and if they did, in the words of one member, they would have to "work covertly with one eye watching our backs." It was agreed that the group would provide an environment of trust and support that would enable them to focus on personal and clinical concerns related to working with spiritual material within the medical model of practice, and consider spirituality as a resource in their future work with clients.

The nine sessions proved to be a journey of self-discovery. Having faith in the process, members took spiritual inventories, sought intra-psychic connections, considered spirit-centred interventions, and generously shared spiritual experiences that enabled the members of the group to trust each other deeply. Examining the effects of their own spiritual experiences on their practice involved considerable self-reflection. Alongside moving personal disclosures were accounts of models or interventions that placed trauma and spirituality at their centre.

Spirituality and addictions work

It was generally agreed that "If we know what spirituality means to us, we might be able to assist clients in theirs." Group members were encouraged to share the richness of their positions on the subject, to enrich their mutual understanding and create a safe environment, and within the early sessions five significant practice issues or questions emerged that drove the meetings.

What is spirituality and where does it fit in counselling and addictions work?

The group began by examining "spirituality" and "religion" and suggested that these "common experiences" were often interpreted through the lenses of "belief" and "faith" as well as by their absence. Religion was very broadly associated with the group's Judaeo-Christian origins and identified as being an ideology, an organisation, or a community in which members shared similar beliefs, values, moral rules, and behaviours, whereas spirituality suggested a larger context, intuitively shared but experienced uniquely with someone or something that transcends the individual, the self, or the ego. Moving to the spiritual, it was suggested by one participant that to understand clients' responses to spirituality, consideration might be given to pivotal moments in life or those in which crisis occurs—"like birth and death and love…where change is negotiated and existential meaning is highlighted." These ideas seemed to correspond perfectly with Ronnie Janoff-Bulman's (1992) work on shattered assumptions in irrevocable experiences of trauma or crisis.

Cautious that the spiritual components of their work with clients in addictions and mental health might be judged by the parent institution as unorthodox, the group had, up until then, played down these aspects of practice. Consequently, participants were understandably hesitant about disclosing hitherto private aspects of themselves for scrutiny. For example, one counsellor disclosed that she was aware of a permanent, parallel, dream-like thread of consciousness that accompanied and informed her day-to-day living and her practice like a continuous sense of déjà vu which she was reluctant to reveal to her senior medical colleagues: "I am not mad but I have these experiences."

In discussion, a critical point was made that if counsellors' experiences are inexplicable and their beliefs remain unspoken, then what distinguishes us from clients? Another added:

> *How do we identify spirituality in the medical model? Name it as part of our practice…normalise it amongst our peers? We've talked about our own spirituality and the client's and how that comes together in a collaborative therapeutic partnership. Now we are talking about what we do in addictions and how spirituality fits into that…how our spiritual journey has led us to this moment and how we can become a vehicle for our clients' spiritualities and raise their awareness.*

It seemed important to understand each other's definitions of spirituality. Mediated as they were by group members' interactions with one another, they offered powerful insights into the potential of counselling processes and relationships, and our potential as human beings.

Sharing spirituality with colleagues and clients

It was acknowledged that our mental health sector in Aotearoa New Zealand has increasingly recognised the customary Māori worldview of wairua/spirituality as a tangible force that permeates life.

Group members noted their effective use of the Māori model of wellness, Te Whare Tapa Wha, which demonstrates the important contribution that wairua/spirituality makes in balancing social relationships, body, mind, and emotions (Durie, 1994). However, as counsellors aware of their roles as agents of change and who, with Melinda Webber (2008), "walk the space between", albeit in a different context, they questioned why spirituality was not more widely accepted as a fundamental pillar of the medical model in New Zealand.

The group also brought together their ideas, previously captured by the American Counseling Association's Summit on Spirituality, about spirituality being an actualising tendency that directs an individual "towards knowledge, love, meaning, hope, transcendence, connectedness, and compassion…creativity, growth, and the development of a values system" ("Summit results", 1995, p. 30). However, it was agreed that these spiritual aspects of ourselves were not often shared with colleagues or clients, and were even consciously withheld. Consequently, the opportunity to bring them, in the words of one member, "alongside aspects of ourselves as professional people" in conversation, "being as fully present as possible," was welcomed. Some members had felt stigmatised because of their belief systems, which could be regarded as unconventional or professionally incompatible, and as one said, "I'm mindful about which clients I talk to about it, which colleagues…I am very cautious" while respecting others' belief systems.

There is no doubt that clients want their counsellors to see them as whole people with resources that inform their well-being and provide healing (Kelly, 1994). Spirituality can be a core component of a client's life experience and a positive resource for coping—or one that has the capacity to contribute negatively to mental pathology (Nelson, 2009). In either case it is vital that counsellors and other mental health clinicians give their clients permission to talk about their spiritual lives (Bray, 2011; Kelly, 1994).

To be effective with clients, it was acknowledged by the group that counsellors should know themselves well, value their own spiritual journeys, and be prepared to recognise and critique the impact of their beliefs, values, and behaviours on clients in their processes toward recovery. In the words of one member, "we must be grounded

and balanced…we need to know who we are before we help others to address their spiritual natures."

Counsellor preparation and education

Here a significant point emerged concerning professional education. One member of the group stated that although she had been traumatically "dismembered" by counselling training and had "been in recovery ever since…[b]eing so fragmented comes with a price but allows us to also be more fully exposed and known." Another group member, discussing suicide and other traumatising aspects in her life, explained how she "knew" that she could not be a counsellor unless she undertook her own journey. She explained that "a number of things came up that I had just walked on from…I hadn't done my grieving"; there were things, she said, that had to be done if she was going to be of use to others. By its very nature, addictions work was regarded by the group as a sensitive balancing act that holds quite contradictory notions for both counsellors and clients, including concepts related to the underlying causes, triggers, and processes related to addiction and post-traumatic growth.

The group suggested that counsellors could also be in danger of "rationalising suffering and pain by positively projecting upon client experiences those spiritual explanations that satisfy us that our work is worthwhile or that there are benefits to be derived from suffering." Another responded that counsellors do not generally indulge in delusory "'benefit-finding' or look for 'silver linings' where there are none." Although counsellor observation and client experiences justify the argument for post-traumatic growth, it would be wrong to assume this in all cases, even when "clients choose to survive because they are not finished [with life]."

> *The paradox is that bad stuff is bad stuff and yet there is some good that comes out of it. I don't know if there is any alternative…we have all had these situations where we have burdened clients…and I've sat there and listened to their stories and thought, 'They're right, it's hopeless.' It's just the most horrible feeling…unless we hold that piece that there has to be something good, when actually in reality there is nothing, there is nothing that we can do…What we might identify as spiritual are the moments of awareness, even in the most difficult and hopeless situations, where the client may glimpse however briefly a moment of peace…There is something in our clients that desires it, is courageous enough to seek the right thing or something better. We admire our clients' ability in appalling adversity to reach out—to connect to something that supports them to perform the simple*

and the miraculous things for themselves. When clients find it hard to have a purpose in life, then as therapists we are stuck.

Admitting spirituality into practice

Freimuth (1996) found that counsellors and psychotherapists from diverse backgrounds held spiritual beliefs not wholly inconsistent with those of the 12-step model, and this was also reflected in the current discussion group. The members wanted to critique this area of their work and embed it in a broader experiential framework. As one commented: "You have got to walk the talk…it comes with a lot of responsibility. That's why it is a vocation…and even that sounds like a spiritual practice."

How much do we as counsellors admit spirituality into our work?

Discussing the qualities of spirituality that enabled them to help others, training, professional development, and the personal experience of recovery from addiction seemed to be important factors to consider. The group members were open to new ideas and had a depth of rich experience in the field. For one member, psychotherapeutic training felt like she had come home, and had answered and "deeply validated" the questions raised by her spiritual worldview "that nothing was impossible." In contrast, another experienced her training as "quite linear, clinical, and cold." Nevertheless, it was agreed that because clients do not have two-dimensional existences, the key point was how spiritual orientations could be aligned with the therapeutic relationship.

There was a good deal of discussion about how some members' unconventional beliefs concerning spirituality positioned them in the therapeutic relationship. It was suggested that, "If we regard spirit as something that originates in ourselves, we might take a different position to that of believing that spirit originates beyond ourselves."

One counsellor took the view that spirituality was a relational connection. She recounted her experience of being with a suicidal client who "had lost the ability to carry on," and identified her client's spirituality as a "thread that might help her to survive." In this case, the counsellor's role was to hold and nurture that fragile "piece…when they can't. Until they are ready to pick it up again."

Considering ourselves, then, "as either individual atoms with nowhere to go but inwards, or fragments of a larger pattern in creation," another clinician, discussing the therapeutic relationship, explained her ability to use psychological radars that "send out energy and receive an inner response." Another introduced the notion of determinism into counselling by suggesting that some counsellors and clients might believe that all encounters, including those in a past life, are part of a predesigned

package that implicates us all in each other's destinies. While this view found a degree of acceptance within the group, it was not without some qualification.

Discussing the spiritual experience of counselling and empathic awareness, one therapist described a synchronicity of connection with clients that transcended existence and was "wonderful." She explained attaining an altered energetic state of consciousness that puts "my whole self into the therapeutic alliance." Another suggested that there was a "dimension of relationship where intuition exists that can provide access to mutually satisfying ways forward."

It was agreed that spirituality permeates all practice, whether overtly introduced by the therapist or through the experiences of the client (West, 2001). One member observed, "Positioning with our clients' consciousness is about awareness and accommodation and expanding our consciousness." It was agreed that to regard spirituality as a private, "no-go" area within counselling ignores or diminishes the significance and power of clients' beliefs and spiritual practices and capacities. Nevertheless, even as private individuals, the group members admitted that they rarely accommodated others' worldviews: "I don't do this with my peers, my friends, and my family," acknowledged one participant.

Thus, a question arose as to a counsellor's control and responsibility in a therapeutic relationship: "How much can I allow myself to disclose to others and how much might this restrict or permit client disclosure and development in this area?" Mirroring our own group process somewhat, members described how they had reached different stages in their disclosure of spiritual beliefs and practices with clients. They also explored in depth the ways in which they managed the apparent imbalances between their personal values and those that they saw as existing between the medical model and their professional codes of ethical practice. One counsellor, for example, accepted that he must put his Christian belief structure aside while still maintaining a space for spirituality with clients. It was also suggested that if we within the group were experiencing reluctance or resistance about disclosure, then permission, confidence, and trust might well be factors for clients. One member suggested that before mutual sharing, there needs to be awareness and a space created where spiritual disclosure is allowed and honoured.

Competence

It has been fiercely argued elsewhere that spirituality is, at the core of counselling, "a profound partnership between scientific empiricism and spiritual ways of knowing" (Bray, 2011, p. 83; Thorne, 1997; West, 2004). In 1980, Carl Rogers, author of the

person-centred approach to counselling, confessed that he had "underestimated the importance of this mystical, spiritual dimension" (Rogers, 1995, p. 130). Thus, spiritually sensitive or spirit-centred approaches to counselling enhance the work that we already do (Morgen, Morgan, Cashwell, & Miller, 2010). Spirituality is at the centre of Rogers' conceptualisation of the empathic relationship and his core conditions permit the counsellor to respond to the client's deep need for universal attachment and tendency to actualise (Rogers, 1995, p. 134). Nevertheless, spirituality does not seem to be effectively addressed in most professional education programmes in counselling, psychotherapy, psychology, and related fields (Bray, 2011).

Counsellor competence with client spirituality

The group members' work primarily included daily client-centred individual and group processes blended with more directive clinical and psycho-educational programmes. These therapists believed they lacked any useful training in working with their current clients' wider concerns and were critical of training programmes that denied the spiritual dimension of existence and the need for relevant training. Their reliance instead on their own convictions to guide their work with clients reflected the circumstances of West's (2001) participants.

One member, describing the spiritual dimension of his work, found it very important to be active and intentional: "I feel genuinely more connected with the people around me. Working with my intuition and naming things was a hundred per cent accurate…like putting spiritual eyes on."

Members also discussed the limited attention that their conventional medical assessment documents paid to categorising their clients' spiritual and religious ways of being. It was suggested that terms like "faith" or having a "Higher Power" barely described how powerful this resource and experience was to their clients.

In the wider institutional context, when spirituality is not largely an empirically validated component of mental health, and recovery is usually measured by observable and quantifiable changes and outcomes, it was cynically suggested that "spirit-led" work may not fulfil institutional requirements that can often be "self-serving rather than client-serving." Although group members had offered medical colleagues the opportunity to observe and discuss their approaches, "time constraints" had made this infrequent. They felt professionally undervalued in a regime where it was best "not to make waves," to behave covertly, and "not to reveal too much imagination or creativity." Thus, it was hard for them to find supervisors and senior managers who

were sympathetic to spiritually centred or even inclusive approaches. In addition, they disclosed that they avoided recording interventions such as "utilising individuals' faiths to strengthen them in their healing" or respecting a "past-life experience" because they had been too readily misinterpreted. It turned out that their work, sometimes done quite independently, shared similar attitudes and approaches.

The group members experienced addiction psychiatry that originated in the Kraeplinian model of mental disorders as having little regard for spiritual experiences and, by implication, those who espouse them (Galanter, 2006). As one brave soul tentatively suggested, "Doctors are gods with a small 'g' and they don't like the competition." Consequently, they had not been able to "publicly" reveal their spiritual experiences because, taken out of context, "inexplicable experiences and psychic phenomena are often modified by [official] interpretations." An example given of a local psychologist's removal because of his unconventional beliefs about spiritual guardians was particularly telling, and emphasised the impediments to open communication. It was a relief to the members to be able to talk about spirituality more openly in the context of the group, removed from the medical model, enabling them to normalise their own and their clients' experiences.

It was apparent that individuals have deeply personal and therefore unique experiences of the spiritual realm that do not always correspond to a culture of origin or other social signifiers. They met their clients on "many different levels" but sometimes they felt unable to discuss with them and others the deeper and more holistic nature of their experiences. Yet it was clear that counsellors needed to be sensitive to the spiritual material that clients present, appreciate its positive contribution to healthy mental and social functioning, and recognise when it begins to activate and shape pathology rather than resolve it (Koenig, 2009). In order to work with clients' spiritual resources, they needed to have confidence in the counselling process and their colleagues; trust their own intuition, timing, and appropriateness; raise client awareness; and manage their own self-care. As for clients, they considered them to be survivors who were already on the road to recovery and making strong connections between their process toward wholeness, "a sense of something better," and spirituality. They recognised clients' resilience as well as their familiarity with spirituality:

> *They have more experience of distressing circumstances—developed spiritual muscles—and therefore have pushed to the line between the natural and the supernatural…they have gone to places that have prepared their psyches to connect with the numinous.*

The group members were unclear about how they might interpret, diagnose, judge, or attribute significance to clients' symptoms and behaviours as originating in spiritual sources. In the words of one member, "spirituality is separate from the job that we do—if you are unwell, spirituality doesn't come into it. It's separate from the Western perspective—the DSM-V."

In the medical model, they were taught to seek the problem in bio-organic origins or in an individual's responses to the impact of external events: "these are explainable and fit the medical analysis—this is the symptom, this is the diagnosis, and this is the drug." However, "spiritual emergency" was a good example of an experience that did not quite fit a "this-makes-sense" diagnosis (Lukoff, 1985).

Precipitated by moments of crisis, spiritual emergencies can be readily diagnosed as trauma or psychosis (Grof & Grof, 1989). In this case, an event overwhelms the ego and it loosens its control which, in turn, opens a doorway to perception. The individual sees the world in a different way: the assumptive world is changed; new material from the Other floods the sensibilities. Although this rarely impairs day-to-day functioning, it can be alarming and clients require understanding and education to make sense and positive use of these intra-psychic experiences.

As clinicians, the group members were awakening to the possibility that they might need to assess whether a crisis of experience was growth-inducing or dangerous. As one observed, "We are powerfully placed to broaden the scope of what is seen as either normal or safe for our clients." They were also very aware that "spiritual experiences can change their [clients'] label or diagnosis" and were concerned not to let that happen. Looking for a pathway that respected both the intangible nature of clients' experiential styles while also accommodating the expectations and constructions of the medically based institution was a genuine challenge. As one counsellor noted, "Either we are accused of being too cautious or unclear in our assessments or we only tick the boxes that enable us to be accountable."

"Tapping into" spirituality in counselling relationships was seen as allowing counsellors to be more present, enhancing mutual understanding, deepening trust, and therefore potentially strengthening and supporting clients' resolve toward recovery. It was also considered important to work holistically and to validate "spirituality experienced in the body," giving clients opportunities to explore the fullness of their spiritual natures through therapeutic conversations.

Engaging one's spiritual energy, or inner "radar" as one member called it, which does not "distinguish between the head and the body" resonated with our group's

understanding of counselling relationships and processes. Referring to the Jungian collective unconscious, one member remarked, "I see it as energy that permeates everything and everywhere and we can tap into that…and it taps into me," suggesting that individuals do not have to be religious in order to be spiritual, and vice versa (Rican & Janosova, 2009). Another described her ability to receive intuitive impressions about clients that may guide her work or be discarded: "I get things [pictures] in my head that don't belong to me."

One counsellor described this energy as an intuitive knowing that seems to emerge in sessions when "things are seamlessly unfolding—flowing, and there is little or no resistance." However, working from an intuitive place also necessitates a secure groundedness in ourselves, while clients' experiences of trauma and addiction may also affect their ability to be "grounded enough" to manage this exposure. The safety of the therapeutic container is crucial to the sharing of spiritual perspectives. One counsellor explained, "Getting in the flow of the spirit, rather than just being present in body and mind, can be focusing in terms of relationship and effective therapy, but it's also consuming." Another explained that he was conscious of the process but did not feel compelled to guide it to a predetermined end:

> *You're in this intuitive flow and it's kind of only being revealed one step at a time…so [you're] kind of on the edge, and it's like that sensation of being pushed from behind and you take the next step, and the next step…*

In therapeutic relationships, it was suggested that the depth and intensity of a client's spiritual energy and experience could resonate with or otherwise affect their therapist. For example, "in group I expand my awareness to get to how they [clients] are and not just what they are saying." Another member expressed awareness of the need for protection: "when clients bring 'a dark aura' or 'negative spiritual energy'…that is nothing to do with me, I need to protect myself from spiritual attack." There was some discussion about the need for a "blessing or cleansing" from "darker energy that can exist within the client" or elsewhere in the session, and whether "the client [is] a receptacle or a conduit for it." However, if she were to be shut off from this intuitive awareness, one counsellor believed that it would limit her effectiveness with her clients: "I couldn't do my work without it."

Trauma and change

The phenomenon of perceived psychological growth or expansion following highly stressful and traumatic life events is commonly discussed in philosophical, spiritual, and

religious traditions and teachings. It is also central to the notion of organismic "actualisation," "peak experience," and "spiritual emergency" in the work of humanistic and transpersonal psychologists and educators that include Carl Rogers (1961), Viktor Frankl (1963), Abraham Maslow (1971), Stan Grof (1985), and Christina Grof (1993). More recently, this realistic tendency toward growth in the wake of crisis is referred to in the positive psychological writings of Stephen Joseph (2012) and with Alex Linley (2004) as "adversarial growth," "stress-related growth," and "benefit finding," and in Richard Tedeschi and Lawrence Calhoun's inventory and model of "posttraumatic growth" (Tedeschi & Calhoun, 1996).

In the literature, the influence of traumatic life events and mental health CEPs, the misuse of drugs and alcohol and subsequent addiction, are substantially linked and currently intensely researched (Keyser-Marcus et al., 2014). Meanwhile, despite the constraints of the medical model in the context in which group members were working, the addictions literature suggests that spiritual approaches to treatment are substantially supported by staff working in the field, and that spirituality is a recurring theme in client change and recovery as well as both a protective and a risk factor (DiClemente, 2013; Forman, Bovasso, & Woody, 2001; Hansen, Ganley, & Carlucci, 2008).[3]

Does trauma hold the potential for growth-promoting change?

Putting these ideas together, the group discussed trauma as a trigger to addiction: "the damage is done…you have arrived at a place where you can't go back. You can no longer be who you were." Indeed, the group suggested that the dysfunction of addiction is also likely to be traumatic "when it creates something worse than the thing you are trying to avoid." The group conceived the recovery process as a need to make meaning, and saw this as the basis of their work in guiding clients in the journeys from the "false normal" of an addicted emotional self back into balance. As one therapist explained:

> *There is a point where you [clients] are forced into and must confront the next piece…when they have to come and seek out helping professionals and work through managing losses, sense of self, all of the fractured bits and pieces, and then making meaning without drugs, and recreating a life without that…*

The metaphor of a glass case expressed counsellors' perceptions of the painful struggles of clients to reach their potential: "I can see what I want but I can't touch it…I can understand the expectations but I also understand how hard it is to break through the glass." Because they cared about their clients, it was hard on the counsellors to watch

them return to their pre-trauma environment. It was important for them to acknowledge the steps forward that clients achieved and to resist becoming too invested in their success or overwhelming them with too many expectations, to have faith in the therapeutic process and to believe in clients' capacity to achieve recovery. "We hold that potential for them that they may never see…and that's our job…if we didn't have that [passion], what would our work be like?"

Discussing clients' struggles in undertaking rehabilitation and their self-sabotaging with unreal expectations, one therapist observed that the cumulative effect of repeated "failures and relapses that affect the psyche" could often be just as traumatising as the impact of major crisis events. Acknowledging negative long-term effects, another saw a return to drug use as a self-soothing and "escapist" attempt to move out of the pain and get closer to healing and spirituality. Referring to substance use in traditional cultures, group members described a return to a community that shares similar values and where using drugs was a ritualised and temporarily spiritual activity. One commented, "The doors to perception are opened" but clients, especially those with coexisting conditions, are poorly equipped psychologically to manage "something that might cause more trauma…if it is a psychic opening it can be overwhelming and disturbing."

At this point, the group made a distinction between those who were addicted and those who purposefully used addictive substances in a controlled way without becoming addicted. They discussed this animatedly, suggesting that "no one knows where the line is between control and addiction," and questioning how "controlled" the use of alcohol and substances can be when enjoyed as a reaction to an emotional stimulus or used to manage a crisis event without formal support. Similarly, they agreed that "you may control what you take but you can't always control its effect," and suggested that it is more likely to be a "stuck place where it becomes addiction, and spirituality is numbed-out or disconnected rather than a place of continual enlightenment." The overwhelming experience of the group seemed to be expressed in the following statement:

> *The drugs, whilst opening the Pandora's box of experience, also lower your resistance and ability to achieve actualisation…on the one hand you take something which enables you to enhance or to actualise and on the other hand you've crippled yourself by the very act of doing that because you are not ready to do that. You are not psychologically prepared.*

The management of the complexity of clients' processes was also identified as a problem when the therapists lacked understanding and training. Nevertheless, it was generally recognised that the metaphor of a client's spiritual journey—although not always uppermost in their minds—was useful and unconsciously informed their work: "I see them [clients] as having been off their pathway through drug use and alcohol abuse…I work quite hard to reconnect them to where they need to be right now to do what they need to do."

Trauma and spirituality

One of the group's initial aims was to consider a common-sense model of inclusive practice that corresponded to their experiences of spirituality in their work with trauma and addiction recovery. Based on a synthesis of post-traumatic growth and psycho-spiritual transformation (Bray, 2010), this model suggests a notional pathway to recovery that plots the client's journey pre-trauma and continues into developing post-addiction opportunities.

Conceptualising spirituality in addiction counselling practice

The group began by regarding recovery as a survival process that equipped the individual to overcome behaviours—addictions in this case—which originated in trauma. Later, they incorporated self-actualisation in the survival process and suggested that it was fuelled by spirit and facilitated in a spiritual dimension. Their ideas suggested that trauma significantly disrupts or wounds the human organism's natural tendency to actualise and creates less effective pathways to achieving or to recovering the capacity to reach higher states of consciousness. Thus the group conceived of addiction as the false or unwelcome outcome of a struggle for meaning in a disrupted journey, and the process of recovery as being a client's spiritual quest to reconnect with his or her lost potential. It was also agreed that even though the identification of spiritual resourcing may be difficult, it seems to have a place in the process of recovery likened to a "shamanic" journey beyond trauma.

> *You have come through the pain. You have come through the experience and you have come back with the word and the knowledge and you know that there is a door—you know that there is a way out. You know the route.*

The clinician's role as a guide is to assist the client in this integrative process of re-attachment and re-alignment "so that the journey can continue." This rupture is used

as a "space where informed choices are being made and actions are tentatively taken, disruptions are being challenged, and meaning and learning is happening." The group agreed that for some, this space was more complicated than for others. It was also acknowledged that "the spiritual part of them [clients] is quite depleted when they come here." One member sympathetically added that:

> *I experience the clients here as the more sensitive souls in the world. The substance has been a way to armour-up. We don't have to go too far to find that…life is awful and the world is not a nice place…they absorbed all of the negative stuff in the family whilst others have managed to get above that somehow or do something different, but that person holds a lot of the family issues and uses alcohol, drugs or behaviour to manage and escape from that.*

The group noted that in recovery, when clients eventually become unstuck and the outcomes are encouraging, it is easier for them to regard their experiences as necessary and valuable. "Clients are grateful for their addiction journeys because they can't hide from the insights they provide about themselves, who they once were, and how to relate again to the world."

The group found that their clients' responses to therapy did not always fit their counselling expectations, especially among borderline patients whose "needs may be articulated through difficult behaviours rather than in self-consciously transparent language." In many cases, counsellors found that "making adjustments, synchronised or attuned with the spiritual character of clients, and accepting their views and aspirations" made it easier not to judge them by their addictions. Another added that since all human beings face major or minor disruptions throughout their development, addiction as a specific response to difficult life events could be seen as one of many normal responses: "Some of us work through our trauma without addiction and some of us have got addiction as a way of coping."

It was suggested that for some clients, exposure to trauma had been so encompassing that they were unaware of it and it was not until the counsellor revealed what was already there, and that the world could have been different, that the client became deeply affected. Quite possibly this reaction was associated with grieving for the related losses in their lives. It was suggested that addiction can be both a response to and a cause of trauma:

> *Our work here is to look for what created the addiction, why that person needs to use substances…when they come here they are already defined as being a dependent*

substance user. Some accept the diagnosis and some don't but the real struggle is to accept that they will need to be abstinent for the rest of their lives…that they can never use substances again as a coping mechanism is the real trauma.

Conclusion

These counsellors hold a tense space between the institutions of our society and their clinical obligations to honour and work with their clients' experiences. They recognise that the "addict" is not the totality of the client, or merely a broken part searching to fulfil its seemingly insatiable appetites. They understand that there is something greater going on. Human beings have the need to be whole, to be all that they can be, and this is only finally resolved in nurturing relationships with others in their communities and through life-affirming and meaningful activities. Unfortunately, many recovering addicts return to the places where their traumas began and where their greatest challenge is to continue with their abusers and those they have abused who may need as much help as they do.

Nevertheless, in spite of the deficits of our society, counsellors and their clients continue to do their work to reintegrate the needy and vulnerable parts of clients with the whole. Together they engage in meaningful relational processes that draw upon profound personal resources to facilitate recovery and transformation.

"That is spiritual…that's a bloody miracle!"

Notes

1. Clients are followed up in three- and six-month intervals after discharge to see if they are experiencing functional improvements in relationships, employment, and a reduction in criminal activities. Client progress is monitored by using the Alcohol and Drug Outcome Measure—Version 2 (ADOM). ADOM was developed for use in community-based outpatient addiction services, including community-based "after care" programmes, where outcomes (change) can be measured over a period of time. This tool collects data on alcohol and other drug use, lifestyle and well-being, and recovery..
2. The American Psychiatric Association summarises the steps as a six-phase process:
    1. Admitting that one cannot control one's addiction or compulsion;
    2. Recognising a higher power that can give strength;
    3. Examining past errors with the help of a sponsor (experienced member);
    4. Making amends for these errors;
    5. Learning to live a new life with a new code of behaviour;

6. Helping others who suffer from the same addictions or compulsions.

3. In "Spirituality, intoxication and addiction: Six forms of relationship" (pp. 1109–1113), Robin Room (2013) discusses intoxication as a means of communication with a spiritual world.

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